

**Do Mental Health Professionals in the UK ask about
Experiences of Adversity and Respond Appropriately?**

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ABSTRACT

This study ascertained the extent to which mental health professionals working in adult community mental health services directly ask clients about adverse experiences, how often they are aware of those experiences, and how well they respond when such experiences do become known. The clinical records of 400 adult clients using four London community mental health teams were reviewed, using similar methodology to previous studies so as to enable comparisons. The results suggest that routine enquiry about adverse experiences is not taking place, despite this being NHS policy. Identification of adversities was poor. Only 13% of clinical records contained documentation of one or more forms of adverse experience. Only 1% showed clear evidence that service users had been asked about adversities by a clinician. This study included adverse experiences not previously studied, and documentation rates of these within clinical records was also low. The clinical records of female clients contained a higher total number of adverse experiences than males. People with a diagnosis indicative of psychosis were significantly less likely to have adverse experiences documented in their file. There was significant variation in documentation of adversities between the four services. Overall rates of response to known adversities were high, with 90.4% of clinical records containing documentation that the service user was offered some type of relevant support following disclosure of an adverse experience. There were no significant differences in the number of appropriate responses provided by mental health professionals in relation to age, diagnosis, community mental health team location or gender. Theoretical and conceptual knowledge relating to why some mental health professionals do not routinely ask about adverse experiences is discussed. Recommendations are proposed regarding the need for policies, staff training and guidelines to improve routine enquiry and responses to disclosures of adversity. Future research endeavours are recommended, linked to some of the methodological limitations of this study. Implications for both mental health services and broader societal factors are discussed.

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1. INTRODUCTION

1.1. Overview

This study explores some of the key issues related to adverse life experiences and circumstances of users of adult community mental health services in the UK. It focuses on whether mental health professionals routinely ask service users about adverse experiences and how professionals respond when such experiences become known. It aims to establish a theoretical framework for understanding barriers to routine enquiry about adversity. Within this introductory section I will describe different definitions of adversity and their prevalence. I will then explore the nature of these experiences and their long term impact on people's lives. I will discuss prominent theoretical attempts to understand the relationship between adverse experiences in childhood and negative outcomes across the lifespan. Consideration will be given to national and international policy and service user perspectives on whether mental health services should routinely enquire about experiences of adversity. Two literature reviews will be presented to provide a summary of studies investigating enquiry about adverse experiences and how disclosures are responded to. Barriers to asking about adversity will be outlined, followed by a discussion about conceptual and theoretical attempts to understand these barriers further. A summary will be provided before stating the rationale, research questions, and hypotheses for the current study.

1.2. Definitions and Terminology

Terms like 'mental illness' or 'mental health' carry many implicit assumptions, often influenced by context and dominant discourses, about the behaviours and experiences they refer to (Pilgrim & Tomasini, 2012). Whilst these terms can be seen as problematic, they are frequently used in the research literature drawn upon for this thesis and will therefore be used throughout. The terms 'client' and 'service user' are also used, but it is acknowledged that these could imply voluntary use of services, which is not always the case (Johnstone & Boyle, 2018).

Both 'adversity' and 'adverse experiences' will be used as overarching terms throughout in recognition that negative experiences in people's lives are frequently continuous or repeated rather than discrete 'one off' events. These terms are therefore occasionally used to encompass experiences such as abuse, neglect and violence. I recognise that these experiences are qualitatively different and that there is no 'right answer' as to what constitutes an adverse experience. This chapter will however attempt to give an overview of the most prevalent conceptualisations; from both consensus definitions and the research literature.

1.3. The Relationship between Adverse Experiences and Poor Long-Term Outcomes for Mental Health

The circumstances of people's lives are thought to play a major role in the development and maintenance of psychological, emotional and behavioural problems across the lifespan (Johnstone et al., 2018). Within both clinical and research settings it is recognised that there exists a relationship between adverse experiences and poor long-term outcomes, especially for mental health. This is highlighted by the high prevalence rates of adverse experience, including abuse and violence, in both the childhoods and adult lives of mental health service users. This section will explore this relationship, beginning by describing various definitions of adverse experiences and their prevalence.

1.3.1. Definitions and Prevalence of Childhood Adversity

There have been many attempts to describe and categorise events and experiences we might refer to as childhood adversities. Authors of the Power Threat Meaning (PTM) Framework, for example, describe adverse experiences in childhood which have received the most attention from mental health professionals and researchers. These include: neglect, sexual, physical and emotional abuse, poverty, witnessing violence in the home, bullying, experiencing significant losses such as loss of a parent and 'everyday adversities' which arise from normal cultural practices (Johnstone et al., 2018). The World Health Organisation (WHO) offers a consensus-based definition of

childhood adversities as “interpersonal loss (e.g. parental death, divorce), parental maladjustment (mental illness, substance misuse, violence), maltreatment (e.g. physical, sexual, neglect) and other adversities (life threatening physical illness, economic adversity) which occur before the age of 18” (Kessler et al., 2010, p. 379).

Research-based definitions describe child abuse and neglect as any act or series of acts of commission or omission by a parent or other caregiver (e.g. clergy, coach, teacher) that results in harm, potential for harm or threat of harm to a child (Leeb, Paulozz, Melanson, Simon & Arias, 2008). Acts of commission are described as deliberate and intentional, and include: physical abuse, sexual abuse and psychological abuse. Acts of omission refer to a failure to provide needs or protect from harm or potential harm, including physical neglect, emotional neglect, inadequate supervision and exposure to violent environments.

Large-scale general population surveys such as the Adverse Childhood Experiences (ACEs) project in the United States of America conceptualise adverse experiences as stressful events which occur in childhood (Felitti et al., 1998). Cronholm and colleagues (2015) broadened the concept to include adversities experienced at the community level, referred to as ‘expanded ACEs’ alongside ‘conventional ACEs’ already used to measure adversity. These include:

Conventional ACEs

- physical abuse
- a household member using substances
- emotional abuse
- a household member experiencing mental health difficulties
- witnessing domestic violence
- sexual abuse
- a household member being in prison
- emotional and physical neglect.

Expanded ACEs

- witnessing violence
- living in foster care
- living in an unsafe neighbourhood
- experiencing discrimination
- experiencing bullying.

With regards to prevalence, WHO conducted a survey in 21 countries and reported that between 38.4% and 39.1% of respondents had experienced some form of childhood adversity (Kessler et al., 2010). Prevalence was consistent across high and low income countries and the most frequently reported adversities were parental death, physical abuse, family violence and parental mental health difficulties. A U.S.A. population study found that over 50% of respondents had experienced at least one form of childhood adversity (Felitti et al., 1998). Of these, 23.5% reported living with someone with substance misuse difficulties, 19.3% reported an unwanted sexual experience, 10% reported experiencing psychological abuse and 9.6% physical abuse.

The literature inevitably deploys varying definitions and types of adversity as well as varying types and specificity of outcomes (Read & Mayne, 2017). Despite this, it is clear that many people experience significant adversities early in life and that these experiences frequently contribute to a range of negative outcomes across the lifespan, which this chapter will go on to discuss.

1.3.2. The Nature and Impact of Adverse Experiences in Childhood

There is a robust and consistent body of evidence, across cultures, which strongly links adverse experiences in childhood to a range of negative outcomes (Friedli, 2009; WHO, 2000, 2013). Many large-scale, patient and population-based studies have linked adverse childhood experiences to an array of functional psychiatric diagnostic categories (Johnstone et al., 2018), including: 'anxiety and mood disorders', 'eating disorders', 'personality disorders', 'conduct disorders' and 'psychosis' (Bebbington et al., 2011; Bellis et al., 2014; Couper & Mackie, 2016; Cutajar et al., 2010; Green et al., 2010;

McLaughlin et al., 2010; Phillips, Hammen, Brennan, Najman & Bor, 2005; Public Health Wales NHS Trust, 2016; Varese et al., 2012). Adverse outcomes are not restricted to psychological distress, but also include: low educational achievement, relationship difficulties, severe physical health problems such as cancer and ischemic heart disease, sexual and reproductive health issues and premature death (Anda, Butchart, Felitti & Brown, 2010; Felitti et al., 1998).

Individuals who suffer adversity in childhood are more likely to: be admitted to a psychiatric hospital; have earlier, longer and more frequent admissions; self-harm and have higher global symptom severity (Hepworth & McGowan, 2012; Lipschitz et al., 1996; Mullen, Martin, Anderson, Romans & Herbison, 1993; Read, 1998). They are also more likely to be prescribed psychotropic medications as adults; ten times more so for antipsychotics and 17 times more likely for antidepressants (Anda et al., 2007). Childhood sexual abuse (CSA) in particular has been reported to be a stronger predictor of suicidality than a current diagnosis of depression (Read, Agar, Barker-Collo, Davies & Moskowitz, 2001).

The impact of adverse experiences in childhood is particularly evident in the research of mental health service user populations. In general, there is a higher prevalence of abuse histories in users of mental health services than is found in the general population (Herman, 1992; Jacobson & Richardson, 1987). A review of 46 studies of female service users, both in community and outpatient settings, most of whom were experiencing psychosis, revealed that 48% reported having been subjected to sexual abuse as a child and 48% to physical abuse. A majority of 69% of these women had been subjected to one or both of these types of abuse as a child. After reviewing 31 studies, researchers reported that the corresponding figures for men were: CSA, 28%; CPA, 50%; either one or the other (or both), 59% (Read, van Os, Morrison & Ross, 2005). A later review of 52 studies conducted within inpatient mental health settings found that over 50% of the men and over 60% of the women had experienced either CSA or CPA (Read, Fink, Rudegeair, Felitti & Whitfield, 2008). Rates of childhood neglect for adult inpatients range from 22% to 62% (Read, Goodman, Morrison, Ross, & Aderhold, 2004). A 2004 study of adults experiencing first episode psychosis within an inpatient setting, of whom the sample was mostly

male, reported that 39% had experienced CSA and 78% CPA. They also found that 94% had experienced emotional abuse, 89% emotional neglect and 89% physical neglect (Compton, Furman & Kaslow, 2004).

In community studies, women who survived emotional abuse as a child were five times more likely to have had a psychiatric admission (Mullen et al., 1996). In a study of adult community service users with a diagnosis of schizophrenia, 35% had suffered emotional abuse as a child, 42% physical neglect and 73% emotional neglect (Holowka, King, Saheb, Pukall & Brunet, 2003). A British study of 390 people experiencing a first episode of psychosis reported that separation from, and death of a parent before the age of 16 were both strongly associated with a two-to-threefold increased risk of psychosis. These individuals were 12.3 times more likely than a control group to have had their mother die. These findings remained after controlling for other variables such as parental history of mental health difficulties (Morgan et al., 2007).

A growing body of research is concerned with how different features of psychosis appear to be associated with distinct adverse experiences in childhood. A consistent finding from this research base is of a specific association between a history of CSA and hallucinatory experiences as an adult (Bentall & Varese, 2012; Hammersley et al., 2003; Read et al., 2003). In contrast, growing up in institutional care was found to be specifically associated with paranoia and persecutory beliefs (Bentall et al., 2012).

Not only do childhood adversities play a causal role in most mental health problems, but there is a suggested dose-dependent relationship between the range, severity and frequency of adverse experiences and the subsequent impact on mental health (Bentall et al., 2014; Dillon et al., 2012; Read Harper, Tucker and Kennedy, 2017). If a person experiences one type of abuse or adversity they are 87% more likely to experience other types of abuse and adversity; the more types of abuse and adversity a person experiences, the higher the risk of harmful health and social outcomes later in life (Anda et al., 2010; Felitti et al., 1998). For instance, survivors of adverse experiences in childhood are suggested to be at increased risk of revictimisation in adulthood (Del Gaizio, Ekhai & Weaver, 2011). Both men and women experiencing

psychological difficulties who are in contact with mental health services are two to eight times more likely to experience domestic violence or sexual assault (Khalifeh et al, 2015). Difficulties can be further maintained as being subjected to violence in adulthood increases the risk of mental health problems (Boyda, McFeeters & Shevlin, 2015; Read, Fink, Rudegear, Felitti & Whitfield, 2008).

The impact of experiencing adversity in childhood, therefore, seems not only to be cumulative but synergistic, in that experiencing an adversity increases the likelihood of experiencing subsequent adversities (Bebbington et al., 2011). Authors have emphasised the importance of acknowledging it is not simply that harmful social contexts are often made up of multiple adversities, but once someone has experienced serious adversity, such as CSA or early loss of a parent, they are likely to face more adversity later in life and to have fewer resources for coping (Aglan, Kerfoot & Pickles, 2008; Korkeila et al., 2010).

1.3.3. Theoretical Attempts to Understand the Relationship between Childhood Adversity and Negative Outcomes

All types of adverse event and circumstance appear to raise the risk for all types of mental health presentations (Johnstone et al., 2018). It is beyond the scope of this thesis to explore theoretical attempts to make sense of this relationship in detail, but the most prominent of these will now be outlined. These encompass: cognitive models, biopsychosocial models, attachment styles and biological mechanisms.

1.3.3.1 Cognitive models

Cognitive models propose that early adversities contribute to cognitive vulnerabilities which are characterised by negative schemas about the self, others and the world. Fowler and colleagues (2006) describe how core beliefs can develop, such as 'I am vulnerable', 'other people cannot be trusted' and 'the world is not safe'. Ongoing experiences of adversity throughout the lifespan are suggested to promote the development of further negative schemas (Birchwood et al., 2004). Bentall and colleagues (1994, 2001, 2009) posit that paranoid beliefs arise as a consequence of severe problems of self-esteem and an

external locus of control, where causes of misfortunes are attributed to malevolent others as a means of coping. Other thought processes and cognitive styles frequently encountered in psychosis include making external, personal attributions for negative events, jumping to conclusions on the basis of limited data and misinterpreting internal thoughts or memories as external events, known as 'source monitoring' (Read & Gumley, 2008). These cognitive biases are especially likely to develop in the context of adverse experiences, including attachment insecurity, victimisation and powerlessness (Read et al., 2009).

1.3.3.2 *Biopsychosocial models*

The stress-vulnerability model (Zubin & Spring, 1977) proposes that cognitive, biological, psychological and social factors interact to create strengths and vulnerabilities for dealing with stress. Psychological distress is understood within the context of an individual being predisposed, due to a biopsychosocial vulnerability, going on to experience further adverse life events resulting in emotional and psychological changes. This model is acknowledged to have become the "bio-bio-bio model" (Read et al., 2009) largely due to adverse events being relegated to that of merely triggering a supposed underlying, genetically based hypersensitivity (Bentall, 2003). However, Read and colleagues (2008) advocate a return to this model, but with an emphasis on the fact that heightened vulnerability to stress is not necessarily genetically inherited, but can be acquired via adverse life events. Their arguments are outlined succinctly in their Traumagenic Neurodevelopmental (TN) Model of distress (Read, Fosse, Moskowitz & Perry, 2014; Read, Perry, Moskowitz & Connolly, 2001).

The TN model proposes that the interactive dynamics of epigenetic processes can account for how early adversities frequently give rise to mental health difficulties. The model suggests that early adverse experiences such as neglect, stress and trauma within the caregiving environment can directly affect brain development. It is theorised that repeated exposure to stress, and the consequent release of cortisol, damages neurons and connections within the developing brain. This results in over activity of the hypothalamus-pituitary-adrenal (HPA) axis, which is the main stress system of the brain, in addition to

hippocampal damage, cerebral atrophy, abnormalities in neurotransmitter systems and reversed cerebral asymmetry (Read et al., 2001). The model describes how epigenetic processes turn gene transcription on and off during brain maturation through mechanisms that are highly influenced by the individual's socio-environmental experiences such as childhood adversity (Read, Fosse, Moskowitz & Perry, 2014). In this context, the marked changes in structure and function within the HPA axis as well as other forebrain regulation regions frequently observed in adults experiencing psychosis can be understood as a result of neurodevelopmental changes following early exposure to adversity, rather than an underlying genetic pathology (Read et al., 2009).

1.3.3.3 *Attachment theory*

Attachment theory is concerned with the emotional bonds infants form with their primary caregivers in order to establish feelings of security and safety. Research demonstrates that infants develop organised patterns of attachment behaviour by 12 months of age. These patterns are consistent with the response the infant receives to their requests for comfort, soothing and protection (Ainsworth, Blehar, Waters & Wall, 1978). The main patterns of attachment have been conceptualised as: secure, avoidant and resistant/ambivalent. A minority of infants fail to develop a recognisable, organised attachment pattern and their way of relating to the caregiver is described as disorganised (Main, 1991).

Attachment styles are thought to influence the development of internal working models, which act as archetypes throughout the lifespan, helping individuals to anticipate and interpret the behaviour of others (Bowlby, 1973). These internal working models inform how an individual views the self, others and the world (Schoore, 2000). Insecure attachment styles have been linked with various presentations, including low mood, worry, disordered eating and relational difficulties (Beck, 2011; Levy, Johnson, Clouthier, Scala & Temes, 2015; Wells, 1997). However, patterns of insecure attachment should not be viewed as always pathological or as inevitably leading to pathology (Sitko, Bentall, Shevlin, O'Sullivan & Sellwood, 2014).

It is likely that adverse experiences early in life contribute to disruptions of early attachment relationships (Sitko et al., 2014). Researchers point to evidence from studies which show that individuals experiencing psychosis report an increased rate of early parental loss due to permanent separation or death (Agid et al., 1999; Morgan et al., 2007). Bentall and Fernyhough (2008) suggest that insecure attachment, which can result in difficulties trusting others, is a factor that can produce a paranoid attributional style, and that paranoia is especially likely to develop as a consequence of early insecure attachment relationships.

Sitko and colleagues (2014) propose that insecure attachment can be understood as part of an explanatory mechanism by which the nature of the relationship between certain adverse experiences and specific mental health experiences can be understood. However, they highlight that it cannot be definitively ascertained whether insecure attachment was present prior to experiencing an adverse event or developed afterwards. As Liotti and Gumley (2008) suggest, it could be that insecure attachment sets the stage for a psychogenic response to adverse experiences, but it could also be that adverse experiences distort attachment relationships (Waters, Merrick, Treboux, Crowell & Albersheim, 2000).

1.3.3.4 Traditional Bio-genetic Models

A relationship between adverse experiences and poor mental health outcomes is largely ignored within the dominant bio-genetic model of psychological distress, which instead draws on bio-genetic explanations such as 'genetics', 'brain disease' or 'chemical imbalance'. This model pays little heed to the role of psychosocial factors or adverse experiences (Bentall, 2003). The impact of this is highlighted by research concerned with causal beliefs, particularly relating to the diagnosis of schizophrenia. A study reported that from a random sample of 154 British psychiatrists, 86% cited 'biomedical abnormalities' and 87% 'family history/genetics'; with only 22% citing 'childhood factors' as relevant (Baillie, McCabe & Priebe, 2009). A larger survey of nearly 3,000 British psychiatrists reported that 0.4% thought the causes of schizophrenia are

'primarily social' whilst 46.1% thought they are 'primarily biological' (Kingdon, Sharma & Hart, 2004).

The most frequently cited support for the bio-genetic model comes from genetic research using family, twin, and adoption studies. However, forty years of research endeavour to identify a 'schizophrenia gene,' has failed to bear fruit (Gilmore, 2010; Joseph & Ratner, 2013; Turkheimer, 2011). The available evidence provides little, if any, support for a genetic basis for schizophrenia, and the research has a number of methodological problems. Family studies in isolation cannot disentangle potential genetic and environmental factors (Plomin, DeFries, McClearn & McGuffin, 2008). The methodology of twin studies is also problematic due to: the lack of an adequate and consistent definition of schizophrenia, the questionable reliability and validity of this diagnostic construct, the use of non-representative samples and investigator bias in favour of genetic conclusions (Joseph, 2013).

Research has demonstrated that bio-genetic explanations of distress do not tend to be held by the general public, who place more emphasis on adverse life events playing a causal role in mental health difficulties than biology or genetics. In 2006, a review of the literature concluded that for diagnoses of both depression and schizophrenia, the general public view acute stress in the form of life events and chronic stress within relationships as the most frequent cause (Angermeyer & Dietrich, 2006). This is supported by research which reports that adversities such as experiences of marginalisation, poverty, racism and violence are correlated with poor mental health (Paradies, 2006). This has led to calls for the acknowledgement of psychological and social factors in the development of mental distress and for this to be reflected in guidance and policy (Read et al., 2009; Read, Sampson & Critchley, 2016).

1.3.3.5 *Attempts to Synthesise Theoretical Models*

Researchers accepting of the causal relationship between adverse experiences and mental distress, have begun to investigate the processes by which, for instance, being regularly beaten or humiliated in childhood leads to, for instance, paranoia or hearing derogatory voices later in life (Read & Dillon, 2013). Many of the theoretical perspectives concerning the relationship between adversity and negative outcomes across the lifespan originate from opposing epistemological and ontological positions. As a result, they can appear distinct and difficult to reconcile. However, all of these different approaches describe the effects of the adverse events as ways of responding to, or coping with, those experiences.

It is unlikely that any of the mechanisms or models can, in isolation, account for and fully explain the link between adverse experiences and psychological distress. It is more likely that they interact with one another and are describing similar processes though different frames of reference. For example, a service users' experience of an intrusive abuse memory as occurring outside oneself might be viewed through the lens of a cognitive researcher in terms of problematic source monitoring, but a psychoanalyst might view this as projection (Read & Dillon, 2013). However, some perspectives can be more closely aligned and are able to be synthesised. For example, internal working models from attachment theory are similarly conceptualised to cognitive schemas.

The internal working model is a fundamental concept within attachment theory. It is described as a mental representation that develops as a result of the experience of care provided by attachment figures. It is used as an explanation as to why early parent-child interactions influence functioning later in life (Bowlby, 1969). However, some suggest that this concept could also be conceptualised as a cognitive schemas (Bretherton, 1990; Waters & Waters, 2006).

Cognitive schemas are described as mental structures for screening, coding, recalling, and organising cognitions, which are also thought to be formed early in life based on relational experiences (Bosmans, Braet, Van Leeuwen, & Beyers, 2006). The content of cognitive schemas is thought to originate from specific early caregiver-child experiences. Therefore, it has been suggested that cognitive schemas hold the very beliefs that internal working models consist of (Chorpita & Barlow, 1996; Holmes, 1993; Mason, Platts, & Tyson, 2005). To this extent, these perspectives not only hold similarities, but are potentially synergistic in their ability to explain the relationship between early adverse life experiences and later-life distress.

1.4. Guidance and Policy

There have been repeated recommendations from researchers that mental health staff should routinely enquire about adversity and be trained in how to ask and how to respond appropriately to disclosures (Agar, Read & Bush, 2002; Read et al., 2016; Sampson & Read, 2017). The response from mental health services has, however, been variable. This can be viewed in part as due to a lack of strategic response from the National Health Service (NHS) to evidence of the large numbers of survivors of adversity either already accessing mental health services or struggling outside of the system (Scott et al., 2015).

With the development of the Women's Mental Health Strategy (2002) came recognition of the long-term consequences of adverse experiences; particularly violence and abuse. The strategy asserted that addressing such consequences should be the core business of mental health services. A national pilot and roll-out was based on the following theory of change:

“If service users are routinely asked about their experiences of violence and abuse as part of mental health assessments by suitably trained staff they will often disclose and the support and treatment they receive is likely to be more helpful than hitherto. At the same time, increased disclosure will encourage better commissioning and development of more specialist services.”

(Scott et al., 2014, p. 10)

The 2006 pilot involved 15 NHS Trusts, and an evaluation confirmed that routine enquiry could be effectively introduced and should be properly embedded within services (Scott & McNeish, 2008). The Department of Health released further guidance stating that all adult mental health services should acknowledge and address the links between the experience of adversity, including abuse and violence, and mental health (Department of Health, 2008). It stated that a question about experiences of violence and abuse should be included in all adult mental health assessments. In addition, it made clear that staff are obliged, once satisfactorily trained, to ask about such experiences routinely and consistently at assessment and provide appropriate care and support subsequent to disclosures.

Eight years after this guidance was issued, researchers asked 53 NHS Mental Health Trusts, via the Freedom of Information (FOI) Act, whether they audited routine enquiry (Brooker, Tocque, Brown & Kennedy, 2016a; Brooker et al., 2016b). Of the 36 who responded, only five confirmed that they did. The researchers also reported that 57% of mental health providers fail to give the Health and Social Care Information Centre (HSCIC) any data about whether mental health service users are asked about adverse experiences including violence and abuse. This is despite further national and international guidance which specifically recommends the implementation of routine enquiry within mental health services (DoH, 2015).

1.5. Survivor and Service User Perspectives

Survivors of adverse experiences consistently say that disclosure has to happen at 'the right time for them', which could be immediately or many years after the event (McNaughton Nicholls, 2012). Most survivors of adverse experiences welcome routine enquiry by mental health professionals, albeit sensitively and properly (Scott, Williams, & McNaughton Nicholls et al., 2015). Research has shown that this is true for individuals who have experienced CSA, individuals who have experienced or continue to experience domestic violence and adults accessing community mental health services (Feder, Hutson,

Ramsay & Taket, 2006; Nelson, 2001; Trevillion, Howard, Morgan, Feder, Woodall & Rose, 2012; Zeitler et al., 2006). Despite this, a survey of nearly 400 adult survivors of child sexual abuse highlighted that the onus frequently falls on service users to speak out about adverse experiences rather than this responsibility being placed on the clinician (Smith, Dogaru & Ellis, 2015).

The Responding Effectively to Violence and Abuse (REVA) project conducted qualitative interviews with 21 survivors of violence and abuse who had accessed a range of adult mental health services within four primary care trusts (Scott et al., 2015). Survivors welcomed being asked about adverse experiences. They reported that not being asked left them feeling as though their experiences were not considered relevant to their mental health and that nobody wanted to hear about these experiences. They suggested the following recommendations for mental health clinicians:

1. Ask as early as possible
2. Ask with interest and concern (rather than as a 'tick box' requirement)
3. Ask more than once (as people may not feel able to respond at first)
4. Ask of everyone, and
5. Responses to any disclosure should be helpful and empathetic; ideally they should be followed up with good services and support, but a lack of availability of services should not be used as an excuse to not ask about experiences of abuse.

1.6. Impact on Clinical Practice

Knowledge of whether users of mental health services have experienced adversity, including abuse, neglect and violence, is important for many aspects of clinical work. Asking 'What has happened to you?' rather than 'What is wrong with you?' can facilitate a broader understanding of emotional distress within therapeutic work (Sweeney, Filson, Kennedy, Collinson & Gillard, 2018). Service users have said that being asked about adverse events facilitated being able to talk about their experiences and provided acknowledgement that such experiences were important. For some, being asked had a tangible impact in supporting them to find a language to disclose adverse experiences and in some cases enabled the start of a therapeutic process (Scott et al., 2015). This is in stark contrast to feeling that such things are best not spoken of, which many service users say is a consequence of not being asked about experiences of adversity (Scott et al., 2015).

For those accessing mental health services, recalling and revisiting adverse experiences, and understanding the role these may have in the onset and maintenance of difficulties, are important elements of the recovery process (Herman, 1992). For clinicians, awareness of a service user's history is necessary in order to formulate the development of presenting problems more accurately and comprehensively, including an assessment of the impact of adverse experiences (Jacobson & Richardson, 1987; Read et al., 2017). This knowledge is also pertinent for developing effective treatment plans (Read et al., 2017). There can also be implications for the therapeutic relationship between service user and mental health professional. By asking about adversities, clinicians demonstrate that they believe such events are important, showing a capacity to deal with the subject matter, which is central to a therapeutic alliance (Jacobson & Richardson, 1987). Awareness of such history can also aid the clinician in understanding and tolerating the potential for slow formation of therapeutic alliance and avoid misinterpreting it as an incapacity for relationships or 'resistance' (Agar, Read & Bush, 2002).

1.7 Literature Review I: Enquiring about Adversity

An electronic database search was conducted in order to review and summarise the available research on whether mental health professionals ask service users about adverse experiences, including abuse and neglect. Due to there being a recent systematic literature review on this topic (Read et al., 2017) this literature search used a replication of the search terms used in the systematic review and searched for records published since December 2016 to November 2018. Appendix A contains further details on the searches conducted including details of search terms, the limiters applied, inclusion and exclusion criteria as well as the number of studies identified.

The search used PsychINFO to replicate the 2017 review and in order to expand the electronic database search, ScienceDirect, CINAHL Plus and Scopus were also used. The following search terms were used: 'child abuse' OR 'child neglect' OR 'sexual abuse' OR 'physical abuse' OR 'emotional abuse' OR 'psychological abuse' OR 'physical neglect' OR 'emotional neglect' OR 'child maltreatment' – AND – 'mental health services' OR 'psychiatric services' OR 'mental health assessment' OR 'psychiatric assessment' OR 'psychological assessment' OR 'psychiatric nursing assessment' OR 'medical records' OR 'patient files'. This search strategy was limited to research articles and dissertations. It produced 4,496 results, the titles and abstracts of which were reviewed for relevance to the topic.

To further expand the literature review in comparison to the 2017 systematic review, additional searches were conducted using Google Scholar and Research Gate, in addition to using the reference lists of relevant papers. The search terms 'adverse child experiences' OR 'adversity' were added to the original search terms but no further studies relevant to how often adult mental health services ask about, and/or record, adversities including abuse and neglect were identified further to the 21 studies found in the recent systematic review. The literature review attempts to summarise the findings from the 21 studies which investigate the practice of enquiry about adverse experiences in childhood in adult mental health services.

1.7.1 Characteristics of the studies

The 21 studies identified focus on the following adversities experienced in childhood: physical neglect, emotional neglect, physical abuse, emotional abuse and sexual abuse. They were all conducted in Western countries; eight in the USA, six in New Zealand, two each in Australia, Northern Ireland and England and one in Ireland. Of the 18 studies which used clinical samples, the samples were predominantly female (a range of 43% to 100%) perhaps a result of the greater prevalence of CSA among females. The earliest study was published in 1987 (Jacobson et al., 1987) and the most recent in 2016 (Cunningham et al., 2016; Mansfield et al., 2016; Sampson & Read, 2016; Xiao et al., 2016).

A majority of the studies adopted a similar research approach which compared the amount of adverse experiences identified by researchers with the amount recorded in the clinical files of service users (Briere & Zaidi, 1989; Craine, Henson, Colliver & MacLean, 1988; Cunningham et al., 2016; Goodwin, Attias, McCarty, Chandler & Romanik, 1988; Jacobson et al., 1987; Lipschitz et al., 1996; Shannon et al., 2011; Rossiter et al., 2015; Wurr & Partridge, 1996).

The remaining studies used a combination of approaches. Four studies asked mental health professionals, both staff and managers, about their practices of enquiry (Lab, Feigenbaum & De Silva, 2000; Cavanagh, Read & New, 2004; Mansfield, Meehan, Forward & Richardson-Clarke, 2016; Mitchell, Grindel & Laurenzano, 1996). Three studies asked service users whether they had been asked about adverse experiences (Lothian & Read, 2002; Read, McGregor, Coggan & Thomas, 2006; Rose, Peabody & Stratigeas, 1991). Three studies reviewed relevant sections on assessment forms held in service users' clinical records (Agar, Read & Bush, 2002; Read & Fraser, 1998a; Sampson & Read, 2016). Two recent studies used an audit approach to review how histories of adverse experiences were documented in service user files (Mansfield et al., 2016; Xiao et al., 2016).

1.7.1.1 Studies that compared the amount of adverse experiences identified by researchers with the amount recorded in service users' files

Using this approach, Rossiter and colleagues (2015) compared the prevalence of childhood adversities recorded in the clinical notes of 129 Irish mental health service users to those ascertained by researchers using the Childhood Trauma Questionnaire (Bernstein & Fink, 1998) and a lifetime retrospective clinical note review. One or more of the five types of childhood adversity assessed by the CTQ were reported by 77% of service users, but their clinical files only produced a rate of 38%. The authors noted that the greatest difference between CTQ reported and clinical note documentation were for emotional neglect (62% versus 13.2%), physical neglect (48.1% versus 5.4%) and CSA (24.8% versus 8.5%). Cusack and colleagues (2004) found that 87% of 142 service users with 'chronic and severe mental illness' had experienced one or more types of childhood, adulthood or lifetime adverse experiences (including 31% child sexual abuse) but that only 28% had adversities documented in their files.

The systematic review conducted by Read and colleagues (2017) combined the findings from nine of the studies which used this research approach, excluding Cusack et al., as these researchers had not specified how many types of each adversity was documented in service user files. They calculated that in the nine studies, less than a third (27.9%) of abuse and neglect identified by researchers was documented in service users' files. The percentage of identified sexual abuse found in clinical files, in these nine studies, ranged from 8.6% to 59% with a weighted average of 30.2%. For physical abuse found in clinical files, from five studies, the percentage ranged from 12.2% to 69.4%, with a similar rated average from four studies of 33.1%. Only three of these nine studies focused on experiences of neglect (physical and emotional) and emotional abuse. The weighted average from these studies were calculated as 44.3% for emotional abuse, 10.3% for physical neglect and 17.4% for emotional neglect. The combined average for the two types of neglect (physical, emotional) was 14.2%, which was calculated as less than half of the 33.3% weighted average for the three types of abuse combined (physical, sexual, emotional).

1.7.1.2. Studies which asked mental health professionals about their asking practices

The systematic review reported three studies taking the approach of asking mental health staff if they ask service users about adverse experiences. Lab and colleagues (2000) surveyed 111 mental health staff working in London. They found that mental health professionals do not routinely enquire about CSA among male service users. A third of the sample (33%) never enquire, almost half (49%) only enquire a quarter of the time and only 18% enquire more than half of the time. The authors reported differences in practice across professional groups, with more nurses (29%) than psychiatrists (4%) or psychologists (7%) believing that men should always be asked about sexual abuse. Cavanagh and colleagues (2004) surveyed 85 mental health professionals working in New Zealand who attended a training programme on asking about CSA. At the time of the training, the total sample believed, on average, that in 64% of cases they knew whether or not the service user had been sexually abused.

In a more recent Australian study, 57 mental health staff were asked to complete a questionnaire which explored factors that influence practice in regard to asking about adverse experiences. Only 13 out of 57 respondents agreed with the statement 'I routinely ask patients about childhood trauma including sexual abuse' (Mansfield et al., 2016). One study in the USA attempted to identify the extent to which adverse experiences are asked about by surveying managers of mental health services regarding asking practices relating to sexual abuse. Of 466 respondents who were nurse managers of psychiatric inpatient units, 69% believed that assessment at admission should always include asking about sexual abuse, but only 43% believed that their facility actually did so (Mitchell et al., 1996).

1.7.1.3. Studies which asked service users if they were asked about adverse experiences

The systematic review found three studies which had asked service users directly whether mental health staff had asked them about adverse experiences in childhood. A New Zealand study surveyed women receiving therapy who had been subjected to sexual abuse in childhood. Only 21.7% of the women who had been in contact with mental health services reported that they had ever been asked CSA (Read et al., 2006). A similar finding was reported by an earlier study which surveyed 72 people about their experience of initial assessments in mental health services. Researchers found that only 20.8% of people had been asked about abuse when assessed, yet 65% reported child abuse when asked by the researcher (Lothian & Read, 2002). In a study which interviewed 89 'heavy users' of mental health services in New York, including acute inpatient and crisis services, 30 people had been sexually abused and 34 physically abused as children, but none of these individuals had ever been asked about sexual or physical abuse (Rose et al., 1991).

1.7.1.4. Studies which reviewed the 'abuse' sections on assessment forms

Three studies, all conducted in New Zealand, reviewed how often questions are asked by mental health professionals, when such questions about adverse experiences are included in assessment forms. The most recent study reviewed the electronic service user records of four adult community mental health services. Out of 153 electronic records, 84 (54.9%) were blank where professionals should have recorded adverse experiences (Sampson & Read, 2016). This study highlighted certain demographic and diagnostic differences amongst service users both asked and not asked about adverse experiences. Male clients were asked about such experiences less often than females; and male staff enquired less often than female staff. Also, individuals with a diagnosis indicative of psychosis, such as schizophrenia, tended to be asked less often and had significantly lower rates of adversity identified in their files.

An earlier study tracked the introduction of a new initial assessment form to an inpatient setting which included questions about sexual, physical and emotional abuse (Read & Fraser, 1998a). The form was used in 53 out of 100 subsequent, consecutive admissions. In 36 of those 53 files (67.9%) these questions were not asked. The data showed that 82% of inpatient service users disclosed either childhood or adulthood sexual/physical abuse if they were asked at admission, compared to just 8% if not asked. This study was replicated in a community setting in 2002 and reported more promising results, that in only 6 out of 26 cases (23.1%) had this section been left blank (Agar et al., 2002). More recently, a study found that newly introduced questions on assessment forms regarding CSA were ignored in 17 out of 52 assessments (32.6%) in inpatient and community settings (Mansfield et al., 2016).

1.7.1.5. Reviews of service users' clinical records

Two recent studies used an audit approach to review how histories of adverse experiences were documented in service user files. A study of 100 inpatient and community files in Australia found that 24 included documentation of child sexual abuse and a further 29 had a note that the client had been asked and responded that they had not been subjected to this type of abuse (Mansfield et al., 2016). A similar study included a broader range of childhood and adult adverse experiences amongst the files of 100 female inpatients in Australia. A 49% rate of 'documentation of trauma history' was reported, meaning that 51% of files lacked any mention of adverse experiences (Xiao et al., 2016).

1.7.2. Summary

Overall, the literature highlights that mental health services consistently fail to enquire about adverse experiences. These studies also highlight demographic and diagnostic differences amongst people who are asked and not asked about adverse experiences. Unfortunately, being a male service user means there is less likelihood of being asked, particularly about sexual abuse (Cavanagh et al., 2004; Lab et al., 2000; Read & Fraser, 1998a). Gender was found to play a further role as a barrier to asking service users about adverse experiences. Three of the studies reported that female clinicians are more likely than their male counterparts to identify and record experiences of adversity in files (Agar et al., 2002; Currier & Briere, 2000; Sampson & Read, 2016). One of the studies found that older women were significantly less likely to have been asked about adverse experiences by mental health services (Read et al., 2006) yet this was not a finding of the more recent study (Read & Sampson, 2016). Finally, a consistent finding amongst these studies was that people diagnosed with psychotic or schizophrenic type disorders were less likely to be asked about adverse experiences than people with other diagnoses (Cavanagh et al., 2004; Lab et al., 2000; Read & Fraser, 1998a; Sampson & Read, 2016).

There is a paucity of studies in this area, reflected in there having only been 21 studies over a 30-year period. Most of these studies focus on enquiry about physical and sexual abuse, with enquiry about neglect and emotional abuse being largely under-researched. It is notable that the literature does not yet reflect whether other adverse experiences, such as bullying, witnessing or experiencing domestic violence and growing up in institutional care, are enquired about within mental health services, despite our knowledge of their relationship to mental health difficulties.

1.8 Literature Review II: Responding to Disclosures of Adverse Experiences

The following narrative literature review attempts to describe and discuss the existing literature concerning how mental health services and staff respond when adverse experiences become known about. A similar search strategy was used in this second literature review. A systematic review on this topic area has also recently been published by Read and colleagues (2018). However, the current literature review expanded the number of electronic databases searched, to include: PsychINFO, ScienceDirect, CINAHL Plus and Scopus. Additional searches were also conducted using Google Scholar and Research Gate. Appendix B contains further details on the searches conducted including details of search terms, the limiters applied, inclusion and exclusion criteria as well as the number of studies identified. No additional studies were identified further to the 13 included in the recent systematic review (Read et al., 2018).

Of the 13 studies addressing the issue of how disclosures of adverse childhood experiences were responded to, three were surveys of mental health professionals (Cavanagh et al., 2004; Lab et al., 2000; Mitchell et al., 1996), three involved interviews with service users (Örmon, Torstensson-Levander, Sunnqvist & Bahtsevani, 2014; Rose et al., 1991; Scott et al., 2015) and seven were reviews of service users' clinical records (Agar & Read, 2002; Eilenberg et al 1996; Goater & Meehan, 1998; Mansfield et al., 2016; Posner et al., 2008; Read & Fraser, 1998; Read et al., 2016).

1.8.1. Surveys of mental health professionals

Three studies, also included in the previous literature review, used self-report questionnaires to assess how mental health professionals respond to disclosures of CSA. Lab and colleagues (2000) asked mental health professionals about what they do if they 'learn a client has a history of sexual abuse'. The two most endorsed responses to a disclosure, both given by 60% of respondents, were 'address the issue with the client' and 'tell another professional'. Following this were 'give community options' (42%) and 'refer to a

psychologist' (34%). The two least favoured response options were 'refer to a psychiatrist' (7%) and 'refer to a social worker' (4%). Worryingly, 11% of respondents endorsed 'no response'. The authors also highlighted that being a male reduces the likelihood of an appropriate response from a mental health professional.

Cavanagh and colleagues (2004) asked 85 mental health professionals to estimate the percentage of disclosures in response to which they use each of five responses: 'Record disclosure in client's file' (86%); 'Offer to refer for abuse-related counselling' (79%); 'Provide information about sexual abuse agencies' (78%); 'Provide information about sexual abuse' (58%) and 'Offer to provide abuse-related counselling yourself' (12%). Of these professionals, 25 were given a further questionnaire asking them to list the most important things they do in response to disclosures of sexual abuse. The responses included: 'Offer to refer for, or give information about, counselling' (68%); 'Affirm that it was a good thing to have disclosed' (56%); 'Check whether client is now safe from abuse' (56%) and 'Ask whether the client thinks there is a connection between the abuse and their current difficulties' (32%).

In the earliest study of this kind, a questionnaire about staff practice in relation to CSA was sent to nurse managers in 1,410 psychiatric inpatient units in the USA (Mitchell et al., 1996). Of the 342 who responded and indicated that histories of CSA were taken at their unit, 147 (43%) reported that the service user 'received inpatient therapy specifically related to the issues of sexual abuse' and 148 (43%) reported that the service user was referred for 'outpatient therapy upon discharge'. Ten of these 342 respondents said that their unit just recorded the abuse and 'gave no further attention to the issue unless it was raised by the patient' (p. 163).

1.8.2. Interviews with service users

Three studies interviewed service users who were known to have been subjected to CSA and/or CPA. In Sweden, Örmon and colleagues (2014) interviewed nine women who were attending a general psychiatric clinic and had disclosed experiences of adversity to a member of staff. Qualitative themes emerged from the data which included: 'being belittled', 'being misinterpreted' and 'being cared for'. The authors concluded that the women made disclosures in an environment where staff are divided into two groups: 'those who believed in and supported the abused women' and 'those who regarded experiences of abuse as a secondary issue and focused on the mental disorder'. Rose and colleagues (1991) reported that out of 41 women who had disclosed CSA or CPA to researchers, of those who had disclosed this to mental health staff (number unspecified) only three had received any response at all. None of the responses 'were appropriate to their needs for legitimization or ongoing support based on the lasting impact of their history of sexual or physical abuse' (p. 501).

Finally, the REVA project interviewed service users accessing support from NHS trusts where routine enquiry had been implemented (Scott et al., 2015). Of the 17 women interviewed, 14 had experienced either CSA or CPA. All four male participants had experienced CSA. The qualitative findings reported that staff 'seemed not to view their experiences of abuse as relevant to their mental health', that 'it was not unusual for disclosures to be dismissed' and there were examples of 'people repeatedly asking for help to deal with their experience of abuse and only being offered medication' (pp. 4-6).

1.8.3. Reviews of service users' clinical records

The most frequent method, used by seven studies, was to review the clinical records of service users. Read and Fraser (1998b) reviewed the service user medical records of 100 consecutive admissions to an inpatient unit. Of the 32 service users who were documented as having disclosed abuse, none were reported to have received support, counselling or information while in hospital, three referrals were made for ongoing counselling and 11 files included documentation of previous treatment or disclosure. None of the 52 separate instances of abuse had been reported to relevant authorities. In a study that same year, Goater and Meehan (1998) randomly selected and then reviewed the clinical records of 680 female service users aged from 16-65 years who had presented to a psychiatric unit in north London between 1976 and 1995. A history of CSA was recorded in 4.7% (32/680) of cases. Of these 32 files, not one recorded the nature of the abuse and 'some reference to the identity of the abuser' was recorded in only ten out of the 32 cases (p. 1). More recently, Mansfield and colleagues (2016) reported that of 24 women known to have been subjected to CSA, 17% (4/24) had this mentioned in their treatment plan, but this was not the case for any of the four men who were also known to have experienced CSA.

Two of the seven studies which reviewed service users' clinical records were follow-up studies. A study based in the USA reported on the files of service users who had disclosed either a 'catastrophic event' (8%) or lifetime sexual or physical abuse (92%) (Eilenberg et al 1996). The 'precise nature' of the adverse experience was recorded in 60% of the files, however the frequency and severity were both noted only in 15% of files. A follow-up at the same clinic after ten years found significant improvements in the recording of both the frequency (59%) and severity (56%) of adverse events, but there was no change with regard to the 'adequate description' of the adversities (Posner et al., 2008).

In 2002 Agar & Read audited data from New Zealand outpatient mental health services in 1997. Of 200 service user files, 46% contained documentation of sexual or physical abuse as children or adults. Of these, only 36% of summary formulations and 33% of treatment plans mentioned the abuse. Only 22% of the

clients received therapeutic support which related to the abuse they had experienced. None of the alleged crimes were reported to legal authorities. In the intervening years best practice recommendations and a one-day training programme had been developed to support staff enquire about adverse experiences and respond therapeutically to disclosures (Cavanagh et al., 2004; Read et al., 2005). In 2016 Read and colleagues (2016) then returned to the service that had been the basis of the Agar and Read (2002) paper in addition to three similar outpatient services. The follow-up study reported improvements across three domains: inclusion of abuse in treatment plans (an increase from 20% to 44% for CSA, and from 12% to 24% for CPA); referrals to relevant therapy (from 17% to 23% for CSA, and from 15% to 20% for CPA) and reporting to police (an increase from 0% to 2% for both CSA and CPA) (Read et al., 2016).

1.8.4. Summary

The findings from these studies bear many similarities to studies concerned with enquiry about adverse experiences. Overall, they consistently show poor clinical practice in all five countries where the 13 studies were undertaken. As we know, the majority of service users are never asked about childhood experiences of adversity (Read et al., 2018). As a consequence, the proportion of people responded to appropriately by mental health services is minimal. Approximately 2% to 6% are referred for appropriate treatment, yet for male service users or people experiencing psychosis this is even fewer. This is because both groups are not only less likely to receive an appropriate response from a mental health professional following a disclosure, but are less likely to be asked in the first place (Lab et al., 2000; Read, Sampson & Critchley, 2016; Read et al., 2018). In general, there is a paucity of studies in this area, leading authors of the recent systematic review to conclude that ‘... it seems the capacity of our mental health services to ignore child maltreatment is paralleled by our research community.’ (Read et al., 2018, p. 18).

1.9 Barriers to Asking and Responding Appropriately

In order to support mental health services to ask about and respond appropriately to experiences of adversity it is important to identify the barriers which prevent this from happening. Studies have identified that staff can: feel there are more immediate concerns to deal with, fear that service users will become too distressed by being asked, worry that enquiry could be suggestive, not know how to respond well to disclosures and believe that disclosures may be false, imagined or delusional (Cavanagh et al., 2004; Lab et al., 2000; Mansfield et al., 2016; Young, Read, Barker-Collo & Harrison, 2001).

1.9.1. 'False Memories'

Publicity surrounding 'false memories' of abuse may lead some clinicians to inappropriately doubt the credibility of a service user's disclosure (Agar & Read, 2002). Clinicians holding particularly strong doubts are both less likely to enquire about adverse experiences in the first place or refer a service user for appropriate support following a disclosure (Young, 1999). However, research shows that mental health services users are equally unlikely as the general population to make incorrect allegations of abuse and actually tend to under report rather than over-report such experiences (Dill, Chu, Grob & Eisen, 1991; Read, 1997).

1.9.2. Levels of Distress

Studies consistently report that the more distressed a service user is, the less likely they are to be asked about adverse experiences by a mental health professional. Clinicians may occasionally decide not to address adverse experiences if a service user is currently in a high state of distress or if there are 'more immediate concerns' (Young et al., 2001). However, multiple researchers have identified a specific bias against asking people with a diagnosis indicative of psychosis about childhood adversities, which we know are a strong risk factor for psychosis (Read et al., 2014; Agar et al., 2002; Cavanagh et al., 2004;

Young et al., 2001). This bias is suggested to be due to traditional assumptions about schizophrenia being a biological phenomenon. Research by Young and colleagues supports this hypothesis, reporting that the degree of belief in biological causation was related to psychiatrists being more likely to ask someone with a diagnosis of 'major depressive disorder' about childhood adversity than someone diagnosed with schizophrenia (Young et al., 2001).

1.9.3. Lack of Training

Insufficient training in 'how to ask' is often cited as a barrier to asking service users about adversities (Courtois & Gold, 2009). Healthcare professionals report that they lack knowledge about adversity inquiry and response (Salyers, Evans, Bond & Meyer, 2004; Warne & McAndrew, 2005). Simply including a question related to adverse experiences in an admission form, nor instructing staff to ask about adversities are effective in increasing inquiry rates without appropriate staff training (Read & Fraser, 1998a; Dill et al., 1991). Instead, specific training for trauma inquiry may be more effective (Currier, Barthauer, Begier & Bruce, 1996; Tilden et al., 1994). Donohue (2010) found that a one-day training course led to 93% of participants considering themselves as having acquired sufficient skill to enquire about CSA and manage disclosures in an appropriate way. Almost half (44%) of course participants claimed to have asked about adverse experiences in 75-100% of cases since the training.

1.9.4. Resources

Systemic pressures such as under-resourced and overstretched services have been found to serve as a barrier to asking about and responding appropriately to experiences of adversity (Agar & Read, 2002; Wilson & Read, 2001). A lack of resources to deal with the consequences of a disclosure, or knowledge that no services will meet the need, can mean a service user is simply not asked about adverse experiences (Rose et al., 2011). Research concerning the barriers to asking about domestic violence highlight factors such as: lack of time to raise the issue, lack of privacy in clinical settings, lack of information about domestic violence and no continuity of care (Bacchus et al., 2003; Rose, Trevillion, Woodall, Morgan, Feder & Howard, 2011).

1.10. Conceptual and Theoretical Attempts to Understand the Barriers to Asking and Responding Appropriately to Adversity

The existing empirical literature does not provide robust conceptual or theoretical explanations as to why staff working in mental health services do not routinely ask about adverse experiences. However, it is important to attempt to identify the conceptual issues involved. This includes consideration of the ways in which clinicians and systems understand and conceptualise adversity in the context of gender, age, and the dominant medical model, and how these perceptions may impact staff inquiry and response to adverse experiences. Consideration is also given to the notion that defence against vicarious trauma may prevent some mental health professionals from asking about adversities.

1.10.1. Gendered Notions of Adversity

The gendered context within which this study operates, as elsewhere in the West, is a legacy of beliefs, attitudes and practices through which social norms about gender were constructed over time. Dualistic social norms of masculinity associated with mastery and control, and femininity with submission and service, were institutionalised in the structure of the patriarchal family, and supported by a belief system and economic and political institutions (Dobash & Dobash, 1979). A product of these social norms is the way in which gendered characteristics of intimate relationships, and family life, influence how women and men tend to think about violence and abuse (Orr, 2007). To some extent, men and women act the way they do because of concepts of femininity and masculinity that they adopt from their culture. Notions of gender are therefore likely to affect both (i) the way in which service users themselves conceptualise and identify adverse experiences, and (ii), how clinician's working in mental health services ask about, and respond to experiences of adversity.

Gendered notions of adversity appear particularly apparent in the context of sexual assault and abuse. It is estimated that 22-29% of all CSA victims are male (Fergusson, Lynskey, & Horwood, 1996b; Finkelhor, 1993; Sobsey, Randall, & Parrila, 1997). However, research has consistently found that males are less likely to be asked about adverse experiences, particularly sexual

abuse, than female service users (Cavanagh et al., 2004; Lab et al., 2000; Read & Fraser, 1998a; Sampson & Read, 2016). One possible explanation for these findings relates to the concept of hegemonic masculinity (Courtenay, 2000), which is an idealised form of masculinity that is a widespread and culturally accepted norm. It characterises *real* men in Western contexts as strong, virile, heterosexual, dominant, powerful, fearless, active and in control of their emotions, which are attributes by which men assert power over one another (Connell, 1995; Petersson & Plantin, 2019). These ideals are institutionalised during early years and in family and sexual relationships (Connell, 1995; Messerschmidt, 1999).

This cultural construction of gender plays a central role in the way sexual assault is experienced, processed, manifested and responded to (Draucker, 2003; Getz, 2011). Being a male victim of sexual assault stands in contrast to hegemonic or conventional norms of masculinity (Petersson & Plantin, 2019). Societal expectations concerning the male gender role impacts significantly on men's understanding of what sexual victimisation means to them. Male service users may not conceptualise their experiences as sexual assault, be it in childhood or adulthood, making it particularly unlikely they would disclose such experiences to mental health professionals, as many studies have reported (Davies, 2002; Mezey & King, 1989; Turchik & Edwards, 2012). A sense of not living up to the ideals of being strong, tough and able to protect oneself from adversity may make some men who have been sexually abused unlikely to seek help due to their fear of ridicule and blame (Lowe & Balfour, 2015).

Mental health professionals are members of society whom are likely as any to be influenced by dominant societal and cultural constructions of gender. Therefore, the enactment of hegemonic ideals at a societal level is likely to impact whether and how clinician's working in mental health services ask about, and respond to experiences of adversity. Inquiry practice, already shown to be poor, is likely to be particularly inhibited with male clients due to these firmly held cultural beliefs that men are more powerful and less vulnerable than women (Courtenay, 2000) and that sexual abuse is, therefore, less likely to happen to them, or to damage them when it does.

1.10.2. Attitudes towards Older People

In a similar way to how cultural constructions of gender might influence clinical practice, perceptions about age should also be considered as a potential barrier to routine enquiry. There is long-standing evidence of discrimination of older people in mental health services, including: infringement of human rights, and unmet need and neglect (Bowers, Eastman, Harris & MacAdam, 2005; Royal College of Psychiatrists, 2005; Age Concern, 2006, 2007, 2008). This discrimination is conceptualised as being a direct result of deep-rooted cultural attitudes to ageing which are particularly evident in mental health care (Royal College of Psychiatrists, 2018; Swift, Abrams, Drury & Larmont, 2016). Recent studies highlight how this discrimination is enacted. Morgan and colleagues (2018) found that older people who self-harm are less likely to be referred to specialist mental health services than younger adults, despite a higher risk of suicide in this group (Morgan et al, 2018). Burns and Warner (2015) reported that 85% of older people with depression receive no support from the NHS, and that older people are a fifth as likely as younger age groups to have access to talking therapies but six times as likely to be on medication.

A 2018 survey of attitudes towards ageing and older people published by the Royal Society for Public Health (RSPH) reported that ageist attitudes were widespread. These attitudes can be seen at all levels of society, and are particularly evident within health and social care contexts. A 2011 literature review highlighted a consistent failure of health and social care professionals to recognise domestic violence between older couples (McGarry, Simpson & Hinchliff-Smith, 2011). The review described a significant deficit in awareness and understanding, particularly with regard to older women and experiences of abuse. It concluded that as a result of this deficit, health and social care professionals rarely ask questions about abuse or adverse experiences and instead assume that injuries, unhappiness, low mood or confusion are the result of age-related conditions. This finding is supported by one study concerning routine enquiry, which reported that older women were significantly less likely to have been asked about adverse experiences by mental health services (Read et al., 2006).

A recent study that looked in more detail at preconceptions of ageing amongst General Practitioners (GPs) provides clues as to why it might be that older people are not routinely asked about experiences of adversity. The study found that GPs tended to have strongly held ideas that depression is an inevitable consequence of ageing, that diverting resources to younger people is more cost-effective, and that addressing physical and social issues among older people should take priority over psychological therapies (Collins & Corna, 2018). It seems therefore that conceptual issues about ageing, which are present at a systemic level, constitute a barrier to routine enquiry about adverse experiences. It is alarming that current experiences of abuse and violence for older people are not being recognised by mental health services. If current adversities are not identified, it makes it unlikely that historic, adverse experiences across the life course, which are highly likely to impact on the health and wellbeing of people in later life, are routinely identified and recorded. Given that the UK has an ageing population, it is clear that more research is needed in order to explore this further.

1.10.3. Dominance of the Medical Model

The current mental health system tends to conceptualise extreme behaviours and distress as symptoms of mental illnesses, rather than coping adaptations to adverse experiences (Sweeney et al., 2018). The reluctance to shift from biomedical causal models of mental distress to holistic biopsychosocial models, or a lack of exposure to alternatives, are a barrier to creating trauma-informed relationships in mental health services (Eilenberg et al., 1996; Sweeney et al., 2018). It is likely therefore that this reliance on, and dominance of, the medical model, contributes and maintains the neglect of clinician inquiry about adverse experiences. This is evidenced by studies reporting that barriers to inquiry, and appropriate response, include the clinician being a psychiatrist (Agar & Read, 2002; Lab et al., 2000), especially a psychiatrist with strong bio-genetic causal beliefs (Young et al., 2001).

The bio-medical paradigm has been described as being particularly unhelpful with regard to psychosis (Bentall, 2003). Individuals presenting with psychosis tend to be asked about adverse experiences less often and have significantly lower rates of adversity identified in their clinical records in comparison to other users of mental health services (Agar et al., 2002; Cavanagh et al., 2004; Read et al., 2014; Sampson & Read, 2016; Young et al., 2001). Existing literature can help us to understand why this observed difference in questioning behaviour might occur.

A 2013 study interviewed clinical psychologists and psychological therapists working in early intervention services in the North of England about their asking practices. It reported that asking about adversity was related to the therapists' conceptualisation of psychosis and knowledge of the literature on trauma-based models of distress (Toner, Daiches & Larkin, 2013). Individual practitioners in the study generally had their own psychological, formulation-orientated, trauma-based "model of psychosis" that reflected why they felt it is important to ask about adverse experiences. The researchers concluded that holding a psychosocial model of psychosis was an essential foundation for conducting thorough assessments, which involved asking about adversities. A theory was developed from the data which proposed that having the skills to ask about adverse experiences is not enough without consistent and developed personal beliefs about psychosis, and a service culture which is also consistent and supportive (Toner et al., 2013).

The question of why mental health professionals do not ask and respond appropriately to adversity appears therefore to be influenced by the culture of the service. Traditionally, schizophrenia and psychosis have been considered endogenous biomedical disorders (Hammersley, 2004). In services where these conceptualisations continue to exist, it is highly likely that this would serve as a barrier to professionals asking about adverse experiences. In contrast, in services where there has been a clear shift from a bio-medical model of mental health to a psychologically based one, such as those described by Toner and colleagues (2013), there is a clear ethos concerning the importance of routine enquiry and evidence that this consistently takes place.

1.10.4. Vicarious Traumatization

Research has highlighted a variety of secondary traumatic stress effects of working with survivors of abuse and adversity. These go some way in providing a conceptual understanding as to why inquiry and response to adverse experiences in the lives of service users is frequently so poor. At a basic level, avoidance may be exhibited as an active effort to avoid thoughts, feelings, activities and situations that remind one of the adverse events of the client (Salston & Figley, 2003). In addition, some mental health professionals may be reluctant to pursue stories of adversity, abuse and trauma because they fear being vicariously traumatised (Eilenberg et al., 1996; Rose, 1986).

In the process of supporting survivors, clinicians are frequently exposed to traumatic material that can affect one's worldview, emotional and psychological needs, cognitions and belief system (Salston & Figley, 2003). A 2009 literature review summarised the available evidence of vicarious traumatization in practitioners working with adult survivors of sexual assault and CSA (Chouliara, Hutchison & Karatzias, 2009). A number of the studies reported high levels of post-traumatic stress disorder (PTSD) symptomatology and self-reported vicarious traumatization (Johnson & Hunter, 1997; Knight, 1997; Way, VanDeusen, Martin, Applegate & Jandle, 2004), as well as high levels of belief disruption (Schauben & Frazier, 1995; VanDeusen & Way, 2006). Disrupted beliefs included: avoidance and intrusion, trust and intimacy, world view, sense of safety, relationship to work, to self, and to others (Benatar, 2000; Johnson & Hunter, 1997; VanDeusen & Way, 2006; Way et al., 2004).

Danieli (1996) proposes that these secondary traumatic stress effects combine with countertransference reactions to the extent that mental health professionals are inhibited from studying, correctly diagnosing, and treating the effects of trauma. Whilst these concepts have not been explored in previous research of this kind, and are therefore untested, it makes intuitive sense that the lack of inquiry behaviour consistently demonstrated by empirical research could be related to a defence against vicarious traumatization. It is beyond the scope of this thesis to explore this fully, but future research agendas would

benefit from considering the extent to which these concepts affect clinician inquiry and response behaviour.

1.11. Summary

It is known that many people in contact with mental health services have experienced early adverse life events (Friedli, 2009; WHO, 2013). A vast research base has shown consistent links between adverse experiences in childhood and adult mental distress (Bentall et al., 2014; Varese et al., 2012). This relationship is increasingly being understood as dose-dependent, with a relationship between the range, severity and frequency of adverse experiences and the subsequent impact on mental health (Bentall et al., 2014; Dillon et al., 2012; Read et al., 2017).

It is national policy that all mental health services should acknowledge and address the links between the experience of adversity and mental health and that staff are obliged, once satisfactorily trained, to ask about such experiences routinely and consistently at assessment (DoH, 2008). Researchers have suggested that experiences of adversity should be systematically and routinely inquired about by clinicians as many service users are reluctant to spontaneously report such experiences (Read & Fraser, 1998a; Read et al., 2006; Wurr & Partridge, 1996). This is particularly the case if the events involve interpersonal abuse by a caregiver (Read et al., 2006). Service users have also called for routine enquiry of adverse experiences (Scott et al., 2015). However, whilst many clinicians believe that systematic screening for adverse events is important, they often fail to do so in their day-to-day practice (Lee, Coles, Lee, & Kulkarni, 2012; Read et al., 2006). As a result, most people who use mental health services are never asked about adverse experiences, including childhood abuse or neglect (Read et al., 2017). In this way, people presenting to mental health services have their symptoms disconnected from the context of their lives (Sweeney, Clement, Filson & Kennedy, 2016).

Conceptual and theoretical attempts to understand the barriers to asking about adverse experiences highlight how perceptions of age, gender, and the

dominant medical model, can interact and play out within mental health services. These perceptions, which are frequently constructed through dominant discourses, may impact staff inquiry and response to adverse experiences. It is also likely that clinicians working in over-stretched and under-resourced services attempt to defend against vicarious trauma, which may result in the prevention of routine enquiry.

Disclosures of adverse experiences require an appropriate and supportive response from clinicians. To be effective, staff should not just attend to the service user's wellbeing in the immediate disclosure situation, but also to the need, where appropriate, to form comprehensive formulations of the current difficulties, consider appropriate treatment plans in relation to the disclosure and consider whether relevant authorities should be alerted (Agar & Read, 2002). Research shows that in the minority of cases where service users are asked about adverse experiences they do not tend to receive an appropriate therapeutic response and instead there is a plethora of inadequate clinical practice.

1.12. Rationale, Research Questions and Hypotheses

The current study seeks to better understand the frequency of asking about and responding to disclosures of adverse experiences in clinical practice within adult community mental health services in England. Previous research of a similar nature has generally focused on experiences of childhood sexual and physical abuse. This study seeks to pay greater attention to other forms of adversity, which we know have a relationship with poor mental health, including: bullying, loss of a parent, emotional abuse, neglect and experiencing and witnessing domestic violence. This study also seeks to address identified gaps in the literature by including adult experiences of adversity, rather than in childhood only, within one UK-based study. Finally, this study seeks to build theoretical knowledge about asking practices amongst mental health professionals. The following primary research questions and hypotheses were formulated in order to address identified gaps in empirical research and conceptual and theoretical knowledge.

1.12.1. Research Questions

- To what extent are a range of experiences of adversity identified and recorded by mental health professionals working in adult mental health services?
- How do mental health professionals working in adult mental health services respond to disclosures of adversity?
- To what extent can conceptual and theoretical frameworks explain the barriers to routine enquiry and disparity in asking practices amongst mental health professionals?

1.12.2. Research Hypotheses

1. Adversities experienced by male service users will be identified and recorded less often than female service users
2. Age of service users will be negatively related to the probability of adversities being identified and recorded in their file
3. Service users with a diagnosis indicative of psychosis will be less likely to have adversities identified and recorded in their file than individuals with a non-psychotic presentation

2. METHOD

2.1. Overview

This chapter will outline the epistemology and methods used to address the research questions. The chapter will begin by outlining the study's epistemological position, which provides the context for the study design. Ethical issues are then considered, before moving on to provide details of the participants, materials and measures, procedures and approach to statistical analysis.

2.2. Epistemological Position

Epistemology refers to the study of the nature of knowledge; how we come to understand and gain knowledge of reality, and the basis for claims to possess knowledge (Schwandt, 2001). Epistemology is a theory of knowledge concerning what is possible to know and the reliability and validity of such knowledge (Willig, 2012). The process of research aims to produce knowledge about the world which can be claimed to be valid (Green & Thorogood, 2010). Epistemological orientations differ across all forms of research, with researchers taking a range of positions in relation to questions about the nature, and status, of any knowledge claims that may be made on the basis of their research (Willig, 2012).

Broadly, epistemological positions can be considered under three categories: realist, phenomenological, and social constructionist (Willig, 2012). Within a social constructionist framework, there is an assumption that knowledge is constructed through relationships rooted in a cultural, socioeconomic, and sociopolitical context, as opposed to being a product or possession of the individual (Burr, 1995; Gergen, 1999). A phenomenological position assumes that whilst experience is the product of interpretation and, therefore, constructed rather than determined, it is nevertheless 'real' to the person who is having the experience (Willig, 2013). Research informed by this position is therefore concerned with the experiences of different people; particularly the essences and meanings attached to such experiences. Within a realist position there is an

assumption that knowledge exists independently of one's awareness of it. There is a continuum from naïve to critical realism, the former of which posits that knowledge can be derived from observing data and this directly reflects a universal reality which can be logically tested and objectively verified. In contrast, a critical realist position holds the view that the perspective of the observer influences what is perceived, therefore any data gathered from observations is limited in its ability to access 'reality' (Willig, 2012).

Choosing an epistemological position is important as it can influence the methodology and method, which can impact how the findings of the research will make sense in relation to the research questions (Carter & Little, 2007; Harper, 2012). This study adopted a critical realist ontological position, which proposes there is a 'real' world in which physical structures, social structures, and psychological processes exist, independent of the researcher's understanding of them (Willig, 2016). The 'knowledge' explored in this study is based on an assumption that there is a 'real' world within which people suffer adverse life experiences.

If one adopted a realist epistemological perspective, they might take the position that mental health professionals record reality; that they record if they do ask about adverse experiences, and the absence of such recording would mean that they did not inquire, or there was no adversity experienced by the service user. However, it is important to recognise that any data gathered from observations is limited in its ability to access reality (Willig, 2012). A critical realist epistemological position, which is adopted in this study, allows recognition that what mental health professionals document, or fail to document, in clinical records is constructed and shaped by how they make sense of what adversity or abuse is, or what constitutes such experiences. These constructions are also likely to influence my own reading of the clinical records, hence the decision to adopt a critical realist epistemological position.

Whilst objectivity is aimed for, a critical realist position accepts that it is not possible to fully comprehend reality as our perceptions are shaped by our own research interests, and limited by our own biases, and historical, social and cultural lens (McEvoy & Richards, 2006; Trochim, 2000). The critical realist

position argues that data is not a direct mirroring of reality, and that all events are caused by multiple, interacting causal processes at material, individual and societal levels (Elder-Vass, 2012). As a result, critical realists accept that data should be interpreted within a social, historical and cultural context, yet this does not form an obstacle in exploring processes and patterns within the data (Elder-Vass, 2012).

The data used in this study is a perspective on experiences which the researcher was not a part of. Adopting a critical realist position provides recognition that a 'reality' exists; people accessing mental health services are likely to have lived experience of adversities, which clinicians may or may not have asked about. However, the position also allows recognition that what constitutes an adverse experience, to myself, or service users or mental health professionals, is influenced by psychological processes, social factors and cultural interpretations (Morrison, 2001). Therefore, it is acknowledged that my perspective as a white, western, middle-class female researcher, with values and beliefs aligned to critical approaches and the need for empathic, trauma-informed services, likely influences my conceptualisation of adversities. Due to the likelihood of my position influencing my perspectives on adversity, both supervision and a reflective journal were used throughout the research process to enhance reflexivity. This will be discussed further in the 'Reflective Review' section of this thesis. Further methodological attempts to address the potential for bias in relation to how people make sense of adversity will be discussed in more detail later in this chapter.

2.3. Design

The epistemological position, research questions and previous research of a similar nature, informed the design of the current study, which collected data by way of a retrospective audit of 400 clinical records. A cross-sectional, quantitative approach was used to explore existing data from service users' clinical records. This design has been utilised successfully in previous research (Agar et al., 2002; Jones, 2018; Read et al., 1998; Sampson et al., 2017). A large sample was needed in order for sufficient analysis and multiple statistical tests to be used (Dancey & Reidy, 2014). This approach allows investigation of patterns, associations and relationships within data and was taken in order to replicate and extend the previous body of research in this area.

The current study used the Clinical Record Interactive Search (CRIS) database to access mental health service users' clinical records, which in the UK are now primarily held electronically. The CRIS system is a software solution which develops service user clinical records into a research tool. It does so by removing information from an electronic medical record that might identify an individual and then produces a de-identified database that can be used for research. It is jointly funded by the Medical Research Council (MRC) and the National Institute for Health Research (NIHR) and provides authorised researchers with regulated, secure access to anonymised information extracted from the electronic clinical records system of NHS Mental Health Trusts (CRIS, 2019).

2.4. Ethical Issues and Approvals

Ethical approval for this study was obtained from the University of East London's School of Psychology Ethics committee (Appendix C). The CRIS database has specific information governance procedures which mean that despite it allowing access to service users' clinical records, ethical approval was not required from the Health Research Authority which governs NHS research. However, further permissions to access the CRIS database were sought through the Research and Development (R&D) department at the NHS Trust hosting the research. These permissions will be further explained in the procedures section of this chapter.

2.4.1. Confidentiality and Anonymity

Service user data accessed through CRIS is 'de-identified.' This de-identification process involves occluding the following information prior to researchers accessing the database:

- name of the service user
- address details, including postcode
- NHS Number and local NHS Trust identifier
- dates of birth are truncated to display as the first of the month

As a further protection of anonymity, all clinical records within the CRIS database are given a unique local system identification number. This number is randomly assigned and not derived from any information on the service user's record. This number does not allow researchers to identify specific service users and cannot be linked to the service user's NHS Number or identifier within the NHS Trust.

All CRIS users are required to use the database in accordance with specific information governance procedures and relevant NHS Trust policies.

Researcher activity within the CRIS system is monitored for auditing purposes. In addition, whilst all CRIS data is de-identified, the security protocol demands that service user data remains within the NHS Trust firewall so CRIS was only accessed using a secure network connection.

2.4.2. Consent

CRIS operates on an 'opt out' basis where consent is assumed unless service users opt out from the database. Therefore, participants were not specifically asked to consent to their records being used for the current study. Rather, consent was assumed by their clinical record already being in the CRIS database.

2.4.3. Seeking Further Permissions

Once ethical approval had been granted, an application was completed in order to register as a user of the CRIS network. The host research site was identified on the basis of it being a large NHS Trust providing mental health services across a number of London boroughs, which used the CRIS database for the purposes of research. Further to the research site being identified, a project application was submitted to the Research and Development Manager of the NHS Trust, who oversees use of the CRIS database. After the project application was approved, permission was granted to access the CRIS database.

As the holder of an existing NHS clinical contract, I did not require an additional honorary research contract with the NHS Trust hosting the research. Instead, an NHS-to-NHS proforma was completed by my employing NHS trust's Human Relations (HR) department (Appendix E). This confirmed that I was an NHS employee who had passed all the necessary employment and safety checks. Further to this, a letter of access was issued by the NHS Trust hosting the research which confirmed my right of access to conduct research within the trust (Appendix F). Finally, a responsible member of staff was identified within

the host NHS Trust who fulfilled the role of an on-site supervisor and was able to organise access to relevant resources and IT equipment.

2.5. Participants

This study was conducted using anonymised, pre-existing data from the CRIS database. Inclusion criteria were kept fairly broad and included:

- adults (aged 18+) currently accessing community mental health services provided by the NHS Trust research site, whose clinical records were held within the CRIS database
- individuals who had attended an assessment appointment with a mental health professional within the service

Exclusion criteria were as follows:

- clinical records which reported no face-to-face contact with mental health staff
- clinical records active in the system for less than five days
- clinical records which showed that a service user had not had an initial assessment with a mental health professional
- adults accessing specialist services, such as: learning disability, older adult, or diagnosis-specific, or experience-specific services.

All 400 participants were adults accessing community mental health services provided by a large NHS Trust operating across a number of outer London boroughs. The services are not identified further for reasons of confidentiality.

2.6. Materials and Measures

A data sheet (Appendix D) was developed specifically for the current study in order to collect clinical and demographic information from service users' clinical records. This data sheet is based on earlier studies of a similar nature (Agar & Read, 2002; Read et al., 2016). However, to reflect the broader research questions of the current study, a wider range of adverse experiences, which are frequently associated with poor mental health outcomes, were added to the

data sheet. Additions to the data sheet for adversities experienced in childhood were: physical neglect, emotional neglect, bullying, parental loss (via death or separation), child poverty, and growing up in institutional care.

The current study further extended previous research to include adverse experiences occurring in the adult lives of mental health service users, rather than focusing on childhood only. This was reflected on the data sheet by including adverse experiences conceptualised by the Social Care Institute for Excellence (SCIE, 2015). These included: adult neglect and acts of omission, domestic violence, adult physical abuse, adult psychological or emotional abuse, adult sexual assault, financial abuse, modern slavery, and discriminatory abuse.

Consistent with earlier research (Agar, Read & Bush, 2002; Read & Fraser, 1998; Sampson & Read, 2017), the operational definition of adverse experiences was based on what the mental health professional considered adverse and documented in the clients' clinical record. Longden, Sampson and Read (2015) provide an example of a clinical record stating 'sexually abused as a child' being sufficient to code for an adverse experience having occurred. In the current study, a comparative example is the inclusion of a record stating the service user had experienced 'sexual, physical and emotional abuse from age of three.' The clinician did not record 'suffered an adverse experience,' but made clear notes about multiple experiences of adversity in the childhood of this service user. This was enough for the researcher to consider it highly likely that this abuse occurred, and therefore the clinical record was retained for further analysis and scored as containing documentation about adverse experiences.

The data sheet was effectively used as a guide to prompt the researcher to record multiple experiences of adversity, and the response from mental health professionals following disclosures, when reviewing the clinical records. Data were also collected on whether there was evidence that clinicians had actually asked about adverse experiences in the following ways:

- clear documentation in clinical record that service user was asked (they said yes/said no)

- recorded as a disclosure from a service user, but no clear evidence of whether service user was or was not asked
- clear documentation in file that service was not asked (with reason why)
- unclear – documentation of adversity in file, but no clear documentation whether service user was asked, or whether service user disclosed.

The data sheet included a section where data were recorded if a clinical record held no information at all about adverse experiences. The data sheet also facilitated the collection of information on how clinicians responded to cases in which adverse experiences were identified. The response categories were also consistent with earlier research and included:

- the service user was given any advice/counselling/support
- adversity formed part of a formulation
- adversity formed part of a treatment plan
- there was a discussion about whether any previous disclosures had been made and how these were responded to
- there was a discussion about, or actual, referral to specialist provision related to the adversity
- there was a discussion about causal beliefs - whether the client feels there is any connection between the adverse experience and their mental health difficulties
- there was a discussion about reporting the adversity to authorities
- the adversity was reported to authorities.

2.7. Procedure

2.7.1. Data Collection

After the relevant permissions and approvals were granted, a training session was attended at the research site in order to familiarise myself with the use of the CRIS database. Data collection took place at the R&D department of the research site over the course of ten separate visits.

The clinical records of service users currently accessing adult community mental health services within the research site were downloaded from the CRIS database. This produced tens of thousands of clinical records from seven adult community health teams provided by the NHS trust. Due to there being such a large amount of data it was decided that the clinical records from only four of the seven community mental health teams would be reviewed. These four teams were chosen due to their relative size and geographical spread across different London boroughs. Clinical records are generated by the CRIS database on a random basis, and so the first 100 consecutive clinical records were selected from each of the four community mental health teams.

The data were coded as to whether they represented examples of adversity, but a coding frame of the kind often used in research of a qualitative nature was not employed in this study. Gibbs (2007) describes coding as a way of indexing or categorising textual data in order to establish a framework of thematic ideas about it. This way of approaching the data did not fit well with the quantitative design of the study and the form of operationalisation, which relied on what the mental health professional considered adverse and documented in the clients' clinical record at the time. Therefore, the approach taken in the current study involved categorising experiences as adverse, by using the data sheet, which was developed specifically for this study, based on previous research and existing clinical conceptualisations of common adverse experiences in childhood and adulthood (Agar & Read, 2002; Read et al., 2016; SCIE, 2015), as a coding frame in its own right. This enabled instances of adversity to be counted and in order to conduct quantitative data analysis.

The separate data sheet (Appendix D) for each participant was used whilst reading their clinical record to capture data relevant to the research questions. Demographic information was recorded in addition to other factors such as psychiatric diagnoses. Where there were multiple diagnoses listed within the clinical record, which was a frequent occurrence, the most recent diagnosis was recorded on the data sheet.

Data concerning adverse experiences were extracted from the four 'core assessment' forms held in service users' electronic clinical records. Staff working within each of the four mental health teams in the current study are required to complete these core assessment forms for every service user accessing the service. These forms are required to be updated after each assessment and when new 'key' information becomes known about. The information in the core assessment forms can therefore span a number of months or years, as this area of the clinical record should be regularly updated so that key information is easy to access to all relevant professionals. There is a core assessment form for each of the following:

- mental health history
- presenting situation
- social history, accommodation and support
- mental state exam

Rather than reading all participants' clinical records in their entirety, only the core assessment parts of the record were reviewed. This decision was made for a number of reasons. Firstly, the electronic files of service users were difficult to navigate and frequently spanned many years, sometimes decades, of clinical notes. Where people had accessed inpatient services, the electronic record was especially difficult to navigate due to the sheer number of clinical notes and observations recorded. The purpose of the core assessment forms within electronic records is to hold key information about the client's history and present situation. If, for example, a service user had experienced abuse and disclosed this to a mental health professional, the clinician should briefly record this information within the core assessment area of the record, and provide a more detailed documentation within the clinical notes. Whilst this approach

allowed for an accurate reflection of current practice, it relied on clinicians using the core assessment forms appropriately.

The largest number of clinical records as possible within the time frame were analysed. The total time spent collecting data amounted to 20 days. Each core assessment form was read in its entirety for all 400 participants, taking approximately 20 minutes per participant, resulting in 133 hours across fifteen days. When adverse experiences were identified within a core assessment form, the whole clinical record was read in its entirety, including the progress notes, in order to extract further detail pertinent to the research questions. This took on average a further 45 minutes per participant, which was a total of 39 hours across five days. Travel time to the research site was 80 minutes per day, which totalled approximately 13 hours across the ten days of data collection.

2.7.2. Retaining Clinical Records for Analysis

In eight cases where a clinical record included notes indicating that adverse events may have occurred but the clinician had not clearly stated this to be the case, and/or the researcher assessed the note to be not obviously conclusive, the researcher and Director of Studies (DOS) independently judged whether it was 'highly probable' that an adversity had been experienced. This approach was used in previous studies, in which the criterion for 'highly probable' was a blinded, independent individual subjective estimation of 95% certainty that the adversity had occurred (Agar & Read, 2002; Sampson & Read, 2017; Read & Fraser, 1998). The impact of this will be further explored in the Discussion section.

In five of the eight cases both the researcher and the DOS independently judged an event in a clinical record to be 'highly probable' and these were included for analysis. The process for determining inclusion involved the DOS reviewing the clinical notes about possible abuse extracted from the client recorded which had been transferred to the data sheet. Three clinical records were excluded from the analysis as a result of this process, due to both the

researcher and DOS agreeing that there was not enough information about adversity to include the clinical record.

Data extracted from clinical records were on occasion unclear and difficult to transfer to the data sheet. As already discussed, it was rare that clinicians recorded clearly and definitively that individuals had, for example, 'experienced child emotional neglect.' As a result, the data sheet was used as a frame of reference in order to aid categorization of adverse experiences. Other records provided clearer, more detailed documentation about adversities. For example, a clinical record included for documentation for DV stated '...talked about the domestic violence she has experienced in the past' and elsewhere in the notes '...blames her mental illness on this experience.' An example of a record included for multiple adverse experiences was '...bullied and sexually abused by brother,' 'physical abuse' and 'death of father' in childhood. Another example of a clinical record included for documentation of CPA is: '...he reported that his mother frequently hit him as a child.'

In order to further illustrate the process of decision-making as to whether clinical records signified experiences of adversity, and should be retained for analysis, exemplars are included in the appendices. For purposes of confidentiality, the exemplar data sheets have been modified in order to contain only relevant information for the purpose of this illustration. Appendices G and H show examples of clinical records which demonstrate clearly that adverse experiences in the lives of clients were recorded in their file by mental health professionals. Appendix G is an anonymised and condensed version of a male service user's data sheet, which refers to him experiencing bullying and child physical abuse. Appendix H is an exemplar of female service user's data sheet which contains clear information relating her experiencing child physical, emotional and sexual abuse, in addition to growing up in foster care.

Appendices I and J are examples of anonymised data sheets which were initially rated as 'query' clinical records showing documentation of adverse experiences, but were included for analysis after discussion with the DOS. Appendix I is a redacted and anonymised data sheet for a male service user whose clinical record indicated that he had reported experiences of detainment

and torture in his country of origin. This data sheet was initially marked as a query due to the quantity of documentation about adversity being relatively small in comparison to other clinical records. In addition, torture was not listed as a category on the data sheet as it does not feature in the types of adult abuse conceptualised by the SCIE (2015), so it was unclear how to categorize this experience. Following review by the DOS, it was agreed that it was highly probable that the adverse experience had occurred, and that rather than adapting the data sheet to expand categories of adversity, the information should be included as an example of 'adult physical abuse.' It was felt that adaptations to the data sheet would likely create confusion, especially due to the high number of clinical records being reviewed. However, it is acknowledged that this decision might not have been the most useful. This is explored further in the Discussion chapter.

Appendix J is a condensed and anonymised data sheet for a male service user whose clinical record indicated that he experienced CSA. This record was initially a query as the documentation suggests that the clinician conceptualised the experience as CSA, but this view did not appear to be shared by the client themselves. Following discussion with the DOS it was agreed that this data sheet would be retained for analysis as the clinician's notes demonstrate that they perceived the information as relating to CSA, evidenced by their suggestion of this to the client and reference to the Trust policy about historical abuse.

Finally, appendices K and L are examples of anonymised data sheets which were not included for further analysis. Both of these data sheets were excluded on the basis that they lacked sufficient information about adverse experiences, even after each clinical record had been read in their entirety. The first example documents a service user having a 'troubled upbringing,' but there was no further information about these experiences within the clinical record. The second data sheet excluded from analysis detailed a client's 'religious and strict' caregiver, but again, there were no further details in the file to support this record being retained for analysis.

2.8. Statistical Analyses

The Statistical Package for the Social Sciences, version 23 (IBM SPSS, 2015) was used for all statistical analyses. Descriptive statistics were computed for participant demographics, the total number of adverse experiences documented in clinical records and the total number of clinician responses to disclosures. A series of Mann-Whitney tests were used to analyse differences involving non-parametric continuous variables. Differences between proportions were tested for statistical significance with the Chi-Square test for independence, using the Yates Continuity Correction, in order to prevent overestimation of statistical significance for small data (Field, 2013). Pearson's correlations were used to analyse differences involving continuous variables, including age of the participants.

3. RESULTS

3.1. Overview

This chapter outlines the participant demographics, exploration of the distribution of data, the relationship between variables of interest and demographic characteristics, and the main analyses for each of first two the research questions.

3.2. Participant Demographics

Participant demographics and characteristics for the 400 individuals in this study are shown in Table 1. The mean age of participants was 50.9 years (SD: 11.56). There were 235 men (58.8%) and 165 women (41.3%). The majority of participants were recorded on the electronic system as being White British (54.5%), followed by Black or Black British (18.8%) and Asian or Asian British (15.3%). A majority of participants were categorised as having a psychotic disorder (83.8%) according to their care cluster (care pathway within the service linked to payment by results). The most frequent diagnosis, by far, was Paranoid Schizophrenia (67%), followed by Schizoaffective Disorder (9.3%) and Bipolar Affective Disorder (8.5%).

Table 1: Summary of Participant Demographics for Total Sample

Demographic	Subcategory/Range	n (% of participants) / Mean (SD)
Gender	Male	235 (58.8%)
	Female	165 (41.3%)
Age	22-80 years	50.9 years (SD: 11.56)
Clinical Service	CMHT Location 1	100 (25%)
	CMHT Location 2	100 (25%)
	CMHT Location 3	100 (25%)
	CMHT Location 4	100 (25%)
Ethnicity	White British	218 (54.5%)
	Black or Black British	75 (18.8%)
	Asian or Asian British	61 (15.3%)
	Any Other Background	46 (11.5%)
Psychiatric Diagnosis	Paranoid Schizophrenia	268 (67%)
	Schizoaffective Disorder	37 (9.3%)
	Bipolar Affective Disorder	34 (8.5%)
	Emotionally Unstable Personality Disorder	17 (4.3%)
	Recurrent Depressive Disorder	13 (3.3%)
	Mental and behavioural disorders due to use of cannabinoids	4 (1%)
	Generalised Anxiety Disorder	3 (0.8%)
	Obsessive Compulsive Disorder	3 (0.8%)
	Borderline Personality Disorder	3 (0.8%)
	Post-Traumatic Stress Disorder	1 (0.3%)
	Other	17 (4.3%)
Care Cluster	Psychotic	335 (83.8%)
	Non-Psychotic	65 (16.3%)

n: Number of participants; SD: Standard Deviation.

3.3. Distribution of Data

To ascertain whether the distribution of continuous data met the assumptions for use of parametric tests, the data were initially explored using histograms and boxplots (Appendix G). Additional statistical tests to check the distribution included a series of Shapiro-Wilk calculations as well as inspecting the skewness and kurtosis values. The Shapiro-Wilk test of normality was used due to its ability to detect differences from normality in both small and large sample sizes (Field, 2013). This test has also been found to have better power than other normality tests, including the Kolmogorov-Smirnov (K-S) test, even after the Lilliefors correction (Steinskog, 2007). The Shapiro-Wilk test demonstrated that all variables except for the age of service users were non-normally distributed (see Table 2).

It has been suggested that in samples with 200 or more participants, visual representations of data distribution should be used in addition to skewness and kurtosis statistics to ascertain whether data is normally distributed (Field, 2009; Tabachnick & Fidell, 2014). The z-scores (>1.96 , $p<0.05$) indicated significant problems with skewness, kurtosis or both, except for the age of service users. Together, these visual and statistical representations of data distribution within the sample indicated that much of the data, except for service user age, was not normally distributed.

Data transformations can be a useful statistical tool in order for thorough analysis (Field, 2009). However, the transformation of non-normally distributed data can lead to difficulties with the interpretation of variables if the scale is meaningful, and often do not remedy data distribution issues (Tabachnick & Fidell, 2014; Wright & Field, 2009). In the current study, there were meaningful scales concerning both the number of adverse experiences documented in clinical records, and the number of appropriate responses provided by clinicians once adverse experiences became known about. As a result, the data were not transformed and analysis proceeded with the use of non-parametric tests.

Table 2: Descriptive Statistics of Variables of Interest

Variable	N	Mean	SD	Range	Skewness Z-score	Kurtosis Z-score	Shapiro- Wilk
Age	400	50.90	11.56	22-80	0.54	-2.94	0.99; p=0.001
Total Adverse Experience Types	400	0.30	0.95	0-6	30.43	59.30	0.37; p <.001
Total Response Types	400	0.57	1.67	0-8	23.54	28.53	0.38; p <.001

n: Number of participants; SD: Standard Deviation.

3.4. Research Question One: To what extent are experiences of adversity identified and recorded by mental health professionals working in adult mental health services?

Descriptive statistics were used to ascertain the extent to which adverse experiences were documented in the clinical records of service users. Of the 400 participants, 52 individuals (13.0%) had one or more form of adverse experience recorded in their clinical record. These included adverse experiences in either childhood or adulthood. Table 3 shows the types of adverse experience which clinicians had documented in the service user records. Three clinical records were excluded from analysis as it was not deemed 'highly probable' by the Director of Studies and Researcher that the adversity had occurred. There was one clinical record retained for analysis due to documentation of CSA in the core assessment form, which held further documentation about adversities (DV, sexual assault, and financial abuse) elsewhere in the record. None of these further adversities were recorded in the core assessment form in the client's clinical record.

3.4.1. Adverse Experiences in Childhood

Forty-two clinical records had one or more childhood adversities recorded. Twenty-nine service users (7.2%) had CSA recorded in their file, 18 (4.5%) had CPA, and nine (2.3%) had childhood emotional abuse (CEA) documented. Three (0.8%) had childhood emotional neglect (CEN) recorded. None of the clinical records contained documentation of physical neglect in childhood. Eleven (2.8%) had bullying recorded, seven (1.8%) had a history of being fostered or adopted, and two (0.5%) had parental loss documented. Only one (0.3%) contained documentation of child poverty. Twenty-one (5.3%) service users had one type of adverse experience recorded, 11 (2.8%) had two types, four (1%) had three types, five (1.3%) had four types, and one (0.3%) had five different types of adversity documented in their file.

3.4.2. Adverse Experiences in the Adult Lives of Service Users

Twenty-six service users had one or more adulthood adversities recorded.

Thirteen (3.3%) of the 400 service users had domestic violence recorded in their file, ten (2.5%) had sexual assault recorded, and eight (2%) had physical abuse recorded. Only five (1.3%) service users had some form of psychological or emotional abuse documented in their clinical record, and three (0.8%) had financial abuse recorded. Two (0.5%) of the 400 service users had experienced discriminatory abuse in adulthood and had this recorded in their clinical record, and only one (0.3%) service user had neglect recorded in their file. None of the 400 files contained documentation relating to modern slavery.

Fifteen (3.8%) service users had one type of adverse experience recorded, nine (2.3%) had two types, one (0.3%) had three types, and one (0.3%) had six different types of adulthood adversity documented in their clinical record.

Table 3: *Adverse Experiences Documented in the Clinical Records of Service Users*

Adverse Experience	Number of adverse experience types documented in file
Any adversity	N = 52 (13%)
Child Physical Neglect	0 (0%)
Child Emotional Neglect	3 (0.8%)
Child Physical Abuse	18 (4.5%)
Child Emotional Abuse	9 (2.3%)
Child Sexual Abuse	29 (7.2%)
Bullying	11 (2.8%)
Parental Loss	2 (0.5%)
Child Poverty	1 (0.3%)
Fostering/Adoption	7 (1.8%)
Adult Neglect	1 (0.3%)
Domestic Violence	13 (3.3%)
Adult Physical Abuse	8 (2%)
Adult Psychological/ Emotional Abuse	5 (1.3%)
Adult Sexual Assault	10 (2.5%)
Adult Financial Abuse	3 (0.8%)
Adult Modern Slavery	0 (0%)
Adult Discriminatory Abuse	2 (0.5%)

n: Number of participants

3.4.3. Inquiry about Adverse Experiences

The clinical records of the 52 service users who had at least one adversity documented in their 'core assessment' forms were read in their entirety. The rates of inquiry were recorded for each of the individuals for whom adverse experiences were known about. Only four (7.7%) of the records contained clear evidence that the individual had been asked by a mental health professional if they had experienced adversities. Two service users had been asked if they had experienced adversity and confirmed that they had, and two had been asked and replied they had not. Seventeen (32.7%) had documentation suggesting they made a voluntary disclosure relating to adverse experiences. For the majority (31; 59.62%) it was unclear how the adverse experience had come to be known. These numbers were too low to allow further analyses of the kind presented next in relation to documentation.

3.4.4. Participant Characteristics in Relation to Documentation of Adverse Experiences

The majority (61.5%) of the 52 service users who has some form of adult or childhood adverse experience recorded in their file were women. The mean age of the 52 was 47.8 years (SD 10.42). Twenty-five (48.1%) had a diagnosis of Paranoid Schizophrenia, and a majority (36; 69.2%) were categorised under a psychotic care-cluster. The CMHT in location one had the highest number of clinical records within which adverse experiences were documented. In contrast, the CMHT in location three held the least number of records, with only seven service users out of 100 having adversities recorded in their file. Table 4 summarises the demographics of this subset.

Table 4: *Summary of Subset Participant Demographics*

Demographic	Subcategory/Range	n (% of participants) / Mean (SD)
Gender**	Male (n = 235)	20 (8.5%)
	Female (n = 165)	32 (19.4%)
Age	22-80 years	47.81 years (SD: 10.42)
Clinical Service**	CMHT Location One (n = 100)	23 (23%)
	CMHT Location Two (n = 100)	13 (13%)
	CMHT Location Three (n = 100)	7 (7%)
	CMHT Location Four (n = 100)	9 (9%)
Ethnicity	White British (n = 218)	32 (14.68%)
	Black or Black British (n = 75)	7 (9.3%)
	Asian or Asian British (n = 61)	7 (11.47%)
	Any Other Background (n = 46)	6 (13%)
Psychiatric Diagnosis	Paranoid Schizophrenia (n = 268)	25 (9.33%)
	Schizoaffective Disorder (n = 37)	3 (8.11%)
	Bipolar Affective Disorder (n = 34)	5 (14.7%)
	Emotionally Unstable Personality Disorder (n = 17)	8 (47%)
	Recurrent Depressive Disorder (n = 13)	5 (38.46%)
	Mental and behavioural disorders due to use of cannabinoids (n = 4)	1 (25%)
	Generalised Anxiety Disorder (n = 3)	1 (33.33%)
	Borderline Personality Disorder (n = 3)	1 (33.3%)
	Post-Traumatic Stress Disorder (n = 1)	1 (100%)
	Other (n = 17)	2 (11.76%)
Care Cluster**	Psychotic (n = 335)	36 (24.61%)
	Non-Psychotic (n = 65)	16 (%)

n: Number of participants; SD: Standard Deviation, ** significant at $p < 0.01$.

3.4.4.1. *Research hypothesis one: adversities experienced by male service users will be identified and recorded less often than female service users*

Research hypothesis one aimed to test whether there was a difference in the number of adverse experiences recorded in files according to the gender of service users. It was hypothesised that adversities experienced by male service users would be identified and recorded less often than female service users. The data supported this hypothesis. A Mann-Whitney U test indicated that gender was significantly related to the overall number of adverse experiences documented. Females ($Mdn = 214$, $n = 165$) had a significantly great number of adverse experiences documented than males ($Mdn = 191$, $n = 235$) ($U = 17138$, $Z = -3.41$, $p = .001$, $r = -.17$). According to Cohen's (1988) guidance on the interpretation of effect size, this is a small effect. However, Lakens (2013) suggests rather than relying on arbitrary cut offs, effect size should be interpreted in relation to other effects in the literature and the practical consequences of the effect.

To further explore this finding, a series of Chi-square tests for independence were used to explore the relationship between gender and specific adverse experiences. Due to the small number of adverse experiences recorded in clinical files, calculations were only computed for adversities that were most frequently recorded in the records (CSA, DV, CPA, bullying). Twenty-nine clinical records contained documentation about CSA. Of these, 19 (65.5%) were female service users and ten were male (34.5%). A Chi-square test for independence, with Yates Continuity Correction, indicated a significant association between gender and documentation of CSA, $\chi^2(1, n = 400) = 6.56$, $p = .01$. All 13 of the clinical records containing documentation about DV belonged to female service users rather than males: $\chi^2(1, n = 400) = 16.71$, $p = <.001$

Eighteen of the clinical records had documented experiences of CPA. Eleven (61.1%) of these were female service users and seven (38.89%) were males. There was no significant association between gender and documentation of CPA, $\chi^2(1, n = 400) = 2.27$, $p = .13$. Similarly, there were 11 documented

experiences of bullying. Seven (63.6%) of these records belonged to male service users, and four (36%) belonged to female service users. Again, there was no significant association; $\chi^2(1, n = 400) = .001, p = .98$.

3.4.4.2. Research hypothesis two: age of service users will be negatively related to the probability of adversities being identified and recorded in their file

The second hypothesis aimed to test whether there was a difference in the number of adverse experiences recorded in files according to the age of service users. It was hypothesised that adversities experienced by older service users would be identified and recorded less often than younger service users. The data did not support this hypothesis. A Pearson's correlation was computed to assess the relationship between age and the number of adverse experiences documented within the clinical records. There was no significant correlation between the two variables, $r = -.06, n = 400, p = .255$.

3.4.4.3. Research hypothesis three: service users with a diagnosis indicative of psychosis will be less likely to have adversities identified and recorded in their file than individuals with a non-psychotic presentation

The third research hypothesis aimed to test whether having a diagnosis indicative of psychosis was associated with having less adverse experiences identified and recorded in clinical records. It was hypothesised that adversities experienced by individuals with psychosis would be identified and recorded less often than individuals with a non-psychotic presentation. The data did supported this hypothesis. Individuals with a diagnosis indicative of psychosis were less likely to have adverse experiences documented ($Mdn = 197, n = 335$) than those categorised in a non-psychotic care cluster ($Mdn = 221, n = 65$); $U = 9546, Z = -2.71, p = .007, r = -.14$).

People categorised as psychotic were significantly more likely to have CSA ($\chi^2 = 6.26, df = 1, p = .01$) and DV ($\chi^2 = 6.70, df = 1, p = .01$) documented. There was no significant relationship between care cluster and rates of documentation for CPA or bullying.

3.4.4.4. CMHT site

The 23 adverse experiences recorded at CMHT 1 ($Mdn = 108$, $n = 100$) was significantly higher than the seven recorded at CMHT 3 ($Mdn = 93$, $n = 100$), $U = 4257$, $Z = -2.97$, $p = .003$, $r = -.21$, and the nine recorded at CMHT 4 ($Md = 94$, $n = 100$), $U = 377.500$, $Z = -2.42$, $p = .016$, $r = -.17$. There were no other significant differences found between CMHT services (see Table 5).

Table 5: Mann-Whitney U Tests of CMHT Location and the Number of Adverse Experiences Documented in Clinical Records

U	n	Median	Z-score	r^1	p-value
4577.500	CMHT 1: 100 CMHT 2: 100	CMHT 1: 105 CMHT 2: 96	-1.56	-.11	.119
4257.00	CMHT 1: 100 CMHT 3: 100	CMHT 1: 108 CMHT 3: 93	-2.97	-.21	.003**
4377.500	CMHT 1: 100 CMHT 4: 100	CMHT 1: 107 CMHT 4: 94	-2.42	-.17	.016*
4696.00	CMHT 2: 100 CMHT 3: 100	CMHT 2: 104 CMHT 3: 97	-1.43	-.10	.154
4791.500	CMHT 2: 100 CMHT 4: 100	CMHT 2: 103 CMHT 4: 98	-0.94	-.07	.35
4898.00	CMHT 3: 100 CMHT 4: 100	CMHT 3: 99 CMHT 4: 102	-0.53	-.04	.6

n: Number of participants; ** significant at $p < 0.01$, * significant at $p < 0.05$.

¹ Effect size was calculated by z-score divided by the \sqrt{N} , with N referring to the total participant number for a given comparison (Field, 2013).

3.5. Research Question Two: How do mental health professionals working in adult mental health services respond to disclosures of adversity?

Further analyses were conducted on the data from the 52 clinical records which contained documentation of adverse experiences, in terms of how the service responded to knowledge of the adversities.

3.5.2. Responding to Disclosures of Adverse Experiences

Table 6 shows what was recorded in the medical records about how mental health professionals responded to service users when adverse experiences were known about. The mean number of responses to adversities was 4.35. Five (9.6%) service users received no response at all, one (1.9%) received two responses, two (3.8%) received three responses, eight (15.4%) got four responses, 15 (28.8%) got five responses, and 16 (30.7%) got six or more responses.

3.5.2.1. Providing adversity-related support

There were 52 files in which adverse experiences were recorded (Table 6). Forty-seven of the 52 files (90.4%) contained documentation that the service user was offered some type of relevant advice or support following disclosure of an adverse experience. This ranged from being given information about DV and financial abuse, to being referred for sheltered accommodation or being accompanied to a police station in order to report abuse.

Forty-two of the 52 participants (80.8%) with documented adverse experience were referred to a specialist provision related to the adversity. This included support accessed within the CMHT, most often referrals to Clinical Psychology and Psychotherapy. Some service users were also referred to external agencies, such as Citizen's Advice and local charities.

3.5.2.2. Formulations and treatment plans

Summary formulations which made reference to adverse experiences were present in 39 of the 52 clinical records (75%). Thirty-eight of the 52 files (73.1%) included treatment plans which related to the adversity experienced by the service user.

3.5.2.3. Documentation of previous disclosures

Only five of the files (9.6%) in which adverse experiences were recorded included documentation concerning whether any previous disclosures had been made and how these had previously been responded to.

3.5.2.4. Causal beliefs

Discussion about causal beliefs, particularly whether the service user perceived there to be any connection between the adverse experience and the mental health difficulties, was found in 26 of the 52 files (50%).

3.5.2.5. Reporting to legal authorities

Sixteen of the 52 files (30.8%) contained documentation that a discussion with the individual about reporting the adversity to authorities had taken place. Thirteen of the 52 files (25%) included documentation that the adversity was actually reported to legal authorities. Reporting of adverse experiences to authorities was not always a direct consequence of the discussion. There were eight instances where discussions were recorded about reporting the adverse experience to legal authorities, with the client indicating that this had already been done, and the mental health professional documenting this in their record. Only five of the clinical records contained documentation confirming that the adversity had been reported to authorities following contact with the CMHT.

Table 6: *Responses from Mental Health Professionals*

Response Categories		n (% of the 52 participants with adverse experiences documented in their clinical record)
Response 1	Any type of response	47 (90.4%)
Response 2	Adversity formed part of a formulation	39 (75%)
Response 3	Adversity formed part of a treatment plan	38 (73.1%)
Response 4	Discussion about whether any previous disclosures had been made and how these were responded to	5 (9.6%)
Response 5	Discussion about, or actual, referral to specialist provision related to the adversity	42 (80.8%)
Response 6	Discussion about causal beliefs in relation to mental health difficulties	26 (50%)
Response 7	Discussion about reporting the adversity to authorities	16 (30.8%)
Response 8	Adversity was reported to authorities	13 (25%)
No Response	No response documented in file	5 (9.6%)

n: Number of participants

3.5.3. Variables Related to Level of Response from Clinicians

3.5.3.1. *Gender*

There was no significant overall difference in the number of appropriate responses provided by a clinician once adverse experiences became known about according to the gender of the service user being male ($Mdn = 4, n = 20$) or female ($Mdn = 5, n = 32$), $U = 233.00$, $Z = -1.67$, $p = .096$, $r = -.22$.

3.5.3.2. *Diagnostic cluster*

The number of appropriate responses provided by clinicians were not significantly different according to whether service users were categorised within a psychotic care cluster ($Mdn = 5, n = 36$) or a non-psychotic care cluster ($Mdn = 5.50, n = 16$), $U = 201.00$, $Z = -1.76$, $p = .079$, $r = -.24$.

3.5.3.3. *CMHT site*

There was no significant difference in the total number of appropriate responses documented in clinical records across the four CMHTs.

3.6 Case Examples: Good Practice

Examples of good practice highlight areas where practice and policy are working well to identify adversity and to support service users. One individual's clinical record contained repeated documentation concerning CSA and bullying, in relation to the CSA, experienced as a child (there was no clear documentation about inquiry, so we do not know whether the disclosures were spontaneous or elicited). The adverse experience was included in a psychological formulation and formed part of a treatment plan which involved a referral for psychotherapy relating to the adversities. The file contained clinical notes concerning a discussion about the role these adverse experiences played in the onset of psychological distress. In addition, the notes documented a discussion about reporting the CSA to police as well as confirmation that this was done, with consent, by a mental health professional within the team.

Another service user's file contained details of DV, with documentation spanning a number of years that she was known to the service. After discussion about how she 'blames her mental illness on this experience', a referral to psychology was offered. A social worker's clinical notes described how the service user was 'asked whether she suffered any abuse as a child' in addition to inquiry about current financial, psychological, and physical abuse within a relationship. In one individual's clinical record, past CSA, and current DV was disclosed and documented. The individual was given information about DV and financial abuse. A referral was made to psychology and the clinician accompanied the service user to a police station in order to report current financial abuse. (However, there was no mention of CSA being reported to authorities).

3.7 Case Examples: Practice in Need of Review

Apart from the 348 cases where services know nothing about adversities, there are cases that show starkly how histories of adverse experiences can be known about, yet not acknowledged within services. In a number of clinical records, adverse experiences were identified either at initial assessment or during later interactions with mental health staff, and the information was then added to the core assessment forms. However, there was no further mention of the adverse experiences. For example, the file for a service user who came to the UK as a refugee contained clinical notes referring to him being imprisoned, 'having problems with the government' and 'tortured'. Despite this, there was no documentation of enquiry, referrals, therapy or any further mention of this in later clinical notes. Another file contained documentation of past DV, including 'physical, verbal and emotional abuse.' Whilst this information was held in the core assessment documentation, it was not included in any formulations or treatment plans.

A male service user's file contained clinical notes referring to how his 'father had sexually abused him' and his experience of 'physical and psychological abuse' as a young adult. However, his clinical record showed no evidence of a referral to an appropriate provision related to the adverse experiences, and the information was not included in any treatment plan or formulation. There was no documented discussion about how these experiences linked to the service user's current experience of mental health difficulties, nor was there any discussion about reporting the abuse to authorities. Finally, the clinical records of a female service user referred to her disclosing that she had been 'raped'. Clinical notes suggest that it is unclear to what extent her account is 'coloured by her psychosis', yet there is no documentation of attempts to enquire or investigate this further, despite her being referred to a clinical psychologist.

4. DISCUSSION

4.1. Overview

This chapter summarises the findings addressing the research questions and considers them in the context of existing literature. There follows a discussion about the development of conceptual and theoretical frameworks concerning routine enquiry. Strengths and limitations are outlined, before the implications of these findings for clinical practice, research, and wider societal contexts are then discussed. A reflective account is provided before a final summary and conclusion highlights the key findings and implications of the research.

4.2. Aims and Summary of Findings

This thesis aimed to investigate whether mental health professionals working in adult community mental health services routinely ask clients about adverse experiences, and how professionals respond when such experiences become known. It is NHS policy that clinicians inquire about such experiences routinely and consistently (DoH, 2008). Despite this, research demonstrates that most people who use mental health services are never asked about adverse experiences, including childhood abuse or neglect (Mansfield et al., 2016; Read et al., 2017; Sampson & Read, 2016; Xiao et al., 2016). Whilst previous studies have tended to focus on CSA and CPA, this study sought to address gaps in the literature by including other forms of childhood adversity, as well as those experienced in adulthood. Three research questions guided this exploration, the findings of which are discussed below.

4.2.1. Research Question One: To What Extent are a Range of Experiences of Adversity Identified and Recorded by Mental Health Professionals Working in Adult Mental Health Services?

In this sample of 400 adult mental health service users, only 52 (13%) clinical records contained documentation of one or more forms of a broad range of adverse experience. Forty-two (10.5%) clinical records had one or more childhood adversities recorded, and 26 (6.5%) service users had one or more adulthood adversities recorded. Prevalence rates of the number of adverse experiences documented within records were even poorer than documentation of adversities in previous studies. A 2006 USA study found that 28% of clinical records contained documentation of adverse experiences (Cusack et al., 2006). A more recent study reported that 38% of 129 attenders of inpatient and outpatient services in Ireland had adversities recorded in their file, yet 77% had experienced one or more adverse experience when assessed by the CTQ (Bernstein & Fink, 1998; Rossiter et al., 2015). Two Australian studies (Mansfield et al., 2016; Xiao et al., 2016) reported similar rates of documentation about adverse experiences in clinical records: 53% and 49% respectively. These rates are much higher than the 13% rate in the current study. The findings therefore support previous assertions that experiences of adversity are not routinely identified and recorded in the clinical records of adult mental health service users (Mansfield et al., 2016; Sampson & Read, 2016; Xiao et al., 2016).

Prevalence rates of documentation in which inquiry had definitely occurred (versus spontaneous disclosure) were lower in this study than in previous studies. Only four of the clinical records (1%) showed clear evidence that the service user had been asked by a clinician if they had experienced adversities. (Two individuals had been asked and confirmed that they had, and two were asked and replied that they had not.) Previous research in Australia found that of 100 files, 24 included documentation of CSA and a further 29 had evidence that clients had actually been asked about this (Mansfield et al., 2016). In a New Zealand sample, 164 files (64%) had some form of adult or childhood abuse or neglect recorded. In 153 (61.2%) of the files, clinicians had recorded information in the abuse/neglect section of an assessment form, indicating that inquiry had

taken place (Sampson & Read, 2017). In the current study, however, it is unclear how many of the reports of adversity in the other 50 files were the result of spontaneous disclosure or active inquiry.

It is probable, moreover, that there were instances where service users were asked about adverse experiences without the question or answer being documented in their clinical record. There are a number of reasons why such information might be missing, including: it being documented in the wrong part of the clinical record, it being lost in the transition to electronic records, it being deemed too sensitive to be held in a 'public' area of the record. It is therefore not possible to calculate exactly how many service users were asked about adverse experiences. What is clear however, from the 13% result, is that the majority of adverse experiences experienced by these 400 users of adult mental health services were not identified in their clinical records. This is consistent with the recent review of the literature which found that in nine studies, less than one-third (28%) of abuse and neglect identified by researchers had been documented in clinical records, let alone responded to therapeutically (Read et al., 2017). The figures for emotional neglect and physical neglect were even poorer; 17% and 10% respectively.

4.2.1.1. Adverse experiences in childhood

Comparison with similar studies (Rossiter et al., 2015; Sampson & Read, 2017) allows for a more detailed examination of the findings concerning adverse experiences in childhood. As shown in Table 7, the number of adversities documented in clinical records is poorer in this study than in previous research. Overall, 42 (10.5%) clinical records had one or more childhood adversities recorded. This is significantly smaller than the range of 38–56% reported in the Irish and New Zealand studies (Rossiter et al., 2015; Sampson & Read, 2017). Only 7.2% of clinical notes contained documentation of CSA, in comparison to rates of 8% and 32%. For CPA, 4.5% of individuals had this recorded in their files, in comparison to 20% and 36%. For emotional abuse, the rate of documentation was 2.3%, compared with previous rates of 25%–35% in the other studies.

The identification and documentation of emotional and physical neglect in childhood has been extremely low in previous research, with rates of between 5%–7% for physical neglect and 13%–21% for emotional neglect. This is despite neglect being the most common form of child maltreatment in Britain (Davies et al., 2015). However, no documentation whatsoever of physical neglect was found in the current study. For emotional neglect, only 0.8% of files had this recorded.

Table 7: *Documentation of Childhood Adversities in Comparison with Previous Studies*

Documentation	Rossiter et al., (Ireland – 2015)	Sampson & Read (New Zealand – 2017)	Current study (UK – 2019)
Any child adverse experience	38%	56%	10.5%
Sexual abuse	8%	32%	7.2%
Physical abuse	20%	36%	4.5%
Emotional abuse	25%	35%	2.3%
Physical neglect	5%	7%	0%
Emotional neglect	13%	21%	0.8%

There is no obvious reason why the number of adversities documented in clinical records would be poorer in this study in comparison to previous research. It is unlikely, for example, that clinical practice varies to a significant extent across the three countries in which research has taken place. However, one way to explain this finding could be that by only reviewing the core assessment section of the clinical records for the 400 participants, documentation of adversities elsewhere in the record was missed. For this reason, the New Zealand study (Sampson & Read, 2017) provides the most direct comparison as it looked at documentation following a clients' initial assessment. They found that 115 files (46.06%) indicated that a disclosure of

abuse or neglect, either spontaneous or following enquiry, had taken place during the initial assessment. This study took place after years of training programmes within the services, specifically focused on asking about adverse experiences, which could explain the larger number of adversities documented within clinical records.

As with the findings already discussed, the data does not allow a definitive answer as to why the number of adversities documented in clinical records would be poorer in this study in comparison to previous studies. Whilst the lower number could be a result of only reviewing the core assessments for each participant, another potential explanation could be the difference between the samples in each of these studies. The vast majority of participants in this study (83.8%) were categorized within a psychotic care cluster, and 67% of participants had Paranoid Schizophrenia listed as a primary diagnosis within their clinical record. In contrast, only 14% of the participants in the 2002 New Zealand study (Agar & Read, 2002) had a diagnosis of Schizophrenia, and only 23% of the participants in the 2016 study (Read et al., 2016) had a diagnosis indicative of psychosis. It has been established that individuals with a psychosis presentation are less likely to be asked about adversities and have lower rates identified in their files (Agar et al., 2002; Cavanagh et al., 2004; Cunningham et al., 2016; Young et al., 2001). The high prevalence of psychosis within this sample, could therefore explain to some extent, the low rates of documentation of adversities in this study in comparison to previous research.

This study expanded the research base to include a wider range of adverse experiences. There is no existing literature on whether childhood experiences such as bullying, loss of a parent, or growing up in institutional care or poverty are asked about within mental health services, despite our knowledge of how these adversities relate to poor mental health (Felitti et al., 1998; Kessler et al., 2010). Even without comparison to other research, the low number of adversities documented in clinical records is concerning, and suggests that these other adversities should be included in future research endeavours.

Only 2.8% of the records contained documentation about bullying in childhood. In the general public, approximately 11% of children are bullied on a regular

basis (van Dam et al., 2012). Research indicates that a history of bullying in childhood is particularly common in adults at high risk for psychosis (Valmaggia et al., 2015). The majority of the service users in the current study (83.8%) were categorised within a psychotic care cluster. We can assume, therefore, that well above 11% of the service users had been bullied, and that the 2.8% represents a small fraction of that bullying.

Inquiry about experiences of growing up in foster or adoptive care has not been assessed in previous research. Nationally, the percentage of children and young people looked after by the local authority ranges from 0.4% to 1.2% (Care Quality Commission, 2018). Rates of mental health difficulties are known to be higher within this population. A 2003 survey by the Office for National Statistics (ONS) reported that 45% of young people looked-after between the ages of 5–17 years were assessed as having a mental health difficulty. In this study, 1.2% of participants had experiences of growing up in foster or adoptive care documented in their records. The number of records containing documentation about loss of a parent in childhood were even fewer than other adversities, just 0.5%. It is difficult to draw conclusions, as there is no comparative research, but the figure for growing up in foster or adoptive care is, at least, in line with approximate figures in the general population.

The number of records containing documentation about growing up in poverty was the smallest of any of the adversities in childhood, only documented in one of the 400 files. Poverty is increasingly being viewed as possibly the strongest predictor of mental health problems (WHO, 2014). In a 2010 review of 115 studies that spanned 33 countries across the developed and developing worlds, approximately 80% of the studies showed a strong relationship between poverty and higher rates of mental health difficulties. The review reported that amongst people living in poverty, mental health problems were more severe, lasted longer and had worse outcomes (Lund et al., 2010). Whilst perhaps not a direct cause itself, particular dimensions of poverty clearly have a role in the direct causes of mental health problems, such as adverse experiences in childhood. It is difficult to draw explicit conclusions with regard to adversities not previously studied, yet the current findings can reasonably be interpreted as showing a

failure to identify experiences of adversity in childhood, including poverty, that are highly likely to relate to current presentations of distress in service users.

4.2.1.2. Adverse experiences in adulthood

Only 26 (6.5%) of the 400 service users had one or more adulthood adversities recorded in their file. This number is significantly lower than in similar studies. Read and colleagues (2016) found that one or more forms of adulthood abuse or neglect were recorded in 35% of clinical records within community mental health services. An earlier study by Agar & Read (2002) reported a rate of 27%. Documentation of physical abuse, emotional abuse, emotional neglect and sexual assault were all significantly lower in this study in comparison with these studies (see Table 8).

Table 8: *Documentation of Adult Adversities in Comparison with Previous Studies*

	Read et al., (New Zealand – 2016)	Agar & Read (New Zealand – 2002)	Current study (UK – 2019)
Any adult adverse experience	35%	27%	6.5%
Physical abuse	24%	19.5%	2%
Emotional abuse/neglect	22%	N/A	EA: 1.3% Neglect: 0.3%
Sexual assault	14%	7.5%	2.5%

This study expanded the research base to include adverse experiences not previously studied. The most prevalent of these was DV, which was documented in 13 clinical records, all of these found in the files of female service users. Research consistently demonstrates that women experiencing DV are more likely to experience mental health difficulties, and women with mental health difficulties are more likely to be domestically abused. Thirty to sixty percent of women with a diagnosed mental health difficulty have experienced domestic violence (Howard et al., 2009). Based on there being 165

women service users in this sample, it can be assumed that a minimum of 49 (30%) of these women have experienced domestic violence. There being only 13 clinical records containing such documentation suggests that experiences of domestic violence are poorly identified by clinicians working in these services.

Only 1.3% of the clinical records contained documentation of financial abuse or discriminatory abuse. No records held information about experiences of modern slavery. It is not possible to know the true prevalence of these experiences within the sample, yet some comparisons can be made with prevalence rates in the general population. Financial abuse is a common element in abusive relationships (Robinson, 2003; Stark, 2007). However, it has not received as much research attention as other elements of abusive behavior, so its prevalence is difficult to establish (Wilcox, 2008). In 2014, Citizens Advice UK conducted a survey of its advisers to further understand the extent of financial abuse amongst people seeking support through their service. Nine in ten of the advisers who answered the survey said they had supported individuals who have experienced financial abuse (Citizens Advice, 2014). Research suggests that people with severe mental health problems are at increased risk of experiencing harmful financial abuse. In a 2013 U.S.A. study of individuals accessing inpatient and outpatient mental health services, 85 of 122 (70%) participants reported financial victimisation in the past 28 days (Claycomb et al., 2013). It is likely that a higher number of participants in this study had experienced financial abuse than was documented in the clinical records. It could be that this was simply not known about, or not recorded, or perhaps instances of financial abuse were recorded as DV, of which there were 13 instances within the 400 clinical records.

4.2.1.3. Gender

The clinical records of female clients contained a higher total number of adverse experiences than male clients. Specifically, females had higher rates of CSA and DV documented. This is consistent with previous findings that female users of adult mental health services had significantly higher rates of CSA and ASA identified in their records than men (Sampson & Read, 2017). This reflects the reality that within the general population, women are more likely than men to experience adversities. In general, women are significantly more likely to have

experienced sexual assault than men (Finkelhor, Shattuck, Turner, & Hamby, 2014). A World Health Organization report highlights that a diagnosis of depression in adult life is three to four times more likely for women exposed to CSA or physical partner violence in adult life. Following sexual assault, nearly one in three women will meet criteria for a diagnosis of PTSD, in comparison to one in 20 individuals who have not been raped (Astbury, 2001). This could partially explain the finding of a significant gender difference in the documentation of adverse experiences, particularly CSA and DV.

4.2.1.4. Age

Previous research reported that older service users were significantly less likely to have been asked about adverse experiences (Read et al., 2006). This was not supported by findings in the current study as there was no significant correlation between these variables. Again, the data does not provide an explanation as to why there is a difference in findings in the current study in comparison to previous research. The lower overall numbers may have reduced the probability of finding a significant difference, as the results concerning the age of service users were in the expected direction of previous research.

4.2.1.5. Diagnosis

People with a diagnosis indicative of psychosis were significantly less likely to have adverse experiences documented in their file. These findings are consistent with previous research. A New Zealand study found that individuals with a psychosis-type presentation tended to be asked less often and had significantly lower rates of adversity identified in their files (Sampson & Read, 2016). Numerous other studies have reported similar findings (Agar et al., 2002; Cavanagh et al., 2004; Cunningham et al., 2016; Young et al., 2001).

There is a robust body of evidence demonstrating links between adverse experiences and psychosis, both in community and inpatient samples (Varese et al. 2012). In an inpatient sample of adults with first episode psychosis, 94% had experienced emotional abuse, 89% emotional neglect, 89% physical neglect, 78% CPA and 39% CSA (Compton et al, 2004). In a community sample of adults with a diagnosis of schizophrenia, 35% had suffered emotional abuse as a child, 42% physical neglect and 73% emotional neglect (Holowka et

al., 2003). It is therefore unlikely that the finding that individuals with psychosis are less likely to have adverse experiences documented in their file, is due to there being lower rates of adversity within this group. Rather, this appears to be indicative of a bias against asking individuals with psychosis about adverse experiences.

This bias has been identified repeatedly by previous researchers (Agar et al., 2002; Cavanagh et al., 2004; Cunningham et al; Sampson & Read, 2017; Young et al., 2001), some of whom suggest this is a consequence of traditional assumptions that psychosis is a biological phenomenon, and therefore less related to life events. As outlined in the introductory chapter, this traditional view is not shared by the general public or service users. Yet, support for this bias comes from research which asked mental health professionals about their clinical practice. Psychiatrists working in New Zealand were more likely to ask someone with a diagnosis of depression about childhood abuse than someone diagnosed with schizophrenia, and this was found to be specifically correlated with the degree of belief in biological causation (Young et al., 2001). Another study found that of 35 psychologists and psychiatrists, 41% answered 'yes' when asked if a client's diagnoses influenced the decision whether or not to ask about sexual abuse (Cavanagh et al., 2004).

It is an important finding that only one person out of 400 had a diagnosis of PTSD documented as the primary diagnosis in their clinical record. Exposure to adverse and traumatic events is associated with a range of mental health difficulties (Elhai, Ford & Naifeh, 2010), most notably, PTSD (Bunting, Murphy, O'Neill & Ferry, 2013). In addition to such poor rates of identification of adverse experiences, the failure of practitioners to use the one diagnosis that, by definition, is trauma-based, seems particularly alarming.

4.2.1.6. Variation in clinician inquiry across services

A previous study, in New Zealand, found no significant difference in the probability of adverse experiences being recorded according to which CMHT the client attended (Sampson & Read, 2017). However, in this study there was a significant difference in clinician inquiry according to which of four CMHT service users were accessing. CMHT 1 recorded a significantly higher number

of adverse experiences than both CMHT 3 and CMHT 4. All of these teams belonged to the same NHS Trust, but were separated according to boroughs. Our data does not permit any meaningful understanding of the reasons for these differences. They merely indicate that clinical performance on these issues is not necessarily of a uniform standard, even between services in close proximity to each other and under the same overall management. This finding may be helpful in highlighting that there is relatively good practice within some CMHT services which could be shared with local counterparts to improve consistency across the Trust.

4.2.2. Research Question Two: How do Mental Health Professionals Working in Adult Mental Health Services Respond to Disclosures of Adversity?

Having an accurate history of adverse experiences has significant implications for clinical work. It is extremely important that disclosures are responded to with sensitivity. Furthermore, it is advisable that clinicians are aware whether this is the first time the adverse experience has been disclosed. It is also useful to know how previous disclosures were responded to, and whether the service user sees any connection between the adversities and their current difficulties (Read, Hammersley & Rudegeair, 2007).

Before considering these findings in more detail, it should be clarified that the aim is not for there to be a 100% rate of responses given by clinicians. For example, it would certainly not be appropriate for 100% of the adverse experiences identified in clinical records to be reported to legal authorities, or to result in referrals to therapy. These clinical decisions would depend on the needs and wishes of the client, and how their current difficulties were to be understood within a formulation. However, it is still useful to establish what response service users are experiencing from mental health professionals once adverse experiences become known about.

Within this sample, individuals with a diagnosis indicative of psychosis were significantly less likely to have experiences of adversity documented in their file. However, there was no difference in the number of responses provided by

mental health professionals. There were also no significant differences according to age, CMHT site or gender.

Table 9 shows that the majority of cases of recorded adversity led to some kind of positive response, and that rates of specific responses were higher than in previous studies. Adverse experiences were mentioned in a formulation in 75% of the 52 files in which adversities were recorded, and mentioned in treatment plans in 73.1% of those files. These rates are much higher than those found by Agar & Read (2002), Read and colleagues (2016) and Eilenberg and colleagues (1996). The one exception to higher rates in comparison with previous studies was documentation of discussions about previous disclosures, which only 9.6% of the 52 records contained.

Table 9: *Documentation of Clinician Response in Comparison with Previous Studies*

	Read et al., (New Zealand –2016)	Agar & Read (New Zealand – (2002)	Current study (UK – 2019)
Adversity formed part of a formulation	CSA: 56.8% CPA: 47.3% ASA: 30.6% APA: 31.1%	Overall: 17.4%	Overall: 75%
Adversity formed part of a treatment plan	CSA: 44.4% CPA: 24.2% ASA: 36.1% APA: 23.0%	Overall: 16.3%	Overall: 73.1%
Discussion about previous disclosures and how these were responded to	50%	32.6%	9.6%
Discussion about, or actual, referral to specialist provision related to the adversity	CSA: 23.5% CPA: 19.8% ASA: 19.4% APA: 11.5%	Overall: 21.7%	Overall: 80.8%
Discussion about causal beliefs in relation to mental health difficulties	22.5%	N/A	50%
Discussion about reporting the adversity to authorities	5%	0%	30.8%
Adversity was reported to authorities	2%	0%	25%

Significantly more adverse experiences were reported to legal authorities, or files contained a discussion with the client about reporting to these authorities, in comparison with previous research. There were eight files (15.38%) where these discussions were documented, but the client indicated that the events had already been reported to legal authorities. These examples were included in analysis, which could explain the higher rates of this response in comparison to previous research. However, five (9.62%) of the clinical records contained documentation confirming that the adversity had been reported to authorities directly following contact with the CMHT, which is still higher than previous studies.

One possible explanation for this finding relates to the low number of adverse experiences documented in the clinical records in comparison to previous studies. It could be that within this study, only the most extreme experiences of adversity are documented within the core assessment forms. If this were the case, these experiences of adversity, including CSA or multiple traumas, would necessitate a more proactive and appropriate response from mental health professionals. As a result, the number of responses to disclosures of adversity might therefore be disproportionately higher in this study comparative to previous research. This explanation is merely conjecture and cannot be supported by the data, yet it makes intuitive sense when considering the overall findings. Future research would benefit from exploring this further.

Overall, these findings indicate good clinical practice in relation to how disclosures of adversity are responded to, and are promising when compared with previous research. However, it is important to remember that 9.6% of participants with one or more forms of adversity documented in their file received no response at all following a disclosure. In addition, this finding is likely to be disproportionately higher due to the small number of clinical records which contained documentation of adversities. There is therefore an ongoing need for training to address how mental health professionals should respond once adverse experiences become known about.

4.2.3. Research Question Three: To What Extent can Conceptual and Theoretical Frameworks Explain the Barriers to Routine Enquiry and Disparity in Asking Practices amongst Mental Health Professionals?

This study was primarily concerned with identifying, for the first time in the UK, the extent to which adverse experiences are identified, recorded and responded to, in the clinical records of mental health service users. Similar to other research in this field, the study design was limited in its ability to develop conceptual and theoretical frameworks that might explain *why* routine enquiry does not occur in services. This gap in the literature is a clear direction for future research. However, it is still helpful to consider how the findings from this study can contribute to the development of theoretical explanations about why staff seldom inquire about and record adversities.

4.2.3.1. Gendered notions of adversity

The findings demonstrate that clinical records belonging to female service users contained a higher number of total adverse experiences than male service users. This was especially significant for experiences of CSA and DV. Research demonstrates that women are more likely to experience these adversities than men (Finkelhor et al., 2014). However, the extent to which gendered notions of adversity impact clinicians' potential to be differentially sensitive to service users' experiences should still be considered. As highlighted in the introductory section, the enactment of hegemonic ideals at a societal level is likely to impact whether and how clinicians working in mental health services ask about, and respond to, experiences of adversity. The four instances in this study where service users were definitely asked if they had experienced abuse were all in relation to female service users.

Gender has been highlighted as a key factor in relation to the identification and documentation of adversities in previous research. In the New Zealand inpatient study (Read & Fraser, 1998a), women were asked the abuse questions in admission forms more often than males (43% versus 25%). This finding was replicated in the later New Zealand CMHT study with 54% of women being

asked these questions in comparison to 37% of men (Sampson & Read, 2017). In studies which asked mental health professionals about routine enquiry, 25% said they were less likely to ask about sexual abuse if the client was male (Cavanagh et al., 2004), and 82% of staff said they ask men about sexual abuse less than half of the time (Lab et al., 2000). In the 2015 study which interviewed service users about their experience of routine enquiry, participants reported that staff could stereotype them on the basis of gender (Scott et al., 2015). Male service users reported a lack of awareness and support, with men not being viewed as legitimate victims of abuse. In comparison, female service users experienced services as labelling them as 'hysterical' and 'attention seeking.'

It is difficult to draw conclusions about the role of gendered notions of adversity from the current study alone due to the nature of the data collection. However, this study, and findings from previous research, could serve as a foundation from which future research could explore the extent to which inquiry practice is inhibited by firmly held cultural beliefs that sexual abuse is less likely to happen to, or damage, men because they are more powerful and less vulnerable than women (Courtenay, 2000). One way of exploring this further would be to interview mental health professionals about their attitudes, beliefs and biases in relation to sexual abuse and consider the extent to which this relates to inquiry behaviour according to gender.

4.2.3.2. Inquiry bias in the context of a dominant medical model

The findings from this study support previous suggestions that within adult mental health services there is a bias against asking individuals with psychosis about adverse experiences (Agar et al., 2002; Cavanagh et al., 2004; Cunningham et al; Sampson & Read, 2017; Young et al., 2001), presumably because it is assumed to be primarily bio-genetic in origin, especially compared to other mental health problems. These previous studies were confirmed by the finding that service users in the current study with a diagnosis indicative of psychosis were significantly less likely to have adverse experiences documented. This may be related to the continued dominance of the medical

model within adult mental health services in the UK (Sweeney et al., 2018). Support for this possibility comes from Young and colleagues' (2001) study which identified that espousing biogenetic causal models of mental distress amongst mental health professionals was a barrier to enquiring about childhood abuse.

This study is only the third of its kind in this country. As with other under-researched areas, the conceptual and theoretical frameworks needed to make sense of the data are therefore still in their infancy. The findings firmly establish that routine enquiry is not taking place in these adult mental health services, particularly for individuals with psychosis. However, the quantitative nature of the data limits the extent to which theoretical advancements can be made. More research is needed in order to develop frameworks to understand *why* poor inquiry about adverse experiences occurs and whether this is related to the continuing dominance of biomedical models of psychological distress.

Sweeney and colleagues (2018) explored systemic barriers to creating trauma-informed relationships in mental health services. These ideas can readily be applied to why routine enquiry about adverse experiences is less likely to occur in the context of a dominant medical model. They include:

- reluctance to shift from biomedical causal models of mental distress to holistic biopsychosocial models, or a lack of exposure to alternatives
- strong biomedical focus of training for mental health professionals making it difficult to challenge biomedically dominated cultures
- the biomedical emphasis means that the social and psychological are neglected, leading to a lack of investment in diverse mental health services and treatments
- little exposure to the notion of social, urban, historical and cultural trauma
- the historical underpinnings of psychology, including behaviourism with its erroneous assumptions that empathy and compassion reward bad behaviour

- understanding the extent of trauma exposes human nature as cruel and perverse, challenging our worldview and making it difficult to accept that reality.

A clear next step for future research would therefore be to use qualitative methodology to test these hypotheses further.

4.2.3.3. *Systemic barriers to routine enquiry*

Any attempt to develop theory about why staff may not routinely inquire about adverse experiences should consider the systemic pressures currently at play in the UK public health sector. Community mental health services have undergone considerable reconfiguration in recent years. This has included remodelling, decommissioning and integration. With a shift towards a recovery-model, there is now an expectation of time-limited intervention with prompt discharge to primary care (Gilburt, Peck, Ashton, Edwards & Naylor, 2014). These changes have occurred in the context of austerity. A 2013 Freedom of Information request highlighted the impact of this, with 44 NHS mental health providers reporting a reduction of 2.36% in real-terms funding for services in recent years (BBC News, 2013).

Austerity, underfunding and lack of resources, particularly staff shortages, can make the working environment stressful and overwhelming (Sweeney et al., 2018). Low morale and high staff turnover are increasingly reported in secondary care community mental health services (Gilbert, 2015). The impact of this for service users is clear. In 2015, 28% of people responding to the community mental health team survey rated their experience of care on a scale of 0 to 10 as 5 or lower (Care Quality Commission, 2015a). Respondents reported not feeling listened to by staff, not feeling they were given enough time to discuss their needs, and not feeling that they were treated with dignity and respect. These systemic pressures have resulted in a significantly heightened level of individual and organisational stress for services that continue to struggle to respond to the needs of service users. These factors are highly likely to impact routine enquiry. Indeed, when Young and colleagues (2001) surveyed

psychiatrists and psychologists about their reasons for not asking about abuse, for both professions, one of the most frequently endorsed reason was 'too many more immediate needs and concerns.'

Bloom (2006) explored the notion that mental health services, like individuals, are living systems themselves, vulnerable to stress, which manifest various degrees of health and dysfunction. She suggests that mental health professionals are becoming increasingly demoralised and hostile as a result of frequent psychological and sometimes physical injury. Leaders become increasingly overwhelmed, perplexed and avoidant as they struggle to satisfy commissioners whilst protecting their clients. Staff trained in different models and frameworks frequently struggle to develop a shared understanding of clients. Without a shared understanding of the problem, treatment involves little more than labelling, the prescription of medication, and behavioural 'management'. When clients fail to respond to these measures, they are labelled again, given more diagnoses and termed 'resistant to treatment' (Bloom, 2006). This formulation can help to understand *how* and *why* mental health services might continue to neglect the role of adverse experiences in mental distress. Dominant conceptualisations of distress as symptoms, in a context of stress and under-resourced services, are therefore a likely maintaining factor as to why staff may not enquire about abuse and adversity.

4.2.3.4. *Summary*

There is a clear need for future research to develop conceptual and theoretical frameworks which make sense of why mental health professionals do not routinely ask about abuse and adversity. This gap in the literature can begin to be addressed by building on the findings from this study and its predecessors (Agar et al., 2002; Cavanagh et al., 2004; Cunningham et al; Sampson & Read, 2017; Young et al., 2001). This could involve using qualitative methodologies to explore how gendered notions of adversity, the dominance of the medical model, vicarious traumatisation, and systemic pressures in NHS services impact inquiry behaviour, as well as other factors that open questions in qualitative research may uncover.

4.3. Strengths and Limitations

4.3.1. Data Collection

Use of the CRIS database allowed for geographical reach across a number of London boroughs, so a large number of anonymised service users' clinical records could be investigated with relative ease. Future research could benefit from employing this method of data collection which is still under-utilised in mental health research. This study expanded the number of records usually reviewed in comparison with previous studies. However, it failed to collect data for variables which would have allowed greater comparison with previous findings. For example, previous studies show that women clinicians were significantly more likely to identify abuse or neglect, and were significantly less likely to skip the adversity section of an admission form, in comparison to their male counterparts (Sampson & Read, 2017). The profession of the clinician has also been shown to affect how staff respond once adverse experiences become known about, with psychiatrists providing a lower response level in comparison to colleagues from other professions (Agar & Read, 2002; Lab et al., 2000).

4.3.2. Nature of the Data Collected

Documentation of adverse experiences in clinical records consistently and significantly underestimates the true prevalence rates of such experiences within mental health service user populations (Briere & Zaidi, 1989; Goodwin et al., 1988; Jacobson et al., 1987; Lipschitz et al., 1996; Wurr & Partridge, 1996; Read & Fraser, 1998b). It is not known how many of the 400 participants in this study have experienced adversity in their lifetime. Actual prevalence rates could only be verified by using a validated instrument such as the Childhood Trauma Questionnaire (CTQ) (Bernstein & Fink, 1998) with each of the 400 people involved.

The findings demonstrate that only 1% of the 400 clinical records contained clear evidence that service users had been asked if they had experienced adversities. This could be explained to some extent by poor record-keeping, or clinicians deeming information too sensitive or irrelevant to be recorded. Whilst this may have impacted the findings to a greater or lesser extent, they still constitute poor clinical practice, as accurate documentation of these issues is extremely important. Clinical records were only read in their entirety when one or more types of adverse experience were documented in the 'core assessment' area of the electronic file. This may have precluded further examination of clinical records containing documentation of abuse and adversities, and is most likely the explanation for lower rates compared to earlier studies. In order to investigate the extent to which this precluded clinical records, future research might benefit from reading all service users' clinical records in their entirety.

There is a confounding issue of whether clinical records are an accurate representation of clinical practice. It is possible that clients were asked about adverse experiences, but no note was made in the record, and when disclosures of adversity were made, there may have been more support offered than was documented. Clinicians may not have recorded details of adverse experiences if they perceived them to be too sensitive, not relevant to the referral reason, at the request of the client, or if the client denied having experienced such experiences. It is also probable that by only looking at the core assessment forms, rather than reading each file in its entirety, adverse experiences were missed. Whilst this allowed a larger number of records to be reviewed, and is where such information *should* be stored, this is the most likely explanation for lower rates of adverse experiences compared to earlier studies. It is therefore expected that the subset of participants with no adversities recorded in their clinical record actually have experienced adversities that mental health professionals have no knowledge of. As a result, the proportion of clients with adverse experiences receiving an adequate response from clinicians will have been overestimated by the present study, as is the case with previous research (Read et al., 2016).

The findings are limited in their generalisability to other adult mental health services in the UK and internationally. However, data were not restricted to one CMHT only. Clinician inquiry and response behaviour was assessed across four different CMHT services in separate boroughs, slightly increasing the generalizability of the findings.

4.3.3. Reliability and Coding

Eight of the files that contained documentation of adverse experiences were reviewed separately by the DOS. This was an attempt to enhance reliability of the data collection, by focussing on files where it was not absolutely clear if adverse experiences had been recorded (see Methods and Results). However, there remains a level of subjectivity which may have impacted the extent to which experiences were coded as being abusive or adverse. The emotive nature of many of the clinical records in addition to the inherent biases and assumptions of the researcher, may have influenced the inclusion and exclusion of clinical records. However, this will have been mitigated against to some extent as the files were read in detail for an average of one and a half hours each, and records which required clarification being screened by the DOS. It remains possible, nevertheless, that clinical records may have been included for analysis that other researchers or raters might not have included, and vice versa. Subjectivity is more likely to have affected the data collection process, especially due to the assumptions and biases of the researcher, which are discussed further in the Reflections section.

As discussed in the Method chapter, a traditional coding frame of the kind used in qualitative research was not employed in the current study. This decision was informed by comparisons with previous research of a similar nature (which had used data sheets rather than coding frames), the quantitative design and the epistemological stance of the study. Instead, the data sheet developed for the study was in a sense seen as a coding frame in its own right. It contained 'categorisations' of adverse experience, based on available research and clinical definitions, which guided the process of transferring relevant data from clinical records to the data sheet.

It was frequently the case that the clinical records simply did not contain enough information about adversities in order to retain records for analysis. In the 55 instances when records did refer to adverse experiences (either in the core assessment forms or clinical notes), there tended to be clear evidence that adversity had occurred (as shown in appendices G and H), with only eight records necessitating further screening by the DOS. This may well be linked to the hypothesis outlined later on in this chapter, that the low number of adverse experiences identified in this study is a result of only the most severe examples of abuse being asked or known about.

4.3.4. Contributions to the Research Base

This study makes significant contributions to the existing literature concerning how adult mental health services enquire about, and respond to, experiences of adversity. Previous research had tended to focus on adversities in childhood, particularly CSA and CPA. This study broadened attention to other forms of adverse experiences known to have a relationship with psychological distress, which occur in both adulthood and childhood. The findings are consistent with previous research which strengthens the literature base. It also provides the first prevalence rates for how experiences of bullying, loss of a parent, growing up in institutionalised care or poverty, DV, and financial and discriminatory abuse are documented within the clinical records of adult mental health service users.

4.4. Practical Implications

4.4.1. Policies, Training and Guidelines

The findings of this study demonstrate that mental health professionals do not routinely ask about adversities. It is clear that interventions are required in order to improve both inquiry and response to adverse experiences. It is therefore recommended that all mental health services should have a clear policy that all service users are to be asked about adverse experiences, both in childhood and adulthood. These policies could be facilitated through the provision of training in

how to ask and respond to disclosures. Research has explored barriers to inquiry, which should be considered as part of any training programme. These include: concerns about offending or distressing clients, the need to prioritise more immediate concerns, fear of inducing false memories, concerns regarding vicarious trauma, confidence in asking about and responding to disclosures, and a lack of training in how to do so (Read, Hammersley & Rudegair, 2007). Characteristics of service users such as their clinical diagnosis can also affect inquiry rates (Cunningham et al., 2016; Read et al., 2007), a finding supported by this study.

Training programmes that focus on both asking about and responding to adversities, frequently based on the original New Zealand programme (Cavanagh et al., 2006; Read et al., 2007), have been shown to effectively improve clinical practice. Studies report statistically significant evidence that training is related to: (i) increased frequency of asking about adverse experiences (Donohue, 2010; Lotzin et al., 2018; Murray et al., 2016; Young et al., 2001), and (ii) greater detection of adverse experiences (Currier & Briere, 2000; Currier et al., 1996; Sampson & Read, 2017). Feedback from participants highlight helpful components of training. These include: use of role plays, having a clear structure to training, an informal style of facilitation, and the provision of written summaries (Cavanagh et al., 2004; Donohue, 2010; Lotzin et al., 2018). Training should therefore encompass a skill and educational approach to sufficiently address barriers to inquiry. It should emphasise that most service users are not distressed by being asked about experiences of adversity, and that most service users, particularly men, rarely disclose spontaneously (Eilenberg et al., 1996; Lothian & Read, 2002; Department of Health, 2015; Scott et al., 2015; Young et al., 2001).

The development of new assessment forms that include questions about adverse experiences could also aid inquiry. Studies in New Zealand have shown that significantly more adverse experiences are identified when using an assessment form that includes a specific section for enquiring about and recording adversities (Agar et al., 2002). In an inpatient setting, significantly higher rates of adversity were recorded when such a form was used in its entirety at initial assessment (Read & Fraser, 1998a). However, these forms are

not always used (Read & Fraser, 1998a), and even when they are, questions about adversity can be ignored. A new initial assessment form which included questions about sexual, physical and emotional abuse was used in 53 of 100 consecutive inpatient admissions, but these questions were ignored in 36 of those 53 files (67.9%) (Read & Fraser, 1998a). In an outpatient setting, this section of the new admission form was ignored only in 6 out of 26 cases (23.1%) (Agar et al, 2002).

Systematic inquiry about adverse experiences is a prerequisite for providing an appropriate response to the needs of clients. However, it is important to recognise that improving inquiry may not sufficiently ensure adequate responses from mental health professionals. In this study, the number of responses was higher than previous research, yet 9.6% of people with at least one form of adversity in their file still received absolutely no response following disclosure. A systematic review demonstrated that adversities including child abuse and neglect were incorporated into treatment plans in 12%–44% of cases, and into formulations in 12%–57% of cases. Referrals for therapeutic support which related to the adversity were made in 8%-22% of cases (Read et al., 2018b). In order for clients to be properly supported, training and guidelines need to address how mental health professionals should respond once experiences of adversity become known about.

4.4.2. Service Provision

Practical approaches, like training and developing new assessment forms, have been demonstrated to be effective in improving clinical practice over time. However, these alone are unlikely to resolve the issue of why the majority of clients are never asked about experiences of adversity. Support for these practices needs to become embedded within mental health services, so that all service users are asked regardless of diagnosis, gender or age. This would require a shared responsibility amongst clinicians and commitment from managers, at a local and national level, in order to produce systemic change.

Not every person who has experienced adversity will require or benefit from therapeutic work. However, mental health services need to ensure that there

are adequate resources available, should they be required, once adverse histories become known about. This need would presumably expand if effective training and policies led to adequate rates of inquiry. Many individuals accessing services may have attempted to disclose in the past and been ignored, disbelieved or blamed by family or professionals, and potentially re-traumatised by the mental health system (Agar et al., 2002; Herman, 1992, Jacobson & Herald, 1990). A helpful response from a mental health professional, and appropriate treatment and support following disclosure, is the very least that should be provided.

Mental health services need to develop a culture that acknowledges the role of adverse life experiences in the creation of human distress. This could be done through the provision of trauma-informed services. Such services recognise the importance of engaging with people in such a way to facilitate recovery, rather than re-traumatising through coercive practices, or those which dismiss the occurrence, or impact, of adversities in the lives of service users (Read et al., 2017; Sweeney et al., 2018). This would require support from all stakeholders, including: service users, commissioners, governmental and professional bodies. However, there is ongoing debate as to whether this would be achievable in the current context of mental health provision, whether such changes could only occur after a fundamental paradigm shift, or whether they are a pre-requisite for a paradigm shift (Bentall, 2003; Boyle, 2013; Read & Dillon, 2013, Read et al., 2014; Read et al., 2017).

4.5. Research Implications

Interviews with mental health professionals could help to further inform our understanding of inquiry behaviour, and, more specifically, the barriers to asking. If approached in a sensitive, non-judgmental manner, staff could provide more context to the findings and thereby help guide changes in practice. Future research could also assess changes in practice over time by implementing a longitudinal study design. This would allow researchers to measure the impact of interventions, including staff training, clarity of governance, and changes to policies and guidance. Collecting data from the four CMHTs used in this study would allow for comparison over time. Gradually, best practice models could be

developed in order to facilitate improvements in service provision on a wider scale.

It is interesting to consider the significance of this study being only the third of its kind ever conducted in England. The first was a study within inpatient services (Wurr & Partridge, 1996), and the second interviewed mental health professionals about the childhood sexual abuse of men (Lab et al., 2000). No research of a similar nature has been conducted since the introduction of NHS policy that a question about experiences of violence and abuse should be included in all adult mental health assessments (Department of Health, 2008). It seems therefore that the lack of attention towards experiences of adversity, demonstrated by the mental health services within this study, is paralleled by our research community, despite huge public interest in this area.

4.5.1. Service User Perspectives

Users of mental health services have already made significant contributions to this field of research. Individuals have repeatedly conveyed the role of early adversities in the development of psychological distress, as well as the failure of services to inquire and respond in a supportive way (Dillon, 2010; Longden, 2013; Sen, 2017). Existing research demonstrates that most people who have experienced adversities, including CSA and DV, support routine enquiry by mental health professionals (Scott et al., 2015). Future research in support of interventions to improve inquiry and response to adverse experiences needs to continue to be carried out in collaboration with service users. It would be essential for service user perspectives to inform training programmes, developing assessment proforma, and changes to policy and service provision. This could be done at a national and local level through engagement with established service user groups such as the Hearing Voices Network or other service user representation groups that are already established within local clinical settings. If further training programmes were developed, it would be essential to ask service users to contribute to the design and implementation of these.

It would be important to seek out perspectives that might not be represented by established service user groups. Surveys, questionnaires and interviews could be used within community mental health services to determine views on asking and responding practices, in addition to proposed interventions to improve practice. This could involve collecting qualitative accounts about how experiences of adversity were asked about and responded to. One way to do this could be to conduct further research within the CMHTs used in this study. In addition to providing service user perspectives, this would help to further inform our understanding of the findings from this study. Using these CMHTs for further investigation could also facilitate the use of different methodologies successfully used in previous studies (Cusack et al., 2004; Rossiter et al., 2015). For example, future research could compare the prevalence of adverse experiences documented in clinical notes, which are now known, with those identified by researchers.

4.5.2. Trauma-Informed Services

There is an emerging awareness of the need for trauma-informed approaches to mental healthcare. These aim to improve service users' experiences, and working environments for staff, by creating environments and relationships that promote recovery and prevent re-traumatisation (Sweeney et al., 2018). Within a trauma-informed approach, service users would be sensitively asked about experiences of adversity, and any information concerning such experiences would be used to identify meaningful support (Scott et al., 2015). An extensive literature base underpins the theory behind these approaches, and a few small studies have demonstrated positive outcomes. Sweeney and colleagues (2016) reported reductions in symptoms and in the use of seclusion and restraints, alongside improvements in coping skills, physical health, and shorter inpatient admissions. Further research which considers the potential benefit of trauma-informed approaches, carried out in collaboration with service users and their families, would facilitate development of evidence-based practice in this area.

4.5.3. Monitoring, Policy and Governance

Without sufficient monitoring, the impact of clinical interventions in how to ask and respond to adverse experiences will be limited. The development of tools to measure the extent to which mental health services are implementing effective trauma-informed policies (Read et al., 2017) is therefore recommended as an area for future research. In the absence of such tools, one way to ascertain this information is to request it directly from mental health services using the Freedom of Information (FOI) Act. Brooker and colleagues (2016a; 2016b) used this approach to ask 53 Mental Health Trusts in the UK whether they audited if service users were routinely asked about sexual abuse or assault, as they should according to Department of Health policy (Department of Health, 2008). Of the 36 Trusts to respond, only five (14% – or 9% of all Trusts) said that they did audit this information.

This approach could be utilised in order to further establish how many mental health services are: (i) asking clients about experiences of adversity and providing an appropriate response, and (ii) facilitating staff training to support this, if it is not currently happening. It would be important to also establish the governance related to inquiry, as this appears unclear. A Freedom of Information enquiry was made to the Department of Health, asking whether the 2008 policy was still in place. This enquiry was referred on to NHS England, who in turn referred the enquirers back to the Department of Health (Brooker et al., 2016a; Brooker et al., 2016b).

4.6. Societal Implications

A robust body of evidence demonstrates that a wide range of adversities are consistent predictors of a variety of mental health difficulties. These include adversities explored in this study, in addition to experiences such as: maternal ill health, poor nutrition and high stress during pregnancy, being the product of an unwanted pregnancy, dysfunctional parenting and childhood medical illness (Kessler et al., 2010; Read et al., 2009). It is acknowledged that these experiences occur in interaction with other factors, and are likely to be impacted by attachment, epigenetic processes and predisposition due to a biopsychosocial vulnerability (Read et al., 2014; Sitko et al., 2014). Many of these adverse experiences have been shown to be intergenerational, in that

parents who themselves experienced adversities might go on to struggle to provide an optimum environment when caring for their own children (Read & Bentall, 2012). This intergenerational transmission of adversity is another form of inequality that also serves to reduce social mobility and health and wellbeing (Institute of Health Equity, 2015).

Social inequality is an intergenerational phenomenon that plays a powerful role in psychological distress. The World Health Organisation (2014) reports that indicators of social inequality such as housing, poverty, and low education all significantly impact mental health. Epidemiological research demonstrates that relative poverty is a strong predictor of a range of negative outcomes, including high incidences of mental health problems. Countries with a higher degree of disparity between the highest and lowest incomes, including the UK, have the worst outcomes, not only for mental health, but also for physical health, violence, and general wellbeing in childhood (Wilkinson & Pickett, 2009).

A range of other social factors are also associated with poor mental health outcomes. In a Swedish national cohort study, living in rented accommodation, being of low socioeconomic status, unemployment, and being in receipt of social benefits were associated with having a diagnosis of schizophrenia in adulthood (Wicks, Hjern, Gunnell, Lewis & Dalman, 2005). Living in areas characterised by danger and crime report is associated with higher levels of mistrust and threat, which gives rise to paranoia (Ross & Mirowsky, 2001). Discrimination and racism also play a role. A community survey in the Netherlands demonstrated that individuals who met diagnostic criteria for delusions were more likely to have experienced discrimination previously (Janssen et al., 2003). Similarly, individuals belonging to minority ethnic groups were more likely to experience psychotic symptoms if they reported experiencing racist victimisation in the previous year (Karlsen & Nazroo, 2002).

There is now sufficient evidence connecting adverse experiences in childhood and adulthood with a range of negative outcomes across the lifespan. Clinically, the initial first step is to ask about such experiences in order to facilitate meaningful support within mental health services. Clinicians and researchers also have a duty to continue to highlight the social context in which distress develops. As Clinical Psychologists, professional input to commissioning is

linked to our duty of care and our obligation to advocate for patient safety and the quality of applied psychology (BPS, 2012). Increased involvement in the commissioning of services, in order to develop more trauma-informed services, could be a key role in order to reduce the impact of adverse experiences for users of mental health services.

More widely, a necessary implication lies within the domain of primary prevention. The Institute of Health Equity (2015) outlines what can be done to reduce the prevalence, and inequalities in prevalence, of adverse experiences. Potential areas for action include: (i) tackling social isolation and increasing community connectedness, (ii) mitigating the impact of austerity, (iii) action at a local level, involving education, public health, health care, and work and employment sectors, (iv) tackling inequality and reducing absolute poverty, (v) examining equity impacts, and the differential impact of policy decisions on people on lower incomes. In order to improve the quality of people's lives, prevent the transmission of disadvantage and reduce inequalities across generations, it is fundamental that such actions are taken on the causes and impacts of adverse experiences.

4.7. Dissemination

The findings from this thesis will be disseminated in a number of ways. With the support of the R&D department at the NHS Trust hosting the research, the findings will be provided in written form to the teams from which data were collected. The research will also be submitted to a peer-reviewed journal and submitted as a poster presentation for a British Psychological Society (BPS) conference.

4.8. Reflective Review

This thesis topic was chosen whilst I was on placement in a CMHT and acute mental health ward. Having not previously worked in these settings, I often felt overwhelmed by the sheer levels of distress, and how responses to distress frequently felt incongruent and unhelpful. This was perhaps due to the privileging of a medical model within these settings. I attended a teaching

session which included discussion about why, when and how to ask about childhood abuse (Read et al., 2007). Having noticed that these services did not regularly ask about adversities, I raised this with the team and disseminated the paper. The response was alarming. One clinician raised concerns about false memories, and the majority of the team were not supportive of the suggestion that routine enquiry be implemented. I felt positioned as a critical outsider, whose views were not welcome. Whilst difficult at the time, this experience galvanised my research efforts. I felt compelled to challenge dominant models of distress and highlight the impact of social adversities and inequalities on mental health. I recognise the limitations of the study, but feel proud that I have been able to achieve this to some extent through this research process.

The emotional impact of reviewing the clinical records of individuals who have been through extremely distressing experiences, and repeatedly let down by services, was difficult to bear. This has had implications for my own clinical practice. I have continued to highlight the impact of abuse and adversity in the remainder of my placements, either through continuing professional development (CPD) sessions or peer supervision. I wonder if I would have done this had I not chosen this area of research.

The process has provided opportunities for reflection as to where my strengths and areas for development fall within the research environment. Before doctoral training I was adamant that I wanted to pursue a clinical role post-qualification. However, I am grateful that this research process has given me a new perspective, to the extent that I now hold both clinical and research career pathways in equally high regard. I have been able to reconnect with ideas about how both clinical and research perspectives are essential in the pursuit of systemic change in the conceptualisation and management of psychological distress.

My belief that the profession of clinical psychology has a duty to contribute to societal change has been reinforced during this process. This belief, in addition to those I hold about the need for empathic, trauma-informed services, and the importance of properly acknowledging the role adverse experiences play in mental health difficulties, are likely to have biased this study. My feelings of

anger, frustration and sadness, experienced when working in similar services, were re-enacted whilst reviewing the records. A possible consequence is that clinical records were included as examples of adverse experiences, which another researcher, without the same emotional reaction, might not have included. As a female researcher, it is also conceivable that I over-identified with female participants, perhaps to the extent that I failed to recognise or identify adversities in male participants' clinical records. It is also likely that I judged the response from mental health professionals too harshly, perhaps due to an unconscious motive to demonstrate poor clinical practice, or due to my hope for this study to contribute to systemic change. It is not possible to know the extent to which my feelings, values, gender, and critical perspective impacted the research process, yet it would be interesting to observe how researchers with opposing ontological and epistemological positions would have approached data collection and interpreted the findings. The shared 'probability' ratings with the Director of Studies will have mitigated somewhat against these biases. In hindsight, it may have been helpful to have a more neutral second rater, as the Director of Studies shares many of the biases I hold.

4.9. Summary and Conclusions

There is a robust body of evidence which strongly links adverse experiences, in childhood and later, to a range of negative outcomes across the lifespan (Friedli, 2009; WHO, 2000, 2013). This includes a relationship to an array of mental health problems in adulthood (Johnstone & Boyle, 2018). The research community has made repeated recommendations that experiences of adversity are systematically and routinely inquired about, not least because many people are reluctant to spontaneously report such experiences (Read & Fraser, 1998a; Read et al., 2006; Wurr & Partridge, 1996). In 2008, NHS guidelines were published calling for all mental health service users to be asked about adverse experiences and all staff to be trained in how to do so (NHS, 2008). Despite this, recent research confirmed that the majority of adult mental health service users are not asked about experiences of adversity (Read et al., 2018).

This study sought to better understand whether mental health professionals routinely ask adult service users about adverse experiences, and how

professionals respond when such experiences become known. It attempted to address identified gaps in the literature by including a wider range of adverse experiences, occurring both in adult and childhood, within one UK-based study. The findings are consistent with previous research, with the majority of the core assessments in clinical records (87%) containing no documentation about adverse experiences.

This study provides support for the hypothesis that mental health services are less likely to know, or ask about, adversities experienced by certain groups of people. Consistent with previous research, characteristics of mental health service users were significantly associated with the number of adverse experiences documented in clinical records. Individuals with a diagnosis indicative of psychosis were less likely than individuals in a non-psychotic care cluster to have such experiences documented, despite these individuals being more likely to have experienced adversities in their lifetime (Bentall & Varese, 2012; Hammersley et al., 2003; Read et al., 2003). Some positives can be drawn from the findings concerned with how clinicians respond once adverse experiences were known about. Overall, clinicians in this study were more likely to offer an appropriate response, such as adding the information to a formulation or a treatment plan, in comparison to previous research (Eilenberg et al., 1996; Read et al., 2016).

Future research would benefit from addressing some of the limitations of the current study. It is clear that more could be gained by continuing to conduct research in this area, including within the four CMHT services in this study, in order to fully understand clinician inquiry and response to adverse experiences within UK mental health services. There is also a clear need for staff training in how to ask and respond to experiences of adversity amongst mental health service users. However, it is unclear whether meaningful change could occur without there being a paradigm shift towards more trauma-informed approaches.

The findings of this study once again highlight the failure of mental health services to pay due attention to the impact of adverse experiences on the lives of service users. It is frankly negligent that services that hold such power over

the lives of service users, which are supposed to offer support to ease distress, can continue to ignore the impact of adversity to such an extent. There is a clear need for greater acknowledgement of the social determinants of distress and the importance of routine enquiry about adverse experiences. Without such a change in approach, adversities in people's lives will continue to be ignored, and the subsequent distress stripped of meaning and significance by services which do not attend to, or acknowledge the role these adversities play in the onset and maintenance of psychological distress.

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APPENDIX A: SEARCH STRATEGY FOR LITERATURE REVIEW ONE

The guiding question in the first literature search was: how has the literature to date investigated whether adult mental health services ask about, and/or record, adverse experiences, including abuse and neglect.

The following search terms were used in an attempt to access literature pertaining to clinician inquiry about adverse experiences:

- Child abuse
- Child neglect
- Sexual abuse
- Physical abuse
- Emotional abuse
- Psychological abuse
- Physical neglect
- Emotional neglect
- Child maltreatment
- Adverse child experiences
- Adversity

These key words were searched using the Boolean operators 'AND' and 'OR' alongside the following:

- Mental health services
- Psychiatric services
- Mental health assessment
- Psychiatric assessment
- Psychological assessment
- Psychiatric nursing assessment
- Medical records
- Patient files

Limiters included:

- English language only
- Research articles
- Dissertations

These search terms and limiters were used in the following databases: PsychINFO, ScienceDirect, CINAHL Plus and Scopus. Google Scholar and Research Gate were also searched in addition to reviewing the reference lists of relevant papers. The search produced 4,496 results, the titles and abstracts of which were reviewed for relevance to the topic.

Inclusion criteria:

- Being a study of adult mental health services (inpatient or community)
- Being a study that reports the frequencies or nature of inquiry about adverse experiences

Exclusion criteria were as follows:

- Artistic literature e.g. fiction or poetry
- If the publication was not directly concerned with investigation of clinician inquiry about adverse experiences, but this was just commented on in concluding comments or discussion
- Specialist mental health services e.g. child and adolescent, drug and alcohol, forensic and trauma services

Twenty-one relevant studies were identified that were concerned with the practice of enquiry about adverse experiences in adult mental health services, and were retained for review. These were the same 21 pieces of literature identified by the recent systematic literature review (Read et al., 2017).

APPENDIX B: SEARCH STRATEGY FOR LITERATURE REVIEW TWO

The guiding question in the first literature search was: how has the literature to date investigated how mental health services and staff respond when adverse experiences become known about.

The following search terms were used in an attempt to access literature pertaining to clinician inquiry about adverse experiences:

- Abuse
- Neglect
- Child abuse/
- Childhood trauma
- Trauma history
- Child neglect
- Sexual abuse
- Physical abuse
- Emotional abuse
- Psychological abuse
- Physical neglect
- Emotional neglect
- Child maltreatment
- Adverse child experiences
- Adversity

These key words were searched using the Boolean operators 'AND' and 'OR' alongside the following:

- Mental health services
- Psychiatric services
- Mental health assessment
- Psychiatric assessment
- Mental health professionals
- Psychological assessment
- Psychiatric nursing assessment
- Medical records
- Patient files

- Treatment plan
- Formulation
- Referral
- Psychotherapy
- Trauma therapy
- Reporting
- Staff response

Limiters included:

- English language only
- Research articles
- Dissertations

These search terms and limiters were used in the following databases:

PsychINFO, ScienceDirect, CINAHL Plus and Scopus. Google Scholar and Research Gate were also searched in addition to reviewing the reference lists of relevant papers. The search produced 857 results, the titles and abstracts of which were reviewed for relevance to the topic.

Inclusion criteria:

- Being a study of adult mental health services (inpatient or community)
- Being a study that reports the frequencies of any kind of clinician response to disclosures of adverse experience

Exclusion criteria were as follows:

- Artistic literature e.g. fiction or poetry
- If the publication was not directly concerned with investigation of clinician response to adverse experiences, but this was just commented on in concluding comments or discussion
- Specialist mental health services e.g. child and adolescent, drug and alcohol, forensic and trauma services

Thirteen relevant studies were identified that were concerned how mental health professionals respond to disclosures of adversity, including abuse and neglect. All 13 studies were retained for the literature review. Similar to the first literature review, despite expanding the databases searched and using additional search terms, no further studies were identified than those in a recent systematic literature review (Read et al., 2018).

APPENDIX C: ETHICAL APPROVAL

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Gordon Jinks

SUPERVISOR: John Read

STUDENT: Caitlin Neill

Course: Professional Doctorate in Clinical Psychology

Title of proposed study: TBC

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.
2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below): In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.
3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below): In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

(Please indicate the decision according to one of the 3 options above)

APPROVED

Minor amendments required (for reviewer):

Major amendments required (for reviewer):

Confirmation of making the above minor amendments (for students):

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name (*Typed name to act as signature*):

Student number:

Date:

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER (for reviewer)

Has an adequate risk assessment been offered in the application form?

YES / NO

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐

HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐

MEDIUM (Please approve but with appropriate recommendations)

☒

LOW

Reviewer comments in relation to researcher risk (if any).

Reviewer (*Typed name to act as signature*): Gordon Jinks

Date: 28/2/18

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see
the Ethics Folder in the Psychology Noticeboard

APPENDIX D: DATA SHEET

CLIENT	
CRIS ID	
Gender	
DOB/Age	
Ethnicity	
Diagnoses	
Diagnostic cluster	
CRT	

ANY DOCUMENTED ADVERSE EXPERIENCE IN CORE ASSESSMENT DOCUMENTS?	
Yes	
No	

TYPE OF ADVERSITY	
CHILD	
Child physical neglect	
Child emotional neglect	
Child physical abuse	
Child emotional abuse	
Child sexual abuse	
Bullying	
Parental loss i) death ii) separation	
Child poverty	
Fostering and/or adoption	
ADULT	
Adult neglect and acts of omission (<i>failure to provide or allow access to care</i>)	
Domestic violence (<i>psychological, physical, sexual, financial, emotional</i>)	
Adult physical abuse (<i>assault, slapping, physical punishments misuse of medication (over-sedation)</i>)	
Adult psychological or emotional abuse (<i>enforced social isolation, removing</i>)	

<i>mobility, cyber bullying, threats of harm or abandonment)</i>	
<i>Adult sexual assault (rape, attempted rape & serious sexual assault etc.,)</i>	
<i>Financial abuse (theft of money, fraud etc.,)</i>	
<i>Modern slavery (human trafficking, forced labour, sexual exploitation)</i>	
<i>Discriminatory abuse (unequal treatment, derogatory remarks, harassment or deliberate exclusion)</i>	

ASKED	
Clear documentation in file that client was asked: <ul style="list-style-type: none"> • Client said yes • Client said no 	
Disclosure: No clear further documentation of whether client was or was not asked	
Clear documentation in file that client was NOT asked (with reason why)	
Unclear – documentation of adversity, no clear reasoning if client was asked	
NOTHING	
Nothing about abuse/adversity or whether client was ever asked in record	

RESPONSES	
The client was given any advice/counselling/support	
Adversity formed part of a formulation	
Adversity formed part of a treatment plan	
Discussion about whether any previous disclosures had been made, how responded to	
Discussion about, or actual, referral to specialist provision related to adversity <ul style="list-style-type: none"> 1. Referral made 2. Seen by 3. Engaged with therapy 	
Discussion about causal beliefs - whether the client feels there is any connection between the adverse experience and their mental health difficulties	
Discussion about reporting of the adversity to authorities	
Reporting of the adversity to authorities	

APPENDIX E: NHS to NHS PRO-FORMA

NHS to NHS letter of access: proforma confirmation of pre-engagement checks

Version 1

For NHS researchers who have a substantive NHS contract of employment or clinical academics with an honorary clinical contract with an NHS organisation, and who need an NHS to NHS letter of access from an NHS organisation hosting their research

CONFIRMATION OF PRE-ENGAGEMENT CHECKS

To: R&D Office

Address of NHS site hosting the research:

X

Re: **Researcher's name: Caitlin Neill**

Job title: Trainee Clinical Psychologist

Contract end-date: 26th September 2019

Workplace and postal address:

Department of Psychology (Professional Doctorate in Clinical Psychology)
University of East London
Stratford Campus
Water Lane
E15 4LZ

As the representative of the NHS employer of the above-named person, I can confirm that s/he is employed by this organisation. I understand that the responsibility for ensuring that the appropriate pre-engagement checks have been undertaken rests with us as the individual's substantive employer. I can confirm that the appropriate pre-engagement checks have been completed, commensurate with her/his job description and proposed research role in your NHS organisation, and in line with NHS employment checks standards.

Name of employer's representative: X

Job Title: HR Coordinator

[Redacted signature block]

Email: X

APPENDIX F: LETTER OF ACCESS

05/07/18

Dear Caitlin Neill

Letter of access for research

As the holder of an existing NHS honorary clinical contract you do not require an additional honorary research contract with the X NHS Trust. We are satisfied that such checks as are necessary have been carried out by your employer. This letter confirms your right of access to conduct research through the X NHS Trust for the purpose and on the terms and conditions set out below. This right of access commences on 05/07/18 and ends on 31/07/19 unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct activities associated with such projects as you have received authorisation confirmed in writing from the Research and Development Director of the X NHS Trust. Please note that you cannot start the research until the Chief Investigator for the research project has received a letter from us giving permission to conduct the project.

You are considered to be a legal visitor to the X NHS Trust premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this Trust, in particular that of an employee.

While undertaking research through the X NHS Trust you will remain accountable to your employer Camden and Islington NHS Foundation Trust but you are required to follow the reasonable instructions of your nominated manager Dr X in this Trust or those given on her behalf in relation to the terms of this right of access.

You must act in accordance with the X NHS Trust policies and procedures, which are available to you upon request, and the Research Governance Framework.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Your substantive employer Camden and Islington NHS Foundation Trust is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

You are required to co-operate with the X NHS Trust in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on X NHS Trust premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf>) and the Data Protection Act 1998.

Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution. The X NHS Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by the X NHS Trust in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

Please also ensure that while on the premises you wear your NHS ID badge at all times, or are able to prove your identity if challenged. Please note that this Trust accepts no responsibility for damage to or loss of personal property.

If your circumstances change in relation to your health, criminal record, professional registration or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform your employer through its normal procedures. You must also inform the Research and Development Department and your nominated manager in X NHS Trust.

Yours sincerely

X
Deputy Director of Research and Development,
X NHS Trust

APPENDIX G: DATA SHEET CONTAINING ADVERSE EXPERIENCES

CLIENT	
BRC ID	X
Gender	Male
DOB/Age	X
Ethnicity	Black or Black British - British
Diagnoses	Paranoid Schizophrenia
Diagnostic cluster	Psychotic
CRT	X
ANY DOCUMENTED ABUSE IN CORE ASSESSMENT DOCUMENTS?	
Yes	X
No	

TYPE OF ADVERSITY	
CHILD	
Child physical neglect	N/A
Child emotional neglect	N/A
Child physical abuse	<p>Yes – Core Assessment 2009</p> <p>XXXXX spoke of a strict and deeply religious grandmother called 'Mum', who was physically aggressive towards him if he did anything wrong. He was frightened of her though he associates this with the West-Indian culture.</p> <p>He agreed to the suggestion that his voices were associated with early childhood experiences of being physically abused by his father.</p>
Child emotional abuse	N/A
Child sexual abuse	N/A
Bullying	<p>Yes – Core Assessment 2009</p> <p>XXXXX also recalled being bullied at school and getting into aggressive fights at college. One reason for this was that he thought people were after him. He was angry at being bullied at school and was reluctant to talk about his experiences due to a need to put it in the past.</p>
Parental loss iii) death iv) separation	N/A

Child poverty	N/A
Fostering and/or adoption	N/A
ADULT	
Adult neglect and acts of omission (<i>failure to provide or allow access to care</i>)	N/A
Domestic violence (<i>psychological, physical, sexual, financial, emotional</i>)	N/A
Adult physical abuse (<i>assault, slapping, physical punishments misuse of medication (over-sedation)</i>)	N/A
Adult psychological or emotional abuse (<i>enforced social isolation, removing mobility, cyber bullying, threats of harm or abandonment</i>)	N/A
Adult sexual assault (<i>rape, attempted rape & serious sexual assault etc.</i> ,)	N/A
Financial abuse (<i>theft of money, fraud etc.</i> ,)	N/A
Modern slavery (<i>human trafficking, forced labour, sexual exploitation</i>)	N/A
Discriminatory abuse (<i>unequal treatment, derogatory remarks, harassment or deliberate exclusion</i>)	N/A

ASKED	
Clear documentation in file that client was asked: <ul style="list-style-type: none"> • Client said yes • Client said no 	
Disclosure: No clear further documentation of whether client was or was not asked	
Clear documentation in file that client was NOT asked (with reason why)	
Unclear – documentation of adversity, no clear reasoning if client was asked	X
NOTHING	
Nothing about abuse/adversity or whether client was ever asked in record	

RESPONSES	
The client was given any advice/counselling/support	Yes
Adversity formed part of a formulation	Yes
Adversity formed part of a treatment plan	Yes
Discussion about whether any previous disclosures had been made, how responded to	No
Discussion about, or actual, referral to specialist provision related to adversity 4. Referral made 5. Seen by 6. Engaged with therapy	Yes, Yes, No
Discussion about causal beliefs - whether the client feels there is any connection between the adverse experience and their mental health difficulties	Yes
Discussion about reporting of the adversity to authorities	No
Reporting of the adversity to authorities	No

APPENDIX H: DATA SHEET CONTAINING ADVERSE EXPERIENCES

CLIENT	
BRC ID	X
Gender	Female
DOB/Age	
Ethnicity	White British
Diagnoses	Emotionally unstable personality disorder
Diagnostic cluster	Non Psychotic
CRT	X
ANY DOCUMENTED ABUSE IN CORE ASSESSMENT DOCUMENTS?	
Yes	X
No	

TYPE OF ADVERSITY	
CHILD	
Child physical neglect	N/A
Child emotional neglect	N/A
Child physical abuse	Yes - Progress note 13/12/07 The Mother was verbally and physically abusive to her often hitting her for no reason in front of the family
Child emotional abuse	Yes – Progress note 14/01/13 She described a very unhappy and difficult childhood during which she was abused emotionally, sexually, and physically by her adoptive parents.
Child sexual abuse	Yes - Core assessment 2013 XXXXX was sexually abused by the other male members of this family and the case went to court but was dismissed. XXXXX believes this was because she was not seen as a reliable witness because of her mental health difficulties. The family however was successfully prosecuted for the sexual abuse of foster children, who received compensation. XXXXX believes her childhood experiences are to blame for how she feels about herself but avoids thinking about the past because it is too upsetting for her. Progress note 13/12/07 She had 5 foster brothers who she indicated sexually abused her as did her father.

Bullying	N/A
Parental loss v) death vi) separation	N/A – nothing in file to suggest why separated – cannot code
Child poverty	N/A
Fostering and/or adoption	Yes
ADULT	
Adult neglect and acts of omission (<i>failure to provide or allow access to care</i>)	No
Domestic violence (<i>psychological, physical, sexual, financial, emotional</i>)	No
Adult physical abuse (<i>assault, slapping, physical punishments misuse of medication (over-sedation)</i>)	No
Adult psychological or emotional abuse (<i>enforced social isolation, removing mobility, cyber bullying, threats of harm or abandonment</i>)	No
Adult sexual assault (<i>rape, attempted rape & serious sexual assault etc.,</i>)	No
Financial abuse (<i>theft of money, fraud etc.,</i>)	No
Modern slavery (<i>human trafficking, forced labour, sexual exploitation</i>)	No
Discriminatory abuse (<i>unequal treatment, derogatory remarks, harassment or deliberate exclusion</i>)	No
ASKED	
Clear documentation in file that client was asked: <ul style="list-style-type: none"> • Client said yes • Client said no 	
Disclosure: No clear further documentation of whether client was or was not asked	
Clear documentation in file that client was NOT asked (with reason why)	
Unclear – documentation of abuse, no clear reasoning if client was asked	X
NOTHING	
Nothing about abuse/adversity or whether client was ever asked (nothing)	

RESPONSES	
The client was given any advice/counselling/support	Yes
Adversity formed part of a formulation	Yes
Adversity formed part of a treatment plan	Yes
Discussion about whether any previous disclosures had been made, how responded to	No
Discussion about, or actual, referral to specialist provision related to adversity 7. Referral made 8. Seen by 9. Engaged with therapy	Yes, Yes, Yes
Discussion about causal beliefs - whether the client feels there is any connection between the adverse experience and their mental health difficulties	Yes
Discussion about reporting of the adversity to authorities	No
Reporting of the adversity to authorities	No

APPENDIX I: DATA SHEET CONTAINING ADVERSE EXPERIENCES

CLIENT	
BRC ID	X
Gender	Male
DOB/Age	X
Ethnicity	Black or Black British - African
Diagnoses	1. Paranoid schizophrenia
Diagnostic cluster	Psychosis
CRT cluster	X
ANY DOCUMENTED ABUSE IN CORE ASSESSMENT DOCUMENTS?	
Yes	X
No	

TYPE OF ADVERSITY	
CHILD	
Child physical neglect	N/A
Child emotional neglect	N/A
Child physical abuse	N/A
Child emotional abuse	N/A
Child sexual abuse	N/A
Bullying	N/A
Parental loss vii) death viii) separation	N/A
Child poverty	N/A
Fostering and/or adoption	N/A
ADULT	
Adult neglect and acts of omission (<i>failure to provide or allow access to care</i>)	N/A
Domestic violence (<i>psychological, physical, sexual, financial, emotional</i>)	N/A
Adult physical abuse (<i>assault, slapping, physical punishments misuse of medication (over-sedation)</i>)	<p>Core assessment 09/10/11 "Born in Congo. Came to UK as a refugee in 2001- allegedly had problems with government in Congo where he was held captive for 2 days and tortured."</p> <p>Progress note 09/10/11 "Born in Congo. Came to UK as a refugee. Alleged problems with government, reported that he was held captive and tortured."</p> <p>Progress note 07/11/16 "Born in the DRC, XXXXX first experienced his psychotic features while he was studying in Lagos (Nigeria) in the year 2000. He came to the UK as refugee (from DRC) in 2001 after experiencing problems with the</p>

	Government who held him in prison for 2 days for reasons he does not understand"
Adult psychological or emotional abuse (<i>enforced social isolation, removing mobility, cyber bullying, threats of harm or abandonment</i>)	N/A
Adult sexual assault (<i>rape, attempted rape & serious sexual assault etc.,</i>)	N/A
Financial abuse (<i>theft of money, fraud etc.,</i>)	N/A
Modern slavery (<i>human trafficking, forced labour, sexual exploitation</i>)	N/A
Discriminatory abuse (<i>unequal treatment, derogatory remarks, harassment or deliberate exclusion</i>)	N/A
ASKED	
Clear documentation in file that client was asked: <ul style="list-style-type: none"> • Client said yes • Client said no 	
Disclosure: No clear further documentation of whether client was or was not asked	
Clear documentation in file that client was NOT asked (with reason why)	
Unclear – documentation of abuse, no clear reasoning if client was asked	X
NOTHING	
Nothing about abuse/adversity or whether client was ever asked (nothing)	

RESPONSES	
The client was given any advice/counselling/support	No
Adversity formed part of a formulation	No
Adversity formed part of a treatment plan	No
Discussion about whether any previous disclosures had been made, how responded to	No
Discussion about, or actual, referral to psychology	No
Discussion about, or actual, referral to specialist provision related to adversity	No
Discussion about causal beliefs - whether the client feels there is any connection between the adverse experience and their mental health difficulties	No
Discussion about, or actual, reporting of the adversity to authorities	No

APPENDIX J: DATA SHEET CONTAINING ADVERSE EXPERIENCES

CLIENT	
BRC ID	X
Gender	Male
DOB/Age	X
Ethnicity	Black or Black British - African
Diagnoses	Paranoid schizophrenia
Diagnostic cluster	Psychosis
CRT	X
ANY DOCUMENTED ABUSE IN CORE ASSESSMENT DOCUMENTS?	
Yes	X
No	

TYPE OF ADVERSITY	
CHILD	
Child physical neglect	No
Child emotional neglect	No
Child physical abuse	No
Child emotional abuse	No
Child sexual abuse	<p>Yes – Core assessment 2015</p> <p>In discussing his childhood, XXX said he “used to have lots of girlfriends” and stated “I didn’t make moves on them, they always made moves on me”. XXX said that when he was aged three or four he was “called into the bedroom” by a girl named X whom he said was a neighbour and was aged twelve or thirteen at the time. XXX stated that they then had a sexual relationship that lasted for seven years...When I put it to XXX that this would be viewed as an extremely young age to be sexually active he replied that “most kids do that” and he stated that he had various sexual relationships with “neighbours, friends and schoolmates” who were a (broadly) similar age, from when he was 3 until the age of 22, estimating the number to be approximately 50. XXXX said that he did not consider that there was anything wrong with this and he did not know the whereabouts of any of these individuals (thus preventing further investigation of this issue in line with the Trust policy re: historical abuse).</p>

Bullying	No
Parental loss ix) death x) separation	No
Child poverty	No
Fostering and/or adoption	No
ADULT	
Adult neglect and acts of omission (<i>failure to provide or allow access to care</i>)	No
Domestic violence (<i>psychological, physical, sexual, financial, emotional</i>)	No
Adult physical abuse (<i>assault, slapping, physical punishments misuse of medication (over-sedation)</i>)	No
Adult psychological or emotional abuse (<i>enforced social isolation, removing mobility, cyber bullying, threats of harm or abandonment</i>)	No
Adult sexual assault (<i>rape, attempted rape & serious sexual assault etc.,</i>)	No
Financial abuse (<i>theft of money, fraud etc.,</i>)	No
Modern slavery (<i>human trafficking, forced labour, sexual exploitation</i>)	No
Discriminatory abuse (<i>unequal treatment, derogatory remarks, harassment or deliberate exclusion</i>)	No
ASKED	
Clear documentation in file that client was asked: <ul style="list-style-type: none"> • Client said yes • Client said no 	
Disclosure: No clear further documentation of whether client was or was not asked	
Clear documentation in file that client was NOT asked (with reason why)	
Unclear – documentation of abuse, no clear reasoning if client was asked	X
NOTHING	
Nothing about abuse/adversity or whether client was ever asked (nothing)	

RESPONSES	
The client was given any advice/counselling/support	Yes
Adversity formed part of a formulation	Yes
Adversity formed part of a treatment plan	Yes
Discussion about whether any previous disclosures had been made, how responded to	No

<p>Discussion about, or actual, referral to specialist provision related to adversity</p> <ol style="list-style-type: none"> 1. Referral made 2. Seen by 3. Engaged with therapy 	<p>Yes, Yes, No (client choice)</p> <p>When I asked XXX what he would like to work on in therapy he stated that he does not actually want therapy at all as he does not believe it could help him in any way. Although we discussed this at length, XXX remained certain that meeting again would be of no benefit.</p>
<p>Discussion about causal beliefs - whether the client feels there is any connection between the adverse experience and their mental health difficulties</p>	<p>No</p>
<p>Discussion about reporting of the adversity to authorities</p>	<p>Yes</p>
<p>Actual reporting of the adversity to authorities</p>	<p>No</p>

APPENDIX K: DATA SHEET NOT CONTAINING ADVERSE EXPERIENCES

CLIENT	
BRC ID	X
Gender	Female
DOB/Age	X
Ethnicity	White - British
Diagnoses	1. Paranoid schizophrenia
Diagnostic cluster	Psychosis
CRT cluster	X

ANY DOCUMENTED ABUSE IN CORE ASSESSMENT DOCUMENTS?	
Yes	
No	X (No)

TYPE OF ADVERSITY	
CHILD	Progress note 11/17 “patient had a troubled upbringing” – no further details in clinical record
Child physical neglect	
Child emotional neglect	
Child physical abuse	
Child emotional abuse	
Child sexual abuse	
Bullying	
Parental loss xi) death xii) separation	
Child poverty	
Fostering and/or adoption	
ADULT	
Adult neglect and acts of omission (<i>failure to provide or allow access to care</i>)	N/A
Domestic violence (<i>psychological, physical, sexual, financial, emotional</i>)	N/A
Adult physical abuse (<i>assault, slapping, physical punishments misuse of medication (over-sedation)</i>)	N/A
Adult psychological or emotional abuse (<i>enforced social isolation, removing mobility, cyber bullying, threats of harm or abandonment</i>)	N/A
Adult sexual assault (<i>rape, attempted rape & serious sexual assault etc.,</i>)	N/A

Financial abuse (<i>theft of money, fraud etc.</i>)	N/A
Modern slavery (<i>human trafficking, forced labour, sexual exploitation</i>)	N/A
Discriminatory abuse (<i>unequal treatment, derogatory remarks, harassment or deliberate exclusion</i>)	N/A
ASKED	
Clear documentation in file that client was asked: <ul style="list-style-type: none"> • Client said yes • Client said no 	
Disclosure: No clear further documentation of whether client was or was not asked	
Clear documentation in file that client was NOT asked (with reason why)	
Unclear – documentation of abuse, no clear reasoning if client was asked	
NOTHING	
Nothing about abuse/adversity or whether client was ever asked (nothing)	X

RESPONSES	
The client was given any advice/counselling/support	N/A
Adversity formed part of a formulation	N/A
Adversity formed part of a treatment plan	N/A
Discussion about whether any previous disclosures had been made, how responded to	N/A
Discussion about, or actual, referral to psychology	N/A
Discussion about, or actual, referral to specialist provision related to adversity	N/A
Discussion about causal beliefs - whether the client feels there is any connection between the adverse experience and their mental health difficulties	N/A
Discussion about, or actual, reporting of the adversity to authorities	N/A

APPENDIX L: DATA SHEET NOT CONTAINING ADVERSE EXPERIENCES

CLIENT	
BRC ID	X
Gender	Male
DOB/Age	X
Ethnicity	White British
Diagnoses	Recurrent depressive disorder, current episode severe with psychotic symptoms
Diagnostic cluster	Psychosis
CRT cluster	X
ANY DOCUMENTED ABUSE IN CORE ASSESSMENT DOCUMENTS?	
Yes	
No	X (No)

TYPE OF ADVERSITY	
CHILD	Progress note 05/18 "When discussing his childhood, client described his parents as religious and strict" – no further details in clinical record
Child physical neglect	
Child emotional neglect	
Child physical abuse	
Child emotional abuse	
Child sexual abuse	
Bullying	
Parental loss xiii) death xiv) separation	
Child poverty	
Fostering and/or adoption	
ADULT	
Adult neglect and acts of omission (<i>failure to provide or allow access to care</i>)	N/A
Domestic violence (<i>psychological, physical, sexual, financial, emotional</i>)	N/A
Adult physical abuse (<i>assault, slapping, physical punishments misuse of medication (over-sedation)</i>)	N/A
Adult psychological or emotional abuse (<i>enforced social isolation, removing mobility, cyber bullying, threats of harm or abandonment</i>)	N/A
Adult sexual assault (<i>rape, attempted rape & serious sexual assault etc.</i>)	N/A
Financial abuse (<i>theft of money, fraud etc.</i>)	N/A

Modern slavery (<i>human trafficking, forced labour, sexual exploitation</i>)	N/A
Discriminatory abuse (<i>unequal treatment, derogatory remarks, harassment or deliberate exclusion</i>)	N/A
ASKED	
Clear documentation in file that client was asked: <ul style="list-style-type: none"> Client said yes Client said no 	
Disclosure: No clear further documentation of whether client was or was not asked	
Clear documentation in file that client was NOT asked (with reason why)	
Unclear – documentation of abuse, no clear reasoning if client was asked	
NOTHING	
Nothing about abuse/adversity or whether client was ever asked (nothing)	X

RESPONSES	
The client was given any advice/counselling/support	N/A
Adversity formed part of a formulation	N/A
Adversity formed part of a treatment plan	N/A
Discussion about whether any previous disclosures had been made, how responded to	N/A
Discussion about, or actual, referral to psychology	N/A
Discussion about, or actual, referral to specialist provision related to adversity	N/A
Discussion about causal beliefs - whether the client feels there is any connection between the adverse experience and their mental health difficulties	N/A
Discussion about, or actual, reporting of the adversity to authorities	N/A

APPENDIX M: SPSS GRAPHS

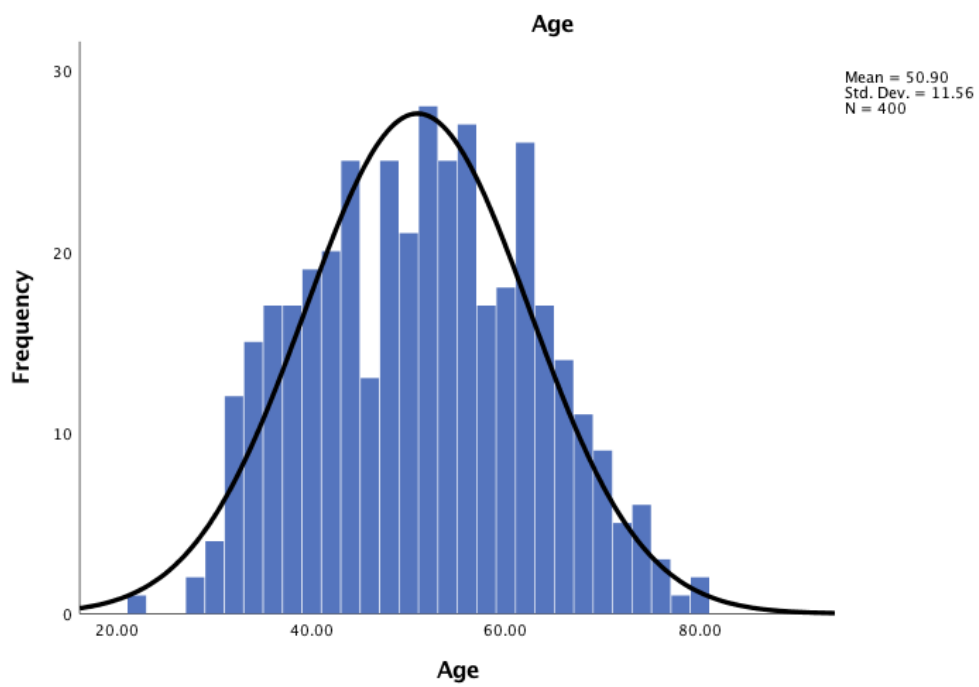


Figure G1: Histogram for age of participants in whole sample

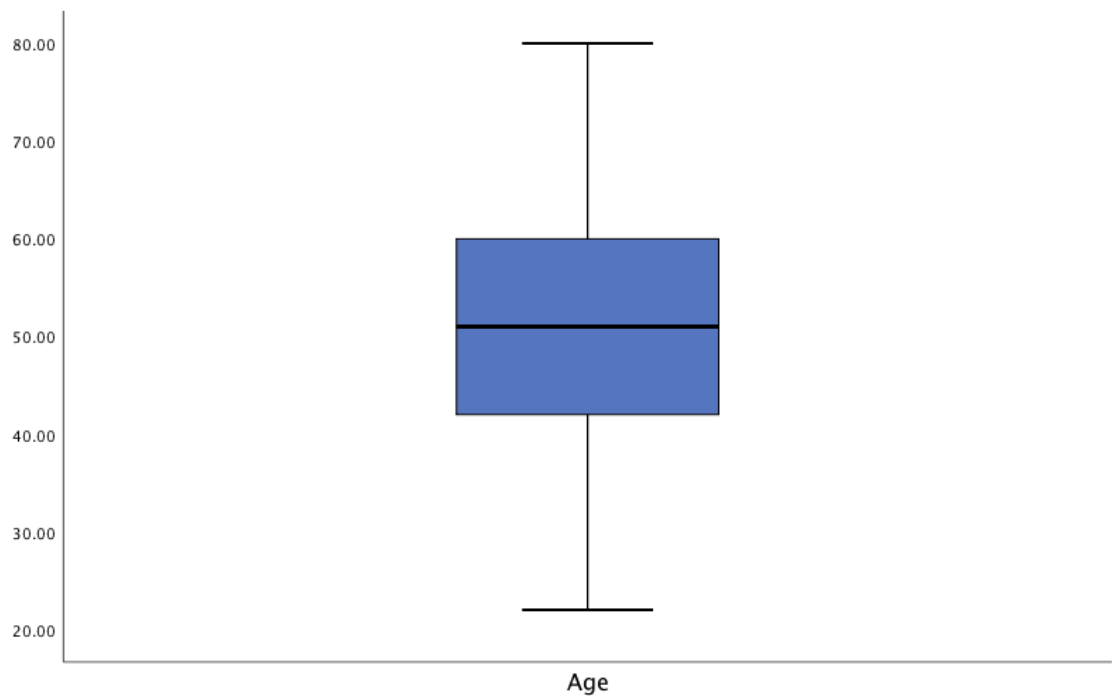


Figure G2: Boxplot for age of participants in whole sample

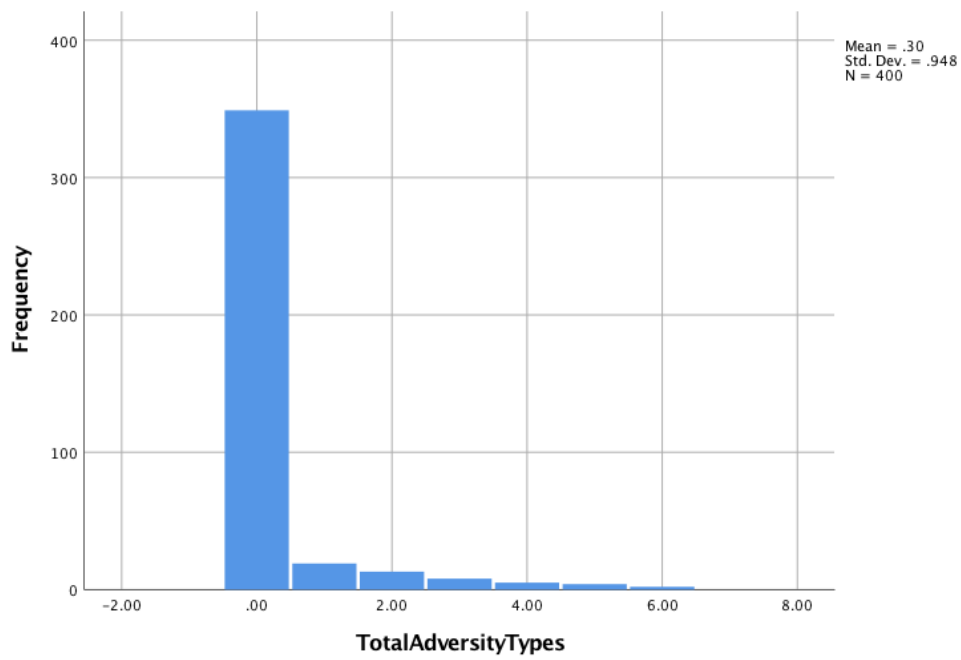


Figure G3: Histogram for total number of adverse experiences documented within clinical records

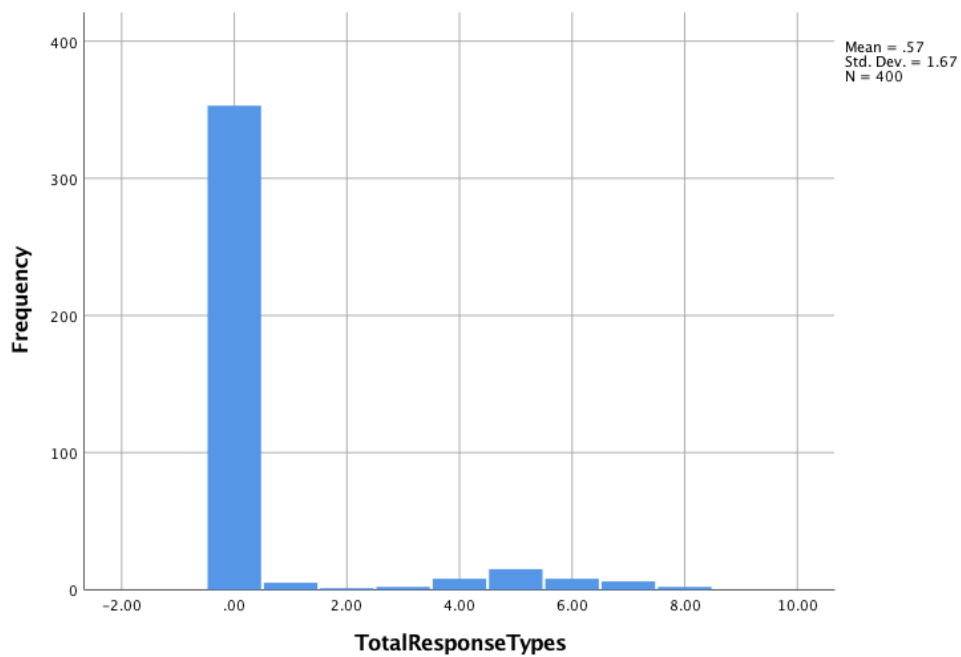


Figure G4: Histogram for total number of responses to adverse experiences documented within clinical records

