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**AUTOBIOGRAPHICAL MEMORY AND DISSOCIATION IN
WOMEN WITH A HISTORY OF CHILD SEXUAL ABUSE**

AND

RESEARCH PORTFOLIO

(Part 1)

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CHAPTER 1

Major Research Project Literature Review

Autobiographical memory and dissociation in women with a history of child sexual abuse – a review of the literature

This paper was written according to the guidelines of *Current Psychology*

**Autobiographical memory and dissociation in women with a history of
child sexual abuse – a review of the literature**

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Abstract

This article presents an overview of the literature on autobiographic memory style and dissociation traits in adults, in the context of childhood sexual abuse. The cognitive research which report on the quality of autobiographical memory in emotionally vulnerable groups is looked at. This is also reviewed with reference to the influences of childhood trauma factors on the development of autobiographical memory style. Dissociation – a common information processing problem following trauma – is reviewed as a concept, with specific attention to dissociation tendencies in adulthood following childhood sexual abuse. The autobiographical memory studies conclude that over-general memory retrieval style is common in people with emotional problems and is independent from mood status. There are suggestions in the literature that this ‘intermediate’ style of memory recall develops from an early age as a function of controlling affect. One study found an association between childhood trauma and over-general memory retrieval in adulthood; there seems to be a further need to look at this relationship. Dissociation has been strongly linked to childhood trauma. Although there are different opinions about the development and definitions of dissociation, it seems to be generally understood as a protective mechanism learned in the face of overwhelming early experiences. Both over-general autobiographical memory style and dissociation traits could be understood as mechanisms of information processing that are utilised to manage difficult emotions. There are some early indications that they may be associated. Further research is required to investigate this relationship.

Introduction

The long-term emotional and cognitive consequences of child sexual abuse (CSA) have been widely reported (Hall and Lloyd, 1995; Briere 1996; Herman 1992). Problems such as depression (e.g. Briere and Runtz, 1987; Bifulco, Brown and Adler, 1991), self-harm (e.g. Santa Mina and Gallop, 1998; Zlotnick et al., 1996), eating disorders (e.g. Waller, 1991; Waller, 1992a), post-traumatic stress disorder (e.g. Saunders, et al., 1992) and dissociative disorders (e.g. Vanderlinden and Vandereycken, 1997) have been found in this population. In the clinical setting these problems often present as complex with multiple therapeutic challenges.

There are different models in the literature that present a theoretical framework for the development of the psychological sequelae of CSA. The four-factor theory of Finkelhor and Browne (1985) is perhaps the most widely quoted model. In short, the model describes sexualisation, stigmatisation, betrayal and powerlessness that are integral parts of the child's experiences and lead to the development of emotional problems. The model underscores the traumagenic dynamics in the impact of child sexual abuse. The authors caution that the model has not been tested empirically or clinically.

Hartman and Burgess (1993) suggest that the above model and other models of child sexual abuse assume a notion of memory, but it is not clearly stated. These authors developed an information processing of trauma model (IPT) to help explain the psychological difficulties (including memory issues) following CSA. This model is concerned with how information is experienced, filtered, and then retrieved. The first

phase considers the pre-trauma individual and the social context prior to the abuse; the second phase, which is the focus of their theory, is called 'trauma encapsulation' and refers to the contextual factors impacting on the child and the individual responses of the child. There is emphasis on the limbic system as the primary neurological system for coding of incoming information. Critical to this phase are the biological considerations i.e. arousal and dissociative processes specific to survival during overwhelming trauma. The outcome of these processes is defined as 'trauma learning' and can present as a chronic part of the victims presentation. These processes are basic to the coping patterns. The model has two further phases: the third is concerned with disclosure and the fourth is the post trauma picture, which refers to the patterns of responses that are often likely to be labelled as a psychiatric problem or character pathology.

Other authors have also identified dissociative tendencies as one of the critical problems in information processing at the time of trauma and after the trauma (van der Kolk et al., 1996, Foa & Hearst-Ikeda, 1996). The latter authors proposed that the presence of neurotic symptoms following trauma reflects on impairment of information processing and that dissociative style prevents the healthy integration of trauma.

The problems resulting from 'trauma learning' may continue to have an impact on how people process information about their lives, and not only the trauma. With this in mind, I turn to the concept of autobiographical memory. This paper reviews the literature on the nature of autobiographical memories, drawn from cognitive research, and adult experiences of dissociation in the context of childhood sexual abuse. The association between these two concepts is discussed. I first examine the evidence of autobiographical memory style in clinical populations.

Autobiographical Memories

Autobiographical memory is one of the oldest and most complex areas that psychology has been interested in. It involves concepts of the self and provides the information for talking-cure psychotherapies (Rubin, 1996). Howe and Courage (1997) present a theory about the emergence/onset of autobiographical memory in childhood. They suggest that it is dependent on the development of a self-concept around the second year in life; this maturation helps to organise memories according to 'me'. Baddeley and Wilson (1986) define personal memory as 'autobiographical memory is (concerned with) the capacity of people to recollect their personal lives'. Verbal narrative, imagery and emotions are all important components of autobiographical memory (Rubin, 1996). Emotions can have an effect on how personal memories develop, as reviewed in the next section.

Relationship between autobiographical memory and mood in adulthood

The cognitive theory of emotion (Beck et al., 1979) suggests that people who are prone to emotional disorders are biased in the way they attend to their world, especially as it relates to the self. Williams (1992) suggests of all information-processing biases, a negative bias in memory for events in one's own life is potentially the most disabling; negative experiences will appear more pervasive and durable.

In early studies about mood and memory bias Lloyd and Lishman (1975) used a list of neutral words as stimuli to cue memories in clinically depressed patients. They found

that the more severe the depression the quicker the patient was to retrieve an unpleasant memory. There were some problems with the interpretation of this data, for example, the depressed patients may have genuinely had more negative life experiences. Taking these problems into account, a series of studies followed and focused on the mood-memory phenomena. For example, Teasdale, Taylor and Fogarty (1980) found in experimental conditions that the same subjects retrieved more happy memories in the elated mood than in the depressed mood and vice versa. Clark and Teasdale (1982) studied the effects of clinical depression on accessibility of memories and reported results broadly similar to the mood-induction studies in the laboratory. This study looked at with-in group differences with patients with diurnal variation in mood and identified significant differences. When mood was improved, memory test results showed more positive recall. These findings were helpful in establishing an association between memory recall and current mood-state and appear robust (Williams and Dritschel, 1988). However, the mood-memory association has not been reliably demonstrated in other clinical conditions such as anxiety, despite suggestions that an anxious mood may have a similar effect on memories (Richards and Whittaker, 1990).

One area in which the literature is inconsistent is the impact mood has on the time taken to retrieve autobiographical memories (Clark & Teasdale, 1982; Williams & Scott, 1988). These studies looked at depressed samples. Also in suicide attempters, no consistent effects have been reported in latency retrieval of memory (Williams & Broadbent, 1986; Williams & Dritschel, 1988).

An associative network model (e.g. Hasher et al., 1985) was adopted as a framework to explain the functioning of autobiographic memory for the studies on mood-memory

bias. This model dealt exclusively with the probability and latency with which positive or negative items are retrieved, in other words, the quantitative aspects of memory recall. It neglected concerns such as the strategies involved in storing and retrieving memories and the specific quality of the memories (Williams 1992). Further research began to focus on this qualitative feature of autobiographic memory and the mechanisms to understand this will be discussed.

Studies highlighting the level of specificity of autobiographical memory

Findings by a group of researchers in the autobiographical memory field in the clinical population over a decade led to consideration of a different focus and mechanism for describing personal memory phenomena. Williams and Broadbent (1986) studied autobiographical memories of patients who had taken an overdose (OD). They compared the group with general hospital patients who were not depressed and with a non-clinical group. In addition to mood congruent memory bias in the time it takes to retrieve a memory, a greater tendency to recall more over-general memories was found in the OD group. (Over-general memories refer to people, places, activities, or objects where a time period was not referred to or was greater than one day. For example, in response to the cue *happy*, a specific answer would be ‘the day we went on holiday’ and a non-specific example would be ‘when I play squash’)(McNally et al., 1994). The latter finding interested the researchers and with a semantic processing task they established that the tendencies to produce over-general memories were not simply due to the effects of the prescribed drugs. Consistent findings of over-general memory retrieval in suicidal patients followed (Williams and Dritschel 1988; Evans et al. 1992).

Williams and Scott's (1988) study of autobiographical memories of depressed patients also found that the depressed patients had more problems recalling specific autobiographical material. Other research with depressed groups supported this finding (Moore et al. 1988; Puffet et al. 1991; Brittlebank et al. 1993). All the studies except for Williams and Dritschel (1988) gave the subjects 60 seconds to retrieve a memory. The studies were also comparable in the method of preparation of the subject before the memory test and all utilised 10 or 20 cue words (positive and negative). Non-clinical groups were used as comparisons in these studies.

Williams and Dritschel (1988) examined patients who had recently attempted suicide and ex-patients who had attempted suicide between 3 and 14 months earlier. They found no correlation between level of mood-disturbance and specificity of recall with either group. Over-general memory recall therefore seems not to be mood-dependent. They also failed to find a relationship between recent crises and recall specificity. This was an important finding to help understand over-general memory.

Difficulties in retrieving specific memories may contribute to emotional disturbance in many ways. Brittlebank et al (1993) did a longitudinal study with depressed patients and assessed autobiographical memory on three occasions over seven months. By doing multiple regression analysis they found that over-general memory strongly predicts failure to recover from depression. In the same study they also looked at dysfunctional attitude, which did not predict the outcome of the depression. They suggest that over-generalisation in memory recall is a trait marker indicating vulnerability to persistent depression. A recent study (Brewin et al., 1999) looked at autobiographical memory and depression outcome. The results did not confirm the Brittlebank et al. (1993) study

results that over-general memories predict failure to recover from depression. Brittlebank et al. (1993) subjects were inpatients and had a greater number of over-general memories at the onset of the study. Confirmation of their findings awaits further research. Evans et al. (1992) studied the relationship between over-general recall and problem solving skills in a para-suicide sample. There was a significant relationship between producing over-general memories and having fewer and less effective problem solving strategies. With the body of research in this field in mind, Williams (1992) argued that certain individuals show a consistent tendency to encode and/or retrieve events at a generic level and that this becomes a long-standing cognitive style that may affect them in various ways.

Model to explain over-general memory phenomena

Theories such as helplessness theory and Beck's cognitive theory of depression (Beck et al., 1979) feature over-general thinking styles. Within the context of cognitive therapy over-generalisation has been described as the most common cognitive distortion with depression (Carver, Ganellen, and Behar-Mitrani 1985). These accounts have not, however identified what the underlying mechanisms are in the development of these tendencies.

In an attempt to explain the above Williams and Dritschel (1988) discussed over-general memory in terms of the 'descriptions' framework of Norman and Bobrow (1979) and Reiser et al. (1985) as opposed to the associative network model. A hierarchical feature is emphasised in this model. In short, this suggests that encoding and retrieval of memory require both general information and more precise episodic information and

that people are normally able to move fluently through the hierarchy. In other words, encoding and retrieval of situations happen on different levels. In particular they include the idea of an intermediate level that allow for over-general or incomplete memories. This model does not allow, however, for the explanation of the different type of over-general memories identified by Williams (1996). Williams discusses the prevalence of 'categorical' over-general memories and 'extended' over-general memories and suggests that the descriptions model itself is too general to account for the mechanisms underlying these.

In view of the descriptions model Williams (1992; Williams et al., 1999) suggests that affective significance of a situation is more likely to attach to more general encoding. The person's proneness to emotional disturbance makes them hypersensitive to the affective aspect of the situation, as opposed to the factual details. Of all the different levels where encoding occurs, the levels that carry most affect are the most general, because they evaluate behaviours according to longer-term criteria. For example, if someone smiles or frowns at a person, they are likely to encode that someone is pleased with them (smile) or angry with them (frown) rather than encoding other relevant situational details (Williams and Dritschel, 1988). Interestingly, van der Kolk and Fisler (1995) wrote about traumatic and ordinary memories that differentiate them along similar lines. They suggest that traumatic memories consist of more general images, sensations and affective states and ordinary memories are more semantic and symbolic. This does not mean, of course, that images and sensations have no specific detail.

The over-general nature of memories is similar to a normal childhood developmental phase to respond to questions about the past in a generic fashion (Morton, 1990). So

why would this style be present in some adults? Williams (1996) suggests that children who suffer negative experiences continue to retrieve memory in a generic fashion as a means of controlling affect.

Childhood adversity and over-general memories

The research in autobiographical memory in the clinical population has not systematically investigated etiological factors (e.g. childhood experiences) to help explain the development of the non-specific style in clinical groups. One study (Kuyken and Brewin, 1995) started to examine the link between this retrieval style and childhood adversity. These authors studied depressed patients, some with a history of physical/sexual abuse and others without such a history. The retrieval of general memories was most significantly related to childhood sexual abuse. It was also significantly related to high levels of avoidance of memories of physical or sexual abuse. With their small sample they could not rule out other variables such as worse parenting and previous number of depressive episodes. However, they were the first authors to indicate that childhood factors may play a role in the quality of autobiographic memories retrieved in adulthood.

Intrusive abuse memories are a common phenomenon with people who have suffered childhood trauma. Kuyken and Brewin (1995) therefore debated that processing space for normal encoding of memories (working memory) would be less available if intrusion is a feature; in other words, over-general recall and intrusion may be associated. However, the results in their study show that avoidance rather than intrusion

(as measured by the Impact of Event Scale, Howoritz et al., 1979) of trauma-related memories correlate with over-general recall. This research provides important information about the impact of early childhood experiences on encoding and retrieval of memory. Either it has an effect on the way the memories are originally encoded or on the styles in which they are retrieved or a combination of the two.

Childhood sexual abuse is often embedded in family dysfunction. Other factors in combination with the abuse could also be responsible for the development of an over-general autobiographical memory system. To this end, Farrar et al. (1997) assessed young children and their parents to understand attachment patterns and autobiographical memory. They found a relationship between attachment style and the emotional content of the parent-child conversation. Girls who have an insecure attachment elaborate on only positive themes and securely attach girls on positive and negative themes. Anderson and Alexander (1996) found that adults with a fearful-avoidant attachment (as measured with the Family Attachment Interview, Bartholomew & Horowitz, 1991) are more incoherent in their description of the past. This attachment predominates in the incestuous abused women they studied. This study relied heavily on retrospective self-reporting. However, quality of attachment seems an important factor in understanding how an individual develops a personal narrative of their life story. These studies did not assess autobiographical memory with a performance measure (for example, AMT), but nevertheless produced interesting thoughts regarding early memory style development.

Like other psychological consequences of childhood abuse and adversity, it would be interesting to investigate what environmental, family and temperamental factors may protect children from developing an over-general cognitive style. The type of trauma

and duration of trauma could be expected to have an impact on this, as well as other known protective factors such as positive family factors and the child's individual resilience. Williams (1996) suggests that some children may be particularly sensitive to even minor negative events or have temperamental difficulty in controlling affect and such traits may make them more vulnerable to over-general retrieval in the absence of significant trauma, and vice versa.

Adult trauma and over-general memories

Research on post-traumatic stress disorder (PTSD) has shown that trauma can alter cognitive representation of the self (Janoff-Bulman, 1992). Trauma can shatter basic assumptions which are deeply embedded in beliefs regarding the meaningfulness of the world and our own self-worth. The question arises whether adult trauma could have an impact on the way autobiographical memories are retrieved.

Empirical evidence for the effects of adult traumatic experiences on autobiographical memory retrieval comes from studies of PTSD and Acute Stress Disorder (ASD). McNally et al. (1994) studied Vietnam veterans who were suffering from PTSD and found more over-general memories than in the veterans with no PTSD. Harvey et al. (1998) studied survivors of road traffic accidents and found more over-general memories from ASD sufferers than non-sufferers, even when the influence of depression was controlled. The retrospective nature of these studies makes it difficult to determine what the pre-morbid retrieval style was. None of these studies enquired about childhood adversity which may have been an important contributor to the development of the PTSD and the over-general retrieval style.

If over-general memory retrieval and/or encoding style is an attempt to control affect in a population with experiences of traumatic events then other information processing difficulties commonly associated with trauma may be related to this. Dissociation is a phenomenon which is widely reported as a symptom in PTSD and a mechanism which has a protective function in the face of trauma, especially chronic and early trauma. In the next section I will review the literature on the link between trauma, especially early sexual trauma, and dissociation. Following that the relation between autobiographical memory and dissociation will be discussed.

Dissociation

Concept of dissociation

Dissociative experiences in adulthood are said to exist on a continuum. This can range from common experiences, such as daydreaming and transient lapses of attention, to more pathological dissociation (Jones et al, 1999). The DSM-IV defines pathological dissociation symptoms as disruptions in the usually integrated functions of consciousness, such as memory, identity, and perception of the environment (DSM-IV, p.477). The concept is largely defined by a set of symptoms which have been observed in persons who experienced trauma in clinical situations. These include amnesia, emotional detachment, feelings of depersonalisation, dreamlike recall of events and

feelings of estrangement (Foa & Hearst-Ikeda, 1996). In the extreme it produces a set of psychiatric syndromes described as dissociative disorders (Putman, 1991).

In the late 1800's, historically important figures in psychology, for example Janet, wrote about dissociation as a clinical concept. After that the concept was neglected in the literature. Over the last two decades there has been a revival of interest in dissociation as a psychological entity. This is possibly due to the widespread diagnosis of post-traumatic stress disorder (PTSD) and dissociation disorders, the active research in childhood trauma and its apparent dissociation sequelae (Spiegel and Cardena, 1991).

There are two major domains of knowledge about dissociation (Putnam, 1991). First is the clinical setting where patients present with this complex picture and related conditions. The second comes from the laboratory studies of hypnosis, which will not be discussed in detail in this review. However, a connection between hypnotizability and dissociation has been proposed on empirical and theoretical grounds (Spiegel and Cardena, 1991).

In the general population Ross et al. (1990) studied the distribution of dissociation levels and the data indicate that minor dissociation is common in the general population. He used the Dissociation Experiences Scale (DES)(Bernstein and Putnam, 1986). The minor experiences involve transient episodes of 'spacing out' or inattention during conversations or driving, intense absorption while reading or watching TV and infrequent episodes of depersonalisation. The median score for this population was seven, where scores can range from zero to 100. About 5% of the population scored above 30, which suggest significant dissociative psychopathology.

Factors that affect the individual's capacity to dissociate (as defined in naturally occurring situations) are discussed by Putnam (1991). It appears that age has an effect on an individual's capacity to dissociate. A number of studies have found that there is a significant negative correlation between age and DES scores in the general population (e.g. Bernstein and Putnam, 1986; Ross et al., 1989). There is no evidence that gender is a significant factor in the experience of dissociation.

In a large study with a clinical population Putnam et al. (1996) investigated dissociation levels across different diagnostic groups. The findings indicate that differences in dissociation scores do not reflect smoothly distributed increases in the DES scores. Instead, it seems that the diagnostic group's mean score was a function of the proportion of subjects within the group who were high dissociators. This challenges the prevailing continuum model of dissociation (Putnam, 1991). They hypothesised that the high dissociators in each clinical group might represent subjects with early and severe abuse in childhood.

Frankel (1996) suggests that the concept of dissociation lacks clarity and also marginalises psychosocial and cultural interpretations which may explain some dissociation phenomena. He proposes that dissociation is used to describe psychoanalytical concepts such as repression and other defences. Spiegel and Cardena (1991) report that a conference with the general topic of repression and dissociation found a number of experts divided as to whether they consider them to be different. A useful thought regarding dissociation is that it could be seen as just being partially out of consciousness (e.g. emotional dissociation). Clinically, dramatic dissociation such as

severe amnesia is relatively unusual; more common are partially dissociated processes or even psychological disconnection.

The Dissociation Experiences Scale (Bernstein and Putnam, 1986) is widely used in the studying of dissociation for its good clinical validity and test-retest reliability. Bernstein and Putnam propose it a trait measure, although this has not been empirically validated. Foa & Hearst-Ikeda (1996) also point out that there are no items about numbing or cognitive avoidance in this scale. Frankel (1996) suggests that some of the items on the scale reflect non-pathological experience. He also argues that a distinctive qualitative difference between subjects in the experience of dissociation symptoms with low and high scores has not been ruled out.

Empirical evidence supporting the relation between trauma and dissociation is based on three sources (Draijer & Langeland, 1999): 1) studies linking dissociation and trauma in adulthood; 2) research examining links between childhood trauma and adult dissociation; 3) prospective studies of children, the latter as reported in Putnam et al., (1995).

Dissociation following adult trauma

A few studies have shown a clear link between adult trauma and dissociation during or after the event (Marmer et al., 1994; Bremner et al., 1992; Carlson and Rosser-Hogan, 1991). However, these studies did not assess or control for the effects of childhood trauma on adult dissociation.

Duncu et al. (1996) finds higher levels of dissociative tendencies in rape victims reporting childhood sexual abuse than in rape victims with no past abuse. Lipschitz et al. (1996) conducted a study with 144 psychiatric patients to determine the relationship between child onset abuse, adult onset abuse and adult dissociation. The study showed clearly that child abuse, especially multiple abuse is related to adult dissociation. The cumulative effect of repetitive trauma is in keeping with Terr (1991) who suggests that dissociation is a developmentally sensitive and learned psychological protection mechanism.

Dissociation in the childhood sexual abuse (CSA) population

The literature reports a strong link between childhood trauma and adult dissociation. (Bernstein and Putnam, 1986). Zlotnick et al. (1996) reported a correlation of 0.40 between self-reported history of CSA and scores on the DES in a sample of 148 female psychiatric inpatients. Chu and Dill (1990) reported a relationship between childhood physical/sexual abuse and adult dissociation. They studied female inpatients and found that the presence of both physical and sexual abuse leads to significantly higher levels of dissociation compared to the one or the other. The link between childhood sexual abuse and adult dissociation has been assumed by some authors and their research has focused on the characteristics of the abuse. An inpatient study using the same measures of dissociation and childhood trauma reported that more invasive sexual abuse was related to higher levels of dissociation (Kirby et al., 1993). Chu et al. (1999) reported that any childhood abuse was related to higher levels of dissociation in a study of female patients in a PTSD unit. Frequent sexual abuse and early onset sexual abuse were particularly associated with elevated levels of dissociation. These studies looked at

the severe end of the scale, namely inpatients. Diagnosis was not recorded and therefore the relation between diagnosis and dissociation not investigated. Also, Merckelbach and Muris (2001) suggest that these findings with the clinical population should be interpreted with caution. Patients with dissociation and a trauma history may well be more likely to come under the attention of mental health services than patients with dissociation and no trauma history.

Waldinger et al. (1994) studied a female outpatient population to investigate CSA and dissociation. They reported higher levels of dissociation among those with a history of sexual abuse than among those with a history of physical abuse or no abuse history. The above studies were cross-sectional and retrospective in nature. They all relied on self-report. Briere (1992) considered this to be a weakness in studying the effects of childhood sexual abuse although the most commonly used design. Also, the majority of the studies fail to investigate family dysfunction.

In the non-clinical college population DiTomaso and Routh (1993) reported a modest but significant correlation between CSA and DES scores (0.21). Rind et al (1998) indicates that such a modest association between self-reported abuse and dissociative symptoms in a college population is typical.

The theoretical assumption is that dissociation is primarily a response to overwhelming experiences, especially in childhood (Spiegel and Cardena, 1991; van der Kolk & Fisler, 1995). Some authors continue to call the above relationship into question. Nash et al. (1993), for example, found that CSA was irrelevant in the development of adult dissociation compared to neglect. The study, however, used a weak measure for

dissociation and also a narrow definition of CSA. In a general population Mulder et al. (1998) call into question the direct relationship between childhood sexual and physical abuse and adult dissociation in a study where they used logistic regression. However, evidence for a link between chronic and severe childhood trauma and a vulnerability to dissociation in adulthood appears fairly robust.

Frankel (1996) suggests that a linear process to understand the relationship between childhood and adult dissociation is conceptually attractive, but over simplistic. He suggests that a direct trauma-dissociation link would mean that all that is required to treat the dissociation symptoms is to uncover traumatic material. It has to be recognised that other complex psychological processes (relationship and interpersonal and intrapsychic problems) need to be taken into account for a comprehensive understanding of the link between dissociation and trauma.

Vanderlinden and Vandereycken (1997) propose a multifactorial model of trauma and dissociation. A number of mediating background factors help to explain why dissociation can develop as a problem.

Insert Figure 1 here

Dissociation and attachment theories

Barach (1991) has drawn attention to attachment-related traumatic experiences in the etiology of extreme dissociative disorders. He suggests that Bowlby's (1982) concept of detachment in childhood reflects a type of dissociation. This can become not only a

temporary reaction to separation or abandonment, but the child's characteristic coping style.

Sexual abuse, especially incestuous abuse is more often than not embedded in other family dysfunction. Barach (1991) describes the parents' failure to respond as an additional trauma for the child. Anderson and Alexander (1996) studied the relationship between attachment and dissociation in adult survivors of sexual abuse by using self-reporting methods and found that fearful avoidant attachment was significantly related to dissociation. Their findings suggest that dissociation may be explained by the family context as well as by specific aspects of the abuse experience. They emphasise the need for better understanding of the 'dissociation-generating' family. Main and Solomon (1986) identified an attachment style which they called the disorganised/disoriented attachment. Because the etiology of disorganised attachment includes the same type of double-bind experience as referred to in dissociation literature (Spiegel, 1986) in theory it may be related to the development of dissociative disorders in adulthood (Anderson and Alexander, 1996). The double-bind experience explains the child's expectations for nurturance from the same person who abused him/her. Lotti (1992) reviewed the literature on disorganised/disoriented attachment and concluded that these individuals are more vulnerable to dissociation.

Draijer and Langeland's (1999) found that both physical and sexual abuse contribute independently to the development of adult dissociation. Their results also point to the importance of the mother's unavailability. They conclude that as well as trauma, object relations and attachment are important in the understanding of the development of dissociation disorders.

Relationship between dissociation and autobiographical memory

As discussed in an earlier section, Howe and Courage (1997) presented the developmental model of autobiographical memory as the organised memories of experiences that happen to 'me' which emerges around age two. In the context of childhood sexual abuse and other adversity, if this concept of self is confused and fragmented as a result of dissociation, the development of an autobiographical memory may be affected. Williams (1996) suggests that over-general memory style may be required during development.

Previous research has begun to indicate that over-general recall and dissociation in the context of childhood trauma may have some relationship. As reported earlier in this review Kuyken and Brewin's (1995) study shows that reports of early adversity are systematically related to depressed patients' performance on information processing tasks (Autobiographic Memory Test). They found that non-specific memories and avoidance of trauma memories were related in a depressed group with childhood sexual and physical abuse histories. Although they did not specifically investigate dissociation one could accept some relation between avoidance of traumatic material and dissociation tendencies. It has also previously been reported that high scores on the avoidance score of the Impact of Event Scale also correlated significantly with the number of overgeneral memories produced (Horowitz et al., 1979).

Jones et al. (1999) studied the relationship between dissociation and autobiographical memories in a group of borderline personality disorder patients. Theory of over-general recall suggests that the encoding and/or retrieval of specific memories may be prematurely aborted in the hierarchical structure due to specific negative episodic experiences (Williams, 1996). Therefore there may be a lack of integration of certain aspects of the experience. Similarly, dissociation functions as an at least momentarily unbridgeable gap of experiences in an effort to avoid being overwhelmed (Putnam, 1991). Since these theories suggest that both dissociation and over-general recall are due to mnemonic strategies for the avoidance of distressing emotions, Jones et al. (1999) expected that there would be an association. They found a significant relationship between the two phenomena. No assessment was made of traumatic experiences in this study and therefore no relationship between trauma and over-general memory was examined.

Jones et al., (1999) speculated whether poor autobiographical memory recall should be considered a dissociation symptom. However, too little is known about the relationship to come to this conclusion at this early stage. Poor autobiographical memory recall may be related to dissociative symptoms such as amnesia and emotional numbing, but not to others reflecting on identity issues, for example depersonalisation and derealisation. The investigations of the relationship between over-general memory recall and high levels of dissociation are in the early stages and have not been studied in other clinical groups, or taking into account child abuse factors.

Summary

This review explored autobiographical memory and dissociation in the context of adults with a history of child sexual abuse. One of the critical psychological sequelae of CSA seems to be the lack of integration of trauma experiences and a subsequent difficulty with dissociative coping style in adulthood. There seem to be early indications in the literature that these information-processing difficulties may have an effect on the development of a healthy autobiographical memory system. Certainly in people with depression and suicidal tendencies there are robust findings of a pattern of over-general memory retrieval that contributes to vulnerability and may pre-date the depression. This style of recall could be understood as a strategy of controlling and regulating affect. This appears to be more prevalent where there is a history of childhood abuse although these findings are in the early stages in the literature. Theories suggest that both over-general autobiographical memory recall and dissociation are mechanisms of memory functioning which aid the individual to cope with distressing experiences. The two concepts have been reported to co-exist in BPD. Further investigation in other clinical groups to explore this relationship, and the contribution of child abuse, awaits research.

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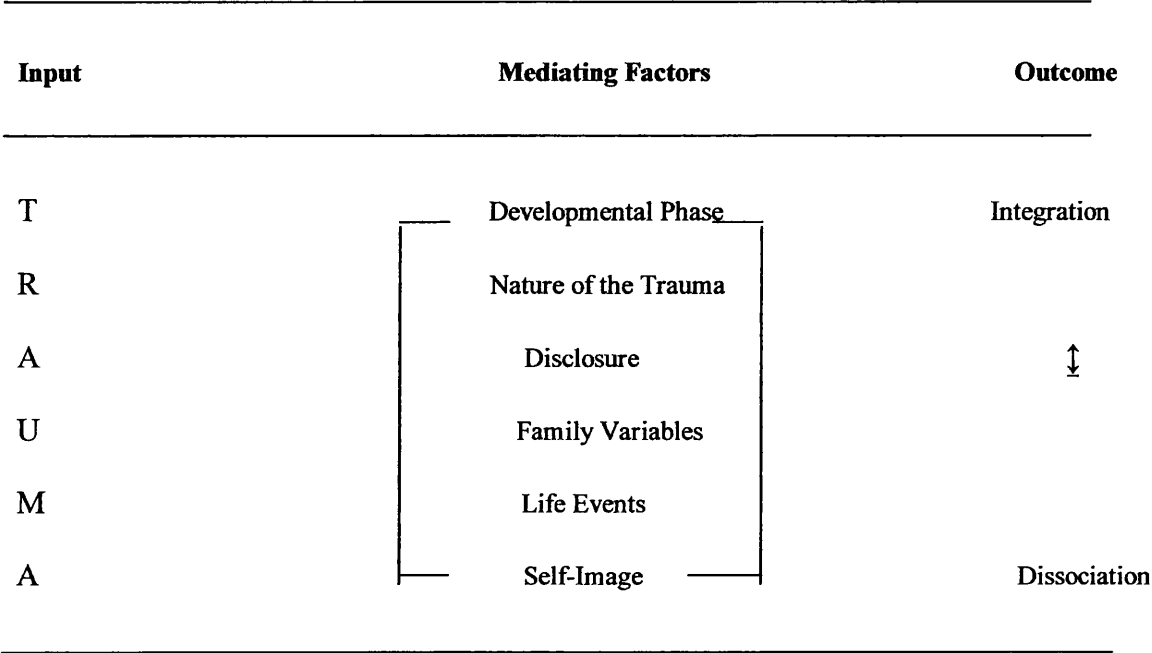
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Figure 1

A Multifactorial Model of Trauma and Dissociation



CHAPTER 2

Major Research Project Proposal

**Autobiographical memory and dissociation in women with a history of
child sexual abuse**

(Word count: 2058)

Summary

Adults with past histories of child sexual abuse often present with a number of emotional and cognitive problems, including difficulties with information processing and memory. To this end, the concepts of autobiographical memory and dissociation are being looked at in this study. Autobiographical memory (AM) recall has been found to be over-general in some psychiatric populations (especially depression and parasuicide) compared to the more specific memory recall of normal controls. These findings seem to be independent of current mood status and appear to be an over-general cognitive style that develops as a means of controlling difficult emotions. The origins of such a memory style are still unknown although one study found that childhood trauma was relevant. Dissociation – a lack of integration of experiences, thoughts and emotion – in adulthood has been strongly linked to early childhood trauma. At the pathological end dissociation can lead to difficulties in recalling significant autobiographical experiences. Based on these available theories, high levels of dissociation are expected to co-exist with over-general AM retrieval. The study aims to explore the quality of AM recall (specific v. over-general) and the levels of dissociation with a group of women with a contact sexual abuse history. The group will be compared with a clinical group of women with anxiety disorders without a history of childhood sexual abuse. The association between dissociation and AM recall will be examined.

Introduction

The long-term emotional and cognitive consequences of childhood sexual abuse (CSA) have been widely reported in the literature (Hall and Lloyd, 1995; Briere, 1996). Of these, problems with information processing (e.g. integration of traumatic experiences v. dissociation from traumatic experiences) have received attention (van der Kolk et al., 1996). Underlying the information processing models of trauma is the notion of memory and how this is integrated, stored and retrieved (Hartman and Burger, 1993). Waller et al. (1996) suggest that extreme and chronic abuse within a particular developmental window may disrupt the development of a healthy autobiographical memory system.

Autobiographical memory has been defined as ‘the capacity of people to recollect their personal lives’ (Baddeley and Wilson, 1986). The cognitive research on autobiographical memory suggests that emotions can have an effect on the way memories are retrieved. There has been a growth of interest in research in autobiographical memory of emotionally vulnerable clinical groups over the last 15 years. Studies have initially focused on the mood-memory phenomena and findings of mood congruent recall of autobiographical memories appear robust (Williams and Dritschel, 1988). Studying para-suicide patients Williams and Broadbent (1986) found, in addition to mood congruent memory bias, an interesting pattern in the quality of memories recalled emerged. There was a greater tendency to produce over-general autobiographical memories in the suicide group compared to the normal controls. *(Over-general memories refer to people, places, activities or objects where a time period was not referred to or was greater than one day. For example, in response to the*

cue happy, a specific answer would be 'the day we went on holiday' and an over-general example would be 'when I play squash' (McNally et al., 1994).

Similar findings were reported by Williams and Dritschel (1988). Williams and Scott's (1988) study of autobiographical memories of depressed patients also found that the depressed patients have in general more problems with recalling specific autobiographical material

The current mood-state does not seem to determine the specificity of the autobiographical recall. Williams and Dritschel (1988) found no correlation between mood disturbance and specificity of recall. Williams (1992) argues that certain individuals show a consistent tendency to encode and/or retrieve events at a generic level and therefore develop a different cognitive style. Brittlebank et al. (1993) found an association between persistence of depression and over-general recall. They conclude that non-specificity is not state-dependent but a trait marker to persistent depression. This finding however was not confirmed in a recent study on autobiographical memory and depression outcome (Brewin et al., 1999). These studies have not investigated any other factors, for example childhood experiences, in an attempt to explain the prevalence of over-general memory retrieval in depressed and suicidal groups.

Clinical problems studied above (depression and suicidal behaviour) are common in the population with child sexual abuse histories (Briere, 1996). In an overview of the specificity of memory recall Williams (1996) suggests that a non-specific recall pattern may be the result of an attempt to control affect and that children with adverse life experiences may continue to utilise this into adulthood. One study found more

significant over-general memory recall in a depressed group with child sexual and physical abuse compared to a depressed group without such histories (Kuyken and Brewin, 1995). The sexual abuse histories were the most significantly associated with the over-general autobiographical memory recall. This was the first study where autobiographical memory was investigated in the context of childhood trauma. In addition, the study reports that patients with high levels of avoidance of spontaneous memories of abuse (as measured with the Impact of Event Scale, Howoritz, et al., 1979) retrieved more over-general memories. One interpretation of these findings is that traumatic early experiences lead to a generalised tendency to inhibit memories.

A critical concept of information processing focused on in the trauma literature is dissociation. Dissociation is understood as primarily a response to overwhelming experiences, especially in childhood (Spiegel and Cardena, 1991; van der Kolk and Fislser, 1995). Research on the effects of childhood sexual abuse has shown that repeated trauma is linked to dissociation levels in adulthood (Chu and Dill, 1990; Kirby et al., 1993; Chu et al., 1999). Dissociation refers to a continuum of experiences ranging from common experiences, such as daydreaming and transient lapses of attention, to pathological failures to integrate experiences, affect, behaviour, sensation and identity into a coherent and unified sense of consciousness (Jones et al., 1999). Perhaps more commonly seen in the clinical situation is partial dissociation or psychological disconnection (Frankel, 1996). Dissociation is widely thought of as an adaptive coping mechanism in the face of severe trauma. Repeated use of dissociation during, for example, incest appears to lead to a tendency to use a dissociative coping style into adulthood (Putnam, 1991). Clinical diagnoses that have been associated with dissociation are dissociative disorders, PTSD and borderline personality disorder

(Putnam et al., 1996). Affective disorders and anxiety disorders scored lower on dissociation in this large study with clinical and non-clinical samples.

The trauma-dissociation link does not seem to be a simple linear process. The family context in which CSA happens is relevant in our understanding of the effects of CSA (Nash et al, 1993; Anderson and Alexander, 1996). Draijer and Langeland (1999) report that in addition to sexual and physical abuse, the unavailability of the mother seems to be important in the development of adult dissociation. These factors need to be taken into account when studying autobiographical memory and dissociation in a CSA population.

Theory suggests that both over-general autobiographical memory and dissociation are perhaps strategies for avoidance of distressing memories or attempts to control affect. It is therefore expected that there may be an association. Jones et al. (1999) reported an association between over-general memory recall and high levels of dissociation. They studied these two concepts in a borderline personality disorder (BPD) sample and found significantly more over-general responses from the BPD group. This has not been looked at in other clinical groups.

Aims of study

The first aim of the current study is to identify differences in quality of autobiographical memories (specific vs. over-general memories) in a group of women who have a history of contact child sexual abuse (CSA) and an age matched control group of anxious women without a history of sexual abuse. Secondly, the study aims to investigate

differences in dissociation levels in these two groups. The third aim is to identify whether elevated levels of dissociation co-vary with the production of over-general memories.

Hypotheses

H1 – The CSA group produce more over-general autobiographical memories in comparison with the control group

H2 – The CSA group have higher levels of dissociation in comparison with the control group

H3 - High levels of dissociation are associated with the production of over-general autobiographical memories

Design and Procedure

Sample – Index group

A female sample of the clinical population with contact child sexual abuse histories will be studied. Subjects will be recruited from a specialist sexual abuse clinic in the North of Glasgow and Clinical Psychology Departments in the Trust. To control gender variance only female patients will be recruited. The definition of CSA will be limited to abuse that involved physical contact; one-off rape experiences will be excluded.

Other exclusion criteria are patients with a history of psychosis, head injury and substance abuse problems.

Approximately 25 women will be recruited. (Over a period of 12 months the specialist sexual abuse clinic receives approximately 160 referrals of which 80% are women. A recruitment goal of 25 subjects seems realistic).

Sample – Control group

The aim is to recruit 20 controls of female patients referred to mental health services for anxiety disorders. This group will be screened for childhood sexual trauma. The groups will be matched for age.

Power Calculation

A power calculation, employing mean values and a standard deviation of a comparable study has been carried out. The study compared depressed subjects with and without a history of sexual abuse on autobiographical memory (Kuyken & Brewin, 1995). With a significance level of 0.01 and 90% power a sample size of a minimum of 14 subjects was suggested.

Measures

Demographic Data

Data on age, occupation, education, area of residence and marital status will be collected. The number of therapy sessions and ICD-10 diagnosis as identified by the clinician involved with the subject will also be recorded.

Autobiographical Memory Test (Williams and Broadbent, 1986)

Emotional cue words will be used to assess autobiographical responses. The test has been widely employed in autobiographical memory research. The five positive words are *happy, safe, interested, successful* and *surprised*. The five negative words are *sorry, angry, clumsy, hurt* (emotional) and *lonely*. Prior to administering the test the subject will be instructed as to what is expected from them. Two examples will be presented as practice. During the test words will be read, positive and negative words alternating. Subjects will be given 60 seconds in each case to retrieve a specific personal memory in response to the word. The latency to the first word of the response will be recorded. The response will be categorised as specific or over-general. Subjects will be prompted to give a more specific memory if it is over-general. Previous research has found that a clear distinction between a general and specific memory can be reliably made in this way. If respondents do not produce a memory within 60 seconds, the next cue word will be presented. The test takes approximately 15 minutes.

When considering the validity of the positive and negative cue words of the AMT it is noted that a memory retrieved from a positive cue word (e.g. *safe*) may in many instances require the individual to first search for the opposite experience (an *unsafe* memory) and that it is perhaps not only a recall of a positive experience. This could be the case with all five positive cue words used in the current study. However, Williams (1996) reviewed studies using different cueing techniques and suggested that

emotionally valent nouns, activity cues, and scenarios all seem to provide similar results regarding vulnerable groups retrieving more over-general memories. Other research is required to investigate the process of how people access the retrieved memory.

Dissociative Experiences Scale – DES (Carlson and Putnam, 1993)

The scale is a 28-item, self-report instrument for the measurement of frequency and intensity of dissociative experiences. A range of experiences commonly conceptualised as dissociation and depersonalisation in a psychiatric population in general and in traumatised individuals in particular, is included. The measurement has test-retest reliability of 0.84 and good split-half reliability. It takes approximately 10 minutes to complete.

Sexual Experiences Questionnaire (Tsai et al, 1979)

An adaptation of this questionnaire (Douglas, 2000) will be used to obtain information about specific characteristics of the sexual abuse.

One question with a 'yes/no' answer was added to establish whether adult physical or sexual trauma was experienced

Questionnaire on other childhood experiences

Six additional questions about negative childhood experiences which have proven to be risk factors for adult pathology will be included. These are derived from the Structured

Trauma Interview (Draijer, 1989) and aim to provide the study with information on other adverse childhood experiences.

Revised Beck Depression Inventory (BDI) (Beck & Steer, 1993b)

This is a self-rating measure of 21 items. The questionnaire assesses the level of depression by asking participants to choose between four statements reflecting the severity of each symptom (scored from 0-3). The sum of ratings given provides the overall score.

Beck Anxiety Inventory (BAI) (Beck & Steer, 1993a)

This consists of 21-items which are descriptive statements of anxiety symptoms. Subjects rate the severity of their symptoms from 0 (not at all) to 3 (severely). The sum of the ratings given provides the overall score.

Data Analysis

Data will be analysed with SPSS 9.0 for Windows.

Descriptive data analysis will be applied to the demographic data and the child abuse characteristics.

Means and standard deviations for the performance on the BDI, BAI and DES II will be computed and appropriate tests will be applied to identify any significant differences between the index and control group.

Means and standard deviations for the two groups for the number of over-general responses to the AMT will be computed. A two-way analysis of variance will be performed, with the index group and control group as the between-groups factor and the cue valence (positive, negative) as the within subject factor.

Scores on the DES II and the performance on the AMT will be correlated to examine the relationship.

Practical Application

Information processing problems and difficulties with chronic posttraumatic stress disorder have proved to be complex challenges in the treatment of CSA survivors. Exploration of the nature of autobiographic memories and the relationship with dissociation will help to shed light on these difficulties. Problems with retrieving autobiographical memories and with dissociation have a number of therapeutic consequences. They may make it harder for the patient to utilise specific cognitive techniques when trying to overcome difficulties (Kuyken and Brewin, 1995). For example, specific details of a patient's life to utilise with problem solving or challenging negative cognitions may not be easily accessible.

Ethical Approval

Ethical approval has been granted by the Trust's Ethics Committee.

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CHAPTER 3

Major Research Project

Autobiographical memory and dissociation in women with a history of childhood sexual abuse

This paper was written according to the guidelines of *Psychological
Medicine*

**Autobiographical memory and dissociation in women with a history of
childhood sexual abuse**

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ABSTRACT

Background. The study examined whether women with a history of childhood sexual abuse (CSA) are more over-general in their recall of autobiographical memory in comparison to a clinical group (anxiety) without a history of CSA. It also investigated whether the CSA group has higher levels of dissociation and whether the dissociation levels are associated with the over-general recall, as expected on theoretical grounds and found in a borderline personality disorder (BPD) group.

Methods. Twenty-eight female patients with CSA history and 22 age-matched clinical controls with anxiety problems and no CSA history completed the Autobiographical Memory Test (AMT) and the Dissociative Experiences Scale (DES). Other self-report measures looked at characteristics of the CSA, other negative childhood experiences and depression and anxiety levels.

Results. The study found that the CSA group had a significantly greater number of over-general memory recall and also experienced higher levels of dissociation. There was no difference on the affective measures between the groups. In addition to sexual abuse, the CSA group reported a higher number of childhood adversities. A significant correlation was found between over-general memories and high levels of dissociation.

Conclusion. Individuals with a history of CSA have a tendency to be more over-general in their retrieval of memories and to have higher levels of dissociation than an anxiety group without a CSA history. Dissociation and over-general were associated. These results highlight the ongoing information processing difficulties when CSA and other trauma were present in childhood.

(Word Count: 240 words)

INTRODUCTION

Child sexual abuse (CSA) is regarded as a severe psychosocial stressor and the psychological consequences have been widely reported and are routinely discussed in clinical environments. Different theoretical models to conceptualise the consequences of CSA are presented in the literature (e.g. Finkelhor & Browne, 1985; Freud, 1961; Hartman & Burgess, 1993). Critical problems with the processing of the early trauma are central to the understanding of the emotional and cognitive difficulties following CSA. Van der Kolk et al. (1996) suggest that 'passive' coping, in other words, 'spacing out' and disengaging at the time of trauma is a common emotional survival technique. Hartman and Burgess (1993) define the outcome of these coping mechanisms following chronic abuse such as incest, as 'trauma learning'.

When the tendency to disengage/dissociate from overwhelming emotional experiences persists into adulthood, the normal integration of the trauma is affected. The presence of dissociation as a mediating factor has been associated with the abuse-psychopathology link in adults with a history of sexual abuse (Ross-Gower et al., 1998).

Problems with the information processing of the trauma may continue to have an impact on how people with a history of sexual abuse store and retrieve everyday memories. Disengaging from normal life experiences may become a style of coping. As suggested by Waller et al. (1996), extreme and chronic abuse within a particular developmental window may disrupt the formation of a healthy autobiographical memory system.

Autobiographical memory has been widely studied in emotionally vulnerable groups over the last two decades; interesting differences have been found in comparison with normal control groups. Mood congruent memory bias findings proved to be fairly robust (Williams & Dritschel, 1988). Latency findings, in other words the time in which positive and negative memories are retrieved, have been much more inconsistent (Clark & Teasdale, 1982; Williams & Broadbent, 1986). Researchers have moved away from these quantitative aspects of autobiographical memories. An interesting pattern in the quality of memory retrieval emerged in research findings. With a sample of patients who recently attempted suicide Williams and Broadbent (1986) found that they had difficulty retrieving specific memories from emotional cue words in comparison with normal controls (For example, in response to the cue *happy*, a specific example would be 'the day we went on holiday' and a non-specific example would be 'when I play squash'). Those initial results were supported by other studies with suicide attempters (Evans et al. 1992; Williams & Dritschel, 1988) and depressed patients (Brittlebank et al. 1993; Puffet et al, 1991; Williams and Scott, 1988). Similar findings have also been reported in people suffering from post-traumatic disorder following adult trauma (Harvey et al., 1998; McNally et al., 1994).

Williams and Dritschel (1988) found no correlation between current mood-state and the tendency to produce over-general memories. This was an important finding in the understanding of the development of over-general autobiographical memory. Williams (1992) suggested that certain individuals perhaps show a tendency to encode and retrieve events at a generic level; this becomes a long-standing cognitive style, rather than just a temporary method during a depressive episode. These thoughts direct us towards the early contributing factors in the formation of an autobiographical memory

system. Investigation of early childhood factors may help us to understand the development of this over-general retrieval style.

Evidence of developmental studies is of interest here. Researchers agree that for a long period the young child's preferential response to questions about the past is to give a generic (over-general) answer (Morton, 1990; Williams, 1996). This is a normal phase of cognitive development. In an attempt to understand the presence of this in adulthood, Williams (1996) suggests that children who suffer negative events continue to retrieve in generic form, as a means of controlling affect when experiences become overwhelming. Theoretical accounts of the underlying mechanisms of over-general recall have tended to use the descriptions model as a framework (Norman & Bobrow, 1979; Williams & Dritschel, 1988). In this model normal encoding and retrieval happen on different levels and require both general information and specific episodic information. It allows for an intermediate level of encoding/retrieval that is relevant with over-general recall. Affective significance is more likely to attach to intermediate encoding. The nature of the trauma experience (or any emotionally loaded experience) may make the individual sensitive to the affective aspects of the situation (Williams 1992); specific episodic information may be neglected.

The present study is interested in autobiographical memory style among women with a history of sexual abuse. Given the presence of antecedent trauma, and diagnosis of PTSD (e.g. Saunders et al., 1992), depression (e.g. Briere & Runtz, 1987) and parasuicide (e.g. Santa Mina & Gallop, 1998) in this population it is expected that similar difficulties as described above will emerge in autobiographical memory. One study (Kuyken & Brewin, 1995) started to examine the link between childhood factors and

autobiographical memory. It studied depressed patients, some with a history of sexual or physical abuse and some with no such history. The retrieval of over-general memories was significantly related to the history of sexual abuse.

If over-general memory retrieval is an attempt to deal with difficult emotions and difficult autobiographical material then other information processing difficulties associated with CSA, such as dissociation, might be expected to co-exist. In addition to focusing on autobiographical memory the present study is also interested in levels of dissociation in this group. Dissociation in adulthood is said to exist on a continuum ranging from common experiences such as daydreaming and transient lapses of attention, to more pathological experiences. At the more severe end a person fails to integrate memory, affect, behaviour and identity. Dissociation seems to be maintained when there is a subsequent failure to activate memories of the experiences and integrate them with inner schemas of the self and the world (Foa & Hearst-Ikeda, 1996). Dissociation has long been linked to trauma. Adult trauma has been identified as a factor in the development of dissociation (e.g. Bremner et al., 1992; Foa & Hearst-Ikeda 1996; Marmar et al., 1994). Trauma in childhood, particularly sexual trauma has been strongly linked to adult dissociation (Chu et al., 1999; Waldinger et al., 1994; Zlotnick et al., 1996) and the earlier and more severe the trauma, the higher the levels of dissociation (Kirby et al., 1993). Research has shown, however, that not only abuse but also the availability of the mother, the quality of attachment relationships, and other family factors are important variables in understanding the development of dissociation (Anderson & Alexander, 1996; Draijer & Langeland, 1999; Nash, et al., 1993).

Theory suggests that both dissociation and over-general recall may be understood as strategies to avoid distressing memories. Jones et al. (1999) have shown in a borderline personality disorder group that these two concepts co-vary and they were the first authors to report this relationship. Jones's study did not assess for childhood trauma. In a study on the association between childhood trauma and over-general recall, Kuyken and Brewin (1995) also reported an association between over-general recall and avoidance of traumatic material (as measured on the Impact of Event Scale, Howoritz et al., 1979) Although they did not measure dissociation as such, one may expect some relation between avoidance of traumatic material and dissociation tendencies.

Investigation of the above concepts in a CSA population could contribute to the understanding of information processing in those with longstanding problems. If over-general recall and high levels of dissociation are associated, information processing models may need to take into account that problems with integration of memory do not only emerge with trauma material, but also with general life experiences.

Studying these concepts in two clinical groups, one with and one without a history of sexual abuse could be a useful way of investigating these effects in emotionally vulnerable individuals. Although anxiety patients do not seem to have significant problems with over-general memory recall (Burke & Mathews, 1992), they do tend to report dissociative symptoms such as depersonalisation and derealisation (Cassano et al., 1989). An anxiety group without a history of CSA was used as a control group. The index group was a clinical group with a history of CSA.

The main questions of the study are 1) whether the CSA group has more over-general autobiographical memories; 2) whether they score higher on a dissociation measure; and 3) whether more over-general recall co-vary with high levels of dissociation.

METHOD

Participants

Twenty-eight female patients with a history of contact sexual abuse were recruited from adult psychology outpatient departments in the Greater Glasgow Primary Care Health NHS Trust. Patients were excluded if they met the criteria for a psychotic illness in the present or past, substance abuse problems or head injury. The age range was between 19 and 54 years. Most subjects were in treatment at the time. The average number of therapy sessions was 4.4 (S.D. = 4.7). The sexual abuse characteristics are summarised in Table 1. Eighty two percent (23) of the CSA group rated 5 on the scale of 1 - 5 for the effect the abuse has had on their life (1 = no effect; 5 = large effect).

Twenty-two female patients were recruited for the clinical control group. The inclusion criteria were patients with an anxiety disorder, or mixed anxiety and depression, with no history of CSA. The group was age matched and the ages ranged between 19 and 53 years. The average number of therapy sessions was 3.3 (S.D. = 3.6), with no significant difference from the index group ($Z = -.4$; NS)

Measures

Autobiographical Memory Test (AMT)

Participants were required to recall specific events from their own lives in response to a list of emotional cue words. The test was originally used by Williams and Broadbent (1986) and has been repeated in a number of studies. Five positive cue words (*happy, safe, interested, successful* and *surprised*) and five negative cue words (*sorry, angry, clumsy, hurt* and *lonely*) were read out alternately to the subject and a time limit of 60 seconds was set for each word. The response was recorded and categorised as over-general or specific. The latency to the first word of each response was recorded. Responses that did not make the time limit were recorded as 60 seconds.

Subjects were instructed as to what was expected of them and an example of a specific and over-general memory was given. The experimental session did not begin until specific personal memories had been retrieved to two practice words (*pleased* and *irritated*). Subjects were prompted to be more specific (*Can you think of a specific time, one particular event?*) when an over-general memory was presented. A memory was categorised as over-general when it referred to people, places, activities, or objects where a time period was not referred to or was greater than one day. Previous research cited inter-rater reliabilities between 0.87 and 0.93 (Williams & Dritschel, 1988). In the present study Cohen's Kappa value of 0.90 was found for the agreement of the researcher and the second rater. This was done with a random selection of 30% of the responses.

When considering the validity of the positive and negative cue words of the AMT it is noted that a memory retrieved from a positive cue word (e.g. *safe*) may in many instances require the individual to first search for the opposite experience (an *unsafe*

memory) and that it is perhaps not only a recall of a positive experience. This could be the case with all five positive cue words used in the current study. However, Williams (1996) reviewed studies using different cueing techniques and suggested that emotionally valent nouns, activity cues, and scenarios all seem to provide similar results regarding vulnerable groups retrieving more over-general memories. Other research is required to investigate the process of how people access the retrieved memory.

Dissociation Experiences Scale (DES) (Carlson & Putnam, 1993)

The scale is a 28-item self-report instrument for the measurement of the frequency of dissociative experiences. It is the most widely used screening instrument for dissociative symptoms. Analyses of the psychometric properties have been reported and found to be satisfactory (Van Ijzendoorn & Schuengel, 1996). Participants are required to rate the percentage of time in their daily lives that they have the experience that is described. The response format ranges from 0 to 100% in 10% increments with 0 representing that the experience never happens and 100 indicating that it happens constantly.

Beck Anxiety Inventory (BAI) (Beck & Steer, 1993a)

This questionnaire consists of 21 items which are descriptive statements of anxiety symptoms. Subjects rate the severity of their symptoms from 0 (not at all) to 3 (severely). The sum of the ratings provides an overall score.

Revised Beck Depression Inventory (BDI) (Beck & Steer, 1993b)

This questionnaire assesses the level of depression by asking participants to choose between four statements reflecting the severity of each symptom. It is a self-report measure of 21 items and the sum of the ratings provides an overall score.

Sexual Experiences Questionnaire (Tsai et al., 1979)

An adaptation of this questionnaire, similar to Douglas (2000) was used to obtain information about the specific characteristics of the sexual abuse.

One question with a 'yes/no' answer was added to establish whether adult physical or sexual trauma had been experienced.

Questionnaire on other childhood experiences

Six questions about negative childhood experiences (excluding CSA), derived from the Structured Trauma Interview (Draijer, 1989) provided the study with information on other adverse childhood experiences. This included questions on physical abuse, separation from parent(s), death of parent(s), mental illness in parent(s), alcohol problem in parent(s), witnessing violence. Participants answered 'yes'/'no' to these questions and where appropriate, identified the relevant parent.

Procedure

The AMT was administered at the end of the session and was audio-taped. The order of measures presented was identical for each subject. Although the other measures may

have influenced the AMT it was thought that a rapport needed to be established prior to the experimental part of the session. The same researcher carried out all the assessments, which lasted approximately an hour. Five subjects were not confident with their literacy skills and the researcher read the questions out aloud and recorded participants' responses.

RESULTS

Data analysis was performed on SPSS, version 9.

Where data was normally distributed, parametric statistics were used. Otherwise, non-parametric statistics were employed.

Demographic variables: There were no significant differences between the CSA group and the control group on any of the demographic variables. The mean age of the CSA group was 35.0 years (S.D.=9.1) and the control group 37.2 years (S.D.=9.5)($t(48) = -.81$, NS.). The mean number of years in full-time education was 14.3 (S.D. = 1.8) and 13.7 (S. D. = 1.6) respectively ($Z = -1.3$; NS). There were no significant group differences on occupation (in paid employment vs. not in paid employment) ($X^2 = 1.30$; $df = 1$; NS), marital status (married/co-habited; divorced; single) ($X^2 = .86$; $df = 2$; NS) or deprivation categories ($X^2 = 4.60$; $df = 2$; NS). The seven deprivation categories for Scotland (Carstairs & Morris, 1991) were collapsed into three categories.

Other trauma: There were significant differences between the two groups in the reporting of other trauma. The mean number of types of childhood adversities experienced, other than the sexual abuse in the CSA group, was 2.6 (S.D. = 1.6) and in

the control group 1.8 (S. D. = 1.2)($t(48) = 2.1$; $p < .05$). Half of the CSA group and 32% of the control group also reported an adult physical/sexual assault.

Clinical variables: Both groups scored within the 'severe range' on the BAI and BDI (Kendall, et al., 1987). On the BAI the CSA group scored an average of 28.1(S.D. = 13.5) and the control group 31.5 (S.D. = 15.6). The CSA group had a mean of 35.4 (S.D. = 14.4) on the BDI and the control group a mean of 33.9 (S. D. = 13.5). Independent t tests were employed to compare the group means on the BAI and the BDI and no significant differences were found ($t(48) = -.80$; NS)($t(48) = .37$; NS). The median on the DES for the CSA group was 21.3 (I-Q range = 23.5) and for the control group 14.4 (I-Q range = 12.6). A significant difference, as predicted, was found between the two groups on the DES ($U = 180.00$; $p = .012$, two-tailed). Twelve women in total scored above the recommended cut-off of 30 that is used to screen for dissociative disorders (Carlson & Putnam, 1993). Ten were in the CSA group (36% of CSA group).

Autobiographic Memory Test (AMT): Means and standard deviations of the measures on the AMT are shown in Table 2.

In line with previous studies, an analysis to test differences in the positive/negative cues on the AMT was employed. A mixed two-way ANOVA, with Group (CSA/Control) as the between-group factor and Cue Valence (Positive/Negative) as the with-in group factor was used to examine the differences in the number of over-general responses. There was a significant between-group effect on the cues ($F(1,48) = 20.64$; $p < 0.01$). No significance was found on the with-in group valence effect nor on the group/valence interaction.

Similar results emerged when an ANCOVA was employed with the same variables and with adding the covariates of DES, BDI and BAI ($F(1,45) = 11.83; p < 0.01$).

A two-way ANCOVA explored differences in the latency of response on the AMT with no difference found on group or valence main effect or interaction.

Correlations: Spearman's rho was used to investigate the statistical association between DES, over-general responses on the AMT and affective measures of the group as a whole. The results are shown in Table 3. Of particular interest to this study, was a significant correlation between the DES and the total number of over-general responses on the AMT in the direction expected.

DISCUSSION

As predicted, this study found that over-general memory recall was significantly greater in the group with childhood sexual abuse, on both positive and negative cues. This was also the case after controlling for dissociation, depression and anxiety. This finding in a CSA group supports one previous study of depressed patients with childhood physical and sexual abuse that reported an association between abuse, especially sexual abuse, and over-general autobiographical memories (Kuyken & Brewin, 1995). Referring to hierarchical theories of memory functioning (e.g. Norman & Bobrow, 1979), it may be that individuals with traumatic experiences from a young age have a tendency to develop a style of information processing that avoids reference to the specific details of difficult events. This may also be true for normal daily emotional experiences, given that there was no difference in style of recall between the positive and negative cues.

No significant effects on the latency for memories were found and this supported the findings of Kuyken and Brewin (1995). This may be because previous findings on retrieval latency are less consistent than those concerning over-general memories (Williams & Broadbent, 1986).

With regard to the trauma-dissociation link, the current study found that dissociation levels in the group of women with a history of childhood sexual abuse were significantly higher than the anxious control group. Previous studies have shown similar results in outpatient and inpatient populations (e.g. Chu et al., 1999; Waldinger et al., 1994). The high number of DES scores above the cut-off of 30 highlights the prevalence of significant problems with dissociation in this clinical group. The control group's dissociation levels are higher than a previous study looking at dissociation levels in the context of diagnosis. Putnam et al. (1996) reported that patients with an anxiety diagnosis had a mean score of 11 (S.D. 10.2) on the DES. The presence of other childhood negative experiences and also adult trauma may explain these moderately elevated dissociation levels in this group.

A significant correlation between the number of over-general memories and dissociation levels was found. One previous study reported this with a BPD sample, but with a more moderate correlation (Jones et al., 1999). The current study is the first to report an association between these two concepts in a child sexual abuse population. Interestingly, Kuyken and Brewin's (1995) study which reported the over-general memories in a CSA sample, also found an association between over-general memories and avoidance of abuse memories. They suggest that traumatic early experiences lead to a generalised tendency to inhibit memories of negative experiences. The inhibitory

processes of memory are well known (see Bjork, 1989 for review). The current study provides us only with a 'snap shot' of subjects' way of producing memories. However, the association suggests that information processing difficulties (i.e. lack/partial lack of integration of information) may generalise to everyday events. Models covering concepts such as 'trauma learning' and dissociative difficulties (Hartman & Burgess, 1993) may be refined by including the difficulties with over-general autobiographical memory style as a long-term effect of CSA.

The differences between the two groups on the depression and anxiety measures were non-significant. The autobiographical over-general recall and high dissociation in the index group were therefore not an outcome of high affective disturbance. This supports the literature that autobiographical memory style is not mood-state dependent, but a trait marker (Brittlebank et al., 1993; Williams & Dritschel, 1988). The current study did not investigate previous episodes of depression in order to gauge whether subjects with previous episodes had a greater association with over-generality. Bernstein and Putnam (1986) propose the Dissociation Experiences Scale as a trait measure. However, dissociation has also been described as a mediating factor in the development of subsequent other psychopathology in sexual abuse survivors (Ross-Gower et al., 1998). Van Ijzendoorn & Schuengel (1996) reported that DES scores and measures of anxiety and depression correlate moderately and this correlation was supported in the current study.

The differences in abuse characteristics across the groups seem to be at least in part an explanation for the differences between the two groups on the DES and AMT. The CSA group represents a population which experienced severe sexual abuse. A large

proportion of the group reported more than one abuser, early onset of the abuse and long duration. Previous studies have found that an early onset of sexual abuse and multiple perpetrators may lead to more significant psychological effects (Kirby et al., 1993). The high prevalence of other childhood adversities in the CSA group supports views in the sexual abuse literature that CSA often co-exists with family dysfunctioning and/or other forms of abuse (Briere, 1996; Foa & Hearst-Ikeda, 1996). This study only reported detailed information about sexual abuse. However, some of the physical abuse (or other adversities) reported may have been as severe and chronic. The high and severe incidence of child abuse, assault in adulthood and the high levels of dissociation suggest that significant post-traumatic symptomatology may be present in the CSA group. Chronic PTSD features are known in this group (Hartman & Burgess, 1993; van der Kolk, et al., 1996). Studies with PTSD patients following adult trauma have shown over-general memory recall compared to normal controls (Harvey, et al., 1998; McNally, et al., 1994). Williams (1996) suggests that over-generality might come about in PTSD patients as a result of a cognitive style acquired early in life and/or as the result of later retrieval being impaired by intrusive thoughts. Future studies could perhaps investigate the relationship between a PTSD diagnosis and over-general recall of autobiographic memory by measuring intrusion and avoidance thoughts with, for example the Impact of Event Scale (Howoritz, et al., 1979).

The clinical implications of the current findings are important. It highlights again that assessment of dissociation symptoms at routine evaluations is recommended, especially when CSA is reported. Sandberg and Lynn (1992) warn, however, that the DES is likely to yield a high percentage of false positives for dissociative disorders. It should therefore be only considered a screening instrument. The link between over-general

autobiographic memory style and high levels of dissociation could contribute to thoughts about clinical work with this population. One study has looked at mindfulness-based cognitive therapy to reduce over-general memory style in depressed patients (Williams, et al., 2000). Patients were trained to focus more carefully on everyday events and to allow cognitions to occur without trying to avoid or suppress them. Over-generality in memory was reduced this way. Although dissociation was not assessed or targeted in this treatment study, mindfulness cognitive therapy addresses an avoidant mode of processing by encouraging patients to practice noticing elements of their experience in a non-judgemental way (Teasdale et al., 1995). This may be a useful treatment consideration when identifying information processing problems in adults who have suffered multiple childhood abuse. Ross-Gower et al. (1998) suggest that attending to these everyday dissociation tendencies may be a necessary early step in the therapy process. These problems could also be considered in the context of metacognitive activities. This refers to higher order thinking which involves active control over the cognitive processes, for example, when learning (Flavell, 1987). An avoidant and over-general style of thinking and attention could be seen as a metacognitive activity initially applied to help regulate affect states and gain control over one's thinking. This issue could be explored in a review of the literature of metacognition and emotional disorders.

A further clinical consideration of the results takes us to the much debated phenomena of recovered memory and false memory of childhood abuse. Memory is inherently unreliable and it is generally accepted that false memories of childhood abuse can occur in some instances (Mollon, 1996). One could argue that an over-general autobiographical memory style, and also its association with high dissociation levels as

found in this CSA group, may make a person more vulnerable to considering inaccurate memories. A more over-general memory system may lead to frustration with not accessing more detailed memories of abusive (or other) experiences and the individual may therefore be more suggestible when in therapy. Mollon (1996) warns strongly against the use of coercive therapeutic techniques such as hypnosis or interpreting of dreams.

In summary, the current study found greater levels of over-generalisation and dissociation in a group with sexual abuse histories, with an association between these two concepts. It is suggested that early trauma plays an important role in the development of over-general cognitive styles and dissociation and that further investigation is required to study this in the context of post-traumatic symptoms.

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Table 1
Sexual Abuse Characteristics (N = 28)

1. <u>Age of onset of abuse</u>	Mean	Std. Deviation	Minimum	Maximum
	7.36	3.61	3	14
2. <u>Relationship to abuser</u>	Father Figure	Male Relative	Male Acquaintance	Female Acquaintance
	4	19	4	1
3. <u>Duration of abuse</u>	Less than a year	1-5 years	Longer than 5 years	
	6	12	10	
4. <u>Frequency of abuse</u>	More than once a week	Once a week	Monthly	Few times a year
	3	11	11	3
<u>Other Abuser(s)</u>	Yes	No		
	13	15		

Table 2

Means and standard deviations of the measures on the Autobiographical
Memory Test (AMT) in the two groups

	<u>OGM</u> (all cues) Mean (S.D.)	<u>OGM</u> (+ cues) Mean (S.D.)	<u>OGM</u> (- cues) Mean (S.D.)	<u>Latency</u> (all cues) Mean (S.D.)	<u>Latency</u> (+ cues) Mean (S.D.)	<u>Latency</u> (- cues) Mean (S.D.)
<u>CSA</u> <u>Group</u> (n=28)	3.4 (2.2)	1.7 (1.3)	1.7 (1.4)	16.4s (6.8s)	15.3s (7.3s)	17.2s (9.9s)
<u>Control</u> <u>Group</u> (n=22)	0.9 (1.7)	0.6 (0.9)	0.3 (0.9)	17.8s (7.2s)	19.6s (9.6s)	15.4s (9.0s)

OGM=over-general memories on Autobiographical Memory Test;
Latency = measured in seconds

Table 3

Intercorrelations of AMT, DES and affective measures within both groups

	AMT	BAI	BDI	DES
AMT	-	.11	.14	.50**
BAI		-	.59**	.28*
BDI			-	.35**
DES				-

** Correlation is significant at the .01 level (1-tailed)

* Correlation is significant at the .05 level (1-tailed)

AMT = number of over-general autobiographical memories; BAI = Beck Anxiety Inventory; BDI = Beck Depression Inventory; DES Dissociation Experiences Scale

CHAPTER 4

Small Scale Service Evaluation Project

Patient satisfaction with clinical psychology: accessibility and care across three locations

This paper was written according to the guidelines for the *Health Bulletin*

**Patient satisfaction with clinical psychology: accessibility and care
across three locations**

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Abstract

Objective This paper examines the views of service users who attend outpatient clinical psychology clinics. The evaluation was made with specific reference to accessibility across three localities and general care issues.

Design and Setting A 'Patient Satisfaction Questionnaire' was designed to measure accessibility qualities of locations, care received, and other miscellaneous relevant issues. The three locations evaluated were: clinics based at a general hospital, psychology clinics at GP practices and clinics at the local community mental health team's premises. Patients were asked to complete the form after their psychology appointment.

Subjects Twenty patients from each of the three locations were recruited and everyone who was approached participated. They were at different stages of their contact with psychology.

Results An overall view of the data reflects high patient satisfaction. Dissatisfaction with waiting lists emerged in 42% of the sample. The majority (70%) travelled with a car to their session with high satisfaction on ease of getting to the appointment. Despite this, seven of the 40 patients not seen at their GP practice preferred to be seen there. Respondents seen at the hospital clinics were significantly less satisfied with the welcoming qualities of the reception area. This was the only location of the three which did not have a visible reception as you entered the building. The care aspects produced high patient satisfaction (97% with the frequency of contact, confidentiality, sensitivity, and their say in treatment). Women felt stronger about the importance of the choice of a

therapist gender. Only 8% of respondents felt that a psychologist should wear a name badge.

Conclusion The evaluation highlighted some concerns about user satisfaction with psychology services such as waiting lists, accessibility when arriving at a clinic with no clear reception area and preference for clinics in GP practices. The results confirmed some concerns previously expressed in the department. Recommendations for changes and future evaluations are made.

Introduction

‘Customer satisfaction’ has recently received a lot of attention in the NHS as one of the elements of service evaluation. The views of individuals using health services are increasingly demanded from professionals, for example in line with the Patients’ Charter. Opinions obtained from service users are valued by service providers in shaping user friendly and appropriate services (Torrens and Harris, 1996)¹.

Carr-Hill (1992)² suggested some reasons for patient satisfaction evaluations in the health service. A service is primarily there to serve the health needs of the public and to understand the relevant concerns. Investigating whether this objective is achieved is important. Satisfaction can also influence the outcome of an intervention; satisfied patients might be more amenable to taking advice on board (Kincey et al., 1975)³. Further, service providers need to know what requires attention in their service and it is necessary to understand the variations in a service, for example across locations.

In the British Psychological Society Clinical Psychology Forum, ‘Client Satisfaction’ has featured relatively frequently as an audit subject (14 articles published over a 3-year period) (Davies, 1998)⁴. Surveys of this nature are popular because they meet the need of consumer involvement, are relatively easy to undertake and they generally indicate a demand for the same sort of service (Hutchings and Pope, 1998)⁵. It is important, however, that they target specific aspects of the service.

There is often debate about where mental health and clinical psychology services should be delivered. With the influence of Local Health Care Co-operatives (LHCC) in

Scotland the presence of psychology within the primary care team has become a likely development (McPherson and Baty, 2000)⁶. Psychology patients have rated high levels of satisfaction with services located within primary care teams (Papworth, 2000)⁷. Other benefits of practice based clinics such as greater accessibility, cost effectiveness and more integrated practice-based services are discussed by Papworth. Three years ago the Department of Health in England stated that methods for delivering psychological therapies equitably across locations should continue to be developed by those who commission and provide services (NHSE, 1996)⁸. Determining what the users of the service prefer or reject about a location could inform the planning outpatient clinics. An audit completed in the department where this study was done recommended that users' perceptions of delivery of psychological services in different locations be investigated (Laithwaite, 2000)⁹.

The clinical psychology department in one of the North sector areas of Glasgow has delivered services at three types of locations over a few years. Patients are seen at the (1) Clinical Psychology department, based at a general hospital; (2) GP surgeries, where weekly clinics are available; and (3) the local community mental health team (CMHT), which is based on premises in close proximity to a psychiatric hospital.

The aims of the study were:

- 1) to provide a tailored measure of patient satisfaction, with accessibility and care issues being the main aspects under consideration
- 2) to evaluate patient satisfaction with psychology services
- 3) to compare the satisfaction levels across three locations

Method

Questionnaire

The researcher devised a 'Patient Satisfaction Questionnaire'. The questionnaire aimed to assess levels of satisfaction with particular reference to location. Service issues and concerns about the user friendliness of the locations had been discussed in the department where the study was done over a number of months. These were included in the evaluation. Two questions on the Patients' Charter recommendation that professionals wear name badges were also added. Recognised elements of psychological care were included to evaluate this in conjunction with the other variables.

The questionnaire has 22 questions. Part one consists of six questions to identify waiting times, means of travel to the appointment, site preference, number of appointments and whether the psychologist wears a name badge. Part two has 16 questions, which are on a 5-point scale (strongly disagree to strongly agree). This provides the study with ordinal data. The questionnaire consists of three sheets and takes approximately 5 - 10 minutes to complete.

Participants

Twenty patients in each of the three locations - 60 in total - were asked to complete the questionnaire following attendance at a psychology appointment. This was done to

avoid poor response rate through a postal method of data collection. There was a 100% response rate of patients who were approached.

Locations

The three locations are in geographically different areas. The GP practices and the local community health team (CMHT) are in closer proximity to the patient catchment area. Reception areas are visible when entering the building at both of these locations. The outpatient clinic at the psychology department has a waiting room at entrance of the building but no reception. Signs direct patients to the reception area, which is at the end of a long corridor. Once a patient reports there they then have to walk back down the corridor to the waiting room.

Procedure

The data was collected over a 3-week period. Five psychologists took part and at least two psychologists collected data at any one location. Subjects were given an envelope in which to seal the questionnaire after completion. When giving an opinion about services received, patients may be concerned that reported satisfaction might influence subsequent care or offend services/individual psychologist. (Gowers & Kushlick, 1992)¹⁰. It was therefore important to collect the data in questionnaire form rather than interview.

Results

1. General Information

Gender

Of the 60 patients recruited, 41 (68%) were female and 19 (32%) were male. This is representative of the usual gender distribution of patients attending clinical psychology (Douglas, 1998)¹¹.

Choice of therapist gender

Forty three percent of respondents would like to have a choice of a male or female psychologist. When analysing this by patient gender as the group variable there was a significant difference between men and women respondents ($Z = -2.3$; $p < 0.05$). Women felt stronger about wanting a choice of the gender of the psychologist they see.

Insert Figure 1

Name badge

Six patients (10%) said that their psychologist wore a name badge (Interestingly, none of the psychologists involved wore a name badge at the time of data collection). The majority of respondents (67%) were neutral about whether the psychologist should be wearing a name badge and another 24% disagreed that they wanted the psychologist to wear this. Only five patients (8%) felt that the psychologist should wear a name badge.

2. Accessibility

Waiting times and appointment times

Eighty percent of patients were seen within 12 weeks of referral and 95% were seen within 20 weeks. Forty two percent of respondents did not agree that the waiting time was reasonable (27% disagree and 15% neutral).

All but one patient waited less than 10 minutes to be taken in for the session on the day of appointment. The vast majority of patients (97%) felt that their appointment was at a convenient time.

Mode of transport

The majority of patients (70%) travelled by car to the session. Ninety two percent of patients agreed that it was relatively easy to travel to the clinic on the day of their appointment. There was no significant difference between sites.

Preference of other site

Ten patients (16%) preferred to be seen at another site. Seven of these respondents seen either at the Psychology department or the CMHT (18% of the 40 patients not seen at the GP practice) preferred to be seen at the GP practice. Three (one seen at the GP practice and two seen at the CMHT) preferred the psychology department as a location for appointments.

Reception function

Across all the localities the majority of patients (88%) knew where they were going when they arrived at the clinic but only 65% felt that the reception area was welcoming. Eighty five percent thought that the receptionist was helpful. There was a significant difference between localities on the reception area variable ($X^2=14.8$; $df=2$; $p< 0.01$). Patients attending the psychology department at the general hospital were significantly less satisfied with how welcoming the reception area was. A similar result emerged from the question on how helpful the receptionist was ($X^2=7.6$; $df=2$; $p< 0.05$), where the patients attending the psychology department at the general hospital were least satisfied.

Insert Table 1

Telephone access

Sixty eight percent of respondents agreed that it was possible to get hold of the psychologist by telephone.

3. Care received

Patient satisfaction was very high on all aspects of psychological care received. The average number of appointments attended at the time of completing the questionnaire was 6.33 (SD 6.38). The questionnaire did not specify at what stage in therapy the

respondents were. The majority (87%) felt their appointments were frequent enough. Ninety seven percent of respondents felt satisfied with the confidentiality of discussions, the sensitivity to their feelings and that they had a say in treatment.

With regard to expectations, 73% of patients agreed that they received what they expected. The relevant question did not specify whether the other 23% felt it was better or worse than they had expected. Two patients noted spontaneously that it was better than they had expected.

Overall 98% of patients felt satisfied with the service they received. A significant difference between the psychology department and the CMHT was found, with the CMHT respondents being less satisfied ($X^2=7.0$; $df=2$; $p< 0.05$). Given the overall satisfaction, this is very relative as the response only differed in depicting ‘agree’ or ‘strongly agree’.

Insert Table 2

4. Comments at end of questionnaire

A last question asked for any other comments. A total of 21 (33%) people responded to this. The majority (18) took this opportunity to thank their clinical psychologist and the service for good care received. The other three patients commented on the location. Two of these complained about the reception area at the Psychology department. One seen at the GP practice commented that the venue was very convenient.

Discussion

How accessible is the service in general and across locations?

One aim of satisfaction evaluation is to discover not only what is right in the service, but also what requires attention. This investigation managed to identify both within a specific context. Nearly half of the sample felt that waiting lists to see a psychologist for assessment were not reasonable. Waiting lists have been a concern for clinical psychologists for some years (Corrie, 1999)¹². One could assume that patients who approach referrers about a psychological problem have considered seeking help over a period of time and a long wait can be frustrating. However, in this study after the wait to be seen, patients seem to be satisfied with the frequency of their contact with the service and minimal waiting at the day of the appointment was apparent.

A high percentage of patients were car owners. Perhaps because of the availability of own transport the majority felt it was easy to travel to all three clinics. Populations which are more reliant on public transport may find travel to appointments a problem and differences across localities may have emerged. McPherson and Murphy (1997)¹³ suggest that deprived groups have less access to health care relative to their needs than the more advantaged. However, a recent study about the accessibility of psychology found that uptake rates were unaffected by social deprivation (Thwaites and Banks, 2001)¹⁴. Interestingly, despite the seeming ease of accessibility of clinics nearly one fifth of the patients who were seen outwith their GP practices preferred to be seen within the practice. The convenience/familiarity factor seemed important and locating

psychology clinics in a local GP practice may be an important factor to consider in how services are delivered.

A third of the respondents felt that the reception area was not welcoming and a quarter reported that the receptionist was not helpful. Significant differences in these two reception functions of three locations were reported. The psychology department at the general hospital was the location respondents felt least satisfied with. This confirms concerns expressed by staff regarding the location of the reception. The site does not have a reception at the entrance and patients have to follow signs through a long corridor to reach the receptionist. At the other locations, the receptionist is visible when entering the building. Respondents also felt that the receptionists at the psychology department were the least helpful. This view may not necessarily reflect negatively on the individuals in reception; it could have been a further reflection of the location of their office.

What do patients think of the care they receive?

An overall view of the data suggests that the vast majority of patients were satisfied with the care they received. They felt that the confidentiality, frequency and flexibility of the service were satisfactory. This supports findings in the UK where patient satisfaction typically reach 85-90% (Carr-Hill, 1992)². However, customer satisfaction studies are potentially beset by a number of methodological difficulties (Gower & Kushlick, 1992; Hutchings and Pope, 1998)^{10,5}. Patients may have a lack of knowledge of the alternatives and therefore find it difficult to criticise what they have received. This may be particularly relevant to a transient outpatient population. A response bias

may be present because the user has a good relationship with the service provider or may want to use the services in future.

In this study, the fact that the respondents' psychologist handed them the questionnaire may have inhibited people to respond critically. It is not unusual for only a small number of respondents to be able to express negative views about the care they received. A further limitation of the study was that patients who did not attend were not included in the study. The sample may thus be biased towards customers who continued to use the service because they felt satisfied with what was delivered.

The care received matched more than two thirds (73%) of the respondents' expectations. Carr-Hill (1992)² reported that expectations would vary according to the presumed success of the intervention and to patients' experience of care in the past. This evaluation did not cover therapy outcome satisfaction. He also suggests that there may be a positive bias in this category to reduce cognitive dissonance about 'my care'.

The only variable of care that produced some difference between the three localities were patients' overall depiction of the service received. The CMHT patients were least satisfied. It has to be noted, however, that none of the respondents were dissatisfied but that the degree of satisfaction ('satisfied' versus 'very satisfied') was different. CMHT patients are likely to have more enduring mental health problems (Cheston and Cone, 1999)¹⁵. One could argue that psychological intervention does not bring about such a significant change in their quality of life as may be the case with brief intervention for less severe problems.

Nearly half of the respondents (43%) felt that it would be important in a psychology service for users to have a choice of gender of the psychologist. There was a significant difference between male and female patients, where female respondents felt stronger about wanting the choice. This supports opinions in women's health in general that female service users often prefer female service providers.

The Patients' Charter instructs health professionals to wear a name badge. None of the psychologists was wearing a badge in this study. The majority of respondents felt neutral about their psychologist wearing this form of identification. About a quarter of respondents disagreed that a psychologist should wear a badge. This may be because many of the patients involved in the study have been attending for a number of sessions and know their psychologist well. A form of identification does not seem important at this point in the contact.

Recommendations

- 1) This study again highlights that waiting lists remain an issue for service users of clinical psychology services. Strategies for getting and keeping waiting times down should continue to be explored and applied, in conjunction with referrers and users.
- 2) With regard to the location of the reception area in the psychology department at the general hospital it is recommended that it be moved to the entrance of the building. Whilst this is under consideration a notice could inform patients to have a seat rather than go through to reception.

- 3) Further consideration should be given to developing more clinics within GP practices as there seemed to be a strong trend to this being the choice of site.
- 4) Where possible, patients of the psychology services should have a choice of gender of the therapist.
- 5) With regard to name badges there was a tendency with service users preferring staff not to wear these.
- 6) An audit on people who dropped out of treatment after a first appointment could provide important information about a group which is difficult to engage. This may identify specific problems in patient satisfaction.
- 7) It may be useful to evaluate patient satisfaction about accessibility in an area with different demographics, for example where car users are less common.
- 8) A neutral investigator in a similar study may elicit different responses and therefore address a response bias which occurs when clinicians request information from their patients.

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Figure 1

Male/Female responses to the statement: ‘It is important to have a choice of gender of therapist’

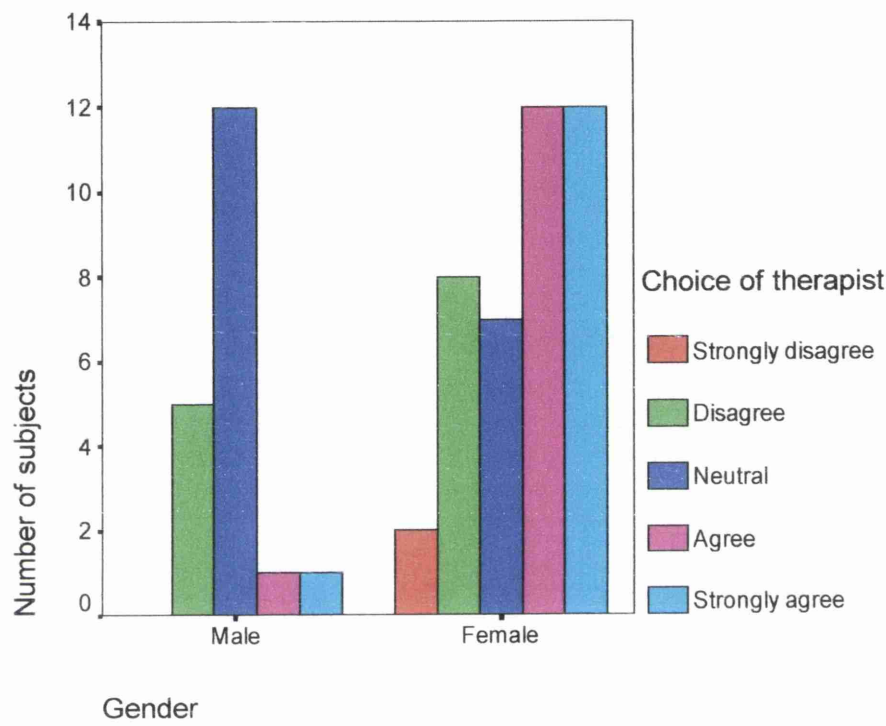


Table1

Comparisons (Kruskal Wallis Test) of mean ranks of accessibility variables across sites

	<u>Site 1</u> Psychology Dept	<u>Site 2</u> GP Practice	<u>Site 3</u> CMHT			
N	20	20	20			
	Mean Rank	Mean Rank	Mean Rank	Chi-square	df	p
Accessibility						
Wait time	30.25	32.00	29.25	0.283	2	n.s.
Appt. time	28.90	35.65	26.95	5.048	2	n.s.
Telephone access	31.92	30.17	29.40	0.276	2	n.s.
Travel to clinic	34.20	30.17	29.40	5.521	2	n.s.
Arrive at clinic	31.20	33.25	27.05	1.792	2	n.s.
Reception area	19.58	38.72	33.20	14.776	2	0.001**
Receptionist	24.75	36.58	30.17	7.635	2	0.022*

**p < 0.01; *p < 0.05

Table 2

Comparisons (Kruskall Wallis Test) of mean ranks of care variables across sites

	Site 1 Psychology Dept	Site 2 GP Practice	Site 3 CMHT			
N	20	20	20			
	Mean Rank	Mean Rank	Mean Rank	Chi-square	df	p
Care						
Frequency	33.15	30.40	27.95	1.317	2	n.s.
Confidentiality	33.13	28.77	29.60	0.908	2	n.s.
Sensitivity	35.20	28.48	27.83	2.887	2	n.s.
Say in treatment	34.00	28.25	29.25	1.784	2	n.s.
Expectations	34.83	26.90	29.77	2.553	2	n.s.
Overall service	36.17	31.75	23.58	7.045	2	0.030*
Other						
Choice of therapist gender	28.30	33.20	30.00	0.866	2	n.s.
Name badge	26.20	31.63	33.67	2.806	2	n.s.

* p < 0.05

CHAPTER 5

Single Case Research Study

Effects of attentional focus on subjective hunger ratings and bulimic thoughts – an experimental case study

This paper was written according to the guidelines of *Behaviour Research and Therapy*

**Effects of attentional focus on subjective hunger ratings and bulimic
thoughts – an experimental case study**

Michele Veldman

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Leverndale Hospital

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Abstract

The patient concerned suffers from bulimia nervosa. Her problems include a difficulty in recognising when to eat/discontinue to eat, and preoccupation with bingeing and vomiting thoughts and behaviour. This experimental single case study investigated the effect of attentional focus on subjective hunger ratings and ratings of binge and vomit thoughts. There were two experimental conditions (non-deprived and deprived). An ABC design provided the experiment with three phases to test out responses to different external cues (neutral, food-related, non-food absorbent). Ratings (hunger, binge thoughts, vomit thoughts) were on a visual analogue scale. The results revealed significant effects of attentional focus, with interesting differences between the two conditions. During the deprived condition hunger ratings decreased significantly with the absorbing cues but remained low and unchanged during the non-deprived condition. This may be some evidence of a lack of recognition of hunger sensations. Binge thought ratings were the most responsive and increased and decreased in the expected directions, but less significantly during the deprived condition. Vomit thought ratings increased and decreased as expected during the non-deprived condition but remained low and unchanged during the deprived condition. These findings point to the clinical importance of attentional focus in the control of undesired binge/vomit thoughts.

(Word Count: 202)

Keywords: Bulimia, Hunger recognition Attentional focus, Binge thoughts, Vomit thoughts

RESEARCH PORTFOLIO APPENDICES

APPENDIX 1

Major Research Project Literature Review

Page

1.1 Suggestions for Authors – *Current Psychology*

120

Current Psychology

Suggestions for Authors

Founded in 1980 at the University of Leeds by Andrew M. Colman and now published by Transaction Periodicals Consortium, *Current Psychology* is an international quarterly for scientific exchange in psychology and animal and human learning. Its authors and the members of its Editorial Advisory Board represent a spectrum of specialties and subdisciplines. *Current Psychology* welcomes submissions that report empirical or conceptual research and especially welcomes conceptual analyses and comprehensive reviews that assess the state of the science in its focal areas.

SUBMISSION OF MANUSCRIPTS. Manuscripts should be submitted in triple "hard copy," either to Noel P. Sheehy, The Queen's University of Belfast, School of Psychology, 10 Lennoxvale, Malone Row, Belfast BT7 1NN, Northern Ireland or Nahtaniel J. Pallone, Rutgers University, 215 Smithers Hall, 607 Alisson Road, Piscataway, NJ, 08854, U.S.A. Each manuscript should be double-spaced and prepared in accordance with the current edition of the *Publication Manual of the American Psychological Association*. The text should be preceded by a detachable title page that contains the preferred mailing address of the senior author (and may also include a statement about the source of support for the research reported) and an abstract. Tables, figures, graphs, or other art work should be prepared on separate pages and must be submitted as "camera ready." A letter accompanying each manuscript submitted for review should attest to the originality of the work and indicate that the work is *not* under consideration for publication elsewhere. Though the editors regard concision as a virtue, *there is no arbitrary limit on the length of the manuscripts.*

BLIND REVIEW. To facilitate "blind review," the name(s) of the author(s) should appear *only* on the detachable cover page.

FINAL SUBMISSION OF ACCEPTED MANUSCRIPTS. Following formal review, a manuscript may be accepted without revision, accepted pending relatively minor (usually stylistic) changes suggested for copyediting, returned to the author(s) for substantive revision and resubmission, or be rejected. If a manuscript is accepted pending minor changes suggested after copyediting, the author(s) will be asked to incorporate the suggested revisions, then submit two "hard" copies of the fully edited manuscript; similarly, if a manuscript is returned for substantive revision and resubmission, the author(s) will be asked to submit two "hard" copies of the revised manuscript. *Publication lag between acceptance of a manuscript in final form customarily averages 9-12 months.*

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PAGE PROOFS. Once a manuscript has been formally accepted for publication by the editors, it is forwarded to Transaction Periodicals Consortium for typesetting. *Page proofs* are sent to the senior author for review and are to be returned to the publisher by the date specified in order to maintain a timely publication schedule.

REPRINTS. Senior authors will receive, directly from Transaction Periodicals Consortium, two bound copies of the issue in which the manuscript is published plus one copy for each coauthor (if any), along with information for ordering additional reprints of the manuscript or of the entire issue.

APPENDIX 2**Major Project Research Proposal**

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2.1 Study: Personal memories and sustained attention with women who have experienced sexual abuse

PATIENT INFORMATION SHEET

You have been asked to take part in a research project. Thank you for taking some time to read through this information sheet. The information aims to explain what the research is about and what will happen if you agree to take part. Here are some of the questions you may want to ask at this stage.

Remember, if you decide not to take part, your decision will not affect the treatment that you receive at the clinic.

Why have I been asked to take part?

I am asking women who attend different clinics for emotional problems to take part in this project. The aim is to get an idea of how women remember everyday events and how their emotional problems affect this. I am hoping to get as many points of view as possible to make the findings of the study representative.

What is the study about?

People remember things about their everyday lives in different ways – some have very specific memories and others less specific memories. I am interested in learning more about this.

If I agree to take part, what would I have to do?

You will be invited for an appointment that will last at the most an hour. First you will be asked to complete a few short questionnaires, including one about your background. If you wanted to, the researcher could stay in the room to help you with the questionnaires, or if you prefer, you will be left in privacy to finish these.

After this the researcher will read you ten words, one at a time, and will ask you to remember a situation (recent or in the past) that is triggered by this word. There will be five positive words (e. g. 'pleased') and five negative words (e. g. 'irritated') and you will be given time to remember. This part of the appointment will be audio taped as the researcher do not want to be distracted by writing things down at the time. **You will not be expected to talk about painful memories in your past.**

What happens to the questionnaires and the tape?

All the information you provide will be completely confidential. Your name will not appear on the questionnaires or on the tape. Only the researcher will have access to this and everything will be destroyed once the study has been completed.

Your GP, who knows you are attending the clinic, will be informed that you are taking part in the study but he/she will not have access to the questionnaires.

Please do not hesitate to ask further questions. I would be happy to discuss this with you. If you would like to be involved please sign the consent form and give it to your therapist. A convenient date will be arranged for your appointment.

Michele Veldman, Clinical Psychologist, Castlemilk Health Centre

2.2 Greater Glasgow Primary Care NHS Trust

Study: Personal memories and sustained attention

CONSENT FORM

I am interested in taking part in the study.

I have read the information sheet on the study and have had the opportunity to discuss it and ask questions.

I understand that I am free to withdraw from the study at any time, without having to give an explanation and the care/treatment I receive will not be affected by this.

I have not been sexually abused as a child/teenager (control group only)

Signed.....

Date.....

Signed by witness

Thank you again for your time

Michele Veldman
Clinical Psychologist
Stobhill Hospital
Tel: 0141 2013607

2.3 Information Letter to GP

Dear Dr.....

Re: Psychological Research

I am currently carrying out a research study titled 'Autobiographical memory and dissociation in women with a history of child sexual abuse'. I am hoping to expand on the current literature on the nature of patients' memories and associated problems with dissociation. The study has been approved by the Trust's Ethics Committee.

My aim is to recruit a group of women with a history of sexual abuse and also a control group of women who present with anxiety and who have no history of sexual abuse.

The above patient has agreed to take part and will be involved in a one off appointment that will last approximately one hour. She will be asked to complete five short questionnaires and a memory test will also be administered. The memory test will be audio-taped and your patient will of course be made aware of this. Her involvement in the study will not influence any treatment she is receiving from the service.

Please do not hesitate to contact me if you want more information regarding the study.

Yours sincerely

Michele Veldman
Clinical Psychologist

**2.4 Study: Autobiographical memory and dissociation in women with a history of
child sexual abuse**

DEMOGRAPHIC DATA

Subject code

Age

Occupation

Education

Postcode

Marital Status

How many therapy sessions have you already attended?

2.5 C.S.A. Questionnaire

This questionnaire asks you a few questions about your history of sexual abuse. It asks you a little about how you felt as a child or teenager, and also how you feel now. The last question is about experiences in your adulthood.

1. At what age were you first sexually abused?
2. What was the relationship of the person to you?
(If she/he was not a relation please state who it was, e.g. neighbour, baby-sitter)
3. How long did the sexual abuse go on for?
(i.e. number of weeks, months or years)
4. How often did the sexual abuse occur?
(i.e. number of times per week, month or year)

People who have been abused may remember having a mixture of feelings at the time. The next few questions ask you about your feelings as a child or teenager. Please circle the number which best describes your feelings at the time.

5. How would you describe your feelings towards that person then?

Very positive 1 2 3 4 5 very negative

6. How much effect do you think the sexual abuse has had on your life?

No effect 1 2 3 4 5 a large effect

7. Were you sexually abused by anyone else as a child or teenager? YES/NO

9. Have you been physically or sexually assaulted as an adult? YES/NO

2.6 Other Childhood Experiences Questionnaire

This questionnaire has six questions about other experiences you may have had as a child or teenager

1. Did you experience physical abuse as a child/teenager?

Yes/No

2. Were you separated from either of your parents as a child/teenager?

Yes/ No

If yes, who?

3. Did either of your parents die when you were a child/teenager?

Yes/No

If yes, who?

4. Did either of your parents have mental health problems?

Yes/ No

If yes, who?

5. Did either of your parents have an alcohol problem?

Yes/ No

If yes, who?

6. Did you witness violence in the house as a child/teenager?

Yes/ No

2.7 Dissociation Experiences Scale

Dissociative Experiences Scale II

(DES II)

Name: _____

Date: / Age: / Sex: M F

This questionnaire consists of 22 questions about experiences that you may have in your daily life. We are interested in how often you have these experiences. It is important, however, that your answers show how often these experiences happen to you when you are not under the influence of alcohol or drugs. To answer the questions, please determine to what degree the experience described in the question applies to you and circle the number to show what percentage of the time you have the experience.

Example:

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

1. Some people have the experience of driving or riding in a car or bus or subway and suddenly realizing that they don't remember what has happened during all or part of the trip. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

2. Some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear part or all of what was said. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

3. Some people have the experience of finding themselves in a place and having no idea how they got there. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

4. Some people have the experience of finding themselves dressed in clothes that they don't remember putting on. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

5. Some people have the experience of finding new things among their belongings that they do not remember buying. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

Dissociation Experiences Scale (continued)

6. Some people sometimes find that they are approached by people who they do not know who call them by another name or insist that they have met them before. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

7. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something and they actually see themselves as if they were looking at another person. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

8. Some people are told that they sometimes do not recognize friends or family members. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

9. Some people find that they have no memory for some important events in their lives (for example, a wedding or graduation). Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

10. Some people have the experience of being accused of lying when they do not think that they have lied. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

11. Some people have the experience of looking in a mirror and not recognizing themselves. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

12. Some people have the experience of feeling that other people, objects, and the world around them are not real. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

13. Some people have the experience of feeling that their body does not seem to belong to them. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

14. Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving that event. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

Dissociation Experiences Scale (continued)

15. Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed them. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

16. Some people have the experience of being in a familiar place but finding it strange and unfamiliar. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

17. Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

18. Some people find that they become so involved in a fantasy or daydream that it feels as though it were really happening to them. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

19. Some people find that they sometimes are able to ignore pain. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

20. Some people find that they sometimes sit staring off into space, thinking of nothing, and are not aware of the passage of time. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

21. Some people sometimes find that when they are alone they talk out loud to themselves. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

22. Some people find that in one situation they may act so differently compared with another situation that they feel almost as if they were two different people. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

23. Some people sometimes find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social situations, etc.). Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

Dissociation Experiences Scale (continued)

24. Some people sometimes find that they cannot remember whether they have done something or have just thought about doing that thing (for example, not knowing whether they have mailed a letter or have just thought about mailing it). Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

25. Some people find evidence that they have done things that they do not remember doing. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

26. Some people sometimes find writings, drawings, or notes among their belongings that they must have done but cannot remember doing. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

27. Some people sometimes find that they hear voices inside their head that tell them to do things or comment on things that they are doing. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

28. Some people sometimes feel as if they are looking at the world through a fog so that people and objects appear far away or unclear. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

APPENDIX 3

Major Research Project

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3.1 Occupational categories

	CSA Group (n = 28)	Control Group (n = 22)
Professional Occupation	4	2
Clerical and Secretarial Occupation	1	3
Craft and related Occupation	2	4
Personal and Protective Service Occupation	3	1
Other	4	4
House Person	6	2
Unemployed	6	4
Student	2	2
Total	28	22
(Total in paid employment)	(14)	(14)
(Total not in paid employment)	(14)	(8)

3.2 Marital Status Categories

	CSA Group (n = 28)	Control Group (n = 22)
Married/Cohabiting	11	11
Single	11	6
Divorced/Separated	6	5
Total	28	22

3.3 Deprivation categories derived from postcodes (DEPCAT) (Carstairs and Morris, 1991)

	CSA Group (n = 28)	Control Group (n = 22)
DEPCAT (1-3)	5	10
DEPCAT (4-6)	13	6
DEPCAT (7)	10	6
Total	28	22

1 = not deprived at all
7 = very deprived

3.4 Diagnostic Categories

	CSA Group (n = 28)	Control Group (n = 22)
Anxiety	5	17
Depression	10	-
Mixed Anxiety and Depression	4	5
PTSD	3	-
Other	6	-
Total	28	22

3.5 Frequencies of Other Childhood Experiences

		CSA Group (n = 28)	Control Group (n = 22)	
<u>Physical Abuse</u>	Yes	17	5	
	No	11	17	
<u>Separation from Parents</u>	Yes	11	7	
	No	17	15	
<u>Loss of a Parent</u>	Yes	4	4	
	No	24	18	
<u>Mental Health Problem in Parent</u>	Yes	8	8	
	No	19	14	
<u>Alcohol Problem in Parent</u>	Yes	15	5	
	No	13	17	
<u>Witnessed Violence</u>	Yes	18	9	
	No	10	13	

3.6 Frequencies of Sexual/Physical Assault in Adulthood

	CSA Group (n = 28)	Control Group (n = 22)
Yes	14	7
No	14	15

3.7 Examples of over-general and specific memories recalled in experiment

Cue	Over-general response	Specific response
Happy	‘When I’m on my own in the house’ (subject 2)	‘When my boyfriend proposed – I never expected it’ (subject 12)
Hurt	‘When I think about the abuse that happened to me years ago’ (subject 3)	‘On Friday when A. caused problems at school again’(subject 50)
Successful	‘When I look back at my life I feel successful’ (subject 25)	‘Passing my driving test’ (subject 18)
Lonely	‘I was always lonely growing up in a home’ (subject 33)	‘Two weeks ago when my husband worked away for a night’ (subject 47)

3.8 Instructions for contributors

Psychological Medicine

PAPERS All papers for publication, except those from the Americas and those on generic topics, should be addressed to the Editor, Professor Eugene Paykel, University of Cambridge, Department of Psychiatry, Douglas House, 18E Trumpington Road, Cambridge CB2 2AH, UK. Papers from the Americas, and papers dealing with genetic topics, irrespective of the country, should be sent to Professor Kenneth S. Kendler, MCV, PO Box 980126, Richmond, VA, 23298-0126, U.S.A.

Contributors should send four copies of the text, tables and figures. Copies other than the first may be photocopied. In addition to longer articles, the Editor is prepared to accept preliminary and brief communications of between 1500 and 2500 words and submitted editorials. Letters to the Editor discussing published papers will also be accepted.

Submission of a paper will be held to imply that it contains original work that has not been previously published and that it is not being submitted for publication elsewhere.

When an article has been accepted for publication, the author is strongly encouraged to send a copy of the final version on computer disk (Apple Macintosh or IBM compatible PC) *together with* the hard copy typescript, giving details of the wordprocessing software used (Microsoft Word, Word or Word Perfect). However, the publisher reserves the right to typeset material by conventional means if an author's disk proves unsatisfactory.

Manuscripts must be typewritten on one side of the paper in double-spacing with wide margins throughout, including references and notes, and all pages consecutively numbered. The following information must be given on the first page (title sheet): (1) title and short title for running head (not more than 60 characters); (2) authors' names, and (3) department in which work was done. A structured abstract of no more than 250 words should be given at the beginning of the article using the headings: Background; Methods; Results; Conclusions. The name of an author to whom correspondence should be sent must be indicated and a full postal address given in the footnote. Any acknowledgements should be placed at the end of the text (before the Reference section). Contributors should also note the following:

1. Italic type should be indicated by underlining and bold type by wavy underlining (italic and bold typefaces may be used only if they are very distinct).
2. S.I. units should be used throughout in text, figures and tables.
3. Authors should spell out in full any abbreviations used in their manuscripts.
4. Foreign quotations and phrases should be followed by a translation.
5. If necessary, guidelines for statistical presentation may be found in: Altman, D. G., Gore, S. M., Gardner, M. J. & Pocock, S. J. (1983). Statistical guidelines for contributors to medical journals. *British Medical Journal* **286**, 1489-1493.

REFERENCES (1) The Harvard (author-date) system should be used in the text and a complete list of References cited given at the end of the article. In a text citation of a work by more than two authors cite the first author's name followed by *et al.* (but the names of all of the authors should be given in the References section). Where several references are cited together they should be listed in rising date order. (2) The References section should be typed in alphabetical order on a separate sheet. Examples follow:

Brown, G. W. (1974) Meaning, measurement and stress of life events. In *Stressful Life Events: Their Nature and Effects* (ed. B. S. Dohrenwend and B. P. Dohrenwend), pp. 217-244, John Wiley: New York.

Brown, J. (1970). *Psychiatric Research*. Smith: Glasgow.

Brown, J., Williams, E. & Wright, H. (1970) Treatment of heroin addiction. *Psychological Medicine* 1, 134-136.

Journal titles should always be given in full.

FIGURES AND TABLES Only essential figures and tables should be included.

Photographs Unmounted photographs on glossy paper should be provided.

Magnification scales, if necessary, should be lettered on these. Where possible, prints should be trimmed to column width (i.e. 70mm). *Diagrams* These should not be included in the text and should be submitted in a form suitable for direct reproduction.

The printed version will normally be reduced to 70mm wide, so care should be taken to ensure that lettering and symbols will remain clearly legible. All photographs, graphs, and diagrams should be referred to as figures and should be numbered consecutively in Arabic numerals.

Ensure that the figure number is marked on the back of the photograph or artwork together with the name of the author and paper title. Captions for figures should be typed double-spaced on separate sheets.

Tables Tables should be numbered consecutively in the text in arabic numerals and each typed on a separate sheet after the References section. Titles should be typed above the table.

PROOFS AND OFFPRINTS Page proofs will be sent to the author designated to receive correspondence. Corrections other than to printer's errors may be charged to the authors. Fifty offprints of each paper are supplied free; additional offprints are available according to a scale of charges if they are ordered on the form supplied when the proof is returned.

APPENDIX 4

Small Scale Research Project

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4.1 Patient Satisfaction Questionnaire	143
4.2 Notes for Contributors – <i>Health Bulletin</i>	146

Male/Female
Site.....

**4.1 Department of Clinical Psychology
Patient Satisfaction Questionnaire**

The psychology department would like to offer the best service possible to people attending. This questionnaire can help us to find out how you feel about your contact with the department. Thank you for completing this and please do not hesitate to ask your psychologist if you have any questions about the service.

Please circle the answer which most applies to you opinion.

Part 1

- 1. How long did you wait to be seen by a psychologist for your first appointment?**

Less than 4 weeks 4 – 12 weeks 12 – 20 weeks More than 20 weeks

- 2. How long do you wait on average in the waiting room to be taken in for you appointment?**

Seen early Seen on time Less than 10 minutes More than 10 minutes

- 3. How did you travel to the clinic today?**

Bus Taxi Car Foot Other

- 4. Would you prefer to see your psychologist somewhere else?**
Yes/No

If yes, where?

GP surgery Stobhill Hospital Local Health Clinic Larkfield Centre

- 5. How many appointment(s) have you attended your psychologist?**

.....

- 6. Does your psychologist usually wear a name badge?**

Yes/No

Part 2

- 7. The waiting time to see a psychologist for a first appointment is reasonable**

Strongly agree Agree Neutral Disagree Strongly disagree

8. My appointment is usually at a convenient time

Strongly agree Agree Neutral Disagree Strongly disagree

9. It is possible to get hold of my psychologist on the telephone if necessary

Strongly agree Agree Neutral Disagree Strongly disagree

10. It was easy to travel to the clinic today

Strongly agree Agree Neutral Disagree Strongly disagree

11. I knew where to go when I arrived at the clinic for my first appointment

Strongly agree Agree Neutral Disagree Strongly disagree

12. The reception area/waiting room is welcoming

Strongly agree Agree Neutral Disagree Strongly disagree

13. The receptionist was helpful

Strongly agree Agree Neutral Disagree Strongly disagree

14. It is important to have the choice of a male or female psychologist

Strongly agree Agree Neutral Disagree Strongly disagree

15. My appointments are often enough

Strongly agree Agree Neutral Disagree Strongly disagree

16. I prefer that my psychologist wear a name badge

Strongly agree Agree Neutral Disagree Strongly disagree

I feel assured that the discussions with my psychologist are confidential
17. (Confidentiality = your psychologist may discuss your case with other professionals, especially when others are involved in your care)

Strongly agree Agree Neutral Disagree Strongly disagree

18. My psychologist is sensitive to my feelings and needs

Strongly agree Agree Neutral Disagree Strongly disagree

19. I feel I have a say in the treatment that I receive

Strongly agree Agree Neutral Disagree Strongly disagree

20. The care I receive is more or less what I expected

Strongly agree Agree Neutral Disagree Strongly disagree

21. Overall, I am happy with the service I have received

Strongly agree Agree Neutral Disagree Strongly disagree

22. Any further comments?

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.....

Thank you for completing this questionnaire

4.2 Notes for Contributors – *Health Bulletin*

Papers, articles and other contributions should be sent to the Editor, *Health Bulletin*, Scottish Executive health Department, Room IEO5, St Andrew's House, Edinburgh EH1 3DE. They must be submitted exclusively for *Health Bulletin*. Acceptance is on the understanding that editorial revision may be necessary. All papers are reviewed by the Editor and by peer review, referees being drawn from a panel of appropriate professionals. No correspondence can be entered into in relation to articles found to be unsuitable and returned to authors.

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Surname and initials of author(s)
 Title of paper
 Full name of journal
 Year published
 Volume number
 Opening and closing page numbers

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