An exploration of the barriers and facilitators to clinical psychologists routinely asking about histories of childhood abuse and neglect

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May 2022

A thesis submitted in partial fulfilment of the requirements of the University of East London for the degree of Professional Doctorate in Clinical Psychology

ACKNOWLEDGEMENTS

I would like to thank all those who have participated in this research, for generously offering their time and sharing their experiences with me. It was truly a pleasure to meet each interviewee and learn their varying perspectives on their clinical work.

I would also like to thank my supervisor, Professor John Read, for his guidance, encouragement and overall approach to supervising me. I have found our meetings to be very containing, thought inducing and supportive - I have learnt so much from him throughout the process of producing this thesis.

Last but not least, I would like to thank my partner, Ajani, for cheering me on from start to finish, my parents for always believing in me and my wonderful friends for regularly checking in with me.

This thesis would simply not have been possible without the support of all of you mentioned here.

ABSTRACT

Aims: The primary aims of this study were to explore the extent to which UK clinical psychologists enquire about experiences of historical child abuse and child neglect, to explore clinical psychologists' beliefs about the practice of routine enquiry and to understand the barriers and facilitators to clinical psychologists engaging in routine enquiry. The secondary aims were to understand how clinical psychologists respond to disclosures and to gather some preliminary data on clinical psychologists' likelihood of enquiring about three other adverse childhood experiences (discrimination, bullying and poverty).

Method: This study used a mixed method (qualitative and quantitative) methodology, gathering initial data using an online survey and following this with qualitative interviews with some of the survey respondents, conducted and analysed using a thematic analysis approach.

Results: Clinical psychologists reported asking more frequently than previous research on mental health professionals' enquiry would predict. However, they also reported varying views on how to ask, ranging from direct questions about child abuse and neglect to broader questions about early life experiences. They reported a number of barriers and facilitators to asking about child abuse and child neglect. They reported that they respond to disclosures of child abuse and neglect using core therapeutic skills such as listening, validating, and formulating. They reported varied practices regarding the extent to which they record enquiry into child abuse and neglect in their clinical notes.

Conclusion: This study provided a useful insight into a previously under researched topic. These results combined with the results from previous research point to the need for greater access to trauma informed training across mental health professional disciplines and to the need for a paradigm shift at the systemic level towards more trauma informed services. The specific implications and directions for future research are discussed.

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1. INTRODUCTION

This research will primarily focus on UK clinical psychologists' (CPs) enquiry about histories of child abuse (CA) and child neglect (CN) for adult clients, with a specific focus on gaining a better understanding of the barriers and facilitators to this. Research into the impact of CA and or CN on the development of mental health (MH) difficulties uses varying terminology. A lot of research refers broadly to the impact of 'childhood trauma' and this term can sometimes be used interchangeably with the terms maltreatment and adversity (Chaiyachati & Gur, 2021).

The term child maltreatment is often used to encompass both CA and CN (McCoy & Keen, 2011). However, there is a lack of definitional consistency in the field of child maltreatment. Sometimes the term 'child abuse' can be used to encompass all forms of child abuse and neglect, and how one author defines child abuse may differ from another (McCoy & Keen, 2011). One of the key ways in which to differentiate CA from CN is through understanding them as acts of commission versus acts of omission, respectively. (McCoy & Keen, 2011).

The choice to focus on CA and CN as opposed to other childhood adversities was primarily due to this research building on, and being informed by, previous work, such as the systematic review published in 2018 'Do adult MH services identify child abuse and neglect? A systematic review' (Read et al., 2018a). This research will differentiate between physical abuse, sexual abuse, emotional abuse, physical neglect and emotional neglect, the five categories of maltreatment listed by the World Health Organization (WHO) (Nanda et al., 2016), and included in other research (Read et al., 2018a). However, the question of whether other forms of adverse childhood experiences (ACEs) are asked about is also of interest and will also be touched upon in this study. The term 'ACEs' was initiated by Felitti et al's. (1998) study evidencing the detrimental impact of CA, CN and household dysfunction on future health, and had since been expanded to include a broader range of ACEs including those that occur at the community level (e.g. witnessing violence, experiencing discrimination or living in an unsafe neighbourhood) (Cronholm et al., 2015).

1.1. Prevalence of Child Abuse and Neglect

It is estimated that one in five people in the UK have experienced 'at least one form of child abuse' (8.5 million people)' (ONS, 2020). Neglect has been found to be the most common type of child maltreatment within families in the UK (Radford et al., 2011). Neglect can encompass both physical and emotional neglect, such as the failure to meet a child's physical needs (e.g. "food, clothing or shelter" (National Society for the Prevention of Cruelty to Children [NSPCC], 2022b, para. 4)) or neglecting to provide a child with "the nurture and stimulation they need. This could be through ignoring, humiliating, intimidating or isolating them" (NSPCC, 2022b, para. 4).

Females are reported to be more likely to experience childhood sexual abuse (CSA) (i.e. a child or young person being "forced or tricked into sexual activities" (NSPCC, 2022c, para. 3)) than males and are also reported to be more likely to experience severe maltreatment overall (i.e. across categories of CA and CN) (Radford et al., 2011).

Also, although CA occurs across socioeconomic groups, reports suggest that it is more prevalent in low income families, whom are more likely to be exposed to stressful circumstances (Sedlak et al., 2010).

1.2. The Impact of Child Abuse and Neglect

There are several overlapping models and frameworks which may support our understanding of the ways in which CA and CN impact upon the development of MH difficulties in adulthood. Fundamentally, when children feel safe they are free to learn about themselves and the world around them in an uninhibited way (Howe, 2005). Whereas when children's early experiences are characterised by fear or confusion their social, emotional and cognitive development becomes jeopardised, as their energies are focused on survival and safety (Howe, 2005).

1.2.1. Psychological Factors

Some of the potential psychological impacts of this are the development of vigilance to threat (Golding et al., 2021), the development of emotion regulation difficulties (Levy et al., 2014) and the development of insecure attachment styles (Widom et al., 2018). Additionally, CA and CN may result in the development of maladaptive schemas/ core beliefs (e.g. fear of emotional deprivation or abandonment in relationships, mistrust of others or a belief that one is defective or unlovable) (Young, 2006).

Vigilance to threat, emotion regulation difficulties, insecure attachment and maladaptive schemas have also all been associated with the development of MH difficulties later in life (Dvir et al., 2014; Gibson et al., 2016; Widom et al., 2018).

1.2.2. Social Factors

As aforementioned, individuals who have experienced CA/CN are also more likely to have grown up in stressful living conditions. This may include living in poverty and poor housing , which may impact upon their ability to perform to their true academic potential, and impede their experiences of socialisation (Corby, 2006). Later in life this may also result in the development of beliefs about being rejected by others, or about being 'defective' or 'unworthy' (Young, 2006). This is particularly true given that living in socio-economic deprivation has been found to result in greater risk of developing MH difficulties later in life, for children exposed to traumatic events (Briggs-Gowan & Carter, 2011).

Furthermore, the impact on one's social and academic development may contribute to further experiences of socio-economic disadvantage later in adulthood, which is also known to impact MH (Murali & Oyebode, 2004). Additionally, childhood adversities have been found to be significantly associated with lower levels of quality of life in adulthood (Davies et al., 2021).

1.2.3. Biological Factors

Finally, CA and CN are thought to have the potential to have greater neurological and biochemical impact than adverse experiences in adulthood due to the plasticity of the brain during development (Perry & Pollard, 1998). For instance, traumatic experiences may alter the circuits and hormonal systems in the brain that are responsible for regulating stress and impact memory and information processing; and change the hypothalamic pituitary adrenal (HPA) axis, impacting upon cognitive and behavioural responses to stress (Dye, 2018).

1.3. Relationship Between Child Abuse and Neglect and Mental Health Difficulties

There is a plethora of research internationally, acknowledging the impact of CA and CN on the development of MH difficulties in adulthood. Strikingly, research suggests that across the globe childhood adversities may account for 29.8% of MH difficulties (Kessler et al., 2010). Furthermore, as will become clear in the synthesis of some of the research below, CA and CN is also almost consistently associated with the severity of an individual's difficulties and with worse treatment outcomes.

1.3.1. Psychosis

'Traditionally, schizophrenia and psychosis have been considered endogenous biomedical disorders' (Toner et al., 2013). However, studies have shown that individuals with a diagnosis of psychosis are almost three times more likely to have been exposed to childhood adversities than controls (Varese et al., 2012) and have consistently high self-report of CA and CN (Bonoldi et al., 2013). CA and CN are also associated with higher symptom severity (Carbone et al., 2019) and there is thought to be a dose-response relationship between number of adversities experienced and number of psychotic symptoms (Longden et al., 2016). Furthermore, the content of auditory hallucinations are often associated to earlier traumatic events (McCarthy-Jones & Longden, 2015) and individuals with psychosis also often attribute their childhood experiences to the development of their difficulties (Hurtado et al., 2021; Read, 2020).

1.3.2. Anxiety and Depression

Studies have also found a strong relationship between CA and CN and anxiety and depression (Davies et al., 2021; Gardner et al., 2019). Individuals who have experienced CA and CN are found to be 2.66 times more likely to develop depression in adulthood (Nelson et al., 2017). ‘Childhood trauma’ has been linked to an increase in obsessive compulsive symptoms (Miller & Brock, 2017), social anxiety (Nanda et al., 2016) and is, as one might expect, associated to the development of PTSD (Rameckers et al., 2021). Additionally, studies have also evidenced that adults who have experienced childhood adversities have poorer treatment outcomes for both depression and anxiety (Hovens et al., 2012; Nanni et al., 2012; Nelson et al., 2017; Verbist et al., 2021).

1.3.3. Eating Disorder

CA and CN have also been found to be relevant to the development of eating disorders and again are often linked to more complex presentations (Briere & Scott, 2007). This may be due to associated difficulties with ‘low self-esteem, shame, [and desires to be] pleasing to others’ (Briere & Scott, 2007). Emotion regulation difficulties are also often associated with bulimia nervosa as binging and purging may serve as forms of emotional avoidance (Briere & Scott, 2007).

1.3.4. Addiction

Furthermore, there is also a strong association between CA and CN and the development of addiction problems (Bernstein, 2000). Fifty percent of individuals with alcohol dependency report at least one form of child abuse and neglect (Huang et al., 2012) and this has also been found to be dose dependent (i.e. the greater the severity of the abuse or neglect, the greater the difficulties with dependency later in life) (Scheidell et al., 2018). Additionally, as is the case with the other diagnostic classifications outlined above, having experienced childhood trauma has been found to result in worse treatment outcomes for addiction interventions (Lotzin et al., 2019).

1.3.5. Suicidality

Finally, it is important to note that there may be a two-three increase in risk for suicide attempts in adulthood, for individuals who have experienced CA and CN (Angelakis et al., 2019). Plus, CA has been found to be more predictive of suicidality than depression (Read et al., 2001), which may suggest that assessing for histories of CA should be considered a key element of conducting a risk assessment (Read et al., 2001).

Overall, these findings have led to the recognition by a number of researchers for the need for greater enquiry into historical CA and CN in clinical practice (Lobbestael et al., 2009; Verbist et al., 2021). Enquiring about historical CA and CN may be considered necessary in order to construct meaningful formulations of presenting problems and to appropriately tailor treatment to meet the needs of clients who have experienced these forms of abuse (e.g. (Lindert et al., 2014; Nanda et al., 2016).

1.4. Other Non-Mental Health Impacts of Child Abuse and Child Neglect

1.4.1. Physical Health

CA and CN are known to have a long term impact on physical health (Felitti et al., 2019), and to increase the risk of chronic disease (Dong et al., 2004). This may in part me attributed to health risk behaviours such as overeating as a method of self-soothing, and poor sleep resulting in obesity, hypertension and diabetes (Dye, 2018).

1.4.2. Criminality

Finally, CA and CN are also known to result in a greater risk of involvement in the criminal justice system, and the prison population is known to have higher rates of childhood trauma than the general population (Dye, 2018).

1.5. Shift Towards Trauma Informed Care

Trauma has traditionally been defined within the field of MH as resulting from ‘exposure to actual or threatened death, serious injury or sexual violence through direct or indirect experiencing or witnessing of the event/s’ (Sweeney et al., 2018). However, this conceptualisation of trauma is highly contested (McHugh & Treisman, 2007). Alternative conceptualisations of trauma include the recognition that “as social animals, we can be traumatised by acts that threaten our psychological/social integrity” (Sweeney et al., 2018), incorporating all forms of CA and CN, as well as other ACEs. Furthermore, as aforementioned, these experiences are widespread across society. Therefore, the shift towards trauma informed care refers to implementation of trauma informed approaches across routine MH services, as opposed to the development of specialist trauma-specific services, based on trauma diagnoses such as PTSD (Sweeney et al., 2018).

The aim is to ‘minimise the risk that people presenting to services have their symptoms disconnected from the context of their lives’ (Sweeney et al., 2016). The dominant medical model (which emphasises diagnosis, symptoms and symptom reduction via medication) runs the risk of communicating to service users that there is something fundamentally ‘wrong’ with them as individuals, as opposed to viewing their difficulties as understandable reactions to what has happened to them (Read, 2019). Instead, alternative approaches such as the Power Threat Meaning Framework champion the practice of making sense of MH ‘symptoms’ through the lens of adverse experiences (Johnstone & Boyle, 2018). Many have neatly described the shift towards trauma informed care as asking ‘what has happened to you?’ instead of ‘what is wrong with you?’ (Read, 2019). Endorsers of trauma informed practice consider that this has the potential to ‘create feelings of validation, safety and hope’ for survivors and that these principles resonate with the values that psychiatric survivors have long expressed (Sweeney et al., 2016).

Two of the key principles of trauma informed practice are recognising trauma (such as CA and CN) through the use of routine enquiry in services (Sweeney et al., 2016) and ensuring that survivors are able to access appropriate trauma specific care if necessary (Sweeney et al., 2016). However, although a number of services have begun to embrace this shift, the move towards trauma informed care remains in its infancy (Ford et al., 2019).

The implications of this are, therefore, that psychologists should seek to understand whether their clients have histories of CA or CN, and actively include this in their formulations of their clients' difficulties (Lab et al., 2000; Mitchell et al., 1996; Young et al., 2001).

Not only is this important for informing appropriate treatment, but it may also be key to the development of a strong therapeutic relationship (Larkin & Read, 2008). Many service users already recognise the link between what has happened to them and their presenting difficulties, and prefer trauma models for understanding their distress over bio-genetic models (Read, 2020). Thus, when clinicians fail to enquire about this, service users may be left feeling that the professional working with them holds differing beliefs to theirs about the aetiology of their difficulties or may be left feeling that their difficulties are not truly understood or seen (Larkin & Read, 2008). This risks denying them the right to have their experiences validated and acknowledged. Furthermore, supporting clients with understanding the relationship between what has happened to them and their presenting difficulties can also be powerful in reducing distress (MacBeth & Gumley, 2006).

1.6. Barriers to Spontaneous Disclosure

The literature suggests that 'abuse survivors are extremely reluctant to spontaneously tell anyone about the abuse' (Read et al., 2006). This may be due to embarrassment, shame, protection of family, or 'previous encounters with people in authority whose responses may have been ill-informed, inadequate and, at times, harmful' (Ingrassia, 2019).

Studies reporting specifically on CSA have found that it took women on average 16 years to disclose what had happened to them (Read et al., 2006). Research suggests that men are even less likely to disclose CSA and are reported to take an average of 20 or more years to disclose (Gruenfeld et al., 2017). Some of the potential barriers for this for both men and women have been found to be experiencing shame and fear of negative consequences (Gruenfeld et al., 2017).

There is a plethora of research exploring shame as an impact of CSA (MacGinley et al., 2019), but shame has also been found to be associated with childhood experiences of childhood physical abuse (CPA) (i.e. any form of deliberate physical harm to a child or young person (NSPCC, 2022a)) (Andrews, 1998), child emotional abuse (i.e. "the continued emotional mistreatment of a child [such as] trying to scare, humiliate, isolate, or ignore a child" (NSPCC, 2022d, para. 3)) (Ross et al., 2019) and experiences of CN (Mojallal et al., 2021). Therefore, shame is also likely to be a barrier to disclosure for all forms of CA and CN. Additionally, people who have experienced CA/ CN may not always identify themselves as 'abused' due to this having been normalised to them (Örmon et al., 2016)

These findings serve to highlight the responsibility that clinicians have to proactively enquire about histories of CA and CN, in order to provide appropriate formulation and treatment (Ingrassia, 2019; Örmon et al., 2016; Read et al., 2006).

1.7. Service Users' Views on Enquiry

Service users have historically reported that they expect to be provided with a space to talk about their feelings and life experiences when they come into contact with MH services (Rogers et al., 1993). They have also reported that lack of enquiry into whether they have historical experiences of CA/ CN has left them disappointed, and made it difficult for them to access the treatment/ support they felt they needed (Lothian & Read, 2002).

Service users have also reported that they advocate for MH professionals asking them about historical experiences of CA and CN (Friedman et al., 1992) and more recently have made a series of recommendations for clinicians regarding this, which include asking all service users as early as possible, asking on more than one occasion, and asking sensitively (Scott et al., 2015).

Finally, a study exploring women's level of discomfort when completing ACEs screening with their health visitors has found it was uncommon for women to report feeling significant discomfort when being assessed, and that 'major discomfort [was] atypical' (Mersky et al., 2019). This may suggest that although service users report that in some cases it may feel uncomfortable to be asked sensitive questions about historical CA/ CN, they also report that it may be necessary and worthwhile in order to access appropriate support.

1.8. Rationale for Engaging in Routine Enquiry

When considering:

1. The well evidenced relationship between CA and CN and the development and severity of MH difficulties
2. The rationale for the shift towards trauma informed care
3. The evidence that service users are unlikely to spontaneously disclose when they have experienced CA or CN and
4. The evidence that many service users endorse routine enquiry ….

… the argument for the need for routine enquiry into CA and CN in mainstream MH services becomes clear. Furthermore, the Department of Health made it a policy in 2008 that histories of CA and CN be enquired about as part of routine clinical practice in all MH assessments (Department of Health, 2008). However, despite all of this, research suggests that enquiry about CA and CN in MH services remains low (Read et al., 2018a).

1.9. Literature Review – How often do Mental Health Professionals Ask the Question?

The conclusion that enquiry about CA and CN in MH services remains low results from a systematic review published in 2018 (Read et al., 2018a). The systematic review searched for any journal articles and/or dissertations which provided data related to the question of how often MH professionals ask adults about histories of CA and CN from the earliest record to December 2016 (Read et al., 2018a). They identified 21 studies (Read et al., 2018a). Given that this thesis aimed to build on these findings, a further systematic review of the literature on this topic was performed, aiming to replicate the search strategy used in the previous 2018 systematic review.

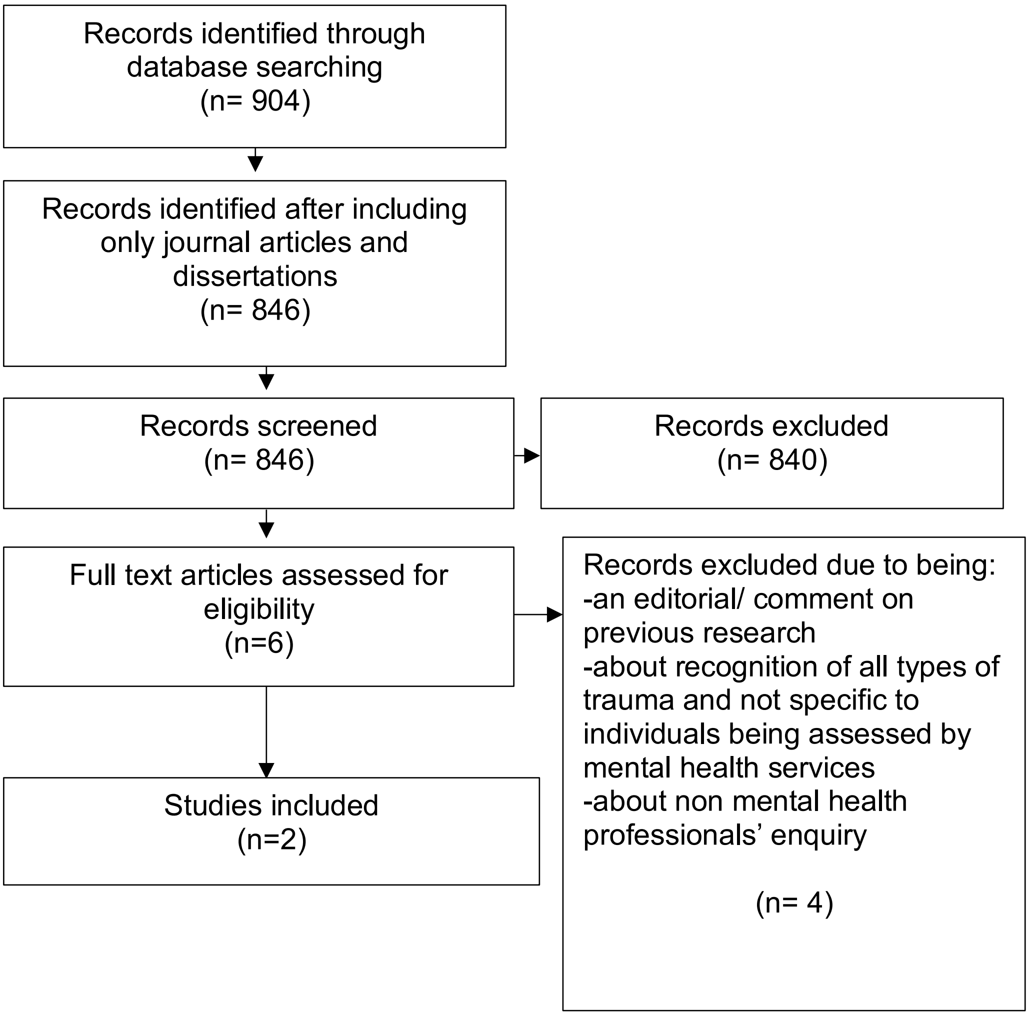
1.9.1. Search Strategy:

An electronic database search was completed on PsychINFO, from December 2016 until January 2022. The same search terms were used as those used in the previous systematic review which were: "'child abuse' OR 'child neglect' OR 'sexual abuse' OR 'physical abuse' OR 'emotional abuse' OR 'psychological abuse' OR 'physical neglect' OR 'emotional neglect' OR 'child maltreatment' OR incest – AND – 'mental health services' OR 'psychiatric services' OR 'mental health assessment' OR 'psychiatric assessment' OR 'psychological assessment' OR 'psychiatric nursing assessment' OR 'medical records' OR 'patient files'" (Read et al., 2018a). This produced a total of 904 reports, the search was then limited to journal articles and dissertations but was not limited by language, producing 846 potential papers.

The titles of these 846 journal articles and/or dissertations were read by the researcher, with the aim of identifying papers which titles suggested they may have the potential to address the question of how often MH professionals enquire about histories of CA and CN with adult clients. If a potentially relevant title was identified the study's abstract was read. In addition to the 2018 systematic review

(Read et al., 2018a) a total of 6 papers were identified which appeared to have titles and abstracts relevant to the aim of the literature review. Of these six studies, four were excluded at the point of reading the article in full. Two of these four were excluded due to being an editorial or response to a previous research article (i.e. not studies), one was deemed not directly relevant as it measured rates of identification of PTSD symptoms in a sample of people both within and outside of MH services and was not specific to childhood trauma and one was excluded due to being about physical health professionals’ enquiry, rather than MH professionals.

Figure 1. Systematic Review Diagram



The same search strategy was repeated using the CINAHL Complete and Scorpus databases, no additional studies were identified. However, an additional study which included data on likelihood of asking was uncovered when completing a separate search for barriers (see Lotzin et al., 2019). The 21 papers identified in the previous 2018 systematic review and the three papers identified by the additional systematic review conducted as part of this thesis (Nagar et al., 2020; Neill & Read, 2022; Lotzin et al., 2019) are synthesised in Table 1.

1.9.2. Results of Systematic Review

Seven studies were conducted in the USA, six in New Zealand, five in the UK, three in Australia, one in Ireland, one in Germany and one in Israel.

Table 1. Summary of Findings on Rates of Enquiry into Child Abuse and Neglect

Methodology	Study, location, and sample	Findings
Calculated the proportion of CA and CN that had been identified by researchers (by surveying or interviewing service users) that was subsequently found to be recorded in their files.	Jacobson et al., (1987) USA, 100 inpatients	10.5% of sexual abuse 12.2% of physical abuse
	Craine et al., (1988) USA, 105 inpatients	44.4% of sexual abuse
	Goodwin et al., (1988) USA, 80 inpatients	20% of sexual abuse
	Briere & Zaidi, (1989) USA ,100 ‘psychiatric emergency room attenders’	8.6% of sexual abuse
	Lipschitz et al., (1996) USA, 120 ‘outpatients’	28.3% sexual abuse 29.3% physical abuse

	Wurr & Partridge, (1996) England, 120 inpatients	30.9% sexual abuse
	Cusack et al., (2004) USA, 97 service users	28% of ‘trauma’ (did not report on which subtype of trauma)
	Shannon et al., (2011) Northern Ireland, 60 MH service users	45.5% of sexual abuse 21.4% of physical abuse 7.7% of emotional abuse 8.3% of physical neglect 9.1% of emotional neglect
	Rossiter et al., (2015) Ireland, 129 inpatients & outpatients	34.4% of sexual abuse 69.4% of physical abuse 61.5% of emotional abuse 11.3% of physical neglect 21.2% of emotional neglect
	Cunningham et al., (2016) Northern Ireland, 45 MH service users	50.0% of sexual abuse 35.0% of physical abuse 26.1% of emotional abuse 8.7% of physical neglect 8.3% of emotional neglect
	Weighted averages of above listed studies provided by 2018 systematic review (Read et al., 2018a)	30.2% of sexual abuse 33.1% of physical abuse 44.3% of emotional abuse 10.3% of physical neglect 17.4% of emotional neglect

Asked service users whether they were asked	Rose et al., (1991), USA, 89 service users	0% reported ever being asked if they had historical experiences of CA/ CN
	Lothian & Read (2002), New Zealand, 72 service users	20.8% of service users reported being asked about historical abuse during their assessments
	Read et al., (2006), New Zealand, 60 female service users receiving therapy for CSA	21.7% reported they had previously been asked about abuse by MH services
Asked MH professionals on how frequently they ask	Lab et al. (2000), UK, 111 MH professionals	'18% said they ask about sexual abuse in men half the time or more and one-third reported that they never ask' (Read et al., 2018a)
	Cavanagh et al., (2014) New Zealand, 85 MH professionals	Estimated than in '64% of cases they knew whether or not their client had been sexually abused' (Read et al., 2018a)
	Mansfield et al., (2017), Australia, 57 MH professionals	23% reported that they routinely ask about childhood trauma, including CSA

Asked managers of MH services how often their staff enquire	Mitchell et al., (1996), USA, 466 nurse managers	43% reported that they believed their service enquired routinely
Measured how frequently abuse questions on assessment forms are used by MH professionals v. ignored	Read & Fraser, (1998) New Zealand, use of forms in inpatient setting	In 67.9% of cases the questions in the abuse section of the assessment forms were not asked
	Agar et al., (2002) New Zealand, use of forms in community MH service	In 23.1% of cases the questions in the abuse section of the assessment forms were not asked
	Sampson & Read, (2017), New Zealand, use of forms in community MH service after computerised medical records were introduced	In 54.9% of cases the questions in the abuse section of the assessment forms were not asked
	Mansfield et al. (2017), Australia, use of newly introduced child abuse questions on assessment forms in inpatient	In 32.6% of cases the questions in the abuse section of the assessment forms were not asked

	and outpatient services	
Looked at rates of documentation of abuse and rates of documentation that the question was asked in service users' clinical records (but did not compare this to rates reported independently by service users)	Mansfield et al. (2017), Australia, 100 clinical case files	24% included documentation of childhood sexual abuse (not necessarily a measure of how many service users were asked, as some may have spontaneously disclosed) 29% included evidence that the SU had been asked, but denied having experienced CSA
	Xiao et al., (2016), Australia, files of 100 female SUs in inpatient services	49% rate of documentation of trauma history (this included both childhood and adulthood experiences). (41% yes, 8% no)
	[1]Neill & Read (2022), UK, 400 clinical case files	7.2% of records included sexual abuse 4.5% of records included physical abuse 2.3% of records included emotional abuse 0.8% of records included emotional neglect

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[1] Study identified by recent literature search

		0% of records included physical neglect
Asked MH professionals to document whether they had asked for each type of abuse	[2]Lotzin et al (2019), Germany, 1,895 service users	Prior to receiving training, the substance use MH professionals reported asking: 47.1% about sexual abuse 54.9% bout physical abuse 41.0% about emotional abuse 39.1% about neglect
Compared service users' reports to professionals' reports by interviewing both groups	[3]Nagar et al., (2020), Israel, Interviewed 170 service users and 80 MH professionals	Professionals accurately identified 50% of cases of CSA and 40% of cases of childhood physical abuse

1.9.3. Summary of Main Findings

The 2018 systematic review reported a paucity of studies in this area (21 studies over a period of 30 years), and the finding that only three additional studies have been conducted over the past 4 years confirms that this continues to be an under researched topic.

The 2018 systematic review (which included all of the studies presented in the above table prior to 2018, reported that overall likelihood of enquiry was concerningly low (Read et al., 2018a). It also reported that overall neglect appears to be asked about even less than overall abuse, and men, older people

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[2] Study identified by recent literature search
[3] Study identified by recent literature search

and people with a diagnosis of psychosis were less likely to be asked (Read et al., 2018a). The Neill & Read (2022) study included in this review replicated these findings.

The 2018 systematic review reported that there may be some improvement over time (Read et al., 2018a). The Nagar et al., (2020) and Lotzin et al., (2019) studies may support this, but the improvement is marginal and it is not possible to draw conclusions based on only two studies. The Neill & Read (2022) study does not support an improvement over time.

1.10. Barriers to Routine Enquiry about Child Abuse and Child Neglect

This naturally leads one to question why rates of enquiry remain so low. Perhaps unsurprisingly, given the scarcity of studies exploring how often MH professionals ask about histories of CA/CN, there have been even fewer studies exploring the barriers to MH professions asking their clients about CA/ CN.

Rather than conducting a systematic review on barriers to enquiry, the papers citing key papers known to discuss barriers were reviewed, as were their references. Therefore, this may not be an exhaustive summary of all of the research on MH professionals’ barriers to enquiry about CA/ CN, but aims to review the key findings.

Nine studies were identified. Three were conducted in the UK (Day et al., 2003; Lab et al., 2000; Toner et al., 2013), two in Ireland (Kennedy et al., 2021; Walsh et al., 2021), two in Australia (Mansfield et al., 2017; McLindon & Harms, 2011), and one each in New Zealand (Young et al., 2000) and the USA (Mitchell et al., 1996).

Five of the nine studies utilised quantitative survey methods to elicit the barriers (Day et al., 2003; Lab et al., 2000; Mansfield et al., 2017, Mitchell et al., 1996 &

Young et al., 2000), and four utilised qualitative interviews (Kennedy et al., 2021; McLindon & Harms, 2011; Toner et al., 2013; Walsh et al., 2021).

The studies covered a range of different MH professions: MH nurses (Kennedy et al. 2021; Walsh et al., 2021), Nurse managers (Mitchell et al., 1996); MH crisis assessment workers (McLindon & Harms, 2011), psychologists and psychiatrists (Young et al., 2000), psychological therapists working in early intervention services for psychosis (Toner et al., 2013) and varied MH professionals (Day et al., 2003; Lab et al., 2000; Mansfield et al., 2017).

However, it is important to note that seven of these nine studies, focused specifically on barriers to enquiry about CSA (Day et al. 2003, Kennedy et al., 2021; Lab et al., 2000; McLindon & Harms, 2011; Mitchell et al., 1996; Walsh et al., 2021).

The main reported barriers to enquiry are summarised below in Table 2.

Table 2. Main Barriers to Mental Health Professionals Enquiring about Child Abuse and Neglect

Barrier	Notes
Therapeutic relationship	MH nurses reported believing that due to the sensitivity of asking about historical abuse, it was best to ask once a therapeutic relationship had been established (Kennedy et al., 2021) and 62% of psychologists and psychiatrists reported that the best time to ask about historical abuse, was once rapport had been established (Young et al., 2001) Psychological therapists working with clients with diagnoses of psychosis reported that they relied upon the therapeutic relationship as well as their own intuition to bring in questions about historical abuse into assessment (Toner et al., 2013)

	Furthermore, MH professionals reported asking could prevent the client from engaging with services, due to the question being too intrusive (Lab et al., 2000) and MH nurses reported being fearful that asking could damage the therapeutic relationship due to being fearful of providing an inadequate response (Walsh et al., 2022)
Remit of the work	MH nurses reported that experiences of CSA were secondary to the presenting problem they needed to ‘treat’ (e.g.: “nobody is admitted to hospital for treatment of CSA” (Kennedy et al., 2021, p. 389)). Additionally, MH professionals reported believing that CSA was not relevant to certain presenting problems such as ‘psychosis’ or ‘simple phobias’ (Lab et al. 2000)
	The biggest barrier, in one study, to asking about historical abuse was reported to be believing that there are too many immediate concerns to deal with (Young et al., 2001). Similarly, MH nurses reported that competing clinical priorities may result in them neglecting to ask about histories of CSA (McLindon & Harms, 2011)
Fear of Harming	MH nurses reported a fear that asking about histories of CSA could result in retraumatising the client (Kennedy et al., 2021) Psychologists and psychiatrists reported being fearful that opening conversations about historical abuse could result in the client’s mental wellbeing deteriorating (Young et al., 2001) and similarly MH professionals in another study reported “it could worsen a patient’s condition” (Lab et al., 2000).
Waiting for the client to disclose	MH nurses reported waiting for the client to bring it up, due to believing that it was important for clients to disclose at their own pace (Walsh et al., 2022), feeling it was important to allow the client to take the lead in disclosing (Kennedy et al., 2021) and believing that due to the distressing nature the topic should not

	be raised unless the client chooses to do so (McLindon & Harms, 2011).
Believing they do not have the required skills to ask or provide support	MH nurses reported that they did not believe they had the skills to support clients after ‘opening up old wounds’ (Walsh et al., 2022), they also reported “not knowing how to respond, [being fearful of] saying the wrong thing” (Kennedy et al., 2021, p. 389), and lacking in confidence in their skills to enquire and respond (Mansfield et al., 2017; Mitchell et al., 1996)). Two surveys on MH professionals’ enquiry into histories of CSA also found that MH professional reported feeling underqualified to ask (Day et al., 2003; Lab et al., 2000).
Vicarious Trauma	MH nurses reported that hearing about disclosures of CSA could negatively impact their own wellbeing for several days (Walsh et al., 2022) and some MH nurses have reported that this could result in them wanting to limit the amount of information clients’ share to protect themselves (Kennedy et al., 2021)
Lack of Training	A range of MH professionals across disciplines reported that they lacked training in enquiring about and responding to disclosures of CA/ CN (Kennedy et al., 2021; Lab et al., 2000;(McLindon & Harms, 2011; Walsh et al., 2022; Young et al., 2021). Furthermore, one study reported that having had training was statistically significantly related to likelihood of asking about historical abuse (Young et al., 2001).
Lack of supervision	MH nurses reported feeling under supported in carrying out work with clients who had experienced historical abuse (Day et al., 2013) and other studies noted that there were inconsistencies in the availability of clinical supervision for MH nurses (Kennedy et al., 2021; Walsh et al., 2022), citing this as a barrier to enquiring about abuse histories.
Discomfort talking about CSA	Several studies exploring barriers across a range of professional groups reported that being uncomfortable about talking about CSA was a barrier to asking (Day et al., 2003; Kennedy et al.,

	2021; Lab et al., 2000; Mitchell et al., 1996; McLindon & Harms, 2011; Walsh et al., 2022)
False Memories	Two of the older studies surveying MH professionals on barriers to enquiry reported that professionals were fearful of implanting “false memories” (Lab et al, 2000, p. 396; Young et al., 2001, p. 409) and one study found that this was highly correlated to “believing that "the client may be experiencing psychotic symptoms and imagine abuse that did not actually occur" (Young et al., 2001, p. 409).
Biological Aetiological Beliefs	One study reported that having strong biological aetiological beliefs for the development of MH difficulties rendered professionals less likely to ask, and that this was particularly true for psychiatrists resulting in a lower likelihood of asking clients with diagnosed with schizophrenia (Young et al., 2001)
Lack of Availability of Appropriate Treatment	Lack of appropriate resources (Lab et al., 2000), knowing that you may not be able to offer consistent care to a client (i.e. may only meet them once) (McLindon & Harms, 2011), and being unclear about the necessary protocols to follow following a disclosure (e.g. where to refer to) (Mansfield et al., 2017) have also all been reported as barriers to enquiry.

In summary, the main barriers to MH professionals enquiring about historical CA/CN were:

1. related to beliefs about enquiry (i.e. only enquiring once the therapeutic relationship is established, believing that asking is not a priority or necessarily relevant or believing it is best for the client to disclose at their own pace)
2. related to aetiological beliefs (i.e. holding strong biological aetiological beliefs)
3. related to being fearful of harming the client (i.e. the client deteriorating, or implanting false memories)

4. related to the professionals' fears for their own wellbeing (i.e. fear of vicarious trauma or discomfort talking about CSA) and
5. related to systematic barriers (i.e. believing they do not have time to ask, lack of access to training, feeling under skilled in how to ask and how to respond, lack of access to supervision, or due to not having the appropriate resources to offer relevant treatment).

1.11. Responses to Disclosures

The authors of the 2018 systematic review on how often MH professionals enquire about CA or CN also conducted a subsequent systematic review into how MH professionals respond when CA or CN is known (Read et al., 2018b). Similarly to the first systematic review they found a scarcity of studies addressing this topic (total of 13) (Read et al., 2018b). They also found concerningly low levels of appropriate response to disclosures of abuse, reporting a: 'range of 12%–57% for inclusion in formulations, through 12%–44% for inclusion in treatment plans, to just 8%–23% for actually referring for appropriate therapy' (Read et al., 2018b). They also reported that appropriate responses 'were lower for neglect than for abuse and were also lower for men and people with a diagnosis of psychosis'. (Read et al., 2018b), again paralleling the findings that CN is less asked about than other forms of CA and that men and individuals diagnosed with psychosis are less likely to be asked (Read et al., 2018a).

The BPS have produced guidance for psychologists on responding to disclosures of non-recent CSA, which primarily focuses on safeguarding procedures and touches upon the impact on the therapeutic relationship (The British Psychological Society [BPS], 2016). However, notably this does not touch upon recommendations for how to engage in appropriate trauma informed care (e.g. recommendations for inclusion in formulations and care plans).

1.12. Trauma Training

Given the findings of the two aforementioned 2018 systematic reviews (Read et al., 2018a; Read et al., 2018b) and the findings that some of the key barriers to asking about histories of CA and CN are feeling under skilled and lack of training, it makes sense that one of the key implications of this is the need for the development and dissemination of more trauma informed training.

In 2001 24% of psychologists and psychiatrists in New Zealand reported that they had not received training regarding how to enquire about abuse and 33% felt that they would benefit from this (Young et al., 2001). Since then a variety of training programmes have been developed utilising the Cavanagh et al. (2004) one day training on asking and responding to disclosures of sexual abuse as a reference; e.g. trauma informed training adapted to working specifically in addiction services (Lotzin et al., 2019). Findings suggest that these training programmes have been successful in improving rates of enquiry and appropriate responses to disclosures of CA and CN (Currier & Briere 2000; Day et al. 2003; McNeish & Scott 2008, Lotzin et al. 2018; Walters et al. 2015) cited in (Read et al., 2018b). Furthermore, they have been found to ‘produce changes in attitudes and clinical practice’ (Cavanagh et al. 2004). However, given that there has been such a scarcity of research into the barriers to clinicians engaging in appropriate trauma informed care, a greater knowledge of these factors would be beneficial to the ongoing development of trauma training programmes. Read et al. (2018b) have already called for a greater focus in training on asking and responding to CA and CN for individuals with a diagnosis of psychosis, for men, and regarding neglect (Read et al., 2018b).

1.13. Aims of This Study

The scarcity of research into how often professionals enquire, how appropriately professionals respond and into the barriers to enquiring and responding appropriately to histories of CA and CN may in itself be considered a barrier to the development of more trauma informed working in mainstream services. Furthermore, the majority of the research in this area has focused on multiple professional groups and utilised quantitative methods. There is therefore very limited research providing a sense of how CPs perform in these areas, and only a limited sense of how the known barriers play out in clinical practice. This research will therefore aim to fill some of these gaps, utilising both quantitative and qualitative methods to gain a sense of how often CPs enquire about different forms of CA and CN, to understand CPs beliefs about routine enquiry and to explore the barriers and facilitators to this. It will also touch on how CPs respond to disclosures.

Although there has been research into health professionals' enquiry about ACEs other than CA and CN (Ford et al., 2019), there is no known research on MH professionals' enquiry into ACEs other than CA and CN. This is surprising considering that multiple studies have found that varying forms of ACEs are significantly associated with each other, co-occur and have a cumulative impact on MH later in life (Dong et al., 2004). This study will therefore also aim to gather some preliminary data on this, by including questions on rates of enquiry into three additional ACEs (discrimination, poverty, and bullying) in the qualitative interviews with CPs. The inclusion of discrimination and poverty amongst a wide variety of potential ACEs was due to a desire to include 'social traumas' and due to the recognition of the impact of poverty and discrimination in childhood on long-term MH (Brown, 2017; Knifton & Inglis, 2020). The inclusion of bullying was due to the prevalence of this across socio-economic groups, and due to research reporting a relationship between childhood experiences of bullying and the development of psychosis in adulthood (van Dam et al., 2012; Varese at al., 2012).

1.13.1. Research Questions

Primary

-To what extent do UK CPs ask about histories of CA and or CN?
-What are CPs' beliefs about the practice of routine enquiry into CA and CN?
-What are the barriers to and facilitators of CPs engaging in routine enquiry?

Secondary

-How do CPs respond to disclosures of CA and CN?

-How frequently do CPs enquire about other childhood adversities?

2. METHOD

2.1. Epistemology

“The terms ontology and epistemology refer to the philosophical/ meta-theories that underpin all research […]. Ontology is about what it is that we think we can know and epistemology is about how we think we can know it” (Braun & Clarke, 2022, p. 166). The epistemological position of a research project must be guided by it’s research questions and shapes the choice of methodology (Carter & Little, 2007).

Realism refers to the notion that “there is a real world out there, independent of whoever may be observing it” (Barker et al., 2016, p. 10) whereas, relativism “rejects the idea of an objective, singular reality and instead views realities – plural – as the product of human actions and sense-making” (Braun & Clarke, 2022, p. 294).

Critical Realism is ontologically realist as it assumes that there are ‘truths’, whilst being epistemologically relativist by acknowledging that it is impossible to get to the truth directly as our perception of reality is ultimately influenced by context (Barker et al., 2016; Braun & Clarke, 2022).

The research questions in this research are exploratory, open ended and discovery oriented. Although, informed by the pre-determined hypothesis that there are barriers to MH professionals enquiring about CA/ CN and although some of these have been identified by previous research, this research seeks to understand CPs’ enquiry into CA/ CN and the barriers and facilitators to this, a previously unresearched topic (Barker et al., 2016). Furthermore, the research questions are seeking to provide a picture of CPs’ experiences in practice, which may later inform training or the promotion of trauma informed care.

A critical realist approach has therefore been chosen, as this study is based on the assumption that there is a real world within which CPs enquire about histories of CA and CN (which are themselves real events in the real world), and that there are real barriers and facilitators which impact upon this. However, this study acknowledges that the psychologists will have their own interpretations of what this looks like for them in practice, and the way in which they report on this, in both the survey and interviews, will depend on the ways in which they interpret the questions they are being asked and the ways in which the questions are formulated by the researcher.

Furthermore, although the aim of a critical realist position is to get as close to objective reality as possible, critical realism accepts that as researchers we approach research and interpret our findings through the lens of our personal context (Howitt & Cramer, 2011). This includes our own life experiences, our individual identities, and ultimately our expectations and vested interests (Howitt & Cramer, 2011). The choice of questionnaire used in the study, the development of the semi-structured interview, and the interpretations of the data made by the researcher, particularly in the qualitative arm of the study are all also informed to some extent by the researcher's position and perspectives. It is therefore important to acknowledge that the researcher is a white, middle-class, British, female, Trainee CP who holds values related to promoting trauma informed practices. To attempt to minimise bias, the researcher will therefore produce a reflexive journal, and will aim to promote coding accuracy though measuring inter-coder agreement.

2.2. Design

The study used a mixed method, quantitative and qualitative, non-experimental approach. The main benefit of using both quantitative and qualitative methods is that when combined they can provide a more enhanced understanding of research phenomena, than either approach independently, e.g through triangulation (Creswell & Plano Clark, 2018).

The research was carried out sequentially, allowing for some of the initial quantitative data to be explored in more depth with participants during qualitative interviews. The results derived from each method were also used complimentarily, after data analysis was complete and combined in the discussion section of this paper (see discussion).

2.2.1. Quantitative Design

Descriptive quantitative data was gathered on CPs enquiry into CA and CN and on factors which may impact upon this, using an online survey. Given that the research questions in this study are open and exploratory, the main aim was to produce descriptive statistical results. However, some additional inferential statistical tests were run, to provide preliminary findings about differences between enquiry practices for CA and CN, and to explore the relationship between some of the variables and the overall likelihood of asking.

2.2.2. Qualitative Design

Qualitative interviews were conducted and analysed using a Thematic Analysis (TA) Approach. The choice to include a qualitative arm to the study was to gain thicker and more nuanced accounts of factors which impact CPs' enquiry practices into histories of CA and CN, deepening our understanding of what is really occurring for psychologists in practice. TA was chosen as it is an approach which is thought to be a good fit for this critical realist epistemology (Braun & Clarke, 2022).

Other qualitative methodologies such as Interpretative Phenomenological Analysis (IPA) or discourse analysis (DA) were not considered appropriate due to their grounding in specific epistemologies, which were not thought to be as relevant to the research questions in this study. IPA for instance is grounded in a phenomenological epistemology and places a greater focus on people's experience of their reality (Braun & Clarke, 2006). DA on the other hand is specifically grounded in a social constructionist epistemology and seeks to understand how people’s experiences are socially constructed (Braun & Clarke, 2022).

The TA was conducted inductively, drawing directly on the data to generate themes rather than being shaped by existing theory (Braun & Clarke, 2022). This was chosen given that there has been very little prior research into psychologist’s enquiry practices into histories of CA and CN. The analysis will be conducted semantically, exploring meaning at the surface level rather than at the underlying or implicit level (Braun & Clarke, 2022) and experientially, aiming to capture the psychologist’s perspectives and understandings as opposed to taking a critical position and attempting to unpack meanings around the topic (Braun & Clarke, 2022).

2.3. Participants

The participants were not offered any inducements or rewards for taking part at any stage of the research.

2.3.1. Quantitative Arm of the Study:

A convenience sampling method was used to recruit the CPs.

The inclusion criteria were:

- CPs practicing in the UK (both within NHS services and privately)
- CPs working with adult clients

The exclusion criteria were:

- Trainee CPs
- Counselling psychologists
- CPs working solely in child and adolescent services
- CPs practicing outside the UK

A research advert (see appendix A) was uploaded to the researcher's Twitter account, LinkedIn account and to a UK CPs Facebook Group. The researcher also contacted two CP professional bodies about advertising the study, who both shared the advert via their Twitter channels.

A secondary snowball sampling method was used in order to gather more participants, which involved the researcher asking qualified and trainee CPs to share the advert with other CPs.

The responses of 136 CPs have been included in the data analysis. Due to the recruitment method, it is impossible to estimate the response rate, as there is no data available on the number of CPs who read the study adverts. Ten CPs started the survey but did not complete it.

2.3.2. Qualitative Arm of the Study

Thirty-five psychologists who completed the survey offered to be contacted for interviews. To interview respondents with a range of views about the topic, a criterion sampling method was used to select psychologists for interviews. The criteria for taking part were scoring over 95% or below 80% on percentage of clients asked about abuse (the overall range of the 35 was 40% to 100% with 12 of the 35 responding 80% or lower and 18 of the 35 responding with 95% or higher).

Thirty of the psychologists who had offered to be contacted for interviews met the criteria, and 28 were contacted by email. Of those 28, 10 consented and were interviewed. This included 5 psychologists who reported that they ask their clients about whether they have a history of abuse 95% of the time or higher and 5 psychologists who reported that they ask 80% of the time or lower.

2.4. Measures

2.4.1 Quantitative Arm of the study

The online survey (see appendix C) was created using Qualtrics software and disseminated via an online link in the research advert.

The preliminary part of the survey consisted of an online participant information sheet (see appendix B), questions regarding consent to participate and questions about the participants' demographics (gender identification, ethnicities, age range, years working in the profession and service context).

The main part of the survey encompassed questions about psychologists' practices regarding enquiry into CA and CN, and was constructed by adapting the Cavanagh et al. (2004) questionnaire exploring MH professionals enquiry into CSA (Cavanagh et al., 2004). This included:

- Asking participants to estimate the percentage of clients they ask, the percentage of clients who spontaneously disclose and the percentage of clients for whom they do not know whether they have experienced CA or CN for each type of abuse and neglect (CSA, CPA, emotional abuse, physical neglect, emotional neglect). It was specified that the total must add up to 100%, for each type of abuse.

- Asking the participants to estimate the overall percentage of clients they ask about 'child abuse'.

- Asking whether client's diagnosis, gender or age impacted upon the likelihood of the participants asking about histories of CA or CN. The participants were given the options of selected 'yes' or 'no' for each.
    - Those who selected yes for any one of those questions were directed to questions which asked them to select from a list of which diagnoses, genders, and age ranges, if any, rendered them more or less likely to ask, respectively.

- Asking what percentage of disclosures of CA and CN the participants believe to be true, imagined, deliberate false allegations or the result of psychotic delusions. It was specified that the total must add up to 100%.

- Asking about the participants aetiological beliefs for depression, schizophrenia, and PTSD by asking them to rate the percentage they believe bio-genetic factors v. psychosocial factors contribute to the development of each disorder. It was specified that the total must add up to 100%.

- Asking three Likert type questions. These asked them to choose from 'Strongly agree'-'Strongly disagree' in response to the statements 'it is important that all clients be asked about histories of child abuse or neglect', 'I have the knowledge and skills to inquire about child abuse and neglect in a sensitive and effective manner' and 'I have the knowledge and skills to respond appropriately to disclosures of child abuse and neglect' (see appendix C for full survey).

At the end of the survey the participants were shown another participant information sheet detailing the information for the qualitative arm of the study (see appendix D).

2.4.2 Qualitative Arm of the Study

The semi-structured interview schedule was designed by the researcher (a trainee CP) based on the results of the survey and areas of interest from previous research on enquiry - see systematic review (Read et al., 2018a). It was then shared with the researcher's supervisor (a CP) and an independent CP for feedback and subsequently reviewed. The decision to include an independent CP in producing the interview schedule was made in order to attempt to make the questions as relevant as possible to members of the profession and to ensure that the focus was not just on areas which were of interest to the researcher and supervisor. This resulted in the addition of the question on the extent to which clients' previous notes inform likelihood of enquiry into CA/CN, and in the question on the role of the service context being moved to earlier in the interview schedule.

The semi-structured interview (see appendix E) explored psychologists' beliefs and experiences of:

- Whether psychologists should engage in routine enquiry
- The role of service context
- How psychologists find out about histories of abuse and neglect
- How a clients' previous notes inform this
- How psychologists ask
- How they feel when asking about this
- At what point they feel it is most appropriate to ask
- Times when they feel it is inappropriate to ask
- Barriers to asking
- The role of gender, age and diagnosis and other demographics
- Whether some forms of abuse are asked about more than others
- How their practice has changed over time
- How much information they record in clients' notes
- How they respond to disclosures

At the end of the interview participants were also asked 'what percentage of your clients do you ask about experiences of discrimination, poverty, and bullying in childhood?'.

The interviews were conducted and recorded using Microsoft Teams.

2.5 Procedure

2.5.1. Ethics

Permission to conduct the research was obtained by the UEL School of Psychology Research Ethics Committee (see appendix L).

2.5.2. Survey

The online Qualtrics survey was disseminated using a web link, taking the participants to the participant information sheet and survey outlined above. The data was collected anonymously but participants were given a random ID number, in case they wanted to withdraw their data after submitting their response. At the end of the survey the participants were shown a second information sheet for the qualitative arm of the survey and asked to provide their contact information if they would like to volunteer to be contacted for an interview.

The survey response data and contact information for interviews were initially stored by the Qualtrics programme. The data was then exported to a password protected Excel spreadsheet and the results of the participants who had volunteered to be contacted for interviews were reviewed. The criteria for the criterion sampling for interviews was decided at this stage (see recruitment section above). A list of interviewees was then generated in a separate password protected file, separated under two group headings. The excel spreadsheet with information linking participants survey responses to their contact information was then deleted.

The total survey responses were then exported to the Statistical Package for the Social Sciences (SPSS). The data exposing the participants contact information was immediately deleted, and a series of descriptive and inferential statistical analyses were performed (see results section). The anonymous raw quantitative data was stored on a password protected device post analysis, for this to be available for re-examination in case of publication.

2.5.3. Conducting the Interviews

The CPs who met the criteria for qualitative interviews were contacted by email. Another copy of a slightly adapted information sheet and consent form was attached to the invitation email, including information about confidentiality and anonymity (see appendix F and G).

At the beginning of the qualitative interviews the researcher provided another verbal summary of the aims of the interview and emphasised that the interviewees were not expected to be experts on the topic, that the aim was for the interview to be a non-judgemental space. The interviewees were given an opportunity to ask questions and were informed that they were welcome to withdraw from the study at any point during the interview or for up to three weeks after the interview was complete. They were also informed that they were welcome to choose not to respond to any of the questions posed by the researcher. At this point the researcher asked for verbal consent to proceed with the interview. Before beginning the recording, the researcher checked for consent to record and informed the psychologists when the recording had begun. The qualitative interviews lasted no longer than one hour and were conducted and recorded over Microsoft Teams and saved to the researcher's Microsoft Stream Library. The interviews were guided by the semi-structured interview schedule, but this was not followed strictly e.g. when participants had already answered a question in a previous response, and when the researcher spontaneously explored topics introduced by the participants.

2.5.4. Transcription

The interviews were transcribed and anonymised by the researcher on Microsoft Word. At the point of transcription, the participants were given a new participant number and the transcriptions were saved to a password protected device, labelled with the participant number and the group which the participant belonged to. Once each transcription was complete, the video recording of the corresponding interview was deleted.

As recommended by Braun & Clarke (2006), the transcribing process involved writing a verbatim account of all the verbal and non-verbal utterances, and careful attention was payed to the use of punctuation in order to ensure the meaning of the transcriptions was as close as possible to the meaning of the participants' verbal accounts.

2.5.5. Conducting the Thematic Analysis

The process of conducting the TA followed Braun & Clarke's six stages for conducting TA (Braun & Clarke, 2006).

The researcher familiarised herself with the data through the process of conducting the interviews, transcribing the interviews and re-reading the transcriptions before engaging in the initial coding process. As recommended by Braun & Clarke (2006), the researcher made notes of initial analytic reflections at every stage to actively engage with the data and begin to generate meanings and patterns in the data (Braun & Clarke, 2006).

During the coding process the researcher engaged with the entire data set systematically, to avoid bias in the analysis (Morse, 2010). The researcher was careful to ascribe codes to all the data which felt relevant to the research question, rather than being influenced by the wider themes that were beginning to emerge throughout the coding and familiarising process. Some segments received more than one code.

As aforementioned, the codes were produced semantically rather than latently, with the aim of ascribing meanings which were as close as possible to the extracts as opposed to aiming to generate more implicit meanings. The codes were also produced inductively rather than deductively (i.e. emerging directly from what the participants had reported rather than being generated on the basis of pre-determined theories in the literature).

The codes and associated extracts were sorted into initial potential themes using tables. The extracts were copied under the headings of the potential themes the researcher believed they belonged to.

The themes were then gradually refined through a process of re-reading the extracts and original data set and utilising Patton's (1990) dual criteria of internal homogeneity and external heterogeneity (e.g. some themes were merged, some were separated into two more specific themes etc.). The number of participants per theme were also reviewed, and due to the large quantity of themes, themes which included extracts from less than three participants' transcriptions were discarded. The extracts were later refined by deleting utterances, or segments of speech which were not directly relevant to the theme and replacing them with the symbol '[…]'.

2.5.6. Inter Rater Reliability

The coherence and replicability of the themes were established by comparing the level of agreement on which extracts belonged to which themes with ratings performed by an independent, blind coder (the research supervisor). This process provided some valuable structure to discussions about the initial themes, without expecting 100% agreement.

A total of thirty-two themes were initially generated. The researcher collated a list of 1-2 extracts per theme, chosen at random, and presented them to the independent coder with the list of themes. The independent coder then assigned each extract to a theme. These codes were compared to the researcher's codes. There were 26 agreements out of 42 extracts (62%). The reasons for the disagreements were recorded and utilised to further refine the themes and subthemes. The recorded reasons for disagreement are summarised below in Table 3.

Table 3. Inter Rater Reliability, Reasons for Disagreements (1)

Reason for Disagreement	Number of Disagreements Accounted For
Lack of Clarity in Theme Description	3
Extract Fit Multiple Themes	4
Extract Did not Accurately Match Theme	3
Two Themes Needing to be Merged Into One	2
Extract Needs More Context	3
Rater Error (i.e. coder misread the extract)	1

One example of this was for the following extract: P5: ‘just trying to give bit psychoeducation and then sometimes if they say something then you can say that and you know where do you think that came from, and sometimes they'll tell you’ which had been under a separate theme named ‘giving psychoeducation’ but was merged with the theme ‘asking indirectly’.

After merging ‘asking by providing psychoeducation’ into ‘asking indirectly’ and making changes to some of the theme descriptions (e.g. changing ‘recognition of lack of trauma awareness in services’ to ‘belief that other professionals neglect to ask’) the list of themes became shorter. The number was also further reduced after re-coding some of the extracts, as some themes were lacking enough responses (i.e. less than 3) once they had been moved and were therefore discarded. Furthermore, an agreement was made following a discussion during the first inter rater reliability meeting to re-structure some of the themes/ subthemes into barriers and facilitators separately. A new list of 27 themes was generated. The independent coder then repeated the process of assigning 37 different extracts to the 27 themes. There was agreement on 28/37 extracts (76%). The recorded reasons for disagreement are summarised below in Table 4.

Table 4. Inter Rater Reliability, Reasons for Disagreements (2)

Reason for Disagreement	Number of Disagreements Accounted For
Lack of Clarity in Theme Description	1
Two Themes Needing to be Merged Into One	3
Extract Did not Accurately Match Theme	1
Extract Needs More Context	2
Rater Error (i.e. rater misread the extract)	2

An example of additional context being required was in the extract: ‘you know why would you go in and tell someone you've never met before about this?’ which was changed to ‘why would you [a client] go in and tell someone you’ve never met before about this [experiences of CA/ CN]’.

An example of two themes being merged into one was the theme ‘Need to have the relationship established and fear of rupturing the relationship’ and ‘Clients won’t tell you if you ask too early’, the extract ‘I think the appropriate time to ask is when [….] you feel as if that rapport has been developed […] and there's that kind of sense of maybe safety’ was considered to apply to both.

After making these changes the final set of themes were produced by the researcher. These are reported in the qualitative results section below.

3. RESULTS

3.1. Quantitative Results:

3.1.1 Participant Demographics

The demographics and characteristics of the 136 participants who took part in the survey are summarised in table 5.

Most of the participants were aged between 31-40 years (53.7%) followed by 41-50 years (30.9%). A very high proportion of the participants were female (93.4%). The participants were able to select more than one ethnicity, or to self-identify their ethnicity. A very high proportion of the participants were white (93.4%). Most of the participants had worked in the profession for less than 5 years (33.8%), followed by 6-10 years (30.9%). The participants were able to select more than one service context. The majority reported working either in secondary care MH services (39%) and/ or in private practice (30.1%).

Table 5. Survey Participant Demographics

Demographic	Category/ Range	N (% of participants)
Age	20-30 years	10 (7.4%)
	31-40 years	73 (53.7%)
	41-50 years	42 (30.9%)
	51-60 years	11 (8.1%)
Gender	Male	8 (5.9%)
	Female	127 (93.4%)
	Third Gender/ Non-Binary	0 (0.0%)
	Prefer not to say	1 (0.7%)
Ethnicity	White	127 (93.4%)
	Asian	3 (2.2%)
	Black	1 (0.7%)
	Mixed Heritage	1 (0.7%)

	'Other'	4 (2.9%)
Years working in the profession, since qualifying	<5	46 (33.8%)
	6-10 years	42 (30.9%)
	11-15 years	20 (14.7%)
	16-20 years	15 (11%)
	21-25 years	8 (5.9%)
	26-30 years	3 (2.2%)
	31< years	2 (1.5%)
Service Context	Secondary Care, CMHT	53 (39%)
	Private Practice	41 (30.1%)
	Inpatient Services	26 (18.4%)
	Physical Health Services	16 (11.8%)
	Older Adult Services	9 (6.6%)
	Primary Care e.g. IAPT	8 (5.9%)
	Learning Disability Services	7 (5.1%)
	Drug & Alcohol Services	1 (0.7%)
	Other	17 (12.5%)

3.1.2 Clinical Psychologists' Likelihood of Asking About Histories of Childhood Abuse and Neglect

One hundred and thirty-six participants estimated the percentage of abuse and neglect experienced by their client's that they knew about because it was spontaneously disclosed, the percentage of their clients abuse and neglect that they knew about because they had asked and the percentage of abuse and neglect that their clients may have experienced but that they did not know about. The means and standard deviations of their responses are presented below in Table 6.

Table 6. Source of Knowledge of Clients' Histories of Different Forms of Child Abuse and Neglect

Measure	Mean	S.D.
Sexual Abuse		
% Spontaneously Disclosed	31.5	24.4
% Asked About	46.8	28.6
% Not Known	21.7	26.8
Physical Abuse		
% Spontaneously Disclosed	37.2	26.5
% Asked About	44.1	27.0
% Abuse Not Known	18.6	24.0
Emotional Abuse		
% Spontaneously Disclosed	37.2	26.0
% Asked About	46.8	26.8
% Not Known	16.0	20.7
Physical Neglect		
% Spontaneously Disclosed	24.7	22.6
% Asked About	46.1	30.6
% Not Known	29.2	30.0
Emotional Neglect		
% Spontaneously Disclosed	29.8	26.2
% Asked About	47.8	28.1
% Not Known	22.4	25.8

Six new variables were computed, using SPSS, to group together the variables presented in table 6, into overall abuse (Sexual Abuse, Physical Abuse and Emotional Abuse) and overall neglect (Emotional Neglect and Physical Neglect). The means and standard deviations are presented below in Table 7.

Table 7. Source of Knowledge of Clients' Histories of Child Abuse and Neglect

Measure	N	Mean	S.D.
Abuse			
% Spontaneously Disclosed	136	35.3	23.0
% Asked About	136	45.9	24.9
% Not Known	136	18.8	21.8
Neglect			
% Spontaneously Disclosed	136	27.2	21.8
% Asked About	136	46.9	27.4
% Not Known	136	25.8	25.4

One hundred and thirty-three participants responded to a subsequent question asking them to rate the overall percentage of their clients they ask about whether they have a history of child abuse. The mean was 79.9% (SD= 28.5). The mean estimate of the 8 male psychologists was 51.3% (SD= 36.0) and lower than the mean estimate of the 124 female psychologists which was 81.6% (SD = 27.1). One participant did not disclose their gender.

3.1.3. Impact of Client's Diagnosis, Gender and Age on Likelihood of Asking about Abuse and Neglect

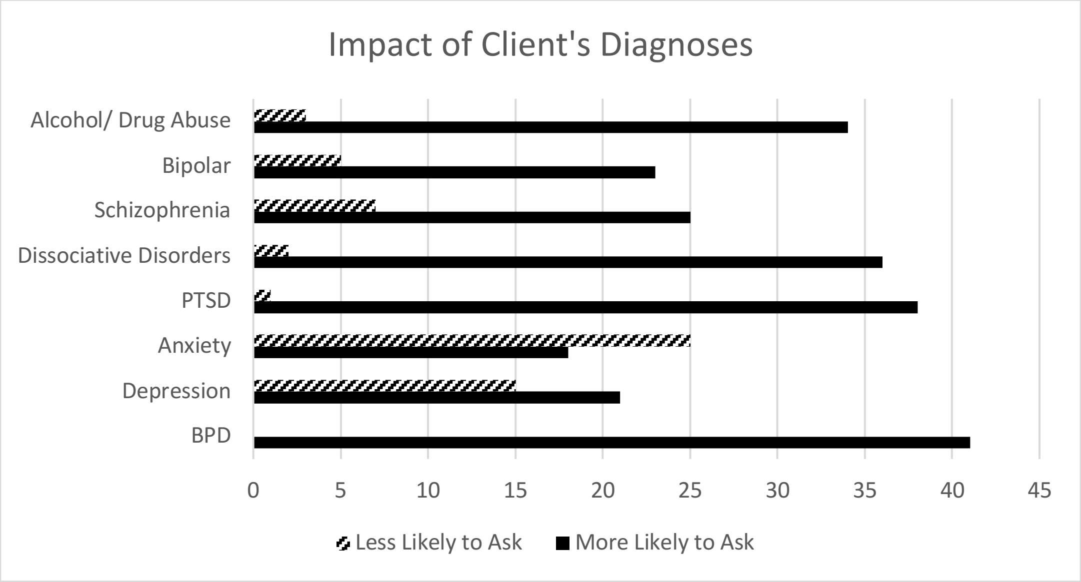
The participants were asked about whether client's diagnosis, gender or age may impact upon their likelihood of enquiring about past histories of abuse and neglect. 43 (31.9%) psychologists reported that diagnosis may impact their likelihood of asking, 19 (14.3%) reported that client's gender may impact upon their likelihood of asking and 18 (13.5%) reported that client's age may impact upon their likelihood of asking. See Table 8 below for overall frequencies.

Table 8. Impact of Client's Gender, Diagnosis and Age

Demographics	N (%) Reporting enquiry practice impacted by these demographics	N total
Diagnosis	43 (31.9%)	135
Gender	19 (14.3%)	133
Age	18 (13.5%)	133

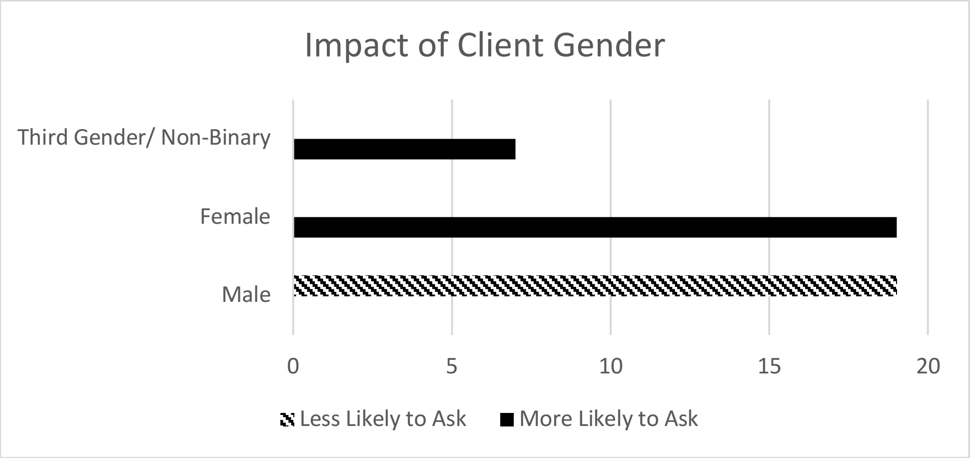
Of the 43 psychologists who reported that client's diagnosis may impact upon their likelihood of asking, 41 reported that they were more likely to ask a client with a diagnosis of Borderline Personality Disorder, 38 reported that they were more likely to ask a client with a diagnosis of PTSD, 36 reported that they were more likely to ask a client with a diagnosis of dissociative disorder and 34 reported that they were more likely to ask a client with a diagnosis of alcohol and drug use. 25 reported they were *less* likely to ask clients with a diagnosis of an anxiety disorder and 15 reported they were likely to ask clients with a diagnosis of depression. For a visual summary of the frequencies of diagnoses that psychologists reported rendered them more likely to ask and less likely to ask, see Figure 2.

Figure 2. Impact of Client's Diagnosis



Of the 19 participants who reported that client's gender may impact upon their likelihood of asking, 19 reported they were more likely to ask female clients, 7 reported they were most likely to ask clients who identify as non-binary or being third gender and 19 reported they were less likely to ask male clients. See Figure 3. below for a visual representation.

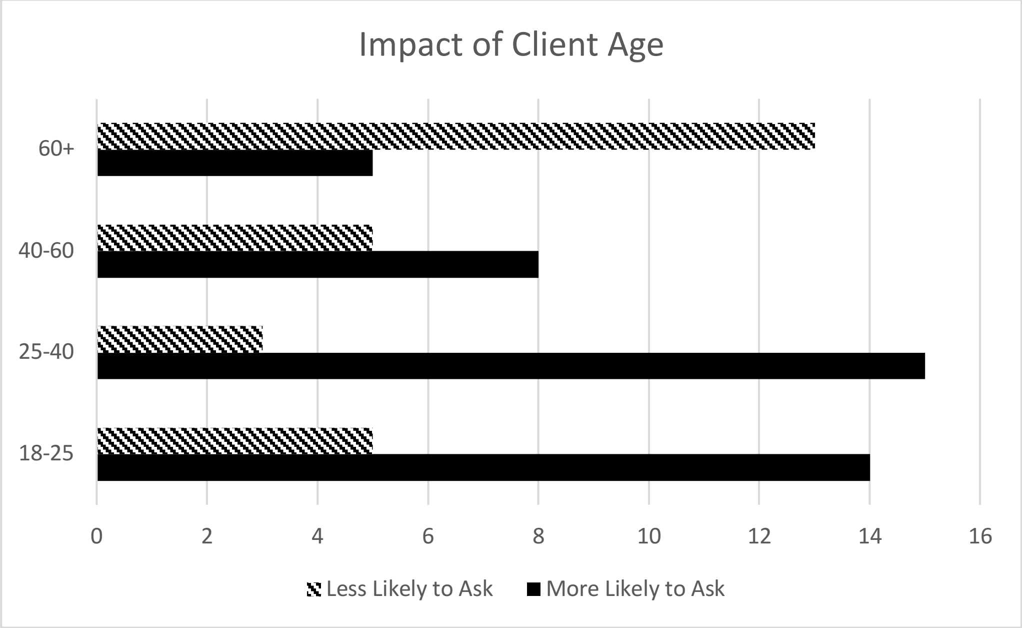
Figure 3. Impact of Client's Gender



Finally, of the 18 psychologists who reported that client's age may impact upon their likelihood of asking, 14 reported they were more likely to ask clients aged

18-25, 15 reported they were more likely to ask clients aged 25-40 and 13 reported they were less likely to ask clients aged 60+. For a visual summary see Figure 4.

Figure 4. Impact of Client's Age



3.1.4. Beliefs about Disclosures of Childhood Abuse and Neglect

One hundred and twenty-nine psychologists responded to a question asking them to estimate the percentage of disclosures of abuse or neglect they believed to be true, to be the result of psychotic delusions, to be imagined or to be deliberate false allegations. The psychologists were asked to ensure that the total sum added up to 100 percent. The means and standard deviations are listed below in table 9.

Table 9. Disclosure Beliefs

Disclosure Beliefs	N	Mean	S.D.
% Of Disclosures believed to be true	129	95.0	5.6
% Of Disclosures believed to be the result of psychotic delusions	129	3.0	2.9
% Of Disclosures believed to be imagined	129	1.5	2.3

% Of Disclosures believed to be deliberate false allegations	129	1.41	2.2

3.1.5 Beliefs about the Causation of Disorders by Diagnosis

One hundred and twenty-six psychologists responded to a question that asked them to rate the percentage of bio-genetic factors versus psychosocial factors they believed contributed to the causation of depression, PTSD and schizophrenia. The psychologists were asked to ensure that the sum added up to 100 percent for each diagnosis. The means and standard deviations are listed in table 10.

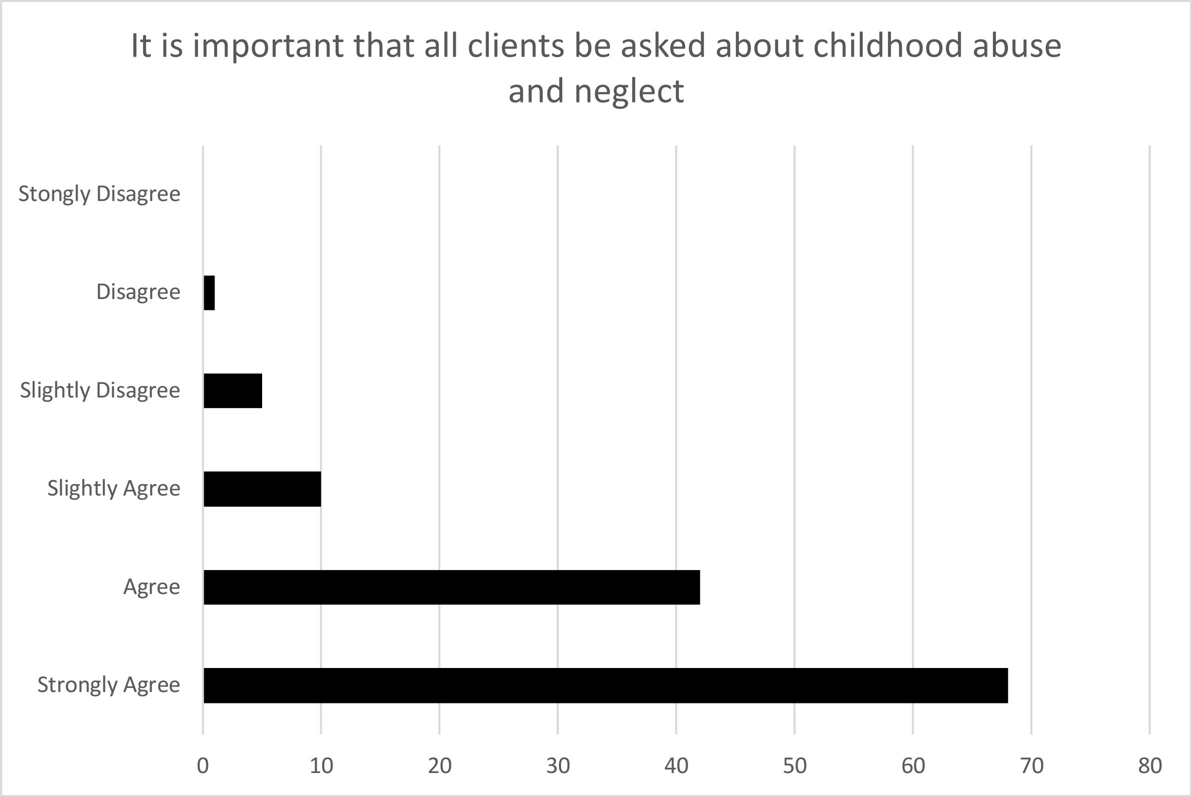
Table 10. Aetiological Beliefs

Diagnosis	N	Biogenetic Factors Mean (SD)	Psychosocial Factors Mean (SD)
Depression	126	17.2 (12.1)	82.8 (12.1)
PTSD	126	8.9 (8.6)	91.1 (8.6)
Schizophrenia	126	22.2 (18.0)	77.7 (18.0)

3.1.6 Beliefs about the Importance of Routine Enquiry

One hundred and twenty-six psychologists responded to a Likert type question on how important they believe it is that all clients be asked about childhood abuse and neglect. 68 (50%) reported that they strongly agree, and 42 (30.9%) reported that they agree. See Figure 5.

Figure 5. Belief in Importance of Routine Enquiry



3.1.7. Psychologists Confidence in their Skills to Enquire about Childhood Abuse and Neglect and Skills to Respond to Disclosures of Childhood Abuse and Neglect

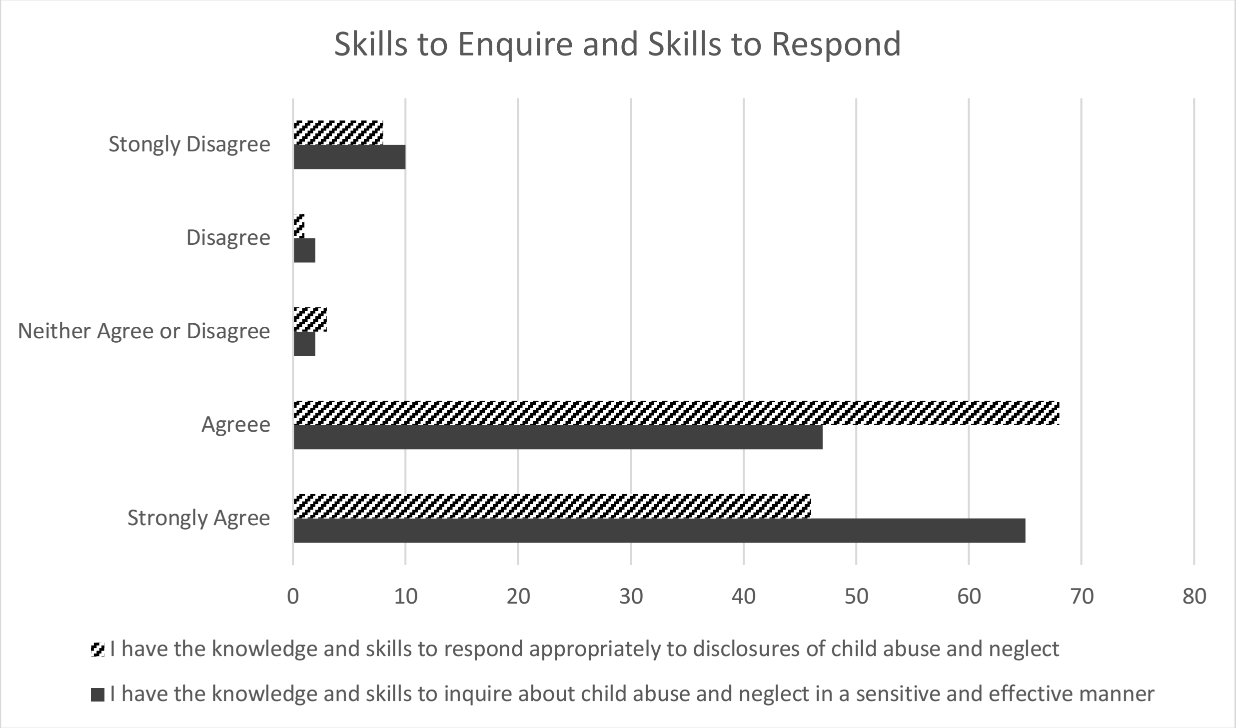
One hundred and twenty-six psychologists responded on Likert scales to the statements ‘I have the knowledge and skills to inquire about child abuse and neglect in a sensitive and effective manner’ and ‘I have the knowledge and skills to respond appropriately to disclosures of child abuse and neglect’.

With regards to the statement ‘I have the knowledge and skills to inquire about child abuse and neglect in a sensitive and effective manner’ 65 (47.8%) psychologists reported that they strongly agree and 47 (34.6%) reported that they agree.

With regards to the statement ‘I have the knowledge and skills to respond appropriately to disclosures of child abuse and neglect’ 46 (33.8%) reported that they strongly agree and 68 (50%) reported that they agree.

For a visual summary of confidence in skills to enquire and skills to respond see Figure 6.

Figure 6. Skills to Enquire and Skills to Respond



3.1.8. Shapiro Wilk Statistics Measuring Normality of the Data

A Shapiro wilk test was run on the continuous variables of interest. This showed a significant departure from normality for all of the variables tested, except for the percentage of overall abuse asked about.

3.1.9. Comparison of Measures for Childhood Abuse v. Childhood Neglect

Given that the data was non-normal a Wilcoxon Signed Ranks test was used to compare the percentage of abuse asked by psychologists with the percentage of neglect asked by psychologists, the percentage of abuse not known by psychologists with the percentage of neglect not known by psychologists and the percentage of abuse spontaneously disclosed to psychologists and percentage of neglect spontaneously disclosed to psychologists.

There was no statistically significant difference between percentage asked about abuse (M=45.9, SD=25.0) and percentage asked about neglect (M=46.9, SD=27.4); Z=-0.82, p= 0.412. However, there was a statistically significant difference between % not know about abuse (M=18.8, SD=21.8) and percentage not known about neglect (M=25.8, SD=25.4); Z=-5.06, p= <0.001 and a statistically significant difference between % of abuse spontaneously disclosed (M=35.3, SD=23.0) and percentage of neglect spontaneously disclosed (M=27.2, SD=21.8); Z=6.38, p<0.001.

3.1.10. Relationship between Psychologists' Likelihood of Asking and Other Variables

Spearman's Rank correlations were used to investigate the relationship between the overall percentage asked about abuse and a number of other variables of interest (see table 11, below). Spearman's Rank (rather than Pearsons) was used because the continuous variables in this data set were not normally distributed, and the other variables were ordinal and therefore also non-parametric.

There was a statistically significant relationship between believing in the importance of engaging in routine enquiry and likelihood of asking, and in feeling skilled in enquiring about and responding to disclosures of childhood abuse and neglect and likelihood of asking. All other variables were unrelated.

Table 11. Relationship Between Overall Percentage Asked about Child Abuse and Other Variables

Variable	R (df)	P
Belief in importance of routine enquiry	-0.56 (121)	<0.001
Skills		
Skills to enquire	0.33 (121)	<0.001
Skills to respond	0.23 (121)	0.01
Aetiological Beliefs		
% Psychosocial factors for depression	-0.06 (121)	0.54
% Psychosocial factors for PTSD	0.00 (121)	1.00
% Psychosocial factors for schizophrenia	-0.35 (121)	0.70
Disclosure Beliefs		
% Believed to be True	0.10 (124)	0.24
% Believed to be the Result of Psychotic Delusions	-0.00 (124)	0.98
% Believed to be Imagined	-0.09 (124)	0.30
% Believed to be Deliberate False Allegations	0.02 (124)	0.80
Psychologists' characteristics		
Psychologists' age	-0.20 (131)	0.82
Years working in the profession	-0.13 (131)	0.15

3.2. Qualitative Results

3.2.1. Participant Demographics

The demographics of the ten interviewees are presented in Table 12.

Table 12. Demographics of Interviewees

Demographic	Category/ Range	N (% of participants)
Age	31-40 years	4 (40%)
	41-50 years	5 (50%)
	51-60 years	1 (10%)
Gender	Female	10 (100%)
Ethnicity	White	9 (90%)
	Mixed Heritage	1 (10%)
Years working in the profession, since qualifying	<5	5 (50%)
	11-15 years	1 (10%)
	21-25 years	3 (30%)
	26-30 years	1 (10%)
Service Context	Secondary Care, CMHT	4 (40%)
	Private Practice	3 (30%)
	Inpatient Services	1 (10%)
	Physical Health Services	2 (20%)
	Drug & Alcohol Services	1 (10%)
	Other (homelessness or gender services)	2 (20%)

3.2.2. Results of the Thematic Analysis

Due to the large number of potential themes and sub-themes, a decision was made to have a minimum of three participants per sub-theme. The main overarching themes related to barriers to asking routinely were ‘Perceptions of the Remit of the Work’, ‘Deciding Intuitively Whether to Ask’ and ‘Therapist’s Fears’. The main overarching themes related to facilitators to asking routinely were ‘Beliefs that Motivate Psychologists to Ask’ and ‘Factors which Enable Asking’. Other themes were associated to how psychologists ask, how psychologists respond and how psychologists record histories of CA/CN in clinical notes. See Table 13 for a full summary of themes, sub-themes and a record of the participants whose responses belonged to each theme.

Table 13. Table of Themes Generated by Thematic Analysis

Themes	**Participants**
1. Barriers to Asking Routinely	
1.1 Perceptions of the Remit of the Work	
1.1.1 The focus on the Presenting Problem	6 (P2, P4, P5, P6, P8, P10)
1.1.2 Limited Time due to Service Context	4 (P1, P6, P8, P9)
1.2 Deciding Intuitively Whether to Ask	3 (P1, P6, P10)
1.3 Therapist's Fears	
1.3.1. Men Presenting as angry or Avoidant	4 (P3, P4, P6, P10)
1.3.2. Fear of Harming the Client	5 (P1, P4, P5, P6, P10)
1.3.3. Therapist's Belief that the Client does not want to be asked	5 (P1, P2, P5, P6, P10)
1.3.4. Only Asking Once Therapeutic Relationship is Established	5 (P1, P4, P5, P6, P8)
1.3.5 Impact of Hearing it on the Therapist	5 (P1, P3, P6, P7, P10)
2. Facilitators to Asking Routinely	
2.1. Beliefs that Motivate Psychologists to Ask	
2.1.1. Belief that Recognising a Client's History of CA and/ or CN is Important and Relevant	10 (P1, P2, P3, P4, P5, P6, P7, P8, P9, P10)
2.1.2. Belief that Other Professionals Neglect to Ask	3 (P3, P7, P9)
2.2. Factors Which Enable Asking	

2.2.1. Gaining Confidence Through Experience and Training	4 (P3, P4, P5, P7)
2.2.2. Supportive Service Culture	5 (P3, P4, P6, P8, P10)
3. How Psychologists Ask	
3.1. Asking Directly	4 (P3, P6, P7, P9)
3.2. Asking Indirectly	5 (P1, P2, P5, P8, P10)
3.3. Giving the Client an Opt out	5 (P1, P4, P5, P8, P9)
4. How Psychologists Respond	
4.1. The Power of Listening	3 (P1, P4, P5)
4.2. The Power of Validating	3 (P3, P4, P7)
4.3. Formulating with the Client	6 (P1, P3, P4, P5, P9, P10)
4.4. Grounding the Client	4 (P1, P4, P6, P7)
5. How Psychologists Record Histories of CA/ CN in clients' notes	
5.1. Keeping Detailed Notes for Other Professionals Understanding	3 (P3, P6, P7)
5.2. Keeping Minimal Notes	3 (P2, P4, P8)
5.3. Recording if Client Denies Abuse	4 (P1, P4, P8, P9)

3.2.3. Barriers to Asking Routinely

Participants reported several barriers to their engaging in routine enquiry.

3.2.3.1. Perceptions of the Remit of the Work

Many participants reported that whether they would enquire about histories of CA/ CN may be dependent on their perception of the remit of the work. Some believed that the remit of the work was to only focus on the client's presenting problem, while others thought the remit of the work was impacted by the length of time they believed they had to offer support to the client.

<u>The focus of the work is dependent on the presenting problem:</u>

Six participants reported there may be times when a client's presentation did not seem indicative of a likely history of CA and/ or CN and that this may render them less likely to ask (e.g. when the client's presentation is mild or the client is requesting support with what appears to be a 'here and now' problem):

P4: 'if it's […] anxiety or kind of, you know, sort of relatively minor depression, I do think automatically you would be less likely to assume or to go [to asking about childhood trauma].'

P6: 'I think it depends what they present [with], so it might be that they have a dog phobia or something, and then it's very focused on the dog phobia and doing exposure but actually […] there could be many, many things leading to the dog phobia'

Most of these participants acknowledged that this may result in them missing relevant information. Two participants described scenarios where this had occurred, where they had later discovered that the client had experienced CA and or CN. On both occasions they reported that the lack of awareness of the client's history had negatively impacted upon the work e.g.:

P8: 'she was referred because she was agoraphobic, but there was just something that just wasn't right, I mean, we're kind of doing all the work […] it took till about appointment five before she then started telling me about her *history. […] but yeah, maybe in that instance it would have been helpful to think about, is there anything else going on that you think might be contributing to this rather than focusing on the problem in hand*'

This may highlight that the barrier of 'focusing on the presenting problem', may result in clients not being able to disclose their histories of CA and or CN in a timely manner, and may negatively impact upon the client's ability to access appropriate care.

Limited Time due to Service Context:

Four participants also reported that in service contexts where the length of involvement with the client is either brief or uncertain, they were less likely to explore histories of CA/ CN:

P8: "I think there's a reluctance if you've only got 8 sessions, 10 sessions, […] to actually ask that question, because I think people worry about opening that can of worms […] I guess from a clinician point of view it can feel quite erm unsatisfying knowing that […] you're not able to help that person resolve everything within the time you have available"

P9: "we don't go into as much detail in the inpatient environment. We do sometimes have people that want to do trauma work when they're in an inpatient environment, and it's really inappropriate to do that because people aren't in an inpatient environment for very long […] Then you'd just be leaving them, dropping them in the middle trauma work"

There was a sense from all four participants that not having enough time to complete the work could be a barrier, and in all cases, this seemed to be at least in part related to the fear that once conversations about histories of CA/ CN had been opened up, it was important to have enough time and space to be able to offer the client a full piece of trauma work.

3.2.3.2. Deciding Intuitively Whether to Ask

Deciding intuitively whether to ask may be considered a barrier to routine enquiry, as this runs the risk of many clients not being asked about histories of CA/ CN.

Three participants reported that they were more likely to be prompted to ask if they sensed that the client was likely to have experienced CA/ CN, based on their interpersonal presentation:

P10: "I listen out for who they're not talking about, because I think that's often a clue […]. I guess I also look for relational clues in the therapeutic alliance, […] you know for me that's quite a clue [if] somebody is extremely ashamed and mistrustful and if I have that sense, I almost always have 'ok, there's definitely something that's gone on here."

P1: "there's just a gut feeling of like oh, I feel like they're trying to tell me something or something feels a bit off here […] I try and like kind of listen to that and think about that and maybe ask"

There was a sense that rather than routinely asking all clients about histories of CA/ CN, many reported holding the possibility of a client having a history CA/ CN in mind and looking for signs or clues regarding this via client's verbal or non-verbal communication. It appeared many of the participants were motivated to work this way, due to a belief that this was a more 'attuned' way of working with clients. However, as aforementioned this may be considered a barrier given that this runs the risk of many clients not being asked.

3.2.3.3. Therapists' fears

Many subthemes regarding barriers were generated under the overarching theme 'Therapists' fears'. Some of these subthemes related to fears of making the client angry, making a mistake, harming the client, or harming the therapeutic relationship. However, one of these subthemes was associated to therapists' fears about the impact on their own wellbeing.

Men presenting as angry or avoidant:

Four of the participants described male clients who had experienced CA or CN as presenting as 'angry'. Two reported that this did not impact upon their practice, as they were familiar and experienced in working with this group. Whereas the other two reported that this may be a barrier to their asking men about abuse.

P3: "I think particularly sexual abuse is something that men have a lot of shame about, erm and the men who have been sexually abused who I have seen quite often present in more antisocial or paranoid or more generally aggressive ways, because they were defending themselves, to keep people away"

P6: "I do feel that with the guys there is much more anger and so it might sort of… […] it keeps me at a distance bit more"

This may also suggest that a general barrier to asking may be a fear of how the client may react/ respond to questions about CA/ CN.

Fear of Harming the Client:

Several participants alluded to fears that asking clients about histories of CA/CN, or asking in the wrong way, may be harmful to the client, which was perceived as a potential barrier to asking the question.

Two spoke about fear of harming the client by asking the question too directly, and viewed this as potentially coercive:

P5: 'it's almost that expectation, I'll ask you the question [and] you tell me the answer […] particularly for people who have been abused, they need to feel in control and as soon as you ask them something […] they will maybe say something because they feel under pressure"

P1: ‘there's nothing therapeutic in forcing someone to talk about something […] like forcing or trying to control someone to go somewhere, and in what might feel like a coercive way’

Both appeared to hold views about the importance of explorations about CA and or CN taking place when this was initiated by the client. Both believed that asking the question too directly could in some way mirror the abuse that clients had experienced in their early life.

Three participants spoke about fear of harming the client by asking the question in the wrong way and/ or feeling nervous when asking the question:

P4: ‘I get a sense of feeling like there's a need to tread very carefully and be very careful and thoughtful about words and language, […] so there's almost a bit of […] trepidation’

P6: ’at times you feel also that you are wearing gloves. [….] you kind of walk on eggshells and that you don't want to go too fast or too slow […] kind of just right’

Although these participants reported that there were times when they may ask clients about histories of CA/ CN more directly, they felt that they needed to be cautious when approaching this exploration. This may reflect a desire to approach the topic sensitively, but equally may be suggestive of an underlying belief that asking the question may harm the client or the therapeutic relationship in some way.

Therapist’s belief/ assumption that the Client does not want to be asked:

Three participants reported that they believed that clients would have difficulty talking about their experiences of CA and CN, if asked:

P5: ‘you realise just how naive is to think that everybody will tell you about their abuse when invited. [Two recent clients] couldn't speak about their abuse […]

they're not going to, we are missing a huge percentage of people who have been abused who are never going to tell you about it [we must] allow them to take their time […] always keeping an open mind that there might be something there that they may tell you at session 10'

P8: 'often the first emotion that will emerge will be around fear, but usually behind that there may be things about shame and people don't like talking about shame or feeling ashamed'

These comments appeared to imply that due to clients' discomfort, it was better not to ask.

Three participants reported that they would avoid asking, if they believed that the client was communicating that they did not want to talk about it:

P1: 'sometimes people don't want to go there, or you can very .. you know you can, can really sense in a session that they feel uncomfortable to kind of do that'

P4: 'if there was a lot of a lot of defensiveness or […] if I was getting that message […] like don't go there or don't ask then I might not, erm but that would probably come from having kind of took gone near that topic and then got that impression rather than there just being a real obvious reason not to approach it at all'

It appeared as though the belief that clients were communicating that they did not want to be asked was being interpreted via the client's non-verbal communication. Therefore, it appeared as though a barrier to asking was the psychologist having a 'hunch' that the client did not want to be asked. It may be possible that clients appeared uncomfortable to the psychologists due to the psychologists' own discomfort around asking the question, or simply because it is a painful topic, rather than due to the clients not wanting to be asked. This also suggests that this perceived discomfort resulted in the psychologists avoiding asking the question, which denied the client the opportunity to either disclose or decide to decline to answer.

Five participants reported that rather than asking their clients about whether they had experienced CA or CN, they would aim to be led by what the client was willing to bring up spontaneously:

P10: 'it's intriguing that some people I end up doing very much […] traditional physical health interventions [with] and I do suspect that some of those may have a history of neglect or abuse. However, is it something that is err kind of currently emotionally a problem? No, because they're not really bringing it'

P1: 'trying to focus the session on […] what's important for them. What do they kind of want to work on and […] not being too hard driven on like in my mind, I must ask this or I want to kind of go there'

It appears some of the psychologists believed that rather than taking an active role in enabling potential disclosures of CA and or CN, it was more important to work with the client on what they were willing to bring spontaneously to the therapeutic encounter. This may suggest that some psychologists have the expectation that clients do not want to be asked and that clients will spontaneously disclose their experiences of CA/ CN if is considered relevant to the work. Previous research suggests, however, that clients are unlikely to spontaneously disclose and would welcome being asked.

Only asking once the therapeutic relationship is established and fear of rupturing the relationship:

Five participants reported that the most appropriate time to ask would be once the therapeutic relationship was established.

P1: 'I think the appropriate time to ask is when [….] you feel as if that rapport has been developed […] and there's that kind of sense of maybe safety'

P6: 'I think trust is such a big thing, especially if that happened to them in the past, so I can understand if they don't feel like talking about it immediately, and it's quite weird of course, because like it's the 1st maybe your first meeting with them and then you ask these very emotive subjects'

Of those five, two also spoke about a fear that opening up conversations about CA or CN too early could lead to a rupture in the relationship:

P5: '[the time to ask is when] they feel psychologically safe within the therapeutic situation, you don't want them to suddenly feel on edge or unsafe, they just won't come back'.

The belief that it is best to have established the therapeutic relationship before engaging in exploration about histories of CA and or CN appears to be common. However, this may be considered a barrier given that only asking once the therapist perceives the therapeutic relationship as being built, is not akin to asking routinely. Moreover, previous research suggests that some clients who have been abused or neglected may struggle to develop a trusting therapeutic relationship with psychologists who do not ask them about CA and/ or CN. Furthermore, as was highlighted by one of the participants who reported holding a belief about the importance of asking early:

P7: '*if you don't [ask] really, really early on, then you establish a relationship where that's not safe, so if you do ask later, the client won't tell you, because you sort of let them know that you don't wanna hear'*

Impact of Hearing it on the Therapist:

Five participants spoke about the ways in which hearing about CA and CN could impact upon their own emotional wellbeing. Some reported that they were able to manage this utilising supervision. All five, however, reported that this could be a barrier if they were not provided with adequate support to manage the impact.

P3: ‘occasionally something does really kind of shock me and I feel quite upset about it and it will bother me for a few days, […] but again I think I tidy up using my supervision and using my own therapy’

P6: ‘my body can kind of feel all cramped because of all this stress that the patient is actually having’

P7: ‘I think that a barrier that I overcame […] is that sense of can I hear this? […] Can I stay intact? Can I stay within my window of tolerance and functioning as a thinking, feeling person with this other person and hear this information? Erm and so sometimes people might be scared, can I handle it? and what will I do with it?’

P10: ‘I think people who are overloaded and burnt out and less likely to ask about it, because you know, they’re less, they're less able to hear it. You'll only hear what you're able to hear’

The recognition that hearing clients’ experiences of CA/ CN could have a significant impact upon the psychologists’ own emotional wellbeing, and that this could consciously or unconsciously impact upon their ability to hear disclosures and therefore their likelihood of asking appeared to be an important barrier to routine enquiry. This may suggest that for a number of psychologists, there was a sense that in order to work in a more trauma informed way, services would need to provide additional support and resources (see subtheme ‘Supportive Service Culture’ theme under ‘Facilitators to Asking’).

3.2.4. Facilitators to Asking

Participants reported several facilitators to their asking about histories of CA/ CN.

3.2.4.1. Beliefs that motivate psychologists to ask

Belief that understanding a client’s history of CA and/ or CN is important and relevant

Both participants who reported engaging in routine enquiry and those who reported aiming to facilitate disclosures via other means reported that they believed that histories of CA and or CN were either common and/or relevant for therapy.

Eight participants reported that they believed that many of the clients they see in services and/or privately are likely to have experienced CA and/ or CN. Seven participants also believed experiences of CA and CN were likely to have an impact on the client's presenting difficulties:

P7: 'their histories are going be super relevant to what's going on and what's brought them to therapy, what they might want our help with'

P4: 'I would probably expect that [for] the majority of people that we come into contact with, this is quite likely to be a part of their history, and [….] our very early experiences […] often do impact and shape […] later presentation of difficulties into mental health services'

P8: 'I think there's an awful lot of stuff […] that people experience in early life which can influence what brings them into a psychological referral pathway, so I do think we should [ask]'

P3: 'I work in a personality disorder service […] and the majority of people that we see have had some really difficult childhoods, erm so I think it's really important to ask about abuse and neglect and I think that even if I worked somewhere else, I would take that practice with me.'

This suggests that on the whole the profession of psychology holds the stance that trauma is a key aetiological factor in the development of MH difficulties, and that this is a significant motivator for exploring histories of CA and/ or CN with clients.

Belief that other professionals neglect to ask

Three of the participants who had strong beliefs about the importance of exploring histories of CA and CN routinely, also had views about the likelihood of other professionals neglecting to ask:

P9: 'What I found really fascinating in my career is that I seem to get an awful lot of disclosures and getting disclosures from people that have had a care coordinator for 15-20 years that they've not disclosed to and I don't think it's because there's anything magical about me or that I'm just amazing at building up these relationships. I think it's because I actually ask and I think a lot of people are too, feel too awkward about asking'

P3: 'So quite often we end up with somebody […] they might be known [to services] for 15 years, bouncing around different services and their notes say 'had a happy childhood' and you're like, how? How could they have had a happy childhood?'

The three participants who reported beliefs about other professionals neglecting to ask were the three participants who reported the strongest beliefs in the importance of asking clients about histories of CA and/ or CN routinely. All alluded to believing that it was their duty to support clients to talk about these experiences.

3.2.4.2. Factors which enable asking

Gaining confidence through experience and training

Gaining confidence through experience and training, in both knowing how to ask and how to respond, appeared to be an important facilitator to asking.
Two participants reported that experience in the field had enabled them to feel more confident about asking, and two reported that training on trauma informed approaches had increased their confidence:

P3: ‘I don't think I had the confidence to ask people in the way that I do now [before working in a specialist trauma informed personality disorder service]. I think I would have had to have an indication that something had happened in order to ask […] I essentially think that I've become more confident rather than my beliefs about it changing. I think I [always] thought it was important, but I also was too scared to ask in case I upset someone.’

P7: ‘the EMDR training definitely massively, massively increased my confidence working in a trauma informed way, and I think probably because […] I now feel I've got the tools; I've got something to offer’

It appears developing confidence in asking and responding particularly reduced fears of harming the client. P7’s report that gaining skills in working in offering trauma informed care may also be associated to a reduction in fear of harming the client, as this may suggest that having something meaningful to offer in response to a disclosure made the disclosure worthwhile for the client.

Supportive service culture

Five participants spoke about the importance of having a supportive service culture for working in a trauma informed way:

P6: ‘I do think our team is really good and they […] realized that […] we get more […] complex patients […]. They already said […], don't take too many people on your caseloads, take care of yourself, always plan half an hour of like free time after patient to like de-stress’

P3: ‘I work somewhere very supportive, and I have the space to go and talk to someone, if someone tells me something horrendous.’

P10: ‘you have to have good supervision; you have to have good support around you and if you don't I think [you’re] probably less likely to ask about it’

P8: ‘I wonder whether we don't really support our colleagues well enough to think about […] how they acknowledge that there is stuff there [or ask] ‘what do you think we should do in terms of helping you deal with this?’’

This subtheme may be considered linked to the barrier ‘Impact on the therapist’. As previously reported several psychologists reported that the emotional impact of hearing about CA and or CN could be significant and could result in being less able to hear disclosures. It was therefore interesting to hear about the role of a supportive service culture in buffering this and about some psychologists’ perspectives that a lack of support may be a barrier to asking.

3.2.5. How people ask

There was a split between participants who advocated for the importance of asking directly (i.e. due to the belief that asking directly gives permission) versus participants who believed in asking indirectly in order to enable clients to disclose at their own pace.

3.2.5.1. Asking Directly

Three participants reported that they ask clients direct questions about whether they have had a history of CA or CN:

P3: ‘I'll ask them about their childhood [and ask about relationships], if I don't get information that way erm.. then I also sometimes just quite bluntly ask, I say, ‘was there ever any abuse in your childhood and that can mean kind of sexual, physical, emotional, being neglected erm it's something that quite commonly people talk about here, was there anything like that in your history, or anything that you felt a bit uncomfortable about and you're not sure about, and people generally volunteer the information in assessments’

P9: ‘I have my own assessment proforma […] which I've written so I follow that and one of the questions on there I specifically ask them about abuse and experiences of abuses’

Three also commented on their views about the role this has in giving client's permission to talk about it and communicating that they as therapists can hear it:

P9: 'I think [asking directly] gives permission, because I think they think well, this person is obviously asking this question because this is what they do, so it gives them permission that they can open up and bring difficult conversations and bring difficult topics'

P7: 'asking the questions after they've shared something with us shows that we're hearing them and shows that we've got that framework and we're open to them bringing the difficult stuff […] and if we we're missing that then unconsciously we're sort of telling them that this isn't a safe space'

3.2.5.2. Asking Indirectly

However, five participants reported that they felt it was more appropriate to ask indirectly:

P8: 'you know you don't go in there and sort of say well, have you been abused in childhood and a really stark question like that, it's more about you know are there other things that have happened in the past that […] have made life more difficult? Or you think have contributed to difficulties now?'

P5: 'so just trying to give bit psychoeducation and then and then sometimes if they say something then you can say […] 'and you know where do you think that came from'[…] I think that if you go in with too blunt an approach for some people they'll just never come back.'

All of the participants who reported asking indirectly appeared to approach explorations of CA/ CN though asking broader questions about early life experiences and relationships or by providing psychoeducation about the potential impact of childhood trauma on presenting difficulties with the aim of facilitating opportunities for clients to spontaneously disclose. There was a sense that asking too directly may be too forceful or insensitive and may impact upon their ability to engage with the therapeutic process, as discussed early in the themes ‘fear of harming the client’, ‘therapist’s belief/ assumption that the client does not want to be asked’ and ‘only asking once the therapeutic relationship is established and fear of rupturing the relationship’.

3.2.4.3. Giving the client an opt out

Five participants preface asking by communicating to their client that they do not have to respond or go into detail if they do not want to:

P8: ‘I don't think it's inappropriate to ask, but I think it's how you ask. I think you have to give people a way out so that they can avoid answering the question if they don't want to that day.’

P4: ‘I think there's that recognition of erm like I know this is a difficult question and you don't have to go into detail now, but just for erm sort of awareness is, is this something that's happened?’

Again, there was a sense that the psychologists felt the need to provide clients with an opt out. P1 and P5 both reported this as well as being fearful that asking too directly about histories of CA/ CN may lead to the client feeling pressurised to disclose when they may not feel ready. There may also be some overlap between the subthemes ‘Asking Indirectly’, ‘Giving the Client an Opt Out’ and the subthemes of ‘Therapist’s belief/ assumption that the Client does not want to be asked’ or ‘Fear of Harming the Client’.

3.2.6. How people respond

When the participants were asked about how they respond to disclosures of CA/ CN most referred to utilising core therapeutic skills as opposed to specific trauma informed therapy models:

3.2.6.1. The Power of Listening

For example, three reported that they believed that demonstrating that they were listening to their clients, following a disclosure of CA and/ or CN could be therapeutic:

P5: ‘Listening to it […] showing that you're listening to it is very powerful for them’

P1: ‘I think kind of like listening in, attuning to that person, […] respecting that, and feeding that back, I think it is a really helpful experience in and of itself’

3.2.6.2. The Power of Validating

Three participants reported that validating their clients distress following a disclosure could be therapeutic:

P3: ‘I often say that that's horrendous, that's horrible, I say that that sounds really awful, I'm really sorry that happened to you’

P7: ‘I will always sort of overemphasize, so ‘this is REALLY sad’, ‘that was dreadful’, ‘that must have been terrifying for you’ or ‘you must have been full of rage’ and again, it's that sense of if the client knows I can go there, so if I can go to rage and the client goes to me ‘Oh no, I was just a bit annoyed’ fine, I can come back, but if I say, ‘Oh yeah, that must have been a bit annoying’ and actually the client was full of rage. Can they go back? and do they know that it's safe?’

3.2.6.3. Formulating with the client (and using this to reduce shame)

Six participants spoke about formulating with the client about how their current difficulties could be made sense of in terms of their experiences of CA/ CN, and of these six four made specific reference to utilising this in order to reduce shame:

P1: ‘formulate and make sense of […] it's not your fault maybe that you struggle with anger now or […] it makes complete sense that you have difficulties in your *relationships, or it makes a lot of sense to me that maybe you do use substances as a way to kind of manage emotions or difficult feelings in the body. So it's kind of not. You know, it's not your fault, so that kind of non-shaming approach.'*

P3: 'you know it makes a lot of sense that you'd have really big problems with your emotions now, or erm that you wouldn't know how to manage them when you have those experiences, or does not that make a lot of sense in terms of your relationships, that you don't feel trusting of people […] that that shouldn't ever have happened to you, that's not your fault.'

3.2.6.4. Grounding the client

Finally, four participants spoke about the importance of grounding the client, particularly at the end of the session after speaking about histories of CA/ CN:

P1: 'it's really important to name perhaps that you've talked about lots of difficult stuff and kind of ground back in that present moment […] how can we just bring our minds back to, you know, we're here in this room. What are your plans for today? What can you do if you feel difficult, what can you do if you're struggling between now and our next session and all those kinds of like more process type stuff just to help contain, help it be a containing experience'

P7: 'at the end of every session I will say 'we've really, we've been in touch with some really painful emotions today, how are you going to look after yourself? What're you gonna do? What nice things can you do for yourself?' So a lot of kind of emotion work in there.'

The use of core therapeutic skills in responding to disclosures of CA/ CN may serve to illustrate that rather than trying to 'fix' or 'rescue' the client, the psychologists believed primarily in facilitating a safe space where the client is enabled to feel heard, understood and supported to make sense of the impact of their difficulties, in a manner which is thought to reduce shame and empower the client. The recognition of the importance of grounding my also serve to illustrate the psychologists' beliefs in the importance of recognising the sensitivity of the topic and the potential impact of opening up and discussing the topic with the client.

3.2.7. Variations in Note Keeping Practices

Finally, the participants were asked about their beliefs around note keeping.

3.2.7.1. Keeping detailed notes for the benefit of other professionals understanding:

Three participants spoke about writing detailed notes about their sessions with clients, with the aim of enhancing other professionals understanding of their clients' difficulties and needs:

P3: 'I'll write a very detailed assessment […] I think it makes [other professionals] look twice at the [clients] that they are judging erm when they understand their history because our clients get really, really badly treated by other mental health services by other professionals a lot of the time because their behaviour isn't acceptable and we don't have any context for it and once they see the kind of horror of what [clients] have been through, they rethink.'

P7: 'I do put quite a lot of detail in erm and make quite detailed notes, […] I'm constantly talking about these symbolic links between the content of psychosis and the underlying trauma, because I'm trying to educate [other professionals] who read the notes to start looking for these links'

Two of the three who described writing detailed notes for the benefit of other professionals understanding made specific reference to doing so with the aim of educating other professionals about trauma histories. This seemed to be linked to the belief that perhaps other professionals are not working in trauma informed ways, and may have some overlap with the subtheme 'Belief that other professionals neglect to ask'.

3.2.7.2. Keeping minimal notes:

However, three other participants reported keeping notes as brief as possible with the aim of protecting the client’s privacy:

P4: ‘I would keep [content of the notes] more on a need-to-know basis if other [professionals] are reading it’

P2: ‘I err on the side of caution about what I would record [in peoples notes] because the electronic record system is not just for mental health, it's also for physical health […] I don't think a podiatrist needs to know about somebody's history of child sexual abuse unless it's impacting on their relationship with physical health care’

3.2.7.3. Recording when a client denies abuse

Finally, there was a mixture of responses regarding the practice of recording when a client says they were not abused/neglected or declines to answer the question. Two participants reported that they would routinely include if a client denies having experienced CA/ CN in their notes, and two reported that they would not record it consistently:

P*8: ‘Yeah… probably not consistently to be fair, but I would record it, I'd probably say […] person didn't identify any specific issues from childhood […] I'm not sure I document it consistently now that I'm thinking about it’*

P9: ‘I'd normally put a line something like ‘they denied ever experiencing any physical or sexual relation or emotional abuse’ and I think it's important that that's in there’

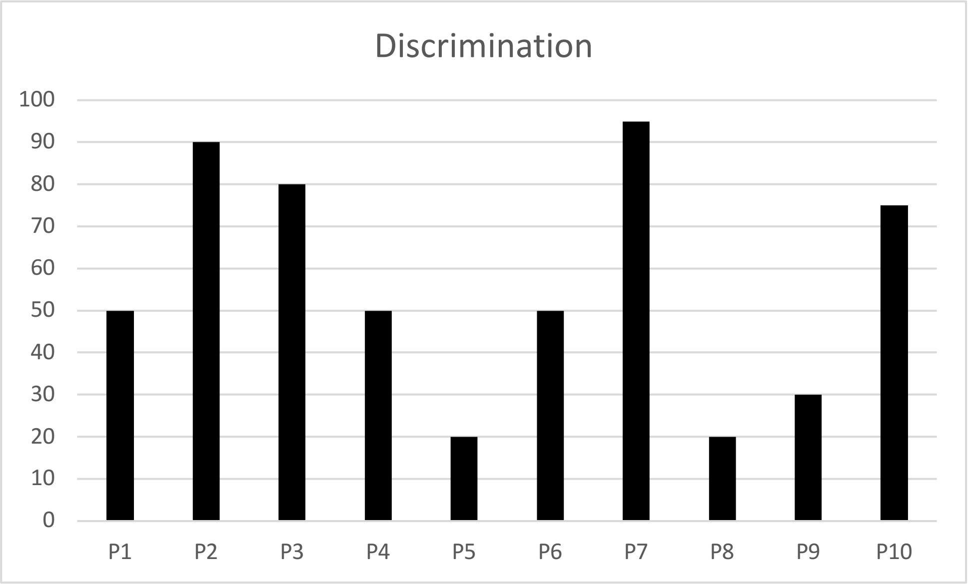
The lack of consistency in the way in which psychologists record if a client has denied having experiences CA/ CN may result in a lack of clarity amongst other professionals, both clinically and in research contexts, over whether a client has been asked or not. There was a sense from some of the participants that this was a question that they had not given much consideration to prior to being asked in the interview, which may reflect the culture and/or attitude in services around the relevance of routine enquiry into histories of CA and or CN.

3.2.8. Findings on Psychologists' Likelihood of Enquiring about Discrimination, Poverty and Bullying in Childhood

The 10 participants reported that their mean likelihood of asking about whether their clients had experiences of discrimination in childhood was 56.0% (SD 27.9, range = 20-96). They reported that their mean likelihood for asking about experiences of bullying in childhood was 75.7% (SD = 26.0, range 35-100). Their mean likelihood of asking about experiences of poverty in childhood was 57.0% (SD = 38.7, range 0-100).

For a full summary of the data see the Figure 7, 8 and 9 and the summary of additional qualitative comments that accompanied the psychologists' estimates of their likelihood of asking about these other forms of ACE.

Figure 7. Likelihood of Clinical Psychologists Enquiring about Childhood Experiences of Discrimination



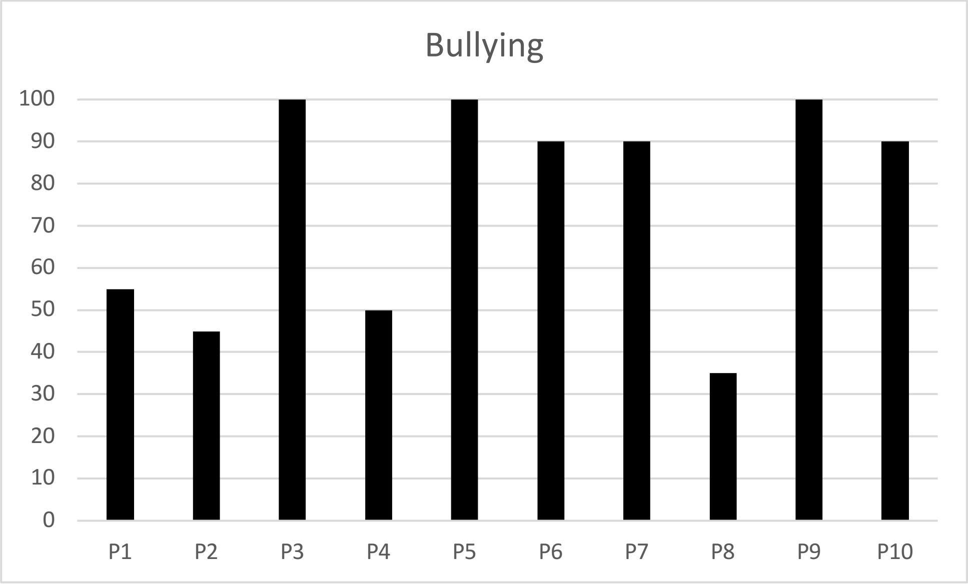
Several but not all participants added additional comments to explain the reason for their estimated percentage likelihood of asking about discrimination.

P5 and P9 reported that they believed they were less likely to ask about this discrimination due to the location of where they worked. They reported that they worked in areas which were not culturally diverse and worked predominantly with white British clients, and that therefore they believed asking clients about experiences of discrimination to be less relevant.

P6 acknowledged that they were less likely to ask clients about racism, and reported that they believed this was due to the additional challenges that come with working with interpreters. However, they acknowledged that this was something they recognised they needed to reflect upon further in their practice. P4 reported that when they worked in the specialist gender service they would always ask about discrimination, but they would not ask about discrimination in their other roles.

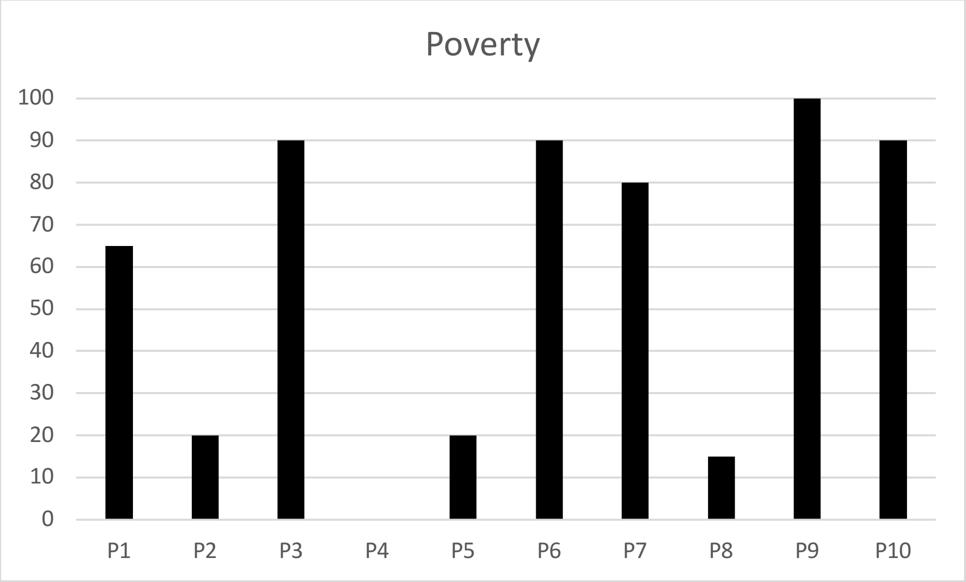
P2 and P3 reported a comparatively high likelihood of asking about discrimination, but reported that they were less likely to ask white, middle class, cisgender, straight clients who did not have known disabilities. P7 reported a high likelihood of asking about discrimination due to holding the belief that clients were not likely to disclose discrimination, due P7’s visible and non-visible but likely assumed characteristics and therefore due to perceived differences. P10 reported that although they worked in a predominantly white British area they were likely to enquire about discrimination due to the belief that it is important to ask about forms of discrimination, other than racism and specifically referred to discrimination on the basis of class differences.

Figure 8. Likelihood of Clinical Psychologists Enquiring about Childhood Experiences of Bullying



P2 and P4 both reported that rather than asking specifically about bullying, they ask their clients about their experiences of early relationships and school. P7 reported that they were slightly less likely to ask about bullying than discrimination, as they believed that bullying was more likely to be asked about by other professionals, and therefore could usually be found in clients' previous notes. P5 reported that they always about bullying due to believing that this was a major factor in the development of low self-esteem.

Figure 9. Likelihood of Clinical Psychologists Enquiring about Childhood Experiences of Poverty



Only two of the participants provided an additional comment, after giving an estimation of their likelihood of asking about poverty. P2 reported that they were less likely to ask about poverty as they believed this more likely to be spontaneously disclosed. Finally, P3 reported that they asked about poverty 90% of the time, rather than 100% of the time as they recognised that they were less likely to ask about experience in poverty if they assumed that their client had experienced wealth growing up, based on the client's characteristics.

4. DISCUSSION

The research questions of this study were:

Primary
-To what extent do UK CPs ask about histories of CA and or CN?
-What are CPs beliefs about the practice of routine enquiry into CA and CN?
-What are the barriers to and facilitators of CPs engaging in routine enquiry?

Secondary
-How do CPs respond to disclosures of CA and CN?
-How frequently do CPs enquire about other childhood adversities?

4.1. Summary of Main Findings

CPs reported higher likelihood of asking than was expected from previous studies. They believed it was important to ask clients about histories of CA/CN, but many reported that they would do this by asking broad questions about early life, rather than specific questions about CA/ CN.

The CPs reported that they were less likely to ask clients with anxiety disorders or depression, male clients, and clients over the age of 60. Other barriers were not having enough time to complete trauma work, only asking when they felt it relevant, being afraid of causing harm, believing the client did not want to be asked, believing it was only appropriate to ask once the therapeutic relationship was established and being fearful of vicarious traumatisation. Facilitators were feeling confident in one's skills to enquire and respond, believing in the relevance of CA/CN to the work and having access to appropriate support.

The CPs believed that the most appropriate ways to respond to disclosures were being human and utilising the core therapeutic skills of listening, validating, formulating, and grounding the client. There was a lot of variation in CPs reports of how they engage in note-keeping.

It appeared as though CPs may be more likely to enquire about ACEs like bullying, rather than 'social traumas' like poverty or discrimination.

These findings provide significant recommendations for future training, the need for systemic change and future research.

4.2. To What Extent do UK Clinical Psychologists Ask About Histories of Child Abuse and Child Neglect?

The CPs self-reported that they ask 80% of clients whether they have histories of 'child abuse' overall. This is inconsistent with the 2018 systematic review which found that only 0% -22% of service users report being asked about child abuse by MH professionals, although these studies were all conducted almost 20 years ago (between 1991 and 2006) (Read et al., 2018a). The only known study to have asked MH professionals about whether they ask about 'childhood trauma' overall using self-report methods conducted in Australia found much lower estimations, reporting that only 23% of MH professionals reported routinely asking (Mansfield et al., 2017)

The CPs estimated asking their clients about each subtype of CA or CN 44% - 48% of the time. Again, this appeared high compared to a study conducted 20 years ago which found that only 18% of MH professionals in the UK reported asking male clients if they had experienced CSA 'half the time or more' (Lab et al., 2000). There are no other known studies exploring the extent to which MH professionals report they ask about CA and CN for each subtype of abuse.

The UK CPs in this study estimated that they know whether their client has experienced each subtype of CA and or CN in 71% - 84% of cases (sexual abuse (78%), physical abuse (81%), emotional abuse (84%), physical neglect (71%) and emotional neglect (77%)).

Similarly, other studies found that MH professionals estimated knowing whether their clients had experienced CSA in 64% of cases (Cavanagh et al., 2004) and that psychologists and psychiatrists estimated knowing whether their clients had experienced childhood emotional abuse in 82% of cases, and CPA in 77% of cases (Young et al., 2001). There are no other known studies to have investigated MH professionals' estimations of frequency of knowing about whether clients have experienced CN.

A recent study comparing MH professionals' reports of whether their clients had experienced CSA and/or CPA, with clients reports (by interviewing both groups) found that MH professionals were able to accurately estimate the occurrence of CSA in 50% of cases, and of CPA in 60% of cases. This suggests that when utilising non-self-report methods the likelihood of MH professionals knowing whether their clients have experienced CA is lower.

Furthermore, studies which have used the methodology of comparing clients' reports to what is documented in clients' notes have suggested even lower MH professionals' awareness of clients' experiences of CA/ CN. This suggested that MH professionals were aware of clients' experiences of CSA in 30% of cases, of CPA in 33% of cases, of emotional abuse in 44% of cases, of physical neglect in 10% of cases and of emotional neglect in 17% of cases (Read et al., 2018a).

4.2.3. Comparisons Between Child Abuse and Child Neglect

The 2018 systematic review suggested that CN is less likely to be recognised by MH professionals than CA (Read et al., 2018a). In this study there was also a statistically significant difference in the amount of overall CA 'not known' and the amount of overall CN 'not known'. There was, however, no statistically significant difference between likelihood of asking about CA and CN. The statistically significant difference between amount known was found to be due to a statistically significant difference in the psychologists' reports of the likelihood of the client disclosing CA compared to CN. Nevertheless, if clients are less likely to disclose CN it is even more important that professionals ensure they ask.

Although, not included in the TA due to there being a minimum of three participants per theme, two of the interviewees reported that they believed clients would be less likely to be able to identify their experiences of neglect e.g.:

> *P4: "I think that absence is harder to ask about and pick up on compared with more like abuse […] it feels almost more obvious or clear to [the client] when there's been abuse, because something will have been done to them, but when it's in something that's missing or absent […] it can feel less clear […] I think it's especially hard [for clients] to recognise the emotional neglect"*

Research has shown that despite neglect being the most common form of abuse, neglect is the least likely form of abuse to be reported on in the media (Davies et al., 2017). Societal discourses may therefore have resulted in CN being perceived by clients, professionals, or society as less 'traumatic' or 'abusive'. Enquiry into neglect is also particularly under researched (Read et al., 2018a), which may both be the result of this discourse and contribute to the maintenance thereof.

4.2.4. Interpretation of these Findings

The 2018 systematic review estimating MH professionals' enquiry into CA/ CN found practices appeared to be improving over time (Read et al., 2018a). This study seemed to replicate this finding.

However, all the studies using self-report methods found that the MH professionals estimated knowing whether their clients had experienced CA/ CN in more cases than research utilising other methods (asking clients, comparing clinician reports to client reports, and reviewing clients' notes) would suggest. This may indicate that MH professionals assume they know, more than they actually do.

It may also be possible that CPs are more likely to ask about and be aware of histories of CA/ CN than other professionals. However, previous research comparing professional groups does not indicate this (see systematic review Read et al., 2018a).

4.3. What are Clinical Psychologists' Beliefs About the Practice of Routine Enquiry

Fifty percent of the psychologists reported they 'strongly agree' and 30.9% reported they 'agree' with the statement 'it is important to ask all clients about whether they had experienced CA/ CN. The MH professionals in the Cavanagh et al (2004) New Zealand study appeared to have less strong beliefs about this, it was reported that the mean response was 2.39 (1= strongly agree, 6= strongly disagree). Furthermore, only 15.3% of the MH professionals in the Lab et al. (2000) study reported that male clients should always be asked about histories of CSA. Again, this may suggest an improvement over time or may suggest that psychologists are more likely to endorse routine enquiry than other professional groups. However, only 7.3% of the psychologists in the Lab et al (2000) study reported believing male clients should always be asked about CSA, compared with 28.9% of the nurses (Lab et al., 2000).

4.3.1. Clinical Psychologists' Beliefs About How to Ask

Although most of the CPs reported agreeing with the above statement the qualitative interviews suggested that they held more nuanced and varied views about the ways in which questions about histories of CA/ CN should be asked. Half of the psychologists who were interviewed reported asking indirectly (e.g. by asking more broadly about early life experiences and relationships), and some reported that they believed it could be harmful to ask 'too' directly. It Is therefore possible that many of the psychologists who took part in the survey perceived 'routine enquiry' as indirect questions about early life, as opposed to asking directly about histories of CA and CN.

Only three out of the ten psychologists interviewed reported asking clients routinely and directly about whether they had experienced CA/CN. They reported that they began by asking a broad question, and then funnelled towards more specific questions. Those who did engage in more direct routine enquiry reported that they believed this had the benefit of giving permission to clients to talk about experiences of CA/ CN, perhaps recognising that clients are unlikely to spontaneously disclose (Ingrassia, 2019; Read et al., 2006). The practice of beginning with broad questions and funnelling towards more specific questions has been recommended in the literature on how to ask about histories of CA and/ or CN (Read et al., 2007), which may suggest that efforts to disseminate training on this have effectively reached a proportion of professionals. The finding that some professionals were utilising the funnelling method was also replicated in Toner et al.'s., (2013) study exploring trauma enquiry with therapists' working with clients who have diagnoses of psychosis (Toner et al., 2013).

Some of the interviewees also reported a desire to 'give the client an opt out' by prefacing their questions by letting the client know that they do not need to respond or to go into detail if they do not want to. The option of providing a preface has been discussed in the literature on how to ask (Read et al., 2007). The literature suggests that professionals may choose to let clients know that they are going to be asked some sensitive questions, explaining why these questions can be helpful to ask and letting the client know that they are not obliged to answer (Read et al., 2007). However, the literature reports that this is not essential, and that clients are most likely able to decline to answer or choose not to disclose of their own volition (Read et al., 2007). 'Giving the client an opt out' may run the risk of communicating to the client that their experiences are too shameful to talk about. Furthermore, one qualitative study on barriers to MH nurses enquiring about CSA found that the nurses reported trying to limit the amount of detail their clients shared about CSA in an attempt to protect themselves from the vicarious trauma this could bring about (Kennedy et al., 2021). It is also possible that this may be at play here.

4.4. What are the Barriers to and Facilitators of Clinical Psychologists Engaging in Routine Enquiry?

4.4.1. Barriers to Enquiry

4.4.1.1. Diagnosis, gender and age of client

Previous research has suggested that clients diagnosed with a psychotic disorder (Cavanagh et al., 2004; Neill, 2021; Read & Fraser 1998; Sampson & Read 2017), male clients (Cavanagh et al., 2004; Neill, 2021; Mansfield et al. 2017; Read & Fraser 1998; Sampson & Read 2017) and older adults (Cavanagh, 2004; Read et al. 2006) are less likely to be asked whether they have a history of CA/ CN or are less likely to have CA/ CN identified in their notes.

The finding that clients diagnosed with psychotic disorders are less likely to be asked was not replicated in this study. Psychotic disorders were amongst the disorders that the CPs reported being *more* likely to ask (54% of the 30% who reported diagnosis impacted their practice). The CPs also rated the psychosocial factors in the causation of Schizophrenia relatively highly (78%), compared with previous research conducted in New Zealand almost 20 years ago (48 % in Cavanagh et al., 2014). This may be indicative of the gradual move away from the previously dominant medical model of psychosis, as was also reported in another study on psychological therapists' enquiry (Toner et al., 2013). However, many of the CPs reported they were less likely to ask clients with anxiety and depression diagnoses. These findings were surprising considering the CPs reported believing that psychosocial factors accounted for 83% of the causation of depression. Some interviewees reported that they were less likely to ask if clients' difficulties were considered 'mild', or a 'here and now' problem, such as 'panic' or phobias. This appeared to be more associated to symptom reduction work (e.g. through engaging in exposure work). This replicated the previous finding that presenting with 'phobia' is a barrier to asking (Lab et al., 2000).

Only 14.3% of the psychologists in this study reported that gender may impact upon likelihood of asking. However, they all reported that they were less likely to ask male clients, replicating the findings from previous research. When asked about this, some interviewees reported that they believed that men who have experienced CA/ CN often present as ‘angry’ or resistant to being asked, which may keep them ‘at a distance’. All interviewees were female, therefore it is possible that is a barrier specific to female psychologists. The fear that the client could become ‘angry or violent’ was listed as a barrier to MH professionals asking men about CSA in one study (Lab et al., 2000). Another study reported that societal narratives about masculinity could result in men being fearful of vulnerability and less likely to disclose CSA (Gruenfield et al., 2017). It is possible that this may result in men presenting with anger. However, this discourse may equally result in MH professionals being more uncomfortable about asking men. Future training could include encouraging MH professionals to question these assumptions.

Only 13.5% of the psychologists in this study reported that age may impact upon their likelihood of asking. However, 70% of the 13.5% reported that they were less likely to ask clients who were age 60 and over, replicating the findings from previous research.

This may be reflective of some of the harmful discourses about ageing which are prevalent both in healthcare settings and in wider society such as “you can’t teach an old dog new tricks” (Ekdawi & Hansen, 2018, p. 142), or ‘it’s best to let sleeping dogs lie’. Additionally, the belief that older people are “fragile”, need protecting, or will not be able to cope (Milton & Hansen, 2018) may prevent MH professionals from asking about histories of CA/ CN, due to a fear of harming or destabilising an older person.

This study did not explore the potential impact of other client demographics such as ethnicity, social class, or sexuality. The study also did not explore the ways in which the professionals’ own characteristics or demographics may interact with the clients’ demographics and impact on likelihood of enquiry. However, it may be possible that the sharing of characteristics could also contribute to likelihood of asking, as some research suggests that shared identities between clients and therapists can improve therapeutic alliance and therapeutic outcomes (Behn et al., 2018; Farsimadan et al., 2007). This may include sharing the same gender identity or being of a similar age but could also include a wide range of other characteristics such as perceived social class, sexuality and/ or ethnicity.

4.4.1.2. Time

Not having enough time to offer the appropriate trauma informed care appeared to be primarily associated to constraints within service contexts, regarding limits to the number of sessions available and fears of 'dropping [the client] in the middle trauma work' (P9). Similarly, lack of appropriate resources (Lab et al., 2000) and knowing that you may not be able to offer consistent care (Davies et al., 2017) have previously been reported as barriers to enquiry.

4.4.1.3. Only asking when the therapist believes it is relevant (i.e. not routinely)

The finding that several of the psychologists reported relying on intuition to determine whether to ask bears similarity to the finding that many MH professionals ask about histories of CSA 'when it comes to mind' (Lab et al, 2000). This may be particularly important when considering the previous findings that professionals consistently under identify CA and CN (Nagar et al., 2020; Read et al., 2018a). This suggests that professionals relying on intuition are neglecting to ask many clients who have experienced CA/ CN.

4.4.1.4. Being fearful of harming the client

Being fearful of harming the client was characterised in this study by being afraid that asking 'too directly' could be experienced as coercive and/ or by being afraid that asking the question in the wrong way could be harmful the client.

Firstly, the belief that asking too directly is coercive suggests that the professionals assume that clients are not able to choose not to disclose, which despite being well meaning disempowers the client. Secondly, one might consider that any question could be viewed as coercive, therefore on this basis this argument does not hold up. Furthermore, avoidance of asking directly about CA and CN may communicate to the client that the therapist does not want to hear disclosures.

The fear of asking the question in the wrong way, was also previously reported by MH nurses (Kennedy et al., 2021). However, although talking about experiences of CA/ CN can be distressing for clients, “there is no evidence that asking causes any serious or permanent damage, and some evidence (Lothian & Read, 2002) that not being asked can cause distress and anger.” (Read et al. 2007).

The fear of harming the client has previously been reported as a barrier in relation to being fearful of re-traumatising (Kennedy et al., 2021) or being fearful of bringing about deterioration to the client’s wellbeing (Lab et al., 2000; Young et al., 2001). These nuances may highlight the benefit of having used qualitative methods in this research to gain a richer understanding of some of the ways in which these barriers are experienced in practice.

4.4.1.5. Believing that the client does not want to be asked

Believing that the client does not want to be asked was characterised by believing that clients do not want to talk about it, making assumptions about non-verbal communication, and believing that it is best to be led by the client (i.e. taking a non-directive approach and waiting for spontaneous disclosure).

Previous research has found that service users advocate for routine enquiry (Lothian & Read, 2002; Scott et al., 2015). Furthermore, the assumption that a client is communicating (non-verbally) that they do not want to be asked may be inaccurate, as there are a number of potential reasons for the client appearing anxious and/or avoidant around a potentially highly emotional topic. Also, this perceived discomfort may in fact be the result of the professionals’ own discomfort around asking the question.

The belief that it is best to be led by the client replicated the findings of two qualitative studies exploring barriers to MH nurses enquiring about CSA. They reported that the nurses believed it was best for the client to initiate the conversation (Kennedy et al., 2021) and that it was better to allow clients to disclose at their own pace (Walsh et al., 2002). Similarly, the Lab et al., (2000) study found that a large proportion of MH professionals believed it was best to wait for the client ‘to bring it up’ (Lab et al., 2000).

However, previous research suggests that clients are unlikely to disclose spontaneously (see introduction), therefore enquiry is often necessary to elicit this information. This may suggest that professionals would benefit from reflecting on their assumptions about ‘what clients want’, and questioning whether there may be other personal barriers located within the therapist or the service culture which are preventing them from engaging in enquiry.

4.4.1.6. Believing that it is only appropriate to ask once the therapeutic relationship is established

Many of the psychologists reported that they believed that the most appropriate time to enquire about histories of CA/ CN was once the therapeutic relationship was established. This replicated the findings from other studies (Kennedy et al., 2021; Toner et al., 2013; Young et al., 2001). Furthermore, some of the interviewees reported being fearful that asking the question too early could lead to a rupture in the relationship. Again, this replicated the findings from previous research, which found that MH professionals reported being fearful that asking about historical CSA could prevent the client from engaging (Lab et al., 2000), or could damage the therapeutic relationship (Walsh et al., 2022).

However, research also suggests that clients frequently hold the belief that their difficulties are caused by the distressing things which have happened to them, and can feel let down by professionals who do not identify this (Lothian & Read, 2002). Therefore, providing the opportunity to discuss historical experiences of CA/ CN may be a prerequisite to developing a meaningful therapeutic relationship (Read et al., 2007). Furthermore, as was highlighted by one of the participants who reported holding a belief about the importance of asking early:

P7: ‘*if you don't [ask] really, really early on, then you establish a relationship where that's not safe, so if you do ask later, the client won't tell you, because you sort of let them know that you don't wanna hear’*

4.4.1.7. Impact of hearing about child abuse/ child neglect on the therapist

Finally, many of the psychologists spoke about the significant impact that hearing about clients' experiences of CA and or CN could have on them. They described hearing about CA and/ or CN as sometimes feeling shocking, upsetting, stressful, difficult to tolerate and reported that this could be a barrier to asking, particularly when experiencing burnout.

Similarly, MH nurses have reported feeling negatively impacted by hearing disclosures of CSA (Walsh et al., 2022) and reported that this could result in them wanting to censor the amount of detail clients provided during disclosures (Kennedy et al., 2021).

This finding felt particularly significant considering that this was also the only barrier reported by the psychologists as being located within themselves, as opposed to being located within the client or the service context. This may also serve to highlight the importance of a supportive service culture which endeavours to ensure measures are in place to support clinicians to engage in trauma informed work. Having a supportive service culture was also reported by the psychologists as being a facilitator to engage in routine enquiry (see section below).

4.4.2. Facilitators of Asking

4.4.2.1. Skills to enquire and respond

Seventy nine percent of the psychologists responding to the survey reported that they either 'strongly agree' or 'agree' that they have the skills to enquire and 84% reported that they either 'strongly agree' or 'agree' that they have the skills to respond about histories of CA/ CN. There was a statistically significant relationship between likelihood of asking and belief in the importance of enquiry, confidence in enquiring and confidence in responding.

Several interviewees reported that having additional training and being experienced in working with historical CA/ CN, were facilitators to asking and led to them feeling more confident about enquiring. Similarly, Young et al., (2001) found that psychiatrists and psychologists who reported that they had received training were statistically significantly more likely to ask about historical abuse (Young et al., 2001).
This finding is particularly important, due to the statistically significant relationship to likelihood of asking, and due to frequency with which feeling under skilled and not having access to training were reported as barriers in previous research across professional groups (see barriers to enquiry reported in the introduction to this paper).

4.4.2.2. Belief that child abuse and child neglect are common and impactful

Believing CA and CN are common and relevant to the difficulties clients present with was a strong theme in the interviews, and frequently reported as the reason why the interviewees believed it was important to ask. Similarly, the psychological therapists in the Toner et al., (2013) study reported that their knowledge of the role of trauma in the development of psychosis, had been a facilitator for trauma enquiry (Toner et al., 2013).

The CPs reported particularly strong beliefs about the psychosocial aetiology of MH difficulties, attributing psychosocial factors to 83% of the causation for depression, 91% for PTSD & 78% for schizophrenia. This may be particular to psychologists, as psychologists have previously been found to hold more psychosocial aetiological beliefs than psychiatrists (Young et al., 2001) and sharing psychosocial formulations is often a key responsibility for CPs working in MDT settings (Christofides et al., 2012).

4.4.2.3. Belief that other professionals neglect to ask

The CPs who held strong beliefs about the importance of asking reported believing that other professionals neglect to ask. These CPs reported believing it was their duty to introduce more trauma informed care into services, suggesting that some CPs believe they have a role in championing this perspective in MDTs.

4.4.2.4. Supportive service culture

Many interviews reported that working in a supportive service where the impact of the work was acknowledged, and steps were taken to attempt to protect staff wellbeing (e.g. space to talk, encouraging breaks and having access to ‘good’ supervision) played an important role in enabling them to be able to hear clients’ experiences of CA/ CN. Similarly, psychological therapists working in an early intervention service for psychosis have reported that support, supervision and having other professionals who “champion” trauma informed practice enabled them to stay committed to engaging in trauma enquiry (Toner et al., 2013)

Furthermore, MH professionals have previously reported that feeling under supported is a barrier to enquiry (Day et al., 2003) and other studies have reported inconsistencies in the availability of supervision for MH nurses (Kennedy et al., 2021; Walsh et al., 2022), citing this as a barrier to enquiring about abuse histories.

Awareness of the risk of vicarious trauma, availability of supervision, and support for staff is also recommended in the New Zealand training programme (Read, 2006) on inquiring about and responding to CA and or CN (Read, 2006). The findings from this study serve to reiterate the importance of including this in future training and may point to the need for this to be raised at the service level.

4.4.3. How Clinical Psychologists’ Respond

The interviewees reported that they utilised core therapeutic skills, rather than specific tools, unique to responding to disclosures of CA/ CN. This included actively listening, validating by emphasising the emotions, formulating, and thinking about how the client will cope after having disclosed by grounding the client. Similarly, MH nurses have reported responding to disclosures by ““being sensitive,” “sitting with,” “supporting,” “listening,” “validating,” “being empathetic” […], “conveying sympathy” [and] “de-briefing”” (Kennedy et al., 2021, p. 388).

Although, not included in the TA due to there being a minimum of three participants per theme, one interviewee specifically described the importance of just being present with the client, as opposed to trying to ‘fix’ the ‘problem’:

P7“I do think as well, there's a sort of myth that you have to do something and somehow just sort of being there, thinking and feeling with that person, sort of isn't doing, but actually that is the doing. That's what you need to do is remain present and feel”

Similarly, Read (2006) suggested that MH professionals “throw away the text books and just be a human being” when hearing a disclosure (Read, 2006, p. 212).

Furthermore, literature on how to respond has suggested that the pull towards wanting to ‘fix’ the problem is neither helpful nor realistic (Read et al., 2007). The recommendation is to focus on the relationship with the client, using similar tools to those described by the interviewees (Read et al., 2007). This may be reassuring for professionals who are fearful of not having the appropriate skills to respond.

4.4.4. Variations in Note Keeping Practices

Finally, the CPs were asked about the ways in which they record disclosures of CA and CN in clinical notes. This was partly motivated by much of the previous research estimating the extent to which MH professionals enquire about CA and or CN by comparing clients’ reports, with what is recorded in their clinical notes (Neill & Read, 2022; Read et al., 2018a).

The psychologists in this study reported varying beliefs about the appropriate way to record disclosures in clinical notes. Some believed it was important to keep detailed notes for the benefit of ensuring other professionals’ awareness of the extent and severity of what the client had experienced. There was a sense that this may somehow protect the clients from stigma (e.g. judgemental attitudes about their presentation) or may go towards ‘educating’ other professionals on the role of trauma in their presentation (e.g. for clients with psychosis).

Similarly, previous research has found inconsistencies in the level of detail recoded in clients’ notes following disclosures of CA/ CN (i.e. some professionals appear to record more detail than others) (Read et al., 2018b).

The interviewees also gave mixed responses about whether they record if a client denies experiencing abuse, suggesting a significant lack of consistency in practice around this. This may suggest that there are cases where clients are asked about histories of CA/ CN, but this is not recorded in client notes. The finding that CA/ CN may be discussed in assessment but not documented has been reported in other studies ((Jacobson et al., 1987; Wurr & Partridge, 1996) cited in Mansfield et al., 2017).

This may be an important area to include in future training, as recording when a client has not been asked enables professionals to know to ask at a later date (Read et al., 2007), and recording when a client has denied abuse may have the ripple effect of normalising routine enquiry for other professionals.

4.5. Factors which were not Associated to Likelihood of Asking

There was no statistically significant relationship between the CPs’ age, length of time working in the profession, or likelihood of believing that disclosures are true and the likelihood of asking. Similarly, Young et al., 2002 also found that the professional’s age and length of time working in the profession were not statistically significantly related to likelihood of asking (Young et al., 2002).

4.6. Likelihood of Enquiring about Childhood Experiences of Discrimination, Bullying and Poverty

The CPs reported that they were more likely to ask about whether clients had experienced bullying in childhood (76% of clients), compared with discrimination (56% of the time) and poverty (57% of the time).

Although CPs are mostly female, they are also predominately white (BPS, 2015) and middle-class (Andleeb, 2021). Thus, although discrimination is not limited to experiences of racism or classism, it is likely that the psychologists' own characteristics may have played a part in their likelihood of asking about discrimination and poverty. Bullying on the other hand may be considered something which is more common across ethnic and socio-economic groups. Furthermore, although not reported in the themes of the TA (due to there being a minimum of three participants per theme) one of the CPs reported that they believe professionals find it easier to ask about bullying as they believe bullying is "the acceptable face of trauma" (P7).

The importance of therapists reflecting on their own social attitudes and addressing the impact of issues such as difference between the client and therapist and experiences of discrimination with clients, is well researched (Lago & Smith, 2003; Mair 2003; Proctor, 2002). However, it would be beneficial for future research to explore how frequently professionals engage in this practice and to further understand the barriers to this.

4.7. Implications for the Profession of Clinical Psychology

Despite the promising finding that the CPs in this study reported asking 80% of their clients about whether they have had histories of experiencing child abuse, other recent research reports that 87% of the core assessments in clients' records contain no documentation of ACEs (including CA/ CN) (Neill & Read, 2022).

Many of the CPs in this study reported preferring to ask broad questions about early life, rather than asking specifically about indicators of experiences of CA/

CN. Furthermore, many reported only asking once they believed the therapeutic relationship was sufficiently established or when based on their intuition, they felt it was relevant. Therefore, despite reporting a high likelihood of asking, it is likely that a large proportion of clients' experiences of CA/ CN are still being missed.

The value of offering additional training in this area has been established. A systematic review of training on how to ask about histories of CA/ CN found that 2/3 studies evidenced that training improved the likelihood of professionals asking about trauma histories and improved the detection of clients' trauma histories (Currier et al., 1996; Currier & Briere, 2000; Sampson & Read, 2017) (cited In Coyle et al., 2019). The systematic review also suggested that future training should go further to address the barriers to enquiry, address the importance of enquiring about all trauma subtypes, and encompass training on how to respond to disclosures (Coyle et al., 2019).

The findings of this study provide useful insight into barriers to be addressed in future training as well as directions for change at the wider service/ systemic level.

4.7.1. Implications for Training

The implications for training are summarised below in Table 14.

Table 14. Areas to be Addressed in Training

Barrier/ facilitator	Training need
The finding that CN is less likely to be identified than CA	To reiterate the relevance of experiences of CN in the development of MH difficulties. To reiterate the importance of asking specific behavioural questions, given that clients may not identify experiences as belonging under the

	label 'neglect' e.g. 'did you caregiver provide you with clean clothes, shelter and regular meals when you were growing up?'
Diagnosis, age, and gender	To reiterate the extent to which trauma is associated with all diagnostic categories, as is recommended by Read et al's. (2007) paper on how to respond. To discuss how societal discourses about masculinity and fragility of older people may impede enquiry. To reiterate that men are even less likely than women to disclose CSA if not asked (Gruenfeld et al., 2017), and to utilise this as an additional justification for engaging in routine enquiry.
Not asking due to fear of not having enough time to complete 'trauma work'	Given that this appeared to be associated to the idea that clinicians needed to provide something to 'fix' the 'problem', to reiterate the value of listening, validating, and formulating with the client and perhaps offering an alternative place to access support if it is not possible to offer more sessions.
Only asking when the therapist believes it to be relevant/ relying on intuition instead of asking routinely	To reiterate the need to ask about CA/ CN routinely, including in cases where it may not appear 'relevant' to the clinician, utilising data which

	evidences that MH professionals fail to identify a large proportion of experiences of CA/ CN.
Fear of harming the client by asking too directly or asking in the wrong way	Sharing of the literature on utilising the funnel model and specific behavioural questions e.g. “When you were a child, did an adult ever hurt or punish you in a way that left bruises, cuts or scratches?’ and ‘When you were a child, did anyone ever do something sexual that made you feel uncomfortable?’” (Read et al., 2007)
Believing that clients do not want to talk about it	To share findings that SUs recommends asking routinely. To discuss the potential harm caused by colluding with avoidance of difficult topics.
Believing that it is best to be led by the client	To share statistics on likelihood of clients spontaneously disclosing, and utilising this to further reiterate the responsibility of the clinician to enquire.
Believing it is only appropriate to ask once therapeutic relationship established	Sharing of literature which suggests that they may not feel able to trust or build relationship if not asked + waiting for opportune moment like this does not tend to work

Believing that other professionals neglect to ask	Sharing the negative consequences of MH professionals not engaging in routine enquiry (e.g. clients not accessing appropriate support, clients feeling that their difficulties are being misunderstood or ignored, etc.)
Lack of consistency in how to record disclosures in clients' notes	To advise professionals of the importance recording when they have chosen not to ask the question, for a good clinical reason. This is to ensure the question is asked at an appropriate time (Read et al., 2007).
Asking about other ACEs	Reiterating the importance of asking about other ACEs, particularly discrimination and poverty and encouraging reflection on the barriers individual psychologists may have regarding this due to their own social demographics

4.7.2. Implications at the Service Level

The service level implications are summarised below in table 15.

Table 15. Areas to be Addressed in Services and at the Wider Systemic Level

Barrier/ Facilitator	Area for change

Not asking due to fear of not having enough time to complete ‘trauma work’	For services to be more trauma informed, it may be beneficial for there to be some more flexibility in services regarding continuity of care.
Impact of hearing about CA/ CN and need for Supportive Service Culture	Services need to acknowledge the impact of this work on their clinical staff and provide appropriate support. All clinical staff need to receive appropriate clinical supervision.

However, for these suggested changes to be maintained in practice, a wider cultural shift is required towards trauma informed care across services.

Toner et al., (2013) usefully highlighted that Burnham’s (1993) Approach-Method-Technique model could be used for thinking about how to maintain changes at the systemic level (Toner et al., 2013). Burnham’s model suggests that effective practice is achieved when the system’s ‘approach’, ‘method’ and ‘techniques’ are clinically aligned (Burnham, 1992). In this model approach refers to the overarching framework used to guide the work (i.e. the trauma informed ethos) which ‘embodies a practitioner's disposition towards their work with clients, colleagues and institutions’ (Burnham, 1992). The ‘method’ refers to organisational protocols used to deliver the approach (i.e. routine enquiry, recording enquiry in clinical notes, and trauma-informed supervision for all clinicians) (Burnham, 1992). Finally, the ‘techniques’ refer to the tools which are used to implement the method (i.e. asking using funnelling and specific behavioural questions, employing clinicians who demonstrate trauma informed values, providing reflective practice spaces and CPD linked to trauma informed practice) (Burnham, 1992).

The implementation of regular reflective practice for instance may be particularly relevant here, as one-off trainings may not be enough for clinicians to implement changes in practice. This may be particularly true given the barriers to routine enquiry present at both the internal and systemic levels. Reflective practice is often considered a useful tool for bridging the gap between theory and practice and enables clinicians to “recognize the traps they fall into routinely” (Taylor, 2010, p. 7). This can be done through questioning the function of these traps/ habits and considering what factors are perpetuating them (Taylor, 2010). For instance, reflective practice may provide a space for clinicians to reflect on how their own fears, and service constraints impact upon their work.

Furthermore, in addition to their current guidance on how to implement safeguarding procedures in response to disclosures of CSA (BPS, 2016) organisations such as the BPS may also benefit from formulating some guidance for best practice on enquiring about and responding therapeutically to disclosures of historical CA/ CN. This may help to establish greater consensus amongst members of the profession on best practice and provide a key document for clinicians to revisit when engaging in regular reflection on this topic.

Finally, it could be argued that for real systemic change to occur these findings and reflections may need to be shared with those responsible for funding services (e.g. commissioners). Working in more trauma informed ways may require greater resource provision (i.e. more breaks for clinicians in between sessions, more trauma informed supervision, more flexibility in numbers of sessions offered to provide greater continuity of care etc.). This may be considered particularly true if rates of enquiry into historical CA/ CN increase, as this may result in an increase in clinicians being exposed to hearing disclosures and to a greater need to provide appropriate trauma informed care.

4.8. Future Research

Overall, there has been a paucity of studies investigating MH professionals' rates of enquiry into CA/ CN (Read et al., 2018a), and particularly into the barriers to this. Therefore, more research in this area is required. The possibility of there being an improvement over time, needs further exploration. Studies replicating previous research designs would provide useful direct comparisons to some of the older research on this topic.

However, research investigating rates of enquiry may also benefit from utilising novel methodologies. A large proportion of the previous research has been conducted utilising the method of screening clients' clinical notes. One of the key limitations of this research methodology, is the level of inconsistency in the extent to which MH professionals are recording disclosures in clients' clinical notes (see findings from this study and Read et al., 2018b). The recent Nagar et al. (2020) study's methodology, which involved interviewing both clients and the MH professionals supporting them to compare their reports of the presence of histories of CA/ CN, may provide more reliable findings than self-report methods, or utilising clinical records.

4.8.1. Research on Child Neglect

CN appears to be particularly neglected in research on asking practices (Read et al., 2018a). Further research must address this, by including CN in research exploring rates of enquiry. Future research should also go further to explore the impact of historical CN on adult MH, given that this is also sparse when compared with CA. Gaining more insight into this, may support professionals to feel clearer about how to ask about CN, why to ask about CN, and how to respond to dislcosures of CN.

4.8.2. Research Exploring Service Users' Views on How and When to Ask

Further research building on Scott et al., (2015)'s research on service users' views on routine enquiry would potentially further benefit the development of training, as this may serve to further reduce professionals' fears about harming clients or may shed further light on the ways in which to ask the question.

Perhaps, this could also include research into specific client groups experiences of this, such as male clients who have had experiences of CSA, or into older adults views on enquiry.

4.8.3. Further Research on Male Professionals Enquiry

Previous research has suggested that male professionals may be less likely to enquire than female professionals (Read et al., 2018a). Therefore, future research may also benefit from repeating a similar methodology to the one utilised in this study but ensuring to include a larger number of male professionals, in order to provide an opportunity to compare practices between male and female professionals.

4.8.4. Further Research about Adverse Childhood Experiences

Further research is needed into enquiry about a broader range of ACEs, and further exploration into the barriers to asking about discrimination and poverty would be beneficial in developing training in this area.

4.9. Reflexivity

4.9.1. Interest in the topic

My interest in this thesis topic begun at the end of my first year of training on the doctorate in clinical psychology. I was coming to the end of my first placement which had been in a CMHT for adults with ‘complex’ MH difficulties. At the start of my placement, I had been struck by the amount of childhood trauma my clients were reporting and by my fears, that I did not have the necessary skills to engage in trauma informed work, and fears that I may inadvertently harm my clients.

When I reflected on my previous experiences of services, I recalled discourses around the risk of re-traumatising the client. I then thought back further to my first experience of working as a support worker on an inpatient ward for young people, at age 21. I remembered how surprised I had initially been at how little we knew about what had happened in the young people's lives which had led them to become so distressed. I had wanted to question this, but felt that my views did not fit with those of the service culture.

It was not until later that I learnt that questioning practices and engaging in on-going critical reflection was going to be integral to me practicing as a CP. When I came across the research which suggests that other MH professionals are not asking clients about histories of CA/ CN, I felt drawn to the topic.

4.9.2. How My Beliefs May Have Impacted the Research

It is likely that my beliefs and values played a role in shaping the design of this research and analysis of the findings. I had wanted to conduct a qualitative study, in part because I felt that a qualitative methodology would enable a better understanding of what the barriers and facilitators to asking really look like in practice. However, I had also been drawn to this due to my personal interest in hearing directly from participants in research and engaging in some dialogue about research phenomena. It is also likely that the interview schedule in this research was informed by my own experiences of clinical practice. Although, I consulted with two other CPs on this. It is also possible that the way I assigned codes to the qualitative data was influenced by my own clinical experiences and to the prior reading I had been doing on the literature discussed in the introduction to this paper, despite my efforts to stick as close to the text as possible.

It is important to note that the way in which I arranged the themes in the qualitative arm of the study, separated into barriers and facilitators was influenced by the research being conducted from a strongly held position regarding best practice, which I believe to be justified by the argument presented in the introduction of this paper. Many of the participants who took part in the qualitative interviews may not have perceived the themes as barriers (e.g. 'being led by the client'), but may have instead considered them factors which influenced the way they practiced, which could act as both barriers or facilitators to enquiry.

Finally, my choice to include 'poverty', 'bullying' and 'discrimination' rather than other ACEs was likely to be influenced by my personal beliefs that social traumas are often neglected in clinical practice.

4.9.3. Reflections During the Process

When conducting the qualitative interviews, I sensed there may be some reluctance from the CPs to acknowledge that they may at times unintentionally neglect to ask about histories of CA and CN. This may in part have been impacted by their knowledge of my status as a trainee CP, with a particular interest in this topic. They may have felt the need to demonstrate their knowledge and expertise, in response to the power dynamic between us, whereby qualified CPs usually have a supervisory role over trainee CPs. This at times may have also prevented me from delving deeper into the barriers they reported, as I was conscious of not wanting the professionals to feel that I was making any negative judgements regarding their practices.

4.10.Limitations

4.10.1. Methodological Weaknesses

Self-report methods run the risk of responses being biased by social desirability. This may have resulted in the CPs overestimating their likelihood of asking. Social desirability may also have been at play during the qualitative interviews; thus, the interviewees may have held back some of their responses.

The survey questions were imperfect. The use of the term 'child abuse' as an umbrella for all forms of CA/ CN in the question on overall likelihood of asking about 'child abuse' may have been interpreted in several different ways. The researcher did not provide the participants with instructions on how the term 'child abuse' was being defined, and this was therefore open to interpretation. Furthermore, as became clearer following the analysis of the qualitative interviews, the notion of asking about 'child abuse' could be interpreted as asking directly or could be interpreted as asking indirectly (i.e. about early life and early life relationships more generally).

The recruitment involved a convenience sampling method, rather than random sampling which may have resulted in sample bias. This may be particularly true given that recruitment involved posting adverts via social media channels such as Facebook, LinkedIn and Twitter. Therefore, CPs who had a prior interest in this topic may have been more likely to volunteer to take part. This may have resulted in a biased sample, towards CPs who are more likely to have an interest in the impact of CA/ CN on the development of MH difficulties and whom are therefore more likely to engage in routine enquiry.

4.10.2. Generalisability

The participants in this study were also predominantly white (93%) and female (93%). Unfortunately, this is representative of the reality of the demography of the profession. The BPS reported in 2015 that around 82% of CPs in the UK were female and around 88% were white (BPS, 2015). However, this does negate the fact that these findings are only generalisable to white, female psychologists. Future research needs to include a more heterogenous sample.

It may be possible that the majority female sample be part of the reason for the results of this study indicating higher rates of enquiry than expected, as previous research has suggested that male clinicians are less likely to ask (Read et al., 2018a). Again, this may point to the need for future research to further explore this finding.

4.11. Conclusions

This study provides a crucial insight into the ways in which UK CPs are practicing clinically, with regards to assessing their clients' histories. There has been no known previous research to date to explore this for this specific professional group. This research is therefore highly relevant to the profession of CP, and points to some important future directions for training and systemic implications. These findings have the potential to contribute significant information required for services and professionals to engage in the shift towards trauma informed care.

The finding that CPs reported asking most of their clients about whether they have experienced CA/ CN, and that they report feeling skilled in this and skilled in responding to disclosures, is encouraging. It suggests that overall CPs underlying beliefs are aligned with trauma informed practices.

The use of a mixed methodology and combination of the quantitative and qualitative findings in this research have provided useful insights into some of the more nuanced ways in which CPs may be missing a large proportion of their clients' experiences of CA/ CN. The barriers and facilitators reported by the interviewees provide valuable insights into areas which need further attention. Recommendations are made for implications for training, systemic change, and future research. This includes the need to incorporate service user voices in research on how to practice, the need for greater attention to be paid to the role of CN, and the need for further research into asking practices about a wider range of ACEs.

4.12. Dissemination

The findings from this thesis will be disseminated in the first instance by providing the interviewees with a summary of the findings, as all reported an interest in receiving this. The findings will also be presented to a large third sector organisation offering psychological therapy to young adults, and conversations regarding the planning of this are already underway with their CEO. Finally, the researcher will aim to publish the findings by submitting to peer review journals and will also be submitted as a poster presentation for a British Psychological Society (BPS) conference.

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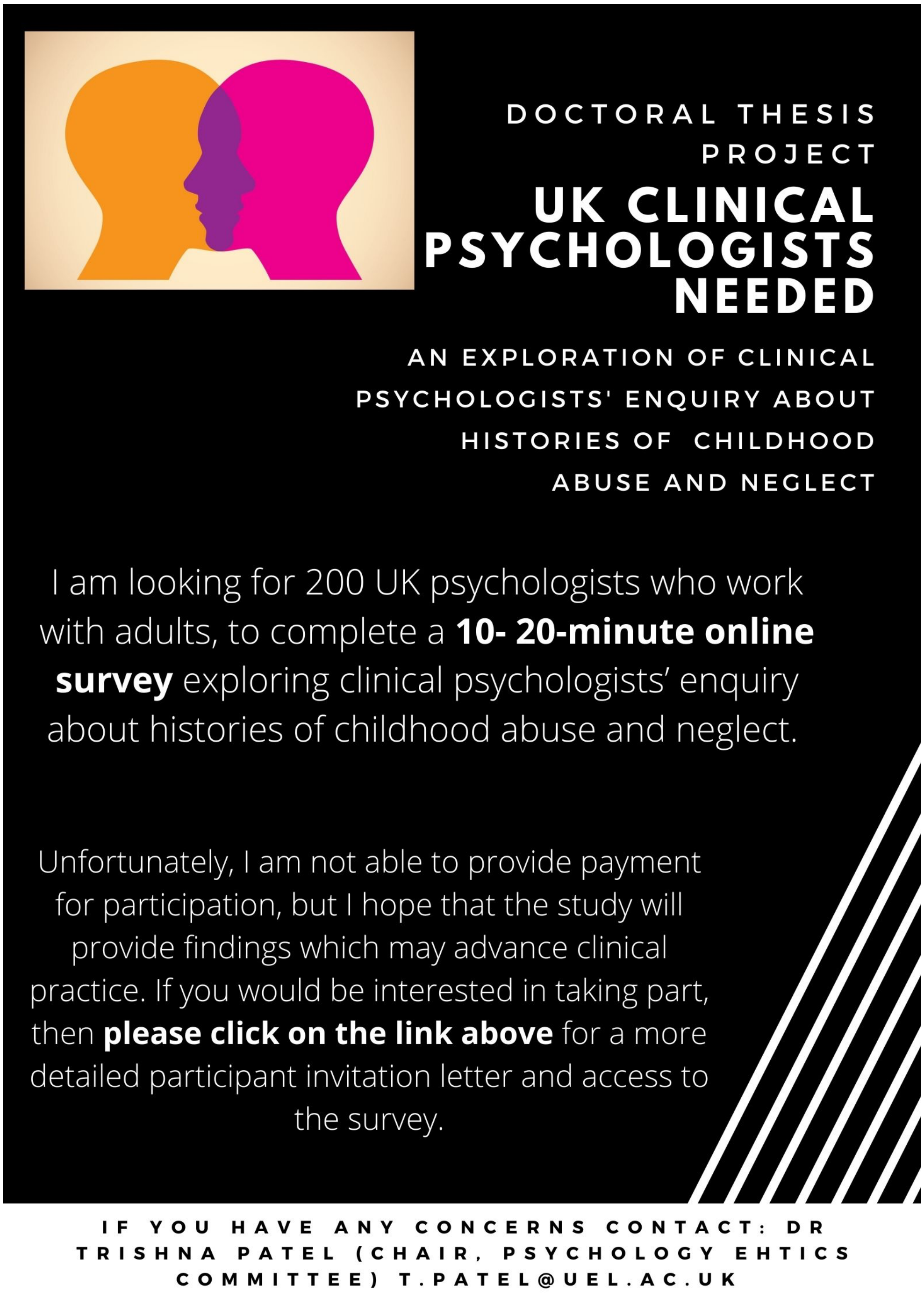
6. APPENDICES

Appendix A: Research Advert



DOCTORAL THESIS PROJECT

UK CLINICAL PSYCHOLOGISTS NEEDED

AN EXPLORATION OF CLINICAL PSYCHOLOGISTS' ENQUIRY ABOUT HISTORIES OF CHILDHOOD ABUSE AND NEGLECT

I am looking for 200 UK psychologists who work with adults, to complete a **10- 20-minute online survey** exploring clinical psychologists' enquiry about histories of childhood abuse and neglect.

Unfortunately, I am not able to provide payment for participation, but I hope that the study will provide findings which may advance clinical practice. If you would be interested in taking part, then **please click on the link above** for a more detailed participant invitation letter and access to the survey.

IF YOU HAVE ANY CONCERNS CONTACT: DR TRISHNA PATEL (CHAIR, PSYCHOLOGY EHTICS COMMITTEE) T.PATEL@UEL.AC.UK

Appendix B: Participant Information Sheet for Online Survey

An exploration of clinical psychologists' enquiry about childhood abuse and neglect.

Participant Invitation Letter

You are invited to take part in an online survey. Before you decide whether to participate, please consider the following information.

Who am I?

I am Raphaelle Dusoulier (u1945448@uel.ac.uk), a postgraduate student at the University of East London, studying for a Professional Doctorate in Clinical Psychology.

What is the research?

The research is my doctoral thesis project exploring clinical psychologists' enquiry about childhood abuse and neglect. The research has been approved by the School of Psychology Research Ethics Committee. This means that the Committee's evaluation of my ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Why have you been asked to participate?

I am recruiting **qualified clinical psychologists in the UK**, who are **currently working with adults in NHS or private services.** I am not looking for 'experts' on the topic. You will not be judged in any way. You are free to decide whether or not to participate and you should not feel coerced.

What will your participation involve?

You will be asked to complete a brief anonymous online questionnaire, including your demographic information. This should take approximately 10-20 minutes to complete. The questionnaire will aim to measure:

-The extent to which psychologists believe they know about clients' histories of different types of childhood abuse and neglect

-The extent to which psychologists believe they are influenced by client's diagnosis, age and gender when deciding whether to enquire about child abuse

-Psychologists' beliefs about disclosures

-Psychologists' beliefs about the causes of mental health difficulties

-Psychologists beliefs about enquiry practices

-Psychologists beliefs about how confident they feel enquiring about and responding to disclosures of child abuse and neglect

At the end of the questionnaire participants will be asked if they consent to being contacted for an online interview. More information on this will be provided at the point where consent to be contacted for interview is requested.

I will not be able to pay you for participating in my research, but your participation would be very valuable in helping to develop knowledge and understanding of my research topic.

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times. Your participation in this online questionnaire will be anonymous, the answers you provide will be recorded by assigning you a participant number.

The demographic information you provide will include age range, gender, ethnicity and range of years working in the profession. Age ranges and ranges of years working in the profession will be used to ensure you cannot be identified on the basis of your demographic information.

What will happen to the information that you provide?

Once the data analysis has been complete, the data will be deleted from Qualtrics, and stored securely on a password protected excel spreadsheet that only the researcher, thesis supervisor and thesis examiners will have access to. The questionnaire data will be reported in the thesis write up using descriptive statistics. Data will be deleted by August 2025. This allows an additional three years after the thesis examination is completed, in case data needs to be re-examined for publication.

What if you want to withdraw?

You are free to withdraw from the research study at any time without providing a explanation or experiencing any consequences. Separately, you may also request to withdraw your data even after you have participated, provided that this request is made within 3 weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible). At the beginning of the survey you will be provided with an ID number. Please keep a note of this as this will be required to identify your anonymous data in order for it to be withdrawn.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.
Researcher name: Raphaelle Dusoulier
Researcher email: U1945448@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Professor John Read. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: j.read2@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Trishna Patel School of Psychology, University of East London, Water Lane, London E15 4LZ.
Email: t.patel@uel.ac.uk

I have read and understood the information provided above. The nature and purposes of the research have been outlined. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

- ○ Yes
- ○ No

I understand that the answers I provide in this survey will be recorded anonymously. It has been explained to me what will happen to the answers I provide in this survey once the research study has been completed.

- ○ Yes
- ○ No

I hereby freely and fully consent to participating in this survey. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data after data analysis has begun (3 weeks after submitting my response).

- ○ I consent
- ○ I do not consent

Here is your ID number: […]

Please save this ID number in order to have the option of withdrawing your data, after the data has been submitted. You can then do so by contacting me, the researcher: Raphaelle Dusoulier, U1945448@uel.ac.uk to request for the data to be withdrawn.

Appendix C: Qualtrics Survey

1. I consider myself to be:
    - Male
    - Female
    - Nonbinary/ third gender
    - Prefer not to say

2. I consider myself to be (please tick one or more boxes):
    - White
    - Asian
    - Black
    - Arab
    - Other: _______

3. Age:
    - 20-30 years
    - 31-40 years
    - 41-50 years
    - 31-60 years
    - 61+ years

4. How many years have you worked as a clinical psychologist since qualifying?
    - 6-10
    - 11-15
    - 16-20
    - 21-25
    - 26-30
    - 31+

5. What service context do you currently work in? (Please tick one or more boxes)
    - ○ Private practice
    - ○ Secondary care community service
    - ○ Inpatient Service
    - ○ Primary care e.g. IAPT
    - ○ Drug & alcohol service
    - ○ Physical health service
    - ○ Older adult service
    - ○ Learning disability service
    - ○ Other, please specify: ________

6. Please estimate for each of the following types of childhood adversity:

    a) what percentage of your clients you know whether they were subject to the adversity because they spontaneously disclosed it to you

    b) what percentage of your clients you know because they were asked and

    c) what percentage of your clients you don't know whether or not they were subject to the adversity.

    Please make your three estimates add up to 100%.

    Sexual abuse:

    - What percentage you know whether they were subject to this adversity because they spontaneously disclosed it ____

    - What percentage were asked ____

- What percentage you don’t know whether or not they were subject to this adversity ____

Physical abuse:

- What percentage you know whether they were subject to this adversity because they spontaneously disclosed it _______

- What percentage were asked _____

- What percentage you don’t know whether or not they were subject to this adversity ______

Emotional Abuse:

- What percentage you know whether they were subject to this adversity because they spontaneously disclosed it _______

- What percentage were asked _____

- What percentage you don’t know whether or not they were subject to this adversity ______

Emotional neglect:

- What percentage you know whether they were subject to this adversity because they spontaneously disclosed it ______

- What percentage were asked _______

- What percentage you don’t know whether or not they were subject to this adversity ______

Physical neglect

- What percentage you know whether they were subject to this adversity because they spontaneously disclosed it [X]

- What percentage were asked [X]

- What percentage you don’t know whether or not they were subject to this adversity

7. What % of your clients do you ask about whether they have histories of child abuse? _____%

8. The following questions are asking about whether diagnosis, gender or age may influence your decision to ask whether clients have histories of child abuse.

Do diagnoses sometimes influence your decision whether or not to ask about child abuse?

- ○ Yes
- ○ No

[For those who answered yes] Please tick the diagnoses which render you more likely to ask about child abuse (you are welcome to select multiple answers):

- ○ Depression

- ○ Anxiety
- ○ PTSD
- ○ Dissociative disorders
- ○ Schizophrenia
- ○ Bipolar Disorder
- ○ Alcohol/ Drug abuse

[For those who answered yes] Please tick the diagnoses which render you less likely to ask about child abuse (you are welcome to select multiple answers):

- ○ Depression
- ○ Anxiety
- ○ PTSD
- ○ Dissociative disorders
- ○ Schizophrenia
- ○ Bipolar Disorder
- ○ Alcohol/ Drug abuse

Does client's gender sometimes influence your decision whether or not to ask about child abuse?

- ○ Yes
- ○ No

[For those who answered yes] Please tick the genders which render you more likely to ask (you are welcome to select multiple answers):

- ○ Identifies as male
- ○ Identifies as female
- ○ Identifies as non-binary/ third gender

[For those who answered yes] Please tick the genders which render you less likely to ask (you are welcome to select multiple answers):

- ○ Identifies as male
- ○ Identifies as female

○ Identifies as non-binary/ third gender

Does the client’s age sometimes influence your decision whether or not to ask about child abuse?

○ Yes
○ No

[For those who answered yes] Please tick the age ranges which render you more likely to ask (you are welcome to select multiple answers):

○ 18-25
○ 25-40
○ 40-60
○ 60+

[For those who answered yes] Please tick the age ranges which render you less likely to ask (you are welcome to select multiple answers):

○ 18-25
○ 25-40
○ 40-60
○ 60+

9. Of all reports of abuse made to mental health professionals in general, I believe that (the total sum must add up to 100):
____% are true
____% are the result of psychotic delusions
____% are imagined (i.e. the client believes them to be true but they are not)
____% are deliberate false allegations (i.e. the client knows the allegations to be untrue)

10. Causes of Depression (the total sum must add up to 100):
I believe that bio-genetic factors contribute to ___% causation of Depression

I believe that psycho-social factors contribute to ___% causation of Depression

11. Causes of PTSD (the total sum must add up to 100):
    I believe that bio-genetic factors contribute to ___% causation of PTSD
    I believe that psycho-social factors contribute to ___% causation of PTSD

12. Causes of Schizophrenia (the total sum must add up to 100):
    I believe that bio-genetic factors contribute to ____% causation of Schizophrenia
    I believe that psycho-social factors contribute to____% causation of Schizophrenia

13. It is important that all clients be asked about childhood abuse and neglect:
    - ○ Strongly agree
    - ○ Agree
    - ○ Slightly Agree
    - ○ Slightly Disagree
    - ○ Disagree
    - ○ Strongly Disagree

14. I have the knowledge and skills to inquire about child abuse and neglect in a sensitive and effective manner:
    - ○ Strongly disagree
    - ○ Disagree
    - ○ Neither agree nor disagree
    - ○ Agree
    - ○ Strongly Agree

15. I have the knowledge and skills to respond appropriately to disclosures of child abuse and neglect:
    - ○ Strongly disagree

○ Disagree
○ Neither agree nor disagree
○ Agree
○ Strongly Agree

Appendix D: Participant Information Sheet for Qualitative Interview

Invitation to Participate in Online Interview

I am looking for volunteers to be contacted for online interviews.

Although, I cannot provide payment for this your participation would be very valuable in helping to develop knowledge of my research topic.

The interview aspect of this study is thought to be highly relevant to clinical psychology, due to its potential for informing future training which may directly impact clinical practice.

You are not expected to be an expert on this topic, I am only interested in hearing about your experiences and reflections on day to day clinical practice.

If you are interested in helping me gather further information on this topic, please read the information below.

What will your participation involve?

If you volunteer for an interview I may contact you to arrange a time to speak, at your convenience. If you are still interested in taking part I will send out another copy of the consent form via email and give you the opportunity to ask questions about the study. If you give your consent we can agree a time for an interview, which will be conducted on Microsoft Teams.

The interview will aim to explore assessment practices, factors which affect enquiry into child abuse and neglect and beliefs about their role in the development of mental health difficulties.

At the end of the interview a short Likert-type questionnaire will be administered, exploring likelihood of asking about other adverse childhood experiences. The interview and short questionnaire are likely to last up to 1 hour. You are welcome to speak for less than 1 hour if you wish.

Your taking part will be safe and confidential

If you choose to consent to being contacted for an interview, I will ask you to provide your contact information. Your contact information will be kept in a separate password protected file along with your participant number, until the survey responses data analysis has been completed. This is because a criterion sampling method will be used to identify two groups of psychologists to conduct **individual** interviews with. One group will be made up of psychologists who score highly on likelihood to enquire about child abuse and neglect, and one group will be made up of psychologists who score low on likelihood to enquire about child abuse and neglect. Once the survey response data analysis is complete I will delete any information linking your name and contact information to your survey responses. However, I will keep a record of which group you belong to. Once the interview is complete I will assign you a new participant number and delete the record containing your name and contact information of which group you belonged to.

Interview recordings will be labelled with the new participant number, your demographic information and the date the interview took place. Interviews will be transcribed by me (the researcher) and anonymised at the point of transcription. In the event that any identifiable information is discussed (e.g. place of work) then this information will be omitted or replaced (e.g. general service context).

During the interview, you are not obliged to answer a question if you do not feel comfortable doing so. Given that the interview may touch on challenging aspects of your work, an opportunity to debrief will be offered at the end.

All information provided will be kept confidential. However, confidentiality may be breached if you disclose information which suggests a risk to yourself or others.

What will happen to the information that you provide?

The interview will be recorded using Microsoft teams and the recordings of the interviews will be saved by default on the Microsoft Stream Library. Recordings will be deleted immediately after transcription.

The anonymised transcriptions will be stored securely on a password protected device that only the researcher will have access to. Anonymised transcriptions will be shared using secure methods with the thesis supervisor and may be shared with the thesis examiners if requested.

The interview transcriptions and demographic information will be deleted by August 2025. This allows an additional three years after the thesis examination is completed, in case data needs to be re-examined for publication.

Anonymised extracts from individual interviews may be included in the write up of the thesis and may be published in academic journals.

What if you want to withdraw?

You are free to withdraw from the research study at any time without providing an explanation or experiencing any consequences. Separately, you may also request to withdraw your data even after you have participated, provided that this request is made within 3 weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

RESEARCH NAME: Raphaelle Dusoulier
RESEARCHER EMAIL: U1945448@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Professor John Read. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: j.read2@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Trishna Patel School of Psychology, University of East London, Water Lane, London E15 4LZ.
Email: t.patel@uel.ac.uk

I have read and understood the information provided above. The nature and purposes of the research have been outlined. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

- ○ Yes
- ○ No

I understand how my contact information will be used, and how the interviews will be conducted. I understand that interview transcripts will be anonymised and it has been explained to me what will happen with the transcriptions once the research study has been completed.

- ○ Yes
- ○ No

I consent to sharing my contact information, in order to be contacted about participating in an online interview:

○ I do not consent
○ I consent, my contact information is ____

Appendix E – Semi Structured Interview Schedule

Introduction

-The aim of the interview today is

-understanding your views on asking adult clients about histories of child abuse and neglect,

-thinking about how you do this in practice, what this can bring up and about any barriers or facilitators to doing this. + generally sense of what you feel is the best way to practice.

Different viewpoints are welcome and you are not expected to be an expert on this topic.

I am hoping that this can feel like a non-judgemental space and answers will be kept confidential and anonymous (unless risk concerns come up).

Semi-structured interview:

1. What are your thoughts on whether we should be asking our clients about whether they have histories of child abuse and neglect?

2. In what ways might service context inform this?

3. How do you go about finding out if clients have histories of child abuse and neglect?

4. To what extent does the individuals' previous notes inform this (colleague or hx)?

   Prompt if abuse recorded – do they ask again directly?
   Prompt if no abuse recorded – do they ask?
   Why?

5. How do you ask about histories of child abuse and neglect?

6. In practice how do you feel when asking clients about this?

7. At what point do you think it is most appropriate to ask? Why?

8. Are there times when you think it might be inappropriate to ask? Explore.

9. Thinking about the experiences you have had of this, what are some of the potential barriers to you asking about these things?

   Prompt - fear of upsetting

   Prompt – fear of destabilising

   Prompt - fear of what it may bring up in the room for you or the client

   Prompt - belief that it is intrusive and that the client should disclose this when they are ready

   Prompt – service context

   If the person feels very strongly that they always ask – what has driven this?

10. Research shows that psychologists are less likely to ask men about hx of child abuse and neglect.

   -Is this true for you? explore why?

   -For those who feel it does not apply– explore why? what helps/ facilitates them?

11. Research shows that clinical psychologists are less likely to ask older adults about hx of child abuse and neglect.

   -Is this true for you? why?

   -For those who feel it does not apply– what helps/ facilitates them?

12. My survey found that clinical psychologists are less likely to ask people who had an anxiety disorder diagnosis.

   Is this true for you? why?

   Are there any other diagnoses that you think may render you less likely to ask the person in practice? Explore.

13. Do you feel that there are any other characteristics that may render you more or less likely to ask?

   Prompt - LD, working with an interpreter, sexuality, ethnicity, class, education,

14. Research has found that some forms of abuse are more likely to be asked about than others. When thinking about your own clinical work do you feel that you ask about some forms of abuse more than others?

    Prompt abuse v. neglect

15. Why?

16. In what ways, if any have your views on asking about histories of child abuse and neglect changed over time?

    Where has this come from?

        Prompt training
        Prompt own clinical experience
        Prompt changes in discourses in the profession

17. How much information do you record in people's notes about hx of child abuse or neglect?

    -Why?
    -Has this always been the case?

18. If someone tells you something really awful, how do you respond?

        What do you ask?

ACEs

When engaging in initial assessments I am _% likely to enquire about whether the client has had experiences of discrimination

When engaging in initial assessments I am _% likely to enquire about whether the client has had experiences of poverty

When engaging in initial assessments I am _% likely to enquire about whether the client has had experiences of bullying

Debrief

At the end of the interview once the recording has ended the participants will be offered an opportunity to debrief.

Appendix F: Interview Information Sheet sent to participants by email

UNIVERSITY OF EAST LONDON

Invitation to Participate in Online Interview

An exploration of clinical psychologists' enquiry about childhood abuse and neglect.

Thank you very much for participating in my survey on this topic and for volunteering to be contacted for an online interview. I am now getting in touch to find out if you are still interested in this, and to offer to arrange a Microsoft Teams meeting at a time which is convenient for you. I am available on evenings and weekends, and during working hours on some days.

Although, I cannot provide payment for this your participation would be very valuable in helping to develop knowledge of my research topic. The interview aspect of this study is thought to be highly relevant to clinical psychology, due to its potential for informing future training which may directly impact clinical practice. You are not expected to be an expert on this topic, I am only interested in hearing about your experiences and reflections on day-to-day clinical practice.

What will your participation involve?

The interview will aim to explore factors which affect enquiry into histories of child abuse and neglect.

At the end of the interview a short Likert-type questionnaire will be administered, exploring likelihood of asking about other adverse childhood experiences. The interview and short questionnaire are likely to last up to 1 hour. You are welcome to speak for less than 1 hour if you wish.

Your taking part will be safe and confidential

You have been selected to take part in this interview based on your survey responses, and have been assigned to one of two groups, one group is for participants who responded highly on likelihood of asking clients about history of child abuse and neglect and another is for participants who responded comparatively lower on this.

Once the survey data analysis is complete I will delete any information linking your name and contact information to your survey responses. However, I will keep a record of which group you belong to. Once the interview is complete I will assign you a new participant number and delete the record linking your name and contact information to which group you belong to.

Interview recordings will be labelled with the new participant number, your demographic information and the date the interview took place. Interviews will be transcribed by me (the researcher) and anonymised at the point of transcription. In the event that any identifiable information is discussed (e.g. place of work) then this information will be omitted or replaced (e.g. general service context).

During the interview, you are not obliged to answer a question if you do not feel comfortable doing so. Given that the interview may touch on challenging aspects of your work, an opportunity to debrief will be offered at the end.

All information provided will be kept confidential. However, confidentiality may be breached if you disclose information which suggests a risk to yourself or others.

What will happen to the information that you provide?

The interview will be recorded using Microsoft teams and the recordings of the interviews will be saved by default on the Microsoft Stream Library. Recordings will be deleted immediately after transcription.

The anonymised transcriptions will be stored securely on a password protected device that only the researcher will have access to. Anonymised transcriptions will be shared using secure methods with the thesis supervisor and may be shared with the thesis examiners if requested.

The interview transcriptions and demographic information will be deleted by August 2025. This allows an additional three years after the thesis examination is completed, in case data needs to be re-examined for publication.

Anonymised extracts from individual interviews may be included in the write up of the thesis and may be published in academic journals.

What if you want to withdraw?

You are free to withdraw from the research study at any time without providing an explanation or experiencing any consequences. Separately, you may also request to withdraw your data even after you have participated, provided that this request is made within 3 weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

RESEARCH NAME: Raphaelle Dusoulier

RESEARCHER EMAIL: U1945448@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Professor John Read. School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: j.read2@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Trishna Patel School of Psychology, University of East London, Water Lane, London E15 4LZ.

Email: t.patel@uel.ac.uk

Appendix G: Consent form for qualitative interviews sent by email

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

An exploration of clinical psychologists' enquiry about childhood abuse and neglect.

I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data after analysis of the data has begun.

Participant's Name (BLOCK CAPITALS)

……………………………………………………………………………………….

Participant’s Signature

………………………………………………………………………………………..

Researcher’s Name (BLOCK CAPITALS)

………………………………………………………………………………………..

Researcher’s Signature

…………………………………………………………………………………………

Date: ……………………..…….

Appendix H: SREC Application

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL FOR RESEARCH INVOLVING HUMAN PARTICIPANTS
(Updated October 2019)

FOR BSc RESEARCH
FOR MSc/MA RESEARCH
FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

Completing the application

1.1 Before completing this application please familiarise yourself with the British Psychological Society's Code of Ethics and Conduct (2018) and the UEL Code of Practice for Research Ethics (2015-16). Please tick to confirm that you have read and understood these codes: ☒

1.2 Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will then look over your application.

1.3 When your application demonstrates sound ethical protocol, your supervisor will submit it for review. By submitting the application, the supervisor is confirming that they have reviewed all parts of this application, and consider it of sufficient quality for submission to the SREC committee for review. It is the responsibility of students to check that the supervisor has checked the application and sent it for review.

1.4 Your supervisor will let you know the outcome of your application. Recruitment and data collection must NOT commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (see section 8).

1.5 Please tick to confirm that the following appendices have been completed. Note: templates for these are included at the end of the form.

- The participant invitation letter ☒
- The participant consent form ☒
- The participant debrief letter ☒

1.6 The following attachments should be included if appropriate. In each case, please tick to either confirm that you have included the relevant attachment, or confirm that it is not required for this application.

- A participant advert, i.e., any text (e.g., email) or document (e.g., poster) designed to recruit potential participants.

  Included ☒ or

  Not required (because no participation adverts will be used) ☐

- A general risk assessment form for research conducted off campus (see section 6).

  Included ☐ or

  Not required (because the research takes place solely on campus or online) ☒

- A country-specific risk assessment form for research conducted abroad (see section 6).

  Included ☐ or

Not required (because the researcher will be based solely in the UK) ☒

- A Disclosure and Barring Service (DBS) certificate (see section 7).

  Included ☐ or

  Not required (because the research does not involve children aged 16 or under or vulnerable adults) ☒

- Ethical clearance or permission from an external organisation (see section 8).

  Included ☐ or

  Not required (because no external organisations are involved in the research) ☒

- Original and/or pre-existing questionnaire(s) and test(s) you intend to use.

  Included ☒ or

  Not required (because you are not using pre-existing questionnaires or tests) ☐

- Interview questions for qualitative studies.

  Included ☒ or

  Not required (because you are not conducting qualitative interviews) ☐

- Visual material(s) you intend showing participants.

  Included ☐ or

  Not required (because you are not using any visual materials) ☒

Your details

1.7 Your name: Raphaelle Dusoulier

1.8 Your supervisor's name: Professor John Read

1.9 Title of your programme: Professional Doctorate in Clinical Psychology

1.9.1 UEL assignment submission date (stating both the initial date and the resit date): May 2022 and August 2022.

Your research

Please give as much detail as necessary for a reviewer to be able to fully understand the nature and details of your proposed research.

1.10 The title of your study:

An exploration of the barriers and facilitators to clinical psychologists routinely asking about histories of childhood abuse and neglect

1.11 Your research questions:

-What factors influence whether clinical psychologists ask about childhood abuse and neglect?
-What are clinical psychologists' beliefs about the practice of routine enquiry into childhood abuse and neglect?
-To what extent are some forms of childhood trauma privileged over others?

1.12 Design of the research:

The research will take a critical realist stance, using a mixed methods design. The quantitative arm of the study will utilise a questionnaire disseminated to a wide pool of psychologists. The qualitative arm will involve interviewing a small number of psychologists, recruited on the basis of the results of the questionnaire. A short Likert type questionnaire will also be disseminated to participants taking part in interviews, administered after the interview is complete. The results of the initial questionnaire will be reported using descriptive statistics, and the interview data will be transcribed and analysed using thematic analysis.

1.13 Participants:

A purposive sampling method will be used with the aim of recruiting 200 clinical psychologists for the initial questionnaire. Criterion sampling will then be used to recruit a total of 10 clinical psychologists for qualitative interviews (5 clinical psychologists scoring low on likelihood of engaging in routine enquiry and 5 clinical psychologists scoring high on likelihood of engaging in routine enquiry). All participants will receive an information sheet outlining the purpose of the research and an informed consent and debrief form.

1.14 Recruitment:

The XXX and the XXX will support with recruitment, by advertising the study and online questionnaire via their social media channels. In addition to this the researcher will post an advert for the study on their personal Twitter and LinkedIn pages, will contact other Mental Health Organisations to request they re-tweet the advert, will contact Clinical Psychology training courses to ask if they are able to send the advert out to their Alumni, and will ask other known qualified or trainee clinical psychologists to circulate the advert to qualified clinical psychologists they know (snowball sampling) via their Twitter pages or by contacting them directly e.g. through What’s app.

1.15 Measures, materials or equipment:

An adapted version of a questionnaire utilised in a similar study by Cavanagh, Read & New (2004) will be utilised in this study. The questionnaire was initially designed to explore barriers to clinicians enquiring about sexual abuse and will be adapted to include other forms of abuse such as physical abuse, emotional abuse, physical neglect and emotional neglect (see appendix H).

An initial draft of the interview schedule has been devised. However, the aim is for it to be developed and edited following consultation with a group of 2- 3 clinical psychologists (see appendix G).

The interviews will be followed by a short questionnaire using a Likert type scale to assess the likelihood of clinicians asking about other forms of childhood adverse experience such as bullying, discrimination and poverty (see appendix I).

1.16 Data collection:

The quantitative data will be collected using an online questionnaire using Qualtrics.

The qualitative interviews and second Likert type scale will be conducted online using the Microsoft Teams app.

1.17 Data analysis:

The quantitative data derived from the initial questionnaire will be analysed using descriptive statistics, to gain a better understanding of clinician asking practices and beliefs about disclosures of abuse and the aetiology of mental health problems. Some simple t-tests and correlations will be used to explore the relationship between participants demographics (e.g. age/ gender) and these outcomes.

The qualitative interviews will be transcribed verbatim and analysed semantically using Thematic Analysis, in order to gather thick accounts of the factors which influence enquiry practices.

The final short Likert type questionnaire will be analysed to report on which forms of childhood adversity are more or less likely to be asked about.

Confidentiality and security

It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations.

1.18 Will participants data be gathered anonymously?

The initial quantitative data will request for participants to provide their demographic information but will otherwise be gathered anonymously. The participants will be asked if they are interested in being contacted for qualitative interviews at the end of the questionnaire. If participants consent to being contacted for interviews, they will be asked to provide their contact information.

1.19 If not (e.g., in qualitative interviews), what steps will you take to ensure their anonymity in the subsequent steps (e.g., data analysis and dissemination)?

When transcribing the recordings of the qualitative interviews, participants names will be replaced with a participant number and any identifiable information will be omitted or replaced (e.g. places of work will be replaced with a description of the service context). In the final report anonymity will be maintained by identifying quotations derived from specific interviews utilising the participant number and demographic information. Participants will be informed of these procedures in the participant information sheet and this will be repeated at the onset of interviews, allowing for participants to ask questions to ensure the information has been understood.

1.20 How will you ensure participants details will be kept confidential?

Participants will be informed that any information they share will be kept confidential, unless they disclose something which may indicate a risk of harm to themselves or a vulnerable person. Consent will be sought for the anonymised transcriptions of the interviews being made available to the thesis supervisor and thesis examiners, and for anonymised extracts of the interviews being reported in the final write up.

1.21 How will the data be securely stored?

Recordings will be stored securely using the Microsoft Teams application. Consent forms, demographic information and transcriptions will be stored securely on an encrypted, password protected USB.

1.22 Who will have access to the data?

The researcher will be the person conducting the qualitative interviews and doing the transcribing. The transcriptions of the interviews and the quantitative data derived from the questionnaires will only be available to the researcher, the thesis supervisor and the thesis examiners should they request to see evidence of the data.

1.23 How long will data be retained for?

The recordings of interviews will be deleted after transcriptions have been completed. Transcriptions and demographic information will be deleted within three years of the thesis examinations. This is because the original data may need to be re-examined for publication.

Informing participants:

Please confirm that your information letter includes the following details:

1.24 Your research title: ☒

1.25 Your research question: ☒

1.26 The purpose of the research: ☒

1.27 The exact nature of their participation. This includes location, duration, and the tasks etc. involved: ☒

1.28 That participation is strictly voluntary: ☒

1.29 What are the potential risks to taking part: ☒

1.30 What are the potential advantages to taking part: ☒

1.31 Their right to withdraw participation (i.e., to withdraw involvement at any point, no questions asked): ☒

1.32 Their right to withdraw data (usually within a three-week window from the time of their participation): ☒

1.33 How long their data will be retained for: ☒

1.34 How their information will be kept confidential: ☒

1.35 How their data will be securely stored: ☒

1.36 What will happen to the results/analysis: ☒

1.37 Your UEL contact details: ☒

1.38 The UEL contact details of your supervisor: ☒

Please also confirm whether:

1.39 Are you engaging in deception? If so, what will participants be told about the nature of the research, and how will you inform them about its real nature.

The research project will not involve any deception.

1.40 Will the data be gathered anonymously? If NO what steps will be taken to ensure confidentiality and protect the identity of participants?

The quantitative data from the first questionnaire will initially be gathered anonymously. At the end of the questionnaire, participants will be asked if they would like to provide their contact information in order to be contacted for recruitment to the qualitative interviews. If participants choose to provide their contact information this will initially be attached to their questionnaire responses in order to utilise a criterion sampling method for the recruitment of the qualitative interviews. Once, their questionnaire responses have been scored I will keep a copy of two groups of potential participants for the qualitative interviews, one group for those who scored highly on likelihood of engaging in routine enquiry and one group for those who scored low. Once I have collated the two groups, I will delete my record of their specific questionnaire response scores. I have outlined this in the participant information sheet. The recordings of the qualitative data will be anonymised at the transcription phase and deleted after transcription.

1.41 Will participants be paid or reimbursed? If so, this must be in the form of redeemable vouchers, not cash. If yes, why is it necessary and how much will it be worth?

No.

Risk Assessment

Please note: If you have serious concerns about the safety of a participant, or others, during the course of your research please see your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g. a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

1.42 Are there any potential physical or psychological risks to participants related to taking part? If so, what are these, and how can they be minimised?

There is no identified physical risk to participants. The interviews may touch on challenges that psychologists experience in their profession, which may cause distress if this leads to individuals feeling self-critical or judged. To minimise this risk questions will be asked in a sensitive manner, and the researcher will aim to remain attuned to how the interviewee is experiencing the interview, offering breaks/ opportunities to end the interview and a debrief at the end.

1.43 Are there any potential physical or psychological risks to you as a researcher? If so, what are these, and how can they be minimised?

No psychological or physical risks have been identified.

1.44 Have appropriate support services been identified in the debrief letter? If so, what are these, and why are they relevant?

Psychologists will be advised to use clinical supervision for support, if required.

1.45 Does the research take place outside the UEL campus? If so, where?

The research is taking place online.

If so, a ‘general risk assessment form’ must be completed. This is included below as appendix D. Note: if the research is on campus, or is online only (e.g., a Qualtrix survey), then a risk assessment form is not needed, and this appendix can be deleted. If a general risk assessment form is required for this research, please tick to confirm that this has been completed: ☐

1.46 Does the research take place outside the UK? If so, where?

No.

If so, in addition to the ‘general risk assessment form’, a ‘country-specific risk assessment form’ must be also completed (available in the Ethics folder in the Psychology Noticeboard), and included as an appendix. [Please note: a country-specific risk assessment form is not needed if the research is online only (e.g., a Qualtrix survey), regardless of the location of the researcher or the participants.] If a ‘country-specific risk assessment form’ *is* needed, please tick to confirm that this has been included: ☐

However, please also note:

- For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on ‘sign in’ and then ‘register here’ using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance.
- For *on campus* students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Head of School (who may escalate it up to the Vice Chancellor).
- For *distance learning* students conducting research abroad in the country where they currently reside, a risk assessment must be also carried out. To minimise risk, it is recommended that such students only conduct data collection on-line. If the project is deemed low risk, then it is not necessary for the risk assessments to be signed by the Head of School. However, if

not deemed low risk, it must be signed by the Head of School (or potentially the Vice Chancellor).

- Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.

Disclosure and Barring Service (DBS) certificates

1.47 Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?

No.

1.48 If so, you will need a current DBS certificate (i.e., not older than six months), and to include this as an appendix. Please tick to confirm that you have included this: ☐

Alternatively, if necessary for reasons of confidentiality, you may email a copy directly to the Chair of the School Research Ethics Committee. Please tick if you have done this instead: ☐

Also alternatively, if you have an Enhanced DBS clearance (one you pay a monthly fee to maintain) then the number of your Enhanced DBS clearance will suffice. Please tick if you have included this instead: ☐

1.49 If participants are under 16, you need 2 separate information letters, consent form, and debrief form (one for the participant, and one for their parent/guardian). Please tick to confirm that you have included these: ☐

1.50 If participants are under 16, their information letters consent form, and debrief form need to be written in age-appropriate language.

Please tick to confirm that you have done this ☐

* You are required to have DBS clearance if your participant group involves (1) children and young people who are 16 years of age or under, and (2) 'vulnerable' people aged 16 and over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, and people who have been involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children click here.

Other permissions

2. Is HRA approval (through IRAS) for research involving the NHS required? Note: HRA/IRAS approval is required for research that involves patients or Service Users of the NHS, their relatives or carers as well as those in receipt of services provided under contract to the NHS.

   No. If yes, please note:

- You DO NOT need to apply to the School of Psychology for ethical clearance if ethical approval is sought via HRA/IRAS (please see further details here).
- However, the school *strongly discourages* BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
- If you work for an NHS Trust and plan to recruit colleagues from the Trust, permission from an appropriate manager at the Trust must be sought, and HRA approval will probably be needed (and hence is likewise strongly

discouraged). If the manager happens to not require HRA approval, their written letter of approval must be included as an appendix.

- IRAS approval is not required for NHS staff even if they are recruited via the NHS (UEL ethical approval is acceptable). However, an application will still need to be submitted to the HRA in order to obtain R&D approval. This is in addition to a separate approval via the R&D department of the NHS Trust involved in the research.
- IRAS approval is not required for research involving NHS employees when data collection will take place off NHS premises, and when NHS employees are not recruited directly through NHS lines of communication. This means that NHS staff can participate in research without HRA approval when a student recruits via their own social or professional networks or through a professional body like the BPS, for example.

2.1 Will the research involve NHS employees who will not be directly recruited through the NHS, and where data from NHS employees will not be collected on NHS premises?

Yes. Some participants will be working for the NHS.

2.2 If you work for an NHS Trust and plan to recruit colleagues from the Trust, will permission from an appropriate member of staff at the Trust be sought, and will HRA be sought, and a copy of this permission (e.g., an email from the Trust) attached to this application?

Recruitment will not involve any NHS trusts.

2.3 Does the research involve other organisations (e.g. a school, charity, workplace, local authority, care home etc.)? If so, please give their details here.

Yes. See Appendix J

Furthermore, written permission is needed from such organisations if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation. If that is the case, please tick here to confirm that you have included this written permission as an appendix: ☒

In addition, before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as ‘my’ or ‘I’ with ‘our organisation,’ or with the title of the organisation. This organisational consent form must be signed before the research can commence.

Finally, please note that even if the organisation has their own ethics committee and review process, a School of Psychology SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s as may be necessary.

Declarations

Declaration by student: I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name (typed name acts as a signature): Raphaelle Dusoulier

Student's number: 1945448 Date: 30/10/20

As a supervisor, by submitting this application, I confirm that I have reviewed all parts of this application, and I consider it of sufficient quality for submission to the SREC committee.

Appendix A: Participant Information Sheet 1 (provided before commencing Qualtrics questionnaire)

PARTICIPANT INVITATION LETTER

An exploration of clinical psychologists’ enquiry about childhood abuse and neglect.

You are invited to take part in an online survey. Before you decide whether to participate, please consider the following information.

Who am I?

I am Raphaelle Dusoulier (u1945448@uel.ac.uk), a postgraduate student at the University of East London, studying for a Professional Doctorate in Clinical Psychology.

What is the research?

The research is my doctoral thesis project exploring clinical psychologists' enquiry about childhood abuse and neglect. The research has been approved by the School of Psychology Research Ethics Committee. This means that the Committee’s evaluation of my ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Why have you been asked to participate?
I am recruiting qualified clinical psychologists in the UK, who are currently working with adults in NHS or private services. I am not looking for ‘experts’ on the topic. You will not be judged in any way. You are free to decide whether or not to participate and you should not feel coerced.

What will your participation involve?

You will be asked to complete a brief anonymous online questionnaire, including your demographic information. This should take approximately 20 minutes to complete. The questionnaire will aim to measure:

-The extent to which psychologists believe they know about clients’ histories of different types of childhood abuse and neglect

-The extent to which psychologists believe they are influenced by client's diagnosis, age and gender when deciding whether to enquire about child abuse

-Psychologists’ beliefs about disclosures

-Psychologists’ beliefs about the causes of mental health difficulties

-Psychologists beliefs about enquiry practices

-Psychologists beliefs about how confident they feel enquiring about and responding to disclosures of child abuse and neglect

At the end of the questionnaire participants will be asked if they consent to being contacted for an online interview. More information on this will be provided at the point where consent to be contacted for interview is requested. I will not be able to pay you for participating in my research, but your participation would be very valuable in helping to develop knowledge and understanding of my research topic.

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times. Your participation in this online questionnaire will be anonymous, the answers you provide will be recorded by assigning you a participant number.

The demographic information you provide will include age range, gender, ethnicity and range of years working in the profession. Age ranges and ranges of years working in the profession will be used to ensure you cannot be identified on the basis of your demographic information.

What will happen to the information that you provide?

Once the data analysis has been complete, the data will be deleted from Qualtrics, and stored securely on a password protected excel spreadsheet that only the researcher, thesis supervisor and thesis examiners will have access to.

The questionnaire data will be reported in the thesis write up using descriptive statistics. Data will be deleted by August 2025. This allows an additional three years after the thesis examination is completed, in case data needs to be re-examined for publication.

What if you want to withdraw?

You are free to withdraw from the research study at any time without providing a explanation or experiencing any consequences. Separately, you may also request to withdraw your data even after you have participated, provided that this request is made within 3 weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible). At the beginning of the survey you will be provided with an ID number. Please keep a note of this as this will be required to identify your anonymous data in order for it to be withdrawn.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

RESEARCH NAME: Raphaelle Dusoulier
RESEARCHER EMAIL: U1945448@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Professor John Read. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: j.read2@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Trishna Patel School of Psychology, University of East London, Water Lane, London E15 4LZ.
Email: t.patel@uel.ac.uk

Appendix B: Participant Invitation Letter 2 Provided at end of Qualtrics Survey

Invitation to Participate in Online Interview

I am looking for volunteers to be contacted for online interviews.

Although, I cannot provide payment for this your participation would be very valuable in helping to develop knowledge of my research topic.

The interview aspect of this study is thought to be highly relevant to clinical psychology, due to its potential for informing future training which may directly impact clinical practice.

You are not expected to be an expert on this topic, I am only interested in hearing about your experiences and reflections on day to day clinical practice.

If you are interested in helping me gather further information on this topic, please read the information below.

What will your participation involve?

If you volunteer for an interview I may contact you to arrange a time to speak, at your convenience. If you are still interested in taking part I will send out another copy of the consent form via email and give you the opportunity to ask questions about the study. If you give your consent we can agree a time for an interview, which will be conducted on Microsoft Teams.

The interview will aim to explore assessment practices, factors which affect enquiry into child abuse and neglect and beliefs about their role in the development of mental health difficulties.

At the end of the interview a short Likert-type questionnaire will be administered, exploring likelihood of asking about other adverse childhood experiences. The interview and short questionnaire are likely to last up to 1 hour. You are welcome to speak for less than 1 hour if you wish.

Your taking part will be safe and confidential

If you choose to consent to being contacted for an interview, I will ask you to provide your contact information. Your contact information will be kept in a separate password protected file along with your participant number, until the survey responses data analysis has been completed. This is because a criterion sampling method will be used to identify two groups of psychologists to conduct individual interviews with. One group will be made up of psychologists who score highly on likelihood to enquire about child abuse and neglect, and one group will be made up of psychologists who score low on likelihood to enquire about child abuse and neglect. Once the survey response data analysis is complete I will delete any information linking your name and contact information to your survey responses. However, I will keep a record of which group you belong to. Once the interview is complete I will assign you a new participant number and delete the record containing your name and contact information of which group you belonged to.

Interview recordings will be labelled with the new participant number, your demographic information and the date the interview took place. Interviews will be transcribed by me (the researcher) and anonymised at the point of transcription. In the event that any identifiable information is discussed (e.g. place of work) then this information will be omitted or replaced (e.g. general service context).

During the interview, you are not obliged to answer a question if you do not feel comfortable doing so. Given that the interview may touch on challenging aspects of your work, an opportunity to debrief will be offered at the end.

All information provided will be kept confidential. However, confidentiality may be breached if you disclose information which suggests a risk to yourself or others.

What will happen to the information that you provide?

The interview will be recorded using Microsoft teams and the recordings of the interviews will be saved by default on the Microsoft Stream Library. Recordings will be deleted immediately after transcription.

The anonymised transcriptions will be stored securely on a password protected device that only the researcher will have access to. Anonymised transcriptions will be shared using secure methods with the thesis supervisor and may be shared with the thesis examiners if requested.

The interview transcriptions and demographic information will be deleted by August 2025. This allows an additional three years after the thesis examination is completed, in case data needs to be re-examined for publication.

Anonymised extracts from individual interviews may be included in the write up of the thesis and may be published in academic journals.

What if you want to withdraw?

You are free to withdraw from the research study at any time without providing an explanation or experiencing any consequences. Separately, you may also request to withdraw your data even after you have participated, provided that this request is made within 3 weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

RESEARCH NAME: Raphaelle Dusoulier

RESEARCHER EMAIL: U1945448@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Professor John Read. School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: j.read2@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Trishna Patel School of Psychology, University of East London, Water Lane, London E15 4LZ.

Email: t.patel@uel.ac.uk

Appendix C: Questions seeking consent on Qualtrics survey, before commencing questionnaire (immediately after participant information letter 1)

I have read and understood the information provided above. The nature and purposes of the research have been outlined. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

Yes X
No X

I understand that the answers I provide in this survey will be recorded anonymously. It has been explained to me what will happen to the answers I provide in this survey once the research study has been completed.

Yes X
No X

I hereby freely and fully consent to participating in this survey. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data after data analysis has begun (3 weeks after submitting my response).

I consent X
I do not consent X

Appendix D: Questions seeking consent for qualitative interview (immediately after participant information letter 2 at end of questionnaire)

I have read and understood the information provided above. The nature and purposes of the research have been outlined. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

Yes X
No X

I understand how my contact information will be used, and how the interviews will be conducted. I understand that interview transcripts will be anonymised, and it has been explained to me what will happen with the transcriptions once this survey once the research study has been completed.

Yes X
No X

I consent to sharing my contact information, in order to be contacted about participating in an online interview:

I do not consent X
I consent, my contact information is: xxx

Appendix E: Consent form which will be emailed to participants before agreeing to participate in qualitative interviews

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

An exploration of clinical psychologists' enquiry about childhood abuse and neglect.

I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data after analysis of the data has begun.

Participant’s Name (BLOCK CAPITALS)

……………………………………………………………………………………….

Participant’s Signature

………………………………………………………………………………………..

Researcher’s Name (BLOCK CAPITALS)

………………………………………………………………………………………..

Researcher’s Signature

…………………………………………………………………………………………

Date: ……………………..…….

Appendix F: Debrief Form

University of East London

PARTICIPANT DEBRIEF LETTER

Thank you for participating in my research exploring clinical psychologists' enquiry about childhood abuse and neglect. This letter offers information that may be relevant in light of you having now taken part.

What will happen to the information that you have provided?

The following steps will be taken to ensure the confidentiality and integrity of the data you have provided.

-Participant contact information, consent forms and recordings will be stored on a password protected device, which only the researcher will have access to.

-Recordings and participant contact information will be deleted after interviews have been transcribed.

-All identifiable information will be anonymised when the interviews are transcribed.

-The anonymised transcription data and data set resulting from the questionnaires will be available to the researcher, thesis supervisor and thesis examiners. Data from the questionnaires will be reported on and anonymised extracts from the transcriptions will be included in the write up, which may be published in academic journals.

-The transcriptions and the data set derived from the questionnaires will be deleted three years after the thesis examinations are complete in August 2025.
-Participants have up to 3 weeks to withdraw the data they have provided (after which it can no longer be withdrawn, as data analysis will likely begin at this point).

What if you have been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise potential harm. Nevertheless, it is still possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways you may find it helpful to discuss this with the researcher, or in your own clinical supervision.

You are also very welcome to contact me or my supervisor if you have specific questions or concerns.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Raphaelle Dusoulier
U1945448@uel.ac.uk

If you have any questions or concerns about how the research has being conducted, please contact the research supervisor Professor John Read. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: j.read2@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: t.patel@uel.ac.uk)

Appendix G: Semi-Structured Interview Schedule

The qualitative interviews will be semi-structured. Below is a draft of a list of questions, which may be developed and changed after consultation with 2-3 clinical psychologists.

Introduction

Before beginning the interviews, participants will be reminded of their right to withdraw at any point and offered an opportunity to ask any questions they have about the interview process. Participants will be reminded that the aim of the study is to gain a better understanding of the barriers and facilitators of routine enquiry into childhood abuse and neglect. Participants will be reminded that this is an opportunity to engage in some reflection about what occurs for them in practice when they are engaging in their clinical work. Emphasis will be placed on the interview being a confidential and non-judgemental space where participants can be honest and open about their experiences.

Once this process is complete participants will be asked again about whether they consent to take part and will be informed when the recording is about to begin.

Semi-structured interview schedule

When engaging in an initial assessment with a client, what are the key areas you aim to cover?

What factors influence what you prioritise in an assessment?

How often do you ask about child abuse?

How often do you ask about child neglect?

How do you decide whether to ask or not?

Are there some clients whom you are more/ less likely to ask than others?

Are there some situations which render you less likely to ask?

In what ways do you feel your service context influences your likelihood of asking about childhood abuse or neglect?

Are there any other factors which might prevent you from asking about childhood abuse or neglect?

What are your thoughts on the link between abuse and neglect and the development of mental health problems?

What are your views on the practice of engaging in routine enquiry about histories of childhood abuse and neglect with all service users presenting to psychologists?

Is there anything I have not asked about this topic you felt I should have covered?

Do you have any last reflections on the practice of clinical psychologists asking about childhood abuse and neglect?

Debrief

At the end of the interview once the recording has ended the participants will be offered an opportunity to debrief.

Appendix H: Questionnaire 1

Demographics (age, gender, years working in profession, ethnicity, service context they currently work in e.g. older adults, IAPT, drug and alcohol etc.)

Please estimate for each of the following types of childhood adversity a) what percentage you know whether they were subject to that adversity because they spontaneously disclosed it, b) what percentage you know because they were asked and c) what percentage you don't know whether or not they were subject to that adversity. Please make your three estimates add up to 100%.

Sexual abuse:
What percentage you know whether they were subject to this adversity because they spontaneously disclosed it
What percentage were asked
What percentage you don't know whether or not they were subject to this adversity

Physical abuse:
What percentage you know whether they were subject to this adversity because they spontaneously disclosed it
What percentage were asked
What percentage you don't know whether or not they were subject to this adversity

Emotional abuse
What percentage you know whether they were subject to this adversity because they spontaneously disclosed it
What percentage were asked
What percentage you don't know whether or not they were subject to this adversity

Emotional neglect
What percentage you know whether they were subject to this adversity because they spontaneously disclosed it

What percentage were asked
What percentage you don’t know whether or not they were subject to this adversity

Physical neglect
What percentage you know whether they were subject to this adversity because they spontaneously disclosed it
What percentage were asked
What percentage you don’t know whether or not they were subject to this adversity

What % of your clients do you ask about child abuse? _____%

The following questions are asking about whether diagnosis, gender or age may influence your decision to ask whether clients have histories of child abuse.

Do diagnoses sometimes influence your decision whether or not to ask about child abuse?

Yes
No

Please tick the diagnoses which render you more likely to ask about child abuse (you are welcome to select multiple answers):

Borderline Personality Disorder
Depression
Anxiety
PTSD
Dissociative Disorder
Schizophrenia
Bipolar Disorder
Alcohol/ Drug Abuse

Please tick the diagnoses which render you less likely to ask about child abuse (you are welcome to select multiple answers):

Borderline Personality Disorder
Depression
Anxiety
PTSD
Dissociative Disorder
Schizophrenia
Bipolar Disorder
Alcohol/ Drug Abuse

Does client's gender sometimes influence your decision whether or not to ask about child abuse?

Yes
No

Please tick the genders which render you more likely to ask (you are welcome to select multiple answers):
Identifies as male
Identifies as female
Identifies as non-binary/ third gender

Please tick the genders which render you less likely to ask (you are welcome to select multiple answers):
Identifies as male
Identifies as female
Identifies as non-binary/ third gender

Does the client’s age sometimes influence your decision whether or not to ask about child abuse?

Yes
No

Please tick the age ranges which render you more likely to ask (you are welcome to select multiple answers):
18-25
25-40
40-60
60+

Please tick the age ranges which render you less likely to ask (you are welcome to select multiple answers):
18-25
25-40
40-60
60+

Of all reports of abuse made to mental health professionals in general, I believe that (the total sum must add up to 100):
% are true
% are the result of psychotic delusions
% are imagined (i.e. the client believes them to be true but they are not)
% are deliberate false allegations (i.e. the client knows the allegations to be untrue)

Causes of depression (the total sum must add up to 100):
I believe that bio-genetic factors contribute to _% causation of Depression
I believe that psycho-social factors contribute to _% causation of Depression

Causes of PTSD (the total sum must add up to 100):
I believe that bio-genetic factors contribute to _% causation of PTSD
I believe that psycho-social factors contribute to _% causation of PTSD

Causes of schizophrenia (the total sum must add up to 100):

I believe that bio-genetic factors contribute to _% causation of Schizophrenia
I believe that psycho-social factors contribute to _% causation of Schizophrenia

It is important that all clients be asked about childhood abuse and neglect
(Strongly agree – strongly disagree)

I have the knowledge and skills to inquire about child abuse and neglect in a sensitive and effective manner:
(Strongly agree – strongly disagree)

I have the knowledge and skills to respond appropriately to disclosures of child abuse and neglect:
(strongly agree- strongly disagree)

Appendix I: Questionnaire 2

When engaging in initial assessments I am _% likely to enquire about whether THE client has had experiences of discrimination

When engaging in initial assessments I am _% likely to enquire about whether the client has had experiences of poverty

When engaging in initial assessments I am _% likely to enquire about whether the client has had experiences of bullying

Appendix J: Communications with Organisations Helping with Recruitment

“Communications <communications@XXXX.uk>
Mon 05/10/2020 10:25

Hi Raphaelle

We can help by sharing your study on our social media channels as long as you have all the necessary ethical approvals from your university.

Once you are ready to share your study drop us an email at XXXX and we’ll be happy to help.

Kind regards

XXXX
Communications Assistant”

““**From:** XXX <XXX@hotmail.com>
Sent: 27 October 2020 22:30
To: John Read <J.Read2@uel.ac.uk>
Subject: Re: XXX

Hi John,
Is your student an XXX member? We've been revamping our website and creating a members area where members can post stuff and a research area will be part of this. Not quite there yet. Probably the best we could do at the moment is to re-tweet or share something on Facebook.
Best wishes XXX”

Appendix K: Participant Advert

RESEARCH PARTICIPANTS NEEDED:

An exploration of clinical psychologists' enquiry about histories of childhood abuse and neglect – link to online survey

Dear Clinical psychologists,

I am looking for 200 psychologists who work with adults, to complete a 20-minute online survey exploring clinical psychologists' enquiry about histories of childhood abuse and neglect, for my doctoral thesis project. Unfortunately, I am not able to provide payment for participation, but I hope that the study will provide findings which may advance clinical practice. If you would be interested in taking part, then please click on this link for a more detailed participant invitation letter and access to the survey: X
If you have any concerns contact; Dr Trishna Patel (Chair, Psychology Ehtics Committee) t.patel@uel.ac.uk

Appendix L: Ethics Approval Letter

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

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

REVIEWER: Angela Gosling

SUPERVISOR: John Read

STUDENT: Raphaelle Dusoulier

Course: Prof Doc in Clinical Psychology

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED <u>BEFORE</u> THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is <u>not</u> required but the student must confirm with their supervisor that all minor amendments have been made <u>before</u> the research commences. Students are to do this

by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

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

Minor amendments required *(for reviewer)*:

Ethical considerations for this study have been approved

A minor point, I think the form being used may need to either be updated or the reference to I.Tucker as Chair of Ethics Committee needs to be changed on the form and on the information sheets being provided to participants

Major amendments required *(for reviewer):*

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

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

Student's name *(Typed name to act as signature):* Raphaelle Dusoulier
Student number: 1945448

Date: 10/06/2021

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

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

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

YES / NO

Please request resubmission with an adequate risk assessment

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

☐ HIGH

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

☐ MEDIUM (Please approve but with appropriate recommendations)

☐ LOW

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

Reviewer *(Typed name to act as signature)*: Angela Gosling

Date: 1st June 2021

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

RESEARCHER PLEASE NOTE:

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

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

Appendix M: Ethics amendment request 1

UNIVERSITY OF EAST LONDON
School of Psychology

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact Dr Trishna Patel (Deputy Research Director/Chair of School Research Ethics Committee).

HOW TO COMPLETE & SUBMIT THE REQUEST

1. Complete the request form electronically and accurately.
2. Type your name in the 'student's signature' section (page 2).
3. When submitting this request form, ensure that all necessary documents are attached (see below).
4. Using your UEL email address, email the completed request form along with associated documents to: Dr Trishna Patel at t.patel@uel.ac.uk
5. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days.

Keep a copy of the approval to submit with your project/dissertation/thesis.

6. Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

REQUIRED DOCUMENTS

1. A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.
2. Copies of updated documents that may relate to your proposed amendment(s). For example an updated recruitment notice, updated participant information letter, updated consent form etc.
3. A copy of the approval of your initial ethics application.

Name of applicant:	Raphaelle Dusoulier
Programme of study:	Doctorate in Clinical Psychology
Title of research:	An exploration of the barriers to clinical psychologists routinely asking about histories of childhood abuse and/or neglect
Name of supervisor:	Professor John Read

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
Original participant information sheet has been split into two and re-written	There are two parts to the study which consist of an online survey and online qualitative interviews which need to be recruited for after the questionnaires are complete. I felt it made more sense to write two separate information sheets as

	participants may choose to consent to one part and not the second.
Questions have been added to the questionnaire (however, these are still drawn from the same previous paper as originally outlined in the ethics application)	After discussions with my supervisor it was felt that it would be beneficial to gather as much data as possible once participants have agreed to complete the questionnaire. The length of the questionnaire has been considered, and an estimation of the length of time to complete the questionnaire has been included in the participant information sheet.
Consent – the consent form questions have been adapted for Qualtrics and split into 2 parts (a set of consent questions for the questionnaire and a set of consent questions for the interview)	Adaptation made for Qualtrics and move to splitting info sheet and consent into 2 sections.
Recruitment advert	Made significantly more concise

Please tick	**YES**	**NO**
Is your supervisor aware of your proposed amendment(s) and agree to them?	X	

Student's signature (please type your name): Raphaelle Dusoulier

Date: 06/09/2021

<table>
<tr><th colspan="3">TO BE COMPLETED BY REVIEWER</th></tr>
<tr><td>Amendment(s) approved</td><td>YES</td><td></td></tr>
<tr><td colspan="3">Comments

- For electronic consent forms, best to set up so that participants can only continue if they tick ‘yes’ to all statements, otherwise a participant may take part (e.g., complete online survey) without consenting to all the statements.
- Some typographical errors in the consent form for interviews.</td></tr>
</table>

Reviewer: Trishna Patel

Date: 10/09/2021

Appendix N: Ethics Amendment Request 2.

UNIVERSITY OF EAST LONDON
School of Psychology

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact Dr Trishna Patel (Deputy Research Director/Chair of School Research Ethics Committee).

HOW TO COMPLETE & SUBMIT THE REQUEST

7. Complete the request form electronically and accurately.
8. Type your name in the ‘student’s signature’ section (page 2).
9. When submitting this request form, ensure that all necessary documents are attached (see below).
10. Using your UEL email address, email the completed request form along with associated documents to: Dr Trishna Patel at t.patel@uel.ac.uk
11. Your request form will be returned to you via your UEL email address with reviewer’s response box completed. This will normally be within five days.

Keep a copy of the approval to submit with your project/dissertation/thesis.

12. Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

REQUIRED DOCUMENTS

4. A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.
5. Copies of updated documents that may relate to your proposed amendment(s). For example an updated recruitment notice, updated participant information letter, updated consent form etc.
6. A copy of the approval of your initial ethics application.

Name of applicant:	Raphaelle Dusoulier
Programme of study:	Doctorate in Clinical Psychology
Title of research:	An exploration of the barriers to clinical psychologists routinely asking about histories of childhood abuse and/or neglect
Name of supervisor:	Professor John Read

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
Changes to recruitment strategy	Original recruitment strategy was not yielding enough responses
‘Clinical psychologists in the UK’ added to participant information sheet, which did not previously	Since the study was advertised by the xxx Twitter page it was re-tweeted by an organisation in India. This brought

specify ‘in the UK’. The study had already been published prior to this amendment, but only 1 response had been recorded.	to light that the original participant information sheet did not specify that the study was specifically about practices in the UK.

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	X	

Student’s signature (please type your name): Raphaelle Dusoulier

Date: 04/11/2021

TO BE COMPLETED BY REVIEWER		
Amendment(s) approved	YES	

Comments

Reviewer: Trishna Patel

Date: 05/11/2021

Appendix O: Request for Title Change to Ethics Application

University of East London

Psychology

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed title change to an ethics application that has been approved by the School of Psychology.

By applying for a change of title request you confirm that in doing so the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed then you are required to complete an Ethics Amendments Form.

HOW TO COMPLETE & SUBMIT THE REQUEST

13. Complete the request form electronically and accurately.
14. Type your name in the ‘student’s signature’ section (page 2).
15. Using your UEL email address, email the completed request form along with associated documents to: Psychology.Ethics@uel.ac.uk
16. Your request form will be returned to you via your UEL email address with

reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.

REQUIRED DOCUMENTS

7. A copy of the approval of your initial ethics application.

Name of applicant:	Raphaelle Dusoulier
Programme of study:	Professional Doctorate in Clinical Psychology
Name of supervisor:	Prof John Read

Briefly outline the nature of your proposed title change in the boxes below

Proposed amendment	Rationale
Old Title: An exploration of the barriers to clinical psychologists routinely asking about histories of childhood abuse and neglect	The qualitative interviews have gathered a lot of data from clinical psychologists who hold strong beliefs about the importance of enquiring about histories of childhood abuse and neglect. Therefore, I have more data than expected on what facilitates them to do this, as well as on the barriers to this.
New Title: Exploring Hospital Policy Makers' Understandings of Forensic Inpatient Sexualities An exploration of the barriers and facilitators to clinical psychologists routinely asking about histories of childhood abuse and neglect	

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	x	
Does your change of title impact the process of how you collected your data/conducted your research?		x

Student’s signature (please type your name): Raphaelle Dusoulier

Date: 11/03/2022

TO BE COMPLETED BY REVIEWER		
Title changes approved	YES	
Comments The new title reflects better the research study and will not impact the process of how the data are collected or how the research is conducted		