The Association of Two Forms of Self Blame with Childhood Trauma: A Schema Based Approach.

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By

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Controversy exists about whether self blame is an important factor in the processing of traumatic experiences. Janoff-Bulman (1979) proposed that two different forms of self blame existed and that the distinction between these was important to clinical work with individuals who have experienced trauma. This study tests the hypothesis that Behavioural Self Blame is associated with better psychological adjustment compared with Characterological Self Blame. Self report measures were used to identify the adolescents' attribution of self blame with respect to childhood trauma and their beliefs about themselves and the world (schemata). The relationships between the nature of the self blame, schemata and psychopathology were explored. The results from a sample of nineteen adolescents in residential care suggest that the two forms of self blame are associated with differences in Self Esteem and Self Control schemata. The implications of these findings and ideas for future areas of research into the concept of self blame are discussed.
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1. Introduction

This study explores the relationship between the concept of self blame and cognitive schemata, following trauma. Firstly, it is important to understand what is meant by trauma and what is known about its impact on individuals. Secondly, the relevance of trauma to a population of adolescents in care is discussed. Thirdly, although a variety of models have been proposed to understand the impact of trauma on individuals; research has concentrated on only a few theoretical models. This study focuses on a cognitive schema based model and the research in this area is described. Finally, the concept of self blame is introduced together with conflicting evidence, relating to the nature of the two separate forms of self blame (behavioural and characterological). The aim of this study is to explore the theoretical predictions linking the schema based model of trauma, to the concept of self blame in an adolescent population.

1.1. Trauma

1.1.1. What is trauma?

The term "trauma", derived from the Greek word meaning "to pierce or wound", has been used to describe a variety of difficult experiences. McCann and Pearlman (1990), state that;

"The experience of trauma begins with exposure to a non-normative or highly distressing event or series of events that potentially disrupts the self"

(McCann and Pearlman, 1990, p.6)

These experiences range from single discrete events such as a car accident or rape, to repetitive experiences of a longer duration such as physical abuse within the family or war. Herman (1992) argued that these two types of trauma should be considered separately, as exposure to repetitive experience is likely to result in more complex psychological difficulties, than exposure to single discrete events. The nature of traumatic experiences may also be distinguished in other ways. They may be experienced in isolation (e.g. rape) or as part of a group (e.g. an
earthquake or aeroplane crash). Although the same traumatic experience may be shared by a number of individuals, each one may be affected in a different way. A number of theories have developed which attempt to explain the process by which individuals are affected by trauma and these theories are discussed later.

Researchers have focused on four main types of trauma resulting from; war, disaster (e.g. plane crash), single incidence of violence (e.g. rape) or childhood trauma (e.g. physical abuse). This study focused on traumatic experiences in childhood, which tend to be repetitive and of an abusive nature. The aim of this study was to extend the understanding of factors which affect the impact of the trauma on the individual.

1.1.2. Effects of childhood trauma

Most of the research to date in the field of childhood trauma has focused on the effect of sexual trauma on the child. The present study suggests that the impact of emotional and physical abuse and neglect can have similar psychological effects. It is considered therefore, that all these forms of childhood trauma should be considered together in this study.

Difficulties associated with childhood trauma can be split into a number of categories; behavioural, emotional, social and cognitive difficulties. Iwaniec (1995) in her work on emotional abuse and neglect described the wide ranging effects of such mistreatment, which included developmental and behavioural difficulties. She argued that the negative impacts on self esteem and self worth resulted from the experience of emotional abuse or neglect. She also indicated that a sense of guilt and self blame can accompany these experiences. The concept of self blame is a central issue in this study and is discussed in depth later.

Conte (1985) reviewed studies of childhood sexual abuse across a number of different populations and found a variety of consequences and associated difficulties. These included emotional difficulties e.g. depression and anxiety, as well as sexual dysfunction, relationship difficulties, inclination to self harm and delinquency. He found these difficulties to be more prevalent in the population of individuals who had been sexually abused rather than those who had not.
1.1.3. The experiences of trauma of adolescents residing in Social Services community homes.

Young people are placed in the care of Social Services for various reasons. These include risk to the child of abuse or neglect and relief for families experiencing difficulties in relationships (DHSS, 1997). Thompson and Fuhr (1992) described a study of 50 children and adolescents in care in Canada. The most common reason for entering care was as a result of sexual abuse (29%). This study indicated higher levels of sexual abuse in the community home sample than in the normal population. Finkelhor (1986) in his review of studies of prevalence of childhood sexual abuse found that the majority of studies using community samples reported a prevalence of 15% or lower for females and 10% or lower for males. In conclusion young people living in care are more likely than the normal population to have suffered trauma in the form of childhood abuse.

1.1.4. The experience of mental health difficulties of young people in social services community homes

Researchers have looked at the mental health of this group and found a higher proportion of mental health difficulties than in the normal population. McCann et al. (1996) found that 96% of his sample of 38 young people in residential care had a clinically significant score on one of a battery of mental health assessments compared to a control sample of 97 individuals; 15% of whom had significant mental health scores. One of the mental health assessments used was the Achenbach Child Behaviour Checklist (CBCL). The main difficulties identified, in the individuals in care were conduct disorder, anxiety based disorder and depression.

Hibbard et al. (1992) looked specifically at depression involving adolescents in care and found that 64% of the sample of 82 adolescents could be identified as depressed on the Beck Depression Inventory. This supports the findings that there is a high rate of mental health difficulties in this population (McCann et al, 1996). Hibbard et al. (1992) looked at the mental health of adolescents in community homes who had experienced different forms of abuse. He found no correlations between types of abuse and mental health problems, but he did find that there was a gender difference. Females experienced lower self esteem and higher rates of depression than males.
Thompson and Fuhr (1992) also looked at the mental health of young people in 'out of home' placements (both foster homes and community homes). They administered a number of tests to indicate psychopathology (e.g. depression, behavioural problems and personality factors), and found that a high proportion (62%) of the sample scored in the pathological range for 2 or more of the 8 subscales used. Surprisingly, only 12% scored in the pathological range for depression which is comparable to the normal population within a similar population.

The evidence suggests that young people in residential care typically experience a level of psychopathology which is higher than that in the normal population. Differences exist in the way psychological difficulties are manifested. Hibbard et al. (1992) found that the level of depression was high in this group, whilst Thompson and Fuhr (1992) found high levels of externalised behaviour.

1.1.5. Adolescent development

A large body of research has been produced to explore the process of adolescent development. Weiner (1992) attempted to summarise this in his work on adolescents. He argued that adolescent development involved a gradual change in identity, with the emphasis on experimentation, an increase in maturity and the stabilisation of the individual's self concepts. Development was also accompanied by continued development of the individual's personality traits.

Weiner (1992) argued that psychological disturbance existed in adolescence at a similar level to the adult population, and that the detection of persistent or severe symptomatology or deviance was an indication of psychological difficulties, rather than normal adolescent development.

1.2. Models of Trauma

Although a variety of theoretical models has emerged to explain the impact of trauma on individuals, this study will focus on three models which have been used widely. These three models of trauma are the Post Traumatic Stress Disorder based model (PTSD), the Four Traumagenic Dynamics Model and the Cognitive Model based on an individual's beliefs about the world (schemata). A large proportion of the research into theoretical models, which exist in the area of trauma, is in relation to sexual abuse (Spaccarelli, 1994). Although the research
focuses on childhood sexual abuse rather than other forms of abuse as discussed earlier, the similarity of the consequences for the individual suggests that it is appropriate to consider them together.

The American Psychiatric Association (1994) provides a definition of PTSD which states that it is the consequence of exposure to a traumatic event which is perceived as a threat and is accompanied by fear, helplessness or horror. The PTSD model of trauma focuses on the observable reactions to trauma, and was drawn from the field of learning theory, in particular classical conditioning to the trauma and associated stimuli which created a situation of phobic avoidance (Foa et al., 1989). This approach has been criticised (Spaccarelli, 1994; Finkelhor, 1987) for failing to identify factors which contributed to the differences between individuals' reactions to trauma. Herman (1992) criticised the PTSD model for failing to explain the impact of repetitive abuse on the individual. Finkelhor (1987) proposed an alternative model; the Four Traumagenic Dynamics model. He argued that the main processes which affect individuals following trauma are traumatic sexualization, stigmatisation, betrayal and powerlessness. Finkelhor (1987) argued that a combination of these factors contributed to the individual's response to trauma. Research evidence to support Finklehor's (1987) model has proved problematic, as his concepts are difficult to define and measure.

A third model was proposed by McCann and Pearlman (1990) which aimed to provide a framework for exploring the effect of trauma on the individual. This was based on the concept that an individual's view of the world and themselves is affected by trauma. Bridging the gap between the PTSD models and the schema based models, Herman (1992) argued that the PTSD model could not be applied to complex repetitive traumas. Referring specifically to childhood sexual abuse, Herman (1992) argued that consideration ought to be given to the changes in the way the individuals' view themselves, their sense of hopelessness and their views of others, i.e. a change in their schemata.

In summary, from a theoretical perspective, it seems that there are a number of limitations involved in applying the PTSD based model or the Four Traumagenic dynamics model to trauma, particularly to childhood traumatic experiences of a repetitive nature. This study has therefore chosen to focus on an alternative theoretical model; a cognitive schema based model.
1.2.1. Schema based models for understanding trauma

McCann & Pearlman (1990) developed a schema based model of trauma from the Cognitive Constructivist Self Development Theory. It was originally drawn from several theories, but was based largely on Epstein's Cognitive Experiential Self Theory (Epstein, 1990). This theory proposes that an individual holds a set of beliefs (schemata) about the world which he applies as a framework to interpret new experiences. Epstein believed that schemata were arranged in a hierarchical form. The earliest schemata to be established were of a more general nature than subsequent schemata. All schemata can be altered through experiences, though this does not occur unless necessary. Early and therefore more central schemata (i.e. core schemata) are believed to be less easily altered.

Epstein (1990) argued that when adverse or traumatic events occur, an individual attempts to make sense of the experience using their core schemata. Traumatic experiences generally cannot be understood within the existing schemata. The individual has two options:

a) Firstly they may assimilate the information, a process by which the experience is re-framed in such a way that the schema remains unchanged or only partially changed. This may occur where the experience is less severe or the effect of the trauma is mediated by some personal resources or the environment. Young (1990) agreed with this hypothesis and believed that individuals distort the incoming information to fit the schemata as far as possible. There are several reasons that a change in schemata may be resisted. One of these may be that it threatens the individual's view of self and the world. Schemata may also be clustered together and a change in one schema may affect further schemata. Changes in schemata may also affect the interpretation of past events (Epstein, 1990).

b) The second option which an individual may adopt according to schema theory, is to accommodate the information. This is a process by which an individual changes their existing schemata and is able to make sense of the experience, by forming new schemata. These schemata are often maladaptive and so provide an unrealistic and negative view of the world. According to Young (1990) accommodation is believed to be more likely, if the experience is severe, or repetitive. These experiences are likely to threaten the most central schemata. It is therefore likely that early traumatic experiences, such as child abuse or parental neglect, will result in maladaptive schemata.
Epstein defined the importance of the schemata, by stating that;

"The strength of the belief is a function of the centrality, intensity and frequency of the experience from which it is derived" (Epstein, 1985, p. 285)

This has implications for early repetitive traumatic experiences, in that maladaptive schemata are more likely to have been established. When beliefs have been altered following trauma, subsequent experiences are interpreted using this new set of beliefs. These central beliefs are labelled cognitive schemata. Cognitive schemata are used in conjunction with an individual's coping resources, their self concept and environmental factors, to make sense of experiences.

Young (1990) defines maladaptive schemata as:-

"Early maladaptive schemas refer to extremely stable and enduring themes that develop during childhood and are elaborated upon throughout an individual's lifetime. These schemas serve as templates for the processing of later experience." (Young, 1990, p. 9)

Another property of schemata described by Young (1990) is that they are self perpetuating, as subsequent experiences are interpreted using the schemata. Following the formation of maladaptive schemata, subsequent situations are interpreted using these new schemata. In this way the individual sees situations which tend to confirm their maladaptive view of the world. This phenomenon in social psychology is explained by the Conformation Bias Theory (Aronson, 1994). The individual also becomes sensitive to experiences which will confirm their maladaptive beliefs. In summary, Young (1990) argued that;

"Early maladaptive schemas seem to be the result of dysfunctional experiences with parents, siblings, and peers during the first few years of an individual's life. Rather than resulting from isolated traumatic events, most schemas are probably caused by ongoing patterns of everyday noxious experiences with family members and peers which cumulatively strengthen the schema." (Young, 1990, p.11)
Schema based theories of trauma suggest that an individual holds a set of beliefs which are used to interpret the world. Following trauma, these schemata may not make sense of what has happened. As a consequence, the individual's beliefs may be changed to accommodate the experience and result in a new negative set of schemata. Schemata formed early in life are believed to be less easily changed. Repetitive and early traumas are thought more likely to influence schemata formation. Figure 1 provides a diagrammatic representation of the schema based model of trauma. This model appears to offer a framework for exploring the individual's response to trauma. A number of different factors contribute to the development of an individual's schemata. These include environmental factors, such as culture or family dynamics; individual's resources, e.g. personality and intelligence and, experiences and relationships.

The individual attempts to make sense of the traumatic experiences through their existing schemata, in a process of cognitive appraisal. A number of techniques appear to be employed in this process, including self blame, denial and minimisation. These techniques may enable assimilation of the experience into the existing schemata rather than accommodation resulting in a change of schemata. It is suggested that PTSD symptoms occur where the trauma has not been fully processed The exact relationship of all of these processes continues to be a source of debate.

To summarise, there are a number of existing models which share common features and are used as tools to understand the effects of trauma on people. Further research would be useful to evaluate which models are the most useful and appropriate tools. This current research aims to explore some of the processes which lead to differing responses to trauma, within the schema model of trauma.
Figure 1
A diagrammatic representation of Schema based model of trauma

Individual resources
Environmental factors

Learning from previous experiences

Development of the individual's framework for viewing the world. (Schemata)

Traumatic experience

Cognitive appraisal (including attribution of blame) ↔ PTSD Symptoms

Assimilation of traumatic experience
Retains existing schema of world and self

Accommodation of traumatic experience
Develops a new set of schemata of the world (new schemata may be maladaptive)
1.2.3. Theoretical predictions about the nature of schemata affected by traumatic experiences.

Several researchers have made proposals about the types of schemata they predict would be involved in processing traumatic situations. However, a difficulty arises because there is no standard definition of the different schemata. Each researcher has slightly different definitions of the types of schema they believe exist. This lack of consensus on a theoretical level creates difficulties in comparing research findings and clarifying theoretical concepts.

Drawing upon the disparate research, a number of key researchers into the effect of trauma have emerged. Janoff-Bulman (1989) has identified a number of general schema areas and concludes that following trauma, individuals see themselves as vulnerable and unworthy and they see the world as less benevolent and meaningful. This perspective has been criticised for being too abstract and therefore difficult to verify experimentally.

Epstein (1990) proposed that five areas of schemata were important in response to traumatic situations. These were; love worthiness, meaningful life, relationships, good world and global self esteem. McCann and Pearlman (1990) attempted to be more specific. They identified ten areas of schemata which they believed would be affected by traumatic experiences. These beliefs about the self and the world are concerned with:-

- safety
- control
- trust and dependency
- esteem
- power and intimacy.

(See Appendix i)

Young (1990) identified a further 13 schema areas which he felt may be affected by traumatic experiences. These were in the areas of autonomy, connectedness, worthiness, limits and standards.

The definition and identification of schemata has proved to be subjective, with each theorist proposing slightly different, but overlapping views of the particular schemata, affected by trauma. In this study, the definitions of the schema used were those defined by McCann and Pearlman (1990). (See Appendix i for details.)
1.2.4. Research evidence that traumatic experiences affect schemata.

Research evidence appears to support the concept that individuals who have experienced trauma tend to hold some negative schemata about themselves and the world. Janoff-Bulman (1989) reported a study in which significant life events were related to schemata. She found that for some events the schemata held by individuals were significantly more negative than those held by others who had not experienced traumatic life events. Thus, Janoff-Bulman did find evidence to support a general relationship between schemata and trauma, although she failed to find any relationships between specific life events and individual schemata.

Fletcher (1988 and described in detail by Epstein, 1990) found that all Vietnam veterans experienced an increase in negative beliefs during the war, but for most, these generally improved over time following their return home. Those who experienced PTSD symptoms however, continued to demonstrate an increase in their negative beliefs about the world, indicating that some individuals undergo permanent changes whilst others do not. This provides some support for Young’s prediction that individuals who develop maladaptive schemata are sensitive to information, which confirms these schemata and will maintain them over time.

Building on this, Catlin and Epstein (1992) found evidence to confirm Janoff-Bulman’s (1989) findings, that traumatic experiences influence the nature of schemata held by an individual. Questions were given to a non clinical sample of 305 undergraduates to identify their experience of thirteen major life events. They also asked them about their beliefs, their self esteem and their childhood experiences. It was discovered that those experiencing five of thirteen life events developed distinct patterns of schemata, which were significantly different from those who had not experienced these particular life events. Three of these five, namely romantic rejection (experienced by 49% of the sample), sexual abuse (14%) and being a victim of violent crime (8%) produced a negative impact on the individual.

In their study, Catlin and Epstein (1992) looked at the effect of these life events on five schema areas, which they termed:-

- love worthiness
- meaningful life
- relationships
- good world
- global self esteem.
Catlin and Epstein (1992) found significantly more maladaptive schemata (in all five schemata areas) amongst the undergraduates who had experienced sexual abuse, than those who had not. Victims of violent crime differed in only two of the five schemata areas, and those who experienced romantic rejection differed in three of the five schemata areas.

The size of the sample used by Catlin and Epstein (1992) was limited and it may be that small differences in schema, relating to the remaining ten experiences investigated, may not have been identified. As the comparison group consisted of undergraduates, some of whom had experienced other traumatic events, possible differences in the schemata may have been masked. In conclusion, Catlin and Epstein found evidence that some negative experiences were related to specific maladaptive schemata.

Research into the specific nature of trauma and schema has been hampered by a number of factors. Firstly, schemata are difficult to measure and although a number of different approaches has been used, none of them have become dominant. Another difficulty is that the target population has differed in the studies, making comparison difficult. The many variables which influence the relationship between experience and schemata make the processing of traumatic experiences complex. Some of these variables may include gender, the age at which the trauma was experienced, the nature of the parental relationship and experience of previous traumatic situations (Catlin and Epstein, 1992).

Dutton and Burghardt (1994) supported some of the findings of Catlin and Epstein (1992). A sample of seventy-two battered women was examined and the women were found to hold negative schemata in the areas of trust and safety. These negative schemata correlated with PTSD symptoms, but not with the women's previous traumatic experiences. This latter finding was in conflict with evidence from Catlin and Epstein's study, which did find a relationship between previous trauma and negative schemata. In their study, Dutton and Burghardt found specific relationships between the women's future expectation of trauma and specific schemata. The expectation of severe violence was linked to negative schemata in the areas of esteem and trust of other people. An expectation of recurrent violence was linked to negative schemata in the area of self trust. This study can be criticised because it contained a small sample, which was self selected (from people who had presented themselves to the mental health services).
Some of the different responses to trauma will be accounted for by the individual's personal resources. For some individuals, their core beliefs remained unaltered, and only their peripheral beliefs were affected by the experience. For these people the resulting maladaptive schemata may be less central and more easily changed by later positive experiences. Previous episodes of trauma and/or poor personal resources will impact on the individual response.

In summary, research evidence appears to demonstrate that maladaptive schemata correlate with specific traumatic experiences in some individuals. However, the research also indicates that this is not a simple, causal relationship. The above studies suggest a number of factors may be important, in particular the individual's existing beliefs, their past experiences and their personal resources.

1.2.5. Association between depression and schemata

Beck (1979) predicted that negative schemata would be associated with depression, and later with personality disorders (Beck, 1990). Greenberg et al. (1988) reported two studies which investigated the link between depression and schemata. Greenberg and colleagues found evidence that the absence of depression or anxiety was associated with more positive schemata. Mixed patterns of positive and negative schemata were held by individuals who experienced mild or moderate depression. Greenberg and colleagues predicted that an increase in the level of depression would be accompanied by an increase in negative schemata.

1.3. Attribution of Blame

By investigating the individuals' attribution of blame for traumatic situations, it may be possible to expand the understanding of the differences in the individuals' responses to similar traumas. In an attempt to understand the trauma experienced, the individual may attribute blame for the trauma either to themselves or to others. It is this concept of attribution of blame to oneself which is the subject of this research and will be discussed in greater depth in the following section.
1.3.1. The role of blame following trauma

Individuals may attribute blame to something to make sense of a traumatic experience and provide some explanation about what has happened. Blame may be attributed to themselves, to others or to fate. When individuals blame themselves for traumatic experiences, they may feel responsible for the trauma, the effect it has on others and themselves, for their behaviour during the trauma or for their character. Alternatively, an individual may blame others who have caused the trauma, or failed to prevent it. They may blame organisations or even God. Some people believe in fate and see experiences as unalterable, attaching no blame to themselves or others. It is assumed that most individuals who experience trauma will experience a combination of these types of blame.

In her study, Janoff-Bulman (1979) argued that the process of blaming one's self may be a process of gaining control of a situation and as a consequence, reduce any feeling of helplessness. Miller and Porter (1983) outline two other reasons for an individual engaging in self blame. They cite Lerner's (1980) argument, that by blaming themselves, rather than other people, they are able to maintain a view of the world as 'just'. Their core schemata therefore remain intact, and the disruption which would result from changing these schemata is avoided. Finally, self blame enables people to make sense of situations which seem incomprehensible, by assigning a reason for the trauma through blame (Silver and Wortman, 1980). Conte (1985) gave similar arguments for the role of the attribution of self blame in a review of the effects of childhood sexual abuse. Miller and Porter (1983) found that women who had experienced marital violence attributed self blame for a variety of different reasons:- for causing the violence, for failing to modify the violence and for tolerating the violence. They found that the longer the women endured the violence, the more they women blamed themselves.

1.3.2. Types of self blame

Janoff-Bulman (1979) went on to define two types of self blame, in an attempt to explain how self blame appeared to be linked to both positive and negative outcomes with respect to coping and psychopathology. She called these two types either 'characterological self blame' (CSB), where one blames one's character, or 'behavioural self-blame' (BSB), where one blames one's actions. She argued that BSB is adaptive as it is thought to enable the individual to maintain a
sense of control, whereas CSB is viewed as maladaptive as it is esteem related and is believed to lead to a negative view of oneself. Janoff-Bulman defined the two forms as follows:

"...individuals can blame themselves for having engaged in (or having failed to engaged in) a particular activity, thereby attributing blame to past behaviours", referring to 'behavioural self blame'.

".....individuals can blame themselves for the kind of people they are, thereby faulting their character", referring to 'characterological self blame'.

(Janoff-Bulman, 1979, p.1799)

A considerable theoretical debate has ensued over how these two forms of self blame could be conceptualised and measured, and whether they actually exist. Janoff-Bulman (1979, 1982) expanded her concept of self blame by suggesting that the two forms differ along an effort and ability continuum. She linked BSB to effort or unstable characteristics within the individual, and CSB to the ability or stable characteristics of the individual. The concept of self blame was also extended along the control continuum. Janoff-Bulman suggested that if an experience was perceived as controllable (BSB), then the opportunity existed to avoid a similar event in the future. This opportunity for control did not exist for CSB, and she predicted that the effects of trauma would be different for each type of self blame. She expected that BSB would correlate with a lower level of depression.

Shapiro (1989) offered a bridge between the concept of learned helplessness, proposed by Abramson et al. (1978), and self blame. Shapiro argued that by breaking down the concepts, it was possible for positive correlations of self blame and hopelessness to be explained. He argued that two types of hopelessness existed; 'universal' and 'personal'. Universal hopelessness is seen as general and stable, whereas personal hopelessness is viewed as specific to that person, at a specific time. Shapiro supported Janoff-Bulman's view that self blame can be broken down into the two different forms, i.e. behavioural and characterological. He suggested that personal hopelessness and BSB would positively correlate and could be adaptive. The individual would be able to view situations as specific to the past and potentially controllable in the future. Thus the trauma is attributed to a specific rather than a global cause.
Following this, the definition of the concept of self blame was drawn together by Anderson et al. (1994), who proposed a working definition of self blame from attribution theory. They defined self blame across the dimensions of internality, stability and controllability as follows:

Characterological Self Blame is the attribution of blame to an internal, stable and uncontrollable cause.

Behavioural Self Blame is the attribution of blame to an internal, unstable and controllable cause.

This definition provides a clearer guide to the two concepts and gives an operational definition for research into self blame. For this study the definition proposed by Anderson et al. (1994) has been used. It guides the development of the attribution of blame questionnaire, which was designed to distinguish between characterological and behavioural self blame. The development of the concept of self blame is summarised in Table 1.

### Table 1. Development of the concept of self blame

<table>
<thead>
<tr>
<th>Behavioural</th>
<th>Characterological</th>
<th>Relevant researcher</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blame for behaviour, concept linked to effort, internal and controllable characteristic</td>
<td>Blame for character, concept linked to stable internal characteristics</td>
<td>Janoff-Bulman (1979)</td>
</tr>
<tr>
<td>Concept linked to personal helplessness, a specific aspect of the individual</td>
<td>Concept linked to universal hopelessness, a global aspect of the individual</td>
<td>Shapiro (1989)</td>
</tr>
<tr>
<td>Blame attributed to internal controllable and unstable characteristics of the individual</td>
<td>Blame attributed to internal, uncontrollable and stable characteristics</td>
<td>Anderson et al. (1994)</td>
</tr>
</tbody>
</table>
1.3.3. Research evidence for the existence of adaptive (BSB) and non-adaptive (CSB) forms of self blame

a. Evidence for the existence of two distinct forms of self blame.

There has been debate about whether the two forms of self blame actually exist and whether they have distinct psychological properties. Janoff-Bulman (1979) attempted to prove that the two different forms of self blame existed. In a study based on Rape Crisis Centres, she asked the counsellors to evaluate how many of their clients at these centres experienced each type of self blame. They reported that 74% of the clients were thought to experience self blame and that only 19% of these experienced self blame which was characterological. As minimisation and denial are common coping strategies for dealing with trauma, it is possible that a proportion of the individuals did not express their self blame. From this study Janoff-Bulman provides some evidence that the two different forms of self blame exist and can be distinguished from each other in a clinical context. However, Miller and Porter (1983) highlighted difficulties that arise when a trauma is repetitive as they found that BSB and CSB appeared more difficult to differentiate from each other. As this study is likely to access participants who have experienced repeated trauma, it may prove difficult to identify the two forms of self blame.

b. Evidence of a difference in the relationship of depression and the two forms of self blame.

In a different study, Janoff-Bulman (1979) sought to provide further evidence for the link between depression and CSB: One hundred and twenty undergraduates were presented with four different vignettes and the students were asked to attribute blame for negative experiences as if they were the character in the story. The study divided the individuals into two groups, those who were considered depressed and non-depressed. She found that the individuals who were in the depressed group gave answers which indicated a greater degree of CSB than the non depressed group. This indicated that CSB correlated with depression. BSB was found to be at a similar level in both groups. Janoff-Bulman argued that CSB was often accompanied by BSB and suggested that BSB was part of CSB, but could also exist without CSB. The study was not directly applicable to survivors of traumatic events, as it involved the use of vignettes to assess attribution style, rather than attributions regarding specific events. In conclusion, Janoff-Bulman's
study does indicate that CSB is linked to depression and that CSB is accompanied by BSB.

In a similar study by Anderson et al. (1994), an investigation of attribution style, using vignettes, with a large sample of undergraduates was undertaken. The study explored the relationship between the two forms of self blame with depression and loneliness. There was a higher correlation between depression and individuals who stated they would experience CSB in hypothetical situations, than for those who did not experience CSB. This evidence supports Janoff-Bulman's original predictions that BSB was more adaptive than CSB. Anderson and colleagues argued for a clear distinction to be recognised between the two forms of self blame. They believed that self would be an important area for further investigation.

Additional evidence was provided by Peterson et al. (1981). Their study asked a group of female undergraduates, with symptoms of depression, to undergo an assessment of attribution style. There was no correlation between depressive symptoms and behavioural self blame, as measured by the Attribution Style Questionnaire. This adds further weight to Janoff-Bulman's prediction about BSB being adaptive.

In contrast, a number of studies which had identified the two types of self blame failed to find any difference between persons using each type in relation to depression. Two studies in particular, using similar methodology, looked at the attribution of blame of rape victims: Meyer and Taylor (1986) and Frazier (1990). In both studies, women were interviewed only three days after the rape and this may have affected the results. It seems unlikely that the trauma would have been fully processed and any long term effects on the individuals were unknown. In addition, the sample used by Meyer and Taylor were women who presented themselves to a Rape Crisis Centre for help, and the sample may have been subject to bias. Both studies used the same set of self statements to identify BSB and CSB, as these statements were felt to be particularly relevant to the incident of rape. Neither study was able to conclude that there were adaptive qualities to BSB, and both found that BSB as well as CSB correlated with depression. This differed from the research by Anderson et al. (1994), who found evidence to suggest that CSB was more maladaptive.
c. Disparity in the research findings in the field of attribution of self blame

There appears to be three major ways in which the studies of blame differ from each other. These differences may help to explain some of the conflicting research findings. Firstly, the studies differed in the definitions of self blame that they used. Secondly, the studies used different methods of measuring self blame. Finally the nature of the trauma investigated differed across the studies. The first area of confusion in the investigation of the attribution of self blame following trauma has been the difficulties in defining BSB and CSB. The problems in defining the types of self blame have been discussed at length previously (Section 1.3.2.).

The next area of discrepancy was that generally self blame has been measured in two different ways: measurement of a style of attribution of self blame and, measurement of the attribution of self blame to specific traumatic events. The employment of attribution style assumes that an individual attributes blame in a characteristic way, e.g. attributing the same type of blame to all negative situations. Typically, this has been measured by asking people to respond to hypothetical scenarios. It may be an inadequate approach because it may not be possible to assume that the same attributions would be made in all situations. If this assumption is not true, the concept of attribution style would be meaningless. Anderson et al. (1994) found that the construct of an attribution of self blame style was most consistent across hypothetical situations, rather than actual situations. This evidence supports the concerns about use of attribution style. There are also problems associated with the measurement of attribution of self blame. (i.e. measuring attribution made to specific events). This method assumes that individuals are conscious of the blame they assign to the event and are willing to disclose these to researchers. In a review of studies of self blame, Anderson and colleagues also argued that the differing findings were the result of a variety of methods of measuring and defining the concept of self blame.

The final area in which the studies of the attribution of self blame following trauma differed was in the nature of the trauma investigated. In some studies, the trauma was of a long term repetitive nature, whilst others concentrated on traumas which were single incidents. Overholser and Moll (1990) found evidence to suggest that the nature of self blame differed if the trauma was of a repetitive nature, with the individual being more likely to internalise the blame and
attribute it to a global cause. This supported the view of Miller and Porter (1983), that characterological self blame was common where abuse was repetitive.

It is likely that all these differences in the methods and populations used to study the attribution of blame following trauma, contribute to confusion in the research findings, over the existence and properties of the two types of self blame.

d. Clinical Implications of self blame

Lamb (1986) maintained that from a legal perspective the responsibility for the abuse resided with the perpetrator. However, she argued in her discussion about the treatment of children who had experienced sexual abuse, that to challenge the child’s perceptions of self blame in therapy could be detrimental. Lamb (1986) believed that self blame experienced by an individual was linked to a greater sense of control and this would be threatened by challenging their perceptions of self blame. Lamb failed to make a distinction between different types of blame; however her link of the concept of self blame to control has similarities with the BSB form of self blame.

Celano (1992) attempted to build on this hypothesis by proposing that only specific forms of the attribution of self blame following trauma were adaptive, and these could be beneficial in maintaining control and reducing the individual’s vulnerability to abuse in the future. Celano argued that two distinct attributions of self blame following abuse appeared to be adaptive. These were: blaming oneself for failing to differentiate right from wrong and; blaming oneself for failing to tell an adult that they had been hurt. These two forms were defined by Celano as being internal unstable and specific attributions of blame. They appear to satisfy the definition of BSB used in this study. Celano argued that these attributions of blame are different as they arise from a failure to meet 'Legitimate Expectations', whereas other forms of self blame result from 'Cognitive Distortions'.

Both Lamb (1986) and Celano (1992) argued that further research ought to be carried out to determine whether these forms of self blame were adaptive. They suggested that if this could be established, then a specific clinical approach would be required for both adaptive and maladaptive forms. Celano (1992) suggested that it would be important to refrain from telling the victim that they were not responsible for the abuse. She suggested that therapists should
endeavour to recognise the nature of the attributions of self blame following trauma. Maladaptive attributions of self blame could then be re-framed with an alternative explanation, one which is adaptive, i.e. attributions of some blame to internal unstable and specific forms. These would emphasise control and avoidance of future trauma. Celano believed that group therapy would be advantageous in eliciting and addressing unspoken attributions of blame.

1.3.4. The significance of age with respect to the attribution of self blame following trauma.

Hunter et al. (1992) looked at the difference in attribution of blame experienced by victims of childhood sexual abuse of different ages. They found that adolescents and women attributed more blame to themselves for the abuse than younger children. Celano (1992) looked at the attribution of self blame in children and found that this varied, depending on the age of the child. However, children from a pre-school age group were able to attribute some forms of self blame and the types of the attributions of self blame changed with age. Pre-school age children, who had been abused, were able to blame themselves, in a limited way, for their participation or failure to seek help. At adolescence, the nature of the blame had become more sophisticated and they were able to blame themselves for a variety of reasons. In summary, the evidence appears to show that

a) from adolescence, individuals have reached a developmental level where they are fully able to experience self blame

b) that adult and adolescents appear to employ self blame in similar ways

1.4. Rationale for research and research hypothesis

1.4.1. Rationale for this research

Research in the area of attribution of self blame for negative experiences has exhibited conflicting results and some of the reasons for this have already been discussed. It would be valuable, however, if a clearer distinction could be drawn between CSB and BSB. This would have important clinical implications. It would be helpful to identify as early as possible those with CSB, as these people are anticipated to have more negative, intransigent schemata. This may give an opportunity for the modification of these negative schemata and a more positive perception of the world and themselves.
Of particular interest to the author was the idea that BSB is linked to perceptions of control of the world and of self, with more adaptive schemata, whilst CSB results in lower sense of control and more maladaptive schemata. The former is related to higher self esteem, and the latter to lower self esteem. Therefore, control and esteem schemata were investigated in this research and were the basis of the hypotheses.

The focus of this research is repetitive trauma in childhood. The nature of the trauma in these cases is severe and thus likely to result in substantial changes in schemata. Research also suggests, that individuals experiencing repetitive trauma would exhibit a high level of CSB, which would make comparisons with BSB possible. Early schemata are the most fundamental, and therefore childhood traumas have been chosen as likely to have the greatest impact on the development of these schemata.

The research participants were chosen from adolescents in the care of the local authority, for three reasons. Firstly, they were likely to have experienced childhood trauma. Secondly, the trauma will have been relatively recent and less complicated by subsequent life events, enabling issues relating to the trauma to be measured more easily. Finally, there is evidence to show that the developmental level of adolescents allows them to feel and attribute blame in a similar way to adults.

As a result of concerns about whether attribution style was valid, this study chose to look at specific attributions of childhood traumas. The methodology was designed to be sensitive to the adolescents and the delicate subject matter, and to minimise the intrusive nature of the questionnaires. A series of self statements was selected. The choice of measurement tool for the schemata was one which measured a wide range of schemata associated with traumas and was less abstract than other tools.
1.4.2. Research hypotheses

The general aims of this research were to study the two different forms of self blame, behavioural self blame (BSB) and characterological self blame (CSB), in adolescents in relation to their childhood trauma and the impact on their psychological adjustment. The following hypotheses were explored.

**Primary Hypotheses**

Hypothesis 1- That adolescents who have experienced trauma have a tendency to experience BSB and/or CSB.

Hypothesis 2- That adolescents who have experienced trauma, and employ BSB only would have less maladaptive Self Esteem and Self Control schemata compared to those who employ CSB **.

Hypothesis 3- That adolescents who have experienced trauma and employ BSB only will have lower levels of depression compared with those adolescents who employ CSB.

**Secondary Hypothesis**

Hypothesis 4- That less maladaptive Self Esteem and Self Control schema will be related to lower levels of depression**.

(** Where higher schema values are maladaptive)
2. Methodology

2.1. Participants

The participants in this study were adolescents aged between ten and sixteen years of age. They were recruited from a population of young people living in community homes in the care of a Local Authority Social Services Department. They were all part of a wider established project, looking at the physical and mental health of young people in residential care. The parent project had both a research and therapy remit and had been ongoing for three years. It was a collaboration of Health and Social Services involving a Clinical Psychologist, a Psychiatrist, a Community Paediatrician, School Nurses, an Educational Psychologist and Social Services managers. The participants were drawn from five community homes within one city.

The entire population of adolescents in this age range and living in these five community homes were approached and asked if they would participate in the study. From a possible total population of thirty-one participants, nineteen completed the assessments, and twelve either did not want to take part or failed to fully complete all the assessments. The percentage of participants involved amounted to 61% of the total population. The majority of the participants were male (84%) and this is representative of the composition of the entire sample. The size of the sample was constrained by the limited number of young people in residential care and the stability of the population. Each participant's keyworker was also asked to complete an assessment of the mental health of the adolescents in their care. All the participants had lived in community homes for a minimum of three weeks, ensuring that the keyworker knew the adolescent well enough to complete the questionnaire. The average age of the participants was 14. Approximately three quarters of the participants described themselves as white, whilst the remaining five defined themselves as of Black African or Caribbean origin or Mixed Race. The participants are described in detail in section 3.2.

2.2. Consent

In view of the sensitivity of the data to be collected, much consideration and thought was given to the procedures used. The mental health workers connected to the project were consulted regarding the suitability of the proposed questionnaires. They agreed these were suitable. Consent for both these and the
The young people were initially approached by residential social workers with whom they were familiar (not necessarily their keyworker), and invited to talk about the project. Informed consent was sought from them after describing the project, the nature of the questionnaires and discussing with them the confidentiality of the project. It was explained that the information would be used both for individual feedback and also for research into the needs of young people in care. The young people were informed that they could discontinue the assessment at any point and that their access to health services would be unaffected by their decision whether or not to participate in this project. The volunteers were asked to complete the consent form (see Appendix iii).

The keyworkers were asked to complete an assessment about their client. The project was explained to the keyworker and they were asked to read the information sheet (see Appendix iv). They were informed that their participation in the project was voluntary and would not affect the health care the adolescents would receive. If they agreed to take part in the study, they were asked to sign a consent form (refer to Appendix v).

Finally, care was also taken to explain to the residential keyworkers the themes which would be covered with the participants. They were also informed that a mental health worker would be available to counsel their clients, if this became necessary or appropriate.

2.2. Design

A between groups design was chosen to look at the difference in schema and psychopathology. A correlational design was also used to explore the relationship between the variables (schemata and psychopathology) in relation to the research hypotheses. The two groups were distinguished by the nature of the self blame they experienced in relation to childhood traumas. A third group was made up of participants, who did not engage significantly in either form of self blame. Self blame was assessed using the Attribution of Blame Questionnaire (ABQ), described in detail later, (Section 2.5.2.).
Group 1: Engaged in a high level of Characterological Self Blame (CSB), as determined by the ABQ.

Group 2: Engaged in a high level of Behavioural Self Blame (BSB), but did not engage in a high level of CSB, as measured by the ABQ.

Group 3: Did not engage in either form of self blame to a high level, the non self blame group (NSB).

Comparison of the groups was carried out with respect to a number of different areas. The Traumatic Stress Institute Belief Scale (TSI-Adolescent Version) was used to provide measurement of the participant's cognitive schema and enable the relationship between self blame and schemata to be examined. In addition to this, the Childhood Trauma Questionnaire (CTQ) was administered to enable the participants to focus on specific childhood traumas. Finally, the Child Behaviour Checklist (CBCL) was completed by the participant's residential keyworker. This provided a measure of the participant's psychopathology (further descriptions of the measures are given in Section 2.5).

2.4. Procedure

Both the participants and their residential keyworkers were asked to provide data. For each participant, there were between one and five data collection sessions. The adolescents completed the TSI, CTQ, ABQ and an additional questionnaire for the parent project. The number of sessions depended on availability of the participants and their ability or willingness to concentrate on the questionnaires. The residential keyworkers completed the CBCL, about the nineteen participants. Some demographic information was collected about the nonparticipants from their keyworkers. This information about the nonparticipants was deemed useful, as it allowed exploration of differences between those who participated and those who did not.

The keyworkers required one session to complete the CBCL, although these were sometimes cancelled and rearranged due to pressure of work. Most of the data was collected by the author (fifteen out of nineteen of the participants and the thirty residential keyworkers). A colleague from the parent project assisted with the remaining four. This was part of a reciprocal arrangement, whereby the data for this project and for the parent project was collected by one person. This minimised the number of people involved with each participant.
Data collection is notoriously difficult with this group as they are typically unused to settling and concentrating for long periods of time. This is illustrated by the fact that few attended school. Therefore, care had been taken to design the project to maintain their interest. The questionnaires were completed on a laptop computer, which was used in preference to written assessments. Many of the young people had tried written assessments in the past and found them arduous, and consequently had been reluctant to complete written assessments. As a further incentive, the young people were able to play games on the computer between the assessments.

In general, the young people appeared happy to participate in the project and enjoyed working on the computer. Where the data was collected over several sessions, participants were asked at the end of the initial session if they would be happy to complete the assessments. They were also informed that if they did not wish to complete the data collection, they would not be required to give any further explanations. Four individuals started, but failed to complete the assessments, including one adolescent who returned to live with his family, and two others who regularly absconded and were consequently difficult to contact.

In the initial design of the study, it was envisaged that both the participant and their keyworker would complete the child behaviour checklist. It was intended that the keyworker would complete a written version of the assessment and the participants would complete their section on the computer. Because of this, a computer programme was requested from America, but unfortunately failed to arrive in sufficient time for the study. Completion of both forms was intended to provide greater reliability of the measurement of the participants' mental health.
2.5. Measures

Five measures were used:

a. The Childhood Trauma Questionnaire (CTQ), (Bernstein and Fink, 1998). See Appendix vi.

b. The Attribution of Blame Questionnaire (ABQ), devised specifically for this study. See Appendix viii.

c. The Traumatic Stress Institute Belief Scale - Adolescent version (TSI), (The Traumatic Stress Institute, 1997). See Appendix x.


e. Additional demographic information.

The order of administration of the questionnaires was decided on the basis of their content and sensitivity. The TSI, or an assessment from the parent project, was administered at the beginning of the first session as they focused on less sensitive personal information. Care was taken to ensure that administration of the CTQ was immediately followed by completing the ABQ. The CTQ enabled the participants to identify childhood traumas and the ABQ followed to identify the attribution of blame for these. All the questionnaires completed by the adolescents were preceded by a practice question, to ensure that they understood how to complete the assessments.

2.5.1. The Childhood Trauma Questionnaire: (CTQ)

(See Appendix vi for a copy of the questionnaire)

This is a 28 item, self-report inventory, which aims to provide a brief and relatively non invasive screening of maltreatment experienced before the age of 18. The CTQ identifies 5 different traumatic experiences:

- Emotional Abuse
- Emotional Neglect
- Sexual Abuse
- Physical Abuse
- Physical Neglect

(Refer to Appendix vii for definitions of these terms)

The CTQ took 10-15 minutes to administer. Participants were asked to consider the twenty-eight statements and to rate each one on a 5 point Likert scale with
responses, ranging from 'never true' through to 'sometimes true' and 'very often true'. Five statements measured each type of trauma. Examples of the statements are:

- When I was growing up, the punishment I received seemed cruel.
- When I was growing up, somebody tried to make me do sexual things or watch sexual things.
- When I was growing up, there was enough food in the house for everyone.

The three remaining statements were specifically designed to provide an opportunity to assess if the participant minimised the experiences they had.

The role of the CTQ in this study was to help the participants to focus on experiences which were difficult in their childhood. In addition, it provided a measure of the traumatic experiences which may be of value to the parent project. The CTQ was specifically chosen to provide a focus for the participant to consider traumatic childhood experiences, in a non threatening, non evasive and sensitive way.

The CTQ had been validated on a variety of adult and adolescent populations, including an adolescent psychiatric population of twelve to seventeen year olds (Bernstein et al., 1997). One of the participants in this study was younger than twelve, but when his intellectual level was taken into consideration, it was deemed appropriate for him to participate in the study. The validity and reliability of the CTQ on both clinical and non-clinical samples was assessed, in both adolescent and adult populations. The internal consistency reliability coefficients ranged from satisfactory to excellent. Sexual abuse scored the highest with a Cronbach's alpha score of 0.92, whilst physical neglect scored the lowest Cronbach's alpha score of 0.66 (Bernstein and Fink, 1998). The test/re-test reliability was also found to be stable. Factor analysis was carried out to establish the construct validity. The correlation values for the five areas of abuse on the CTQ were statistically significant, at the 0.001 level for normal and adolescent psychiatric inpatient population.

The validity of the CTQ was also assessed against other known measures; Childhood Trauma Interview (Fink et al., 1995), and the Childhood Maltreatment Interview of Trauma (Briere, 1992). Correlations of the CTQ with the Childhood Trauma Interview were statistically significant to the 0.001 level for the five areas of abuse (sexual, physical and emotional abuse; emotional and physical neglect) (Bernstein and Fink, 1998). Comparison of the CTQ with the Child Maltreatment
Interview found significant correlation between; the CTQ Sexual Abuse Scale with the Molestation Scale; and the CTQ Physical Abuse Scale with the Child Physical Assault Scale (p<0.001) (Bernstein and Fink, 1998).

2.5.2. The Attribution of Blame Questionnaire (ABQ)
(See Appendix viii for a copy of the questionnaire)

This was a non standardised questionnaire designed specifically by the author for use in this study, to identify the individuals' attributions of blame for traumatic childhood events to a number of causes. The ABQ aims to differentiate between four types of blame, characterological self blame (CSB), behavioural self blame (BSB) and blame of others or fate. These four attributions of blame were chosen as they were commonly investigated in the literature (Feinauer and Stuart, 1996; McMillen and Zuvarin, 1997) and are believed to be relevant to the experience of trauma. In order to balance the questionnaire, the participants were given the opportunity to identify various forms of blame. However, the primary area of interest in the design of this study was self blame following trauma.

The participants were asked to consider the statements on the ABQ with respect to the difficult childhood experiences they had identified in the CTQ. The exact nature of traumatic experience was known only to the participant. It was felt that discussion about the trauma would be unnecessarily intrusive. It was believed to be sufficient that the experience was chosen by the participants as a significant negative event(s) in childhood.

The ABQ consists of twelve statements, three for each type of blame. It aimed to identify the individual's attribution of blame about traumatic events and to address problems about measurement of self blame, as discussed earlier in section 1.3.2. This questionnaire follows the CTQ and asks specifically about childhood trauma, hoping in this way to concentrate on real, rather than hypothetical events. To avoid the criticism of being too abstract, three different questions were designed to focus on specific aspects of the events. A four point Likert scale was used ranging from 'disagree strongly' through 'disagree a little' and 'agree a little' to 'agree strongly'. It was hoped that even those participants who tended to deny blame would have the opportunity to attribute blame, where appropriate. The scale was scored from 0 to 3, (0 = disagree strongly; 3 = agree strongly). Finally, the ABQ provided the opportunity for individuals to attribute blame to a range of sources (themselves, others and fate), and assumes that they
may experience several types of blame for the same event(s). As previously stated, however, this study has focused only on self blame.

Three different versions of the ABQ were designed. The first version was constructed with reference to the literature regarding the attribution of blame. It followed particular recommendations about the nature of the constructs of self blame, as described by Anderson et al. (1994). The following of these recommendations contributed to the construct validity of the measure. The ABQ was discussed with supervisors, with respect to the suitability of the statements for the participants. This resulted in a second, more comprehensible, version (see Appendix ix). To investigate the face validity of the ABQ, the 2nd version was piloted on ten colleagues, who were asked to complete the ABQ in respect of a recent, interpersonal difficulty or conflict. As a result, it became apparent that one original statement (statement 11) was unclear and was open to a number of different interpretations. This statement was altered resulting in the final version of the ABQ. (see Appendix viii).

The questions aiming to measure **Behavioural Self Blame** (BSB) were:

2. If I had talked to someone earlier, I could have avoided some of the things that happened
5. If I had thought the situation through in a different way I could have avoided some of the things that happened
8. If I had acted differently, I might have avoided some of the things that happened.

These statements aimed to measure unstable, internal, controllable factors, (i.e. BSB), in accordance with the recommendations made by Anderson et al. (1994). The following statements aimed to measure stable uncontrollable and internal factors, **Characterological Self Blame** (CSB):

4. Somehow I make bad things happen to me
7. If I was a different person, I could have avoided some of the things that happened
11. Another person might have avoided some of the things that happened, but I don't think there was any way I could have.
2.5.3. The Traumatic Stress Institute Belief Scale (TSI)- Adolescent version.  
(See Appendix x for a copy of the questionnaire)

This scale was devised in accordance with Constructivist Self Development Theory of trauma (McCann and Pearlman, 1990). It measured cognitive schemata about the self and others in five areas: safety, trust, control, esteem and intimacy. These areas were believed to be particularly affected by traumatic experiences. The questionnaire consisted of eighty-five self statements, which the individual rated using a six point Likert scale, indicating the extent to which they agreed or disagreed. Examples of the statements were:-

- I often doubt myself;
- I can make good decisions;
- I trust too many people.

The TSI adolescent version had recently been designed and had not yet been widely used. However, the adult version had been successfully used in a number of studies (e.g. Dutton and Burghardt, 1994). The adult version consists of the same ten subscales. The normative data on the adult version is presented in Table 2. The mean and the standard deviation scores of the ten schema areas are provided. The population used was an undergraduate population and the sample number was two hundred and fifty six. The Cronbach's alpha values for reliability of the sub scales ranged from 0.70 to 0.95.

Table 2. The mean and standard deviation of the scores for the adult version L of the TSI.

<table>
<thead>
<tr>
<th>TSI scales</th>
<th>Mean (SD)</th>
<th>TSI scales</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Safety</td>
<td>2.41 (0.54)</td>
<td>Other safety</td>
<td>2.22 (0.71)</td>
</tr>
<tr>
<td>Self Trust</td>
<td>2.43 (0.63)</td>
<td>Other Trust</td>
<td>2.37 (0.83)</td>
</tr>
<tr>
<td>Self Control</td>
<td>2.40 (0.81)</td>
<td>Other Control</td>
<td>2.66 (0.78)</td>
</tr>
<tr>
<td>Self Esteem</td>
<td>2.57 (0.80)</td>
<td>Other Esteem</td>
<td>1.97 (0.72)</td>
</tr>
<tr>
<td>Self Intimacy</td>
<td>2.42 (0.62)</td>
<td>Other Intimacy</td>
<td>2.57 (0.74)</td>
</tr>
</tbody>
</table>

n=256. Permission to use this assessment and the normative data was obtained from the Traumatic Stress Institute.
2.5.4. The Child Behaviour Checklist. - (CBCL)
(See Appendix xi for CBCL)

This is a widely used, standardised assessment of the mental health and behavioural problems of children and adolescents. The CBCL is part of an assessment which consist of three forms: the Child Behaviour Checklist (CBCL), the Youth Self Report (YSR) and the Teacher Report Form (TRF). The forms are completed by different individuals: the carer or parent, the young person and their teacher. Each part may be used for assessment on its own or in combination with the other forms.

The CBCL is designed to be completed by the individual's parental figure. In this study, the adolescent's keyworker had this role and was asked to complete the assessment. The CBCL identifies levels of depression and anxiety, aggression and somatic difficulties, together with other problems. This assessment was chosen because it provided a measure of depression. Greenberg et al. (1988) found evidence for a relationship between the experience of anxiety and depression. Thus the use of the subtest 'anxious/depressed' on the CBCL appeared appropriate as a measure for depression. Whilst other assessments of depression may have been less cumbersome, the CBCL was already part of the parent project and it was important not to overburden the participants by asking them to complete overlapping assessments.

The Cronbach's alpha values for the parental version, measuring the reliability of the Anxious Depression Scale, were good (0.86 for males aged 12-18 years of age and 0.88 for females ages 12-18). Using the CBCL, it has been possible to discriminate between clinical and non-clinical samples, and therefore to demonstrate content validity. Construct validity has been established by its correlation with other, known measures. The Cronbach's alpha score for the 'anxious/depressed' subtest of the CBCL with the corresponding subtest on the Conners Parental Questionnaire (Conners, 1973) was 0.67. In addition, the CBCL showed good inter-parent correlation and test/re-test reliability for the problem scales with $r=0.89$.

The CBCL has been used in a residential care setting and was found to provide a useful measure of adolescents' problems, (Massey and Murphy, 1991). Verhulst and van der Ende (1991) carried out a study of the CBCL, TRF and YSR and they found that good correlations existed between the different forms. The highest
correlations, which occurred between the parental report (CBCL) and the adolescents' report (YSR), was for the rating of externalising behaviour (Rey et al., 1992).

2.5.5. Additional demographic information
The participants' and nonparticipants' keyworkers were asked to provide additional information about age, gender, ethnic origin and date of entrance to the community home system of the young person.

2.6 Analysis of the data
The nature and distribution of the data and the research hypotheses guided the selection of the statistical procedures. The majority of the data was in the form of interval variables (e.g. the measurements of schema and psychopathology), with the exception of the demographic data, which consisted largely of categorical variables. Bryman and Cramer (1997) argued that the assumption that variables were similar to a normal distribution could be made if three conditions were satisfied:
   a) the data is measured by roughly equally scaled interval data
   b) the distribution of the data is similar to a normal distribution
   c) the variance of the variables are similar.
Bryman and Cramer (1997) indicated that these criteria were flexible and that the parametric assessments, which were used with normal data, were robust and allowed for some variation in the three criteria. The data was explored by examining the distribution of the variables. Not all the variables in this study could be demonstrated to fit these criteria exactly. In particular, the ABQ did not always fit the normal distribution, substantial proportions of responses being rated on 'Strongly Disagree'. In general the variables measuring the schemata and psychopathology were normal. In the light of Bryman and Cramer's (1997) recommendations, parametric statistics were employed for the majority of the analysis. Bryman and Cramer suggested that where the data differed from the criteria, it was possible to apply the equivalent non-parametric assessment. They suggested that this served to confirm the findings of the parametric assessments used. The use of parametric assessments had the advantage that comparisons would be made of the actual differences between the groups of participants. Non-parametric approaches were used with the nominal data, the majority of which was demographic information about the participants and nonparticipants. The analysis of the data is split into two parts.
2.6.1. Description of item analysis

The initial step in the data analysis was to look at the reliability of the ABQ as a measure of the two types of self blame, using a process of item analysis (Streiner and Norman, 1995). Each dimension, BSB and CSB, was measured by three statements, which the participants had rated on a four point, Likert scale. The correlation of the participants’ responses for these three statements was measured for each dimension. Item analysis was appropriate for additive scales, composed of statements measured on a Likert scale, such as the ABQ (Streiner and Norman, 1995).

Item analysis tested the assumption that the three items measured the same underlying factor and therefore could be used in a scale together. The process involved a series of procedures which explored whether sufficient evidence existed to exclude a particular item. The correlations for the three items were measured using the Pearson's product-moment correlation coefficient (Pearson r). This inter item analysis assumes normal distribution of answers to the statements. Where correlations were poor or negative, the distribution of the answers to the individual statements were compared. Items with poor correlation and dissimilar distributions of responses were excluded, on the basis that they were not measuring the same underlying factor. Reliability coefficients for the factors (BSB and CSB) were re-examined, to determine that the exclusion of an item was justified.

2.6.2. Description of the analysis of the main findings

The second part of the data analysis looked at differences between the groups of participants. Parametric assessments were used. A series of two tailed t-tests were applied, to explore differences between two independent groups across a range of independent variables (Greene and D'Oliveira, 1982). Two tailed t-tests measured any difference between the groups and they also indicated the nature of the difference. Where the variance of the groups were unequal, Levene's test was applied (Bryman and Cramer, 1997). In addition, t-tests were chosen as they were appropriate for small sample sizes (Greene and D'Oliveira, 1982). The value of "t" was an indication of the size of the difference between the means for the two groups, taking account of their variance (Greene and D'Oliveira, 1982). This was used to determine the probability of the groups being different. When comparison of normally distributed data across three groups was required, a one
way analysis of variance, ANOVA, was used. The product of this analysis (F) was a measure of the difference of the groups. A 0.05 significance level was used throughout the analysis.

The relationships between two variables were explored by calculating Pearson r. This is a measure on a scale of +1 to -1, where +1 indicates a positive relationship between two variables and -1 indicates a negative relationship. Bryman and Cramer (1997) cite suggestions made by Cohen and Holliday (1982), about guidelines for the interpretation of Pearson r values. They suggest that a value of 0.20 to 0.39 is a low correlation and 0.40 to 0.69 is a modest correlation and 0.70 to 1 is a very high correlation.

For categorical data (e.g. racial group) Bryman and Cramer (1997) recommended the use of non parametric assessments. Chi-Square tests have been employed to explore the differences between categories. A binomial test was used to assess the probability of an event occurring by chance.

Version 6.1 of SPSS (Power Macintosh) was used for statistical interpretation.
3. Results

3.1. Analysis of the Attribution of Blame Questionnaire (ABQ)

The first task was to explore the validity and the reliability of the dimensions in the ABQ. Reliability analysis of the statements, designed to measure Characterological Self Blame (CSB) gave a reliability coefficient of Cronbach’s alpha equal to 0.43 (n=19). The Behavioural Self Blame (BSB) measure gave a reliability coefficient of Cronbach’s alpha equal to 0.67 (n=19). The reliability coefficient for CSB suggested that further exploration using item analysis would show whether or not the three statements, designed to identify CSB, were measuring the same underlying concept.

3.1.1. Item Analysis on the Attribution of Blame Questionnaire (ABQ)

Item analysis identified whether the statements correlated positively with each other and could be assumed to measure the same factor. This process was used to assess the correlations of the three statements for each measure of self blame. Pearson r correlation values were calculated for the three statements, designed to measure CSB. The correlation values for statements 4, 7 and 11 from the ABQ are presented in Table 3.

Table 3. The Pearson r correlation values for the statements measuring CSB

<table>
<thead>
<tr>
<th>ABQ Statements</th>
<th>4</th>
<th>7</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ABQ Statements</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>ABQ Statements</strong></th>
<th>4</th>
<th>7</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td></td>
<td></td>
<td>0.48**</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.25</td>
<td></td>
</tr>
</tbody>
</table>

** p<0.05

Item analysis showed that statements 4 and 7 on the ABQ had a correlation value of 0.48, which was significant (p<0.05). The analysis of statements 4 and 7 with statement 11 gave Pearson r correlation values of -0.12 and 0.25, respectively.
which demonstrated poor correlation between item 11 and items 7 and 4 (n=19). This suggests that statements 4 and 7 were not measuring the same factor as was being measured by statement 11. This is demonstrated in Figure 2. One reason for this discrepancy may have been that statement 11 was confusing for the participants due to its length and complexity.

As a result of the negative and low correlations and the difference in distribution patterns of statement 11, it was excluded from the measure of CSB. Excluding statement 11 from this measurement raises the reliability coefficient of Cronbach's alpha to 0.65 with n = 19.

Item analysis was also performed on the statements designed to contribute to a measurement of BSB. Pearson r correlation values for the three statements were 0.60 (statement 2 and 5), 0.41 (statement 5 and 8) and 0.21 (statement 2 and 8). These correlations are in the low and modest range, as defined by Cohen and Holliday (1982). Because of the low correlation value of statement 8 the possibility of excluding this from the measurement of BSB was explored. The exclusion of statement 8 was found not to affect the composition of three groups, to which the participants were assigned. On the basis of positive correlations for all three statements, they were all accepted as a measure of BSB. The reliability coefficient for the measurement of BSB gave a Cronbach's alpha = 0.67 for all three items when n = 19. The reliability scores of both measures of self blame fell close to the recommended standard of reliability of between 0.7 and 0.9 (Streiner and Norman, 1995)
Figure 2: Distribution of responses to the statements designed to measure CSB

<table>
<thead>
<tr>
<th>Responses</th>
<th>ABQ4</th>
<th>ABQ7</th>
<th>ABQ11</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

0 = Strongly Disagree
1 = Disagree a little
2 = Agree a little
3 = Strongly agree
3.1.2. Assignment of participants to three groups

On the basis of the measures for CSB and BSB from the ABQ, the participants were divided into three groups, which are defined in Table 4.

Table 4. Criteria for the assignment of the participants to groups

<table>
<thead>
<tr>
<th>Characterological Self Blame Score</th>
<th>Behavioural Self Blame Score ≤ 3</th>
<th>Behavioural Self Blame Score ≥ 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 2</td>
<td>Non Self Blame group (NSB) n=7</td>
<td>Behavioural Self Blame group (BSB) n= 6</td>
</tr>
<tr>
<td>≥ 3</td>
<td>Characterological Self Blame group (CSB) n=6</td>
<td></td>
</tr>
</tbody>
</table>

A total of 7 participants were assigned to the Non Self Blame group (NSB), as they had BSB scores less than 4 and CSB scores less than 3. A total of six participants were assigned to both of the remaining two groups. The BSB group contained individuals who obtained a BSB score greater than 3 and a CSB score less than 3. The CSB group comprised individuals who scored greater than 2 on the CSB score, regardless of their other scores.

A summary of the group responses on the ABQ is presented in Table 5. This table presents the mean and standard deviation values for the NSB, BSB and CSB groups in respect of the behavioural self blame score and the characterological self blame score. The first column lists the self blame measures from the ABQ. The second, third and fourth columns contain the mean and standard deviation values of the 3 groups on the self blame measures.

Table 5 demonstrates that for the NSB group the mean scores from both the self blame measures were small. Whereas for the CSB and the BSB group the mean value of the behavioural self blame score was large. Only the CSB group had a large value for the Characterological self blame score.
Table 5. Mean and standard deviation values of the ABQ measures for the three groups.

<table>
<thead>
<tr>
<th>Participant Groups</th>
<th>NSB Mean (SD)</th>
<th>BSB Mean (SD)</th>
<th>CSB Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioural Self Blame Score</td>
<td>1.80 (0.98)</td>
<td>6.17 (0.75)</td>
<td>6.00 (2.19)</td>
</tr>
<tr>
<td>Characterological Self Blame Score</td>
<td>0.67 (0.75)</td>
<td>1.00 (0.89)</td>
<td>3.83 (0.75)</td>
</tr>
</tbody>
</table>

All values are correct to two decimal places.

3.2. Demographic information

Demographic information for the three groups, BSB, NSB and CSB is presented in Table 6.

Table 6 presents the demographic data. The first column identifies the demographic characteristics. The second, third and fourth columns identify the mean values or the proportions of the groups to which the characteristic applies. The fifth column represents the statistical assessments of the difference between the groups.

Chi-Square assessments of difference were performed and demonstrated the groups were of similar composition with respect to age, sex and racial background. The number of participants who reported experiences of childhood abuse or neglect (physical, sexual or emotional) varied across the three groups. The NSB group had the lowest reported incidence of childhood abuse at 57% and the BSB group had the highest reported incidence at 83%. This was measured by the Childhood Trauma Questionnaire (CTQ). Of the six participants who did not report any childhood abuse, four had scores which indicated a process of minimisation or denial had been employed in answering CTQ questions. Across the sample approximately 17% of the CSB group obtained scores on the CTQ which indicated that some degree of minimisation or denial was used, this compared to approximately 50% of the BSB group and 57% of the NSB group. Where possible, information about the length of time in care was collected. No significant differences existed between the three groups.
Table 6. Demographic characteristics of the three groups

<table>
<thead>
<tr>
<th>Demographic characteristics</th>
<th>Behavioural (BSB)</th>
<th>Characterological (CSB)</th>
<th>Non Self Blame group (NSB)</th>
<th>Comparison of difference between the three groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number in the group</td>
<td>6</td>
<td>6</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Age (Mean)•</td>
<td>13.6</td>
<td>13.5</td>
<td>13.8</td>
<td>n.s.peater</td>
</tr>
<tr>
<td>Sex* (% Male)</td>
<td>83</td>
<td>83</td>
<td>86</td>
<td>n.s.peater</td>
</tr>
<tr>
<td>Racial background* (% Caucasian)</td>
<td>67</td>
<td>67</td>
<td>86</td>
<td>n.s.peater</td>
</tr>
<tr>
<td>Percentage of participants reported to have experienced abuse *</td>
<td>83</td>
<td>67</td>
<td>57</td>
<td>n.s.peater</td>
</tr>
<tr>
<td>Percentage of participants living in community homes for six months or less *</td>
<td>33</td>
<td>50</td>
<td>14</td>
<td>n.s.peater</td>
</tr>
</tbody>
</table>

• -Correct to one decimal place.  

* - Correct to two significant figures.  

n.s. - Non significance at the 0.05 level.  

• - One way analysis of variance applied.  

◊ - Chi-Squared test applied.
Table 7. Demographic information about nonparticipants compared to participants

<table>
<thead>
<tr>
<th></th>
<th>Number in group</th>
<th>Age • (Mean)</th>
<th>Sex * (% Male)</th>
<th>Racial back-ground* (% Caucasian)</th>
<th>Percentage of participants living in community homes for six months or less*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonparticipants</td>
<td>11</td>
<td>14.1</td>
<td>72</td>
<td>73</td>
<td>0</td>
</tr>
<tr>
<td>Participants</td>
<td>19</td>
<td>13.6</td>
<td>84</td>
<td>74</td>
<td>32</td>
</tr>
<tr>
<td>Tests of difference</td>
<td>n.s.♫</td>
<td>n.s.◊</td>
<td>n.s.◊</td>
<td>Chi-Square=4.34</td>
<td>DF=1                                                            ♦ **</td>
</tr>
</tbody>
</table>

* - Correct to two significant figures. ** - A 0.05 Significance level.
♫ - One way analysis of variance applied.
◊ - Chi-Squared test applied.
n.s. - Not significant at the 0.05 level.
• - Correct to one decimal place.

Table 7 contains a comparison of the demographic information, between those who participated in the study and those who did not. The first row shows the demographic characteristics. The second and third rows attribute characteristic values for nonparticipants and participants, respectively. The fourth row summarises the statistical assessment of the difference between the groups.

Table 7 appears to show that the nonparticipants have similar demographic characteristics to the participants, with the exception of the length of time spent in community homes. All the nonparticipants had lived in community homes for more than seven months, whilst approximately 32% of the participants had lived in the community homes for less than this time.

3.3 Association between two types of Self Blame and schemata.

A series of two-tailed t-tests was conducted, to compare the mean values of the cognitive schemata of each Self Blame group (measured using the TSI). Table 7 presents the outcome of these tests. The first column identifies the schema areas,
measured by the TSI. The second, third and fourth columns provide a record of the mean and the standard deviation of all three groups (BSB, CSB and NSB). The fifth column contains the t values for the two-tailed t-test performed on the means of the BSB and CSB groups.

Table 8. Means, standard deviations and t-test results from analysis of the schemata between the three groups

<table>
<thead>
<tr>
<th>Schemata</th>
<th>Behavioural Self Blame (BSB) Mean (SD)</th>
<th>Characterological Self Blame (CSB) Mean (SD)</th>
<th>Non Self Blame group (NSB) Mean (SD)</th>
<th>Two tailed t-test comparing BSB and CSB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Esteem</td>
<td>2.20 (0.45)</td>
<td>2.92 (0.50)</td>
<td>2.53 (0.71)</td>
<td>t(10) = -2.62 **</td>
</tr>
<tr>
<td>Self Control</td>
<td>2.30 (0.22)</td>
<td>2.82 (0.51)</td>
<td>2.62 (0.61)</td>
<td>t(10) = -2.30 **</td>
</tr>
<tr>
<td>Self Intimacy</td>
<td>2.90 (0.41)</td>
<td>3.38 (0.76)</td>
<td>3.47 (0.75)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Self Safety</td>
<td>2.50 (0.55)</td>
<td>3.02 (0.50)</td>
<td>3.25 (1.27)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Self Trust</td>
<td>2.90 (0.78)</td>
<td>3.06 (0.42)</td>
<td>3.04 (0.97)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Other Esteem</td>
<td>2.62 (0.28)</td>
<td>2.85 (0.54)</td>
<td>2.36 (0.71)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Other Control</td>
<td>2.88 (0.80)</td>
<td>3.38 (0.29)</td>
<td>2.90 (0.86)</td>
<td>n.s.†</td>
</tr>
<tr>
<td>Other Intimacy</td>
<td>2.44 (0.64)</td>
<td>2.64 (0.53)</td>
<td>2.59 (0.86)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Other Safety</td>
<td>2.96 (0.52)</td>
<td>3.58 (0.94)</td>
<td>2.70 (0.89)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Other Trust</td>
<td>3.07 (0.66)</td>
<td>3.11 (0.46)</td>
<td>2.70 (0.64)</td>
<td>n.s.</td>
</tr>
</tbody>
</table>

All figures accurate to two decimal places. † Levene's test applied. **Significant at the 0.05 level. n.s.-Not significant. High values suggest maladaptive schemata.

Analysis of the two groups, using a two tailed t-test, indicated a statistically significant difference between BSB and CSB groups, in relation to the Self Esteem schema (BSB mean = 2.20, CSB mean = 2.92, t(10) = -2.62, p<0.05). The BSB group had less maladaptive Self Esteem schema than the CSB group. In addition, using the same statistical assessment, there was a statistically significant difference between the two groups, in relation to Self Control (BSB mean = 2.30, CSB mean = 2.82, t(10) = -2.30, p<0.05). The BSB group had significantly less maladaptive Self Control schema, than the CSB group.
There were no significant differences between the two self blame groups, across the other eight schemata, measured by the TSI. However, all the scores for the BSB group were lower than those of the CSB group. Figure 3 shows the profile of the means for the three groups (BSB, CSB and NSB), across the ten schemata. A visual examination of the patterns of the mean schemata scores for the ten different schemata of the two self blame groups, shows clearly that the mean score for each schema of the CSB group was higher than that of the BSB group. The NSB group had mean values for the ten schemata, which were either higher or lower than the mean values for the two self blame groups.

A binomial test measures the probability of an event occurring. In this case it was used to test the likelihood of the BSB mean schema scores being lower than the mean CSB schema scores, for eight of the schemata. These eight schemata chosen were Self Intimacy, Self Safety, Self Trust, Other Esteem, Other Control, Other Intimacy, Other Safety and Other Trust. The statistical test indicated that the probability of the CSB group having a higher mean score for all eight schemata was $p = 0.0039$. This was statistically significant ($p<0.05$). This demonstrated that the BSB group had statistically significant lower schemata scores than CSB, across the eight schemata which were not found to be individually significantly different for CSB and BSB groups using two-tailed t-tests.

In summary, if these two findings were combined it could be stated that the BSB group had significantly lower mean scores on Self Control and Self Esteem schemata, compared with the CSB group. The BSB group also had significantly lower schema scores than the CSB group, when all eight remaining schemata were considered together.
Figure 3: The mean schemata scores for the BSB, CSB & NSB groups
3.4. Association between self blame and psychopathology

Two tailed t-tests were used to measure differences in psychopathology, between the self blame groups, as measured by the CBCL. Table 9 summarises these findings. The first column outlines the areas of psychopathology, as measured by the CBCL. The next three columns provide the mean and standard deviation scores from the CBCL of the three groups (BSB, CSB and NSB). The sixth column contains the results of the two tailed t-tests, on the difference between CBCL scores of the two self blame groups. The fifth column reports the mean and the standard deviation scores, for what Achenbach (1991) describes as the normal male adolescent sample (12-18 years). This normal sample was chosen as most of the participants were of a similar age and gender.

No significant differences were found in psychopathology, between either self blame group (at p<0.05, n=19). A comparison of the mean scores of the CBCL sub scales indicated that the mean values of all the groups exceeded the mean for the normal population of 12 to 18 year old males. Figures 4 and Figure 5 provide visual representation of the data in Table 9.
Table 9. Comparison of the psychopathology scores across the three groups

<table>
<thead>
<tr>
<th>CBCL scores</th>
<th>Behavioural Self Blame (BSB) Mean (SD)</th>
<th>Characterological Self Blame (CSB) Mean (SD)</th>
<th>Non Self Blame (NSB) Mean (SD)</th>
<th>Normal population males (12-18 years) Mean (SD)</th>
<th>Two tailed t-tests comparing BSB and CSB groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>External</td>
<td>29.83 (12.66)</td>
<td>33.67 (16.48)</td>
<td>26.71 (8.22)</td>
<td>8.9 (7.5)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Internal</td>
<td>13.83 (7.73)</td>
<td>13.33 (5.50)</td>
<td>13.29 (7.06)</td>
<td>6.5 (5.3)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Anxious/Depressed</td>
<td>9.00 (3.52)</td>
<td>9.00 (3.85)</td>
<td>8.43 (5.38)</td>
<td>3.2 (3.3)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Withdrawn</td>
<td>4.83 (4.22)</td>
<td>3.67 (2.07)</td>
<td>3.86 (2.27)</td>
<td>2.4 (2.2)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Somatic Complaints</td>
<td>1.17 (1.6)</td>
<td>1.50 (1.05)</td>
<td>2.14 (2.12)</td>
<td>1.0 (1.4)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Social Problems</td>
<td>3.67 (3.93)</td>
<td>5.67 (3.08)</td>
<td>5.14 (2.61)</td>
<td>1.6 (1.9)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Thought Problems</td>
<td>1.67 (2.01)</td>
<td>1.33 (1.51)</td>
<td>1.29 (1.11)</td>
<td>n.a.</td>
<td>n.s.</td>
</tr>
<tr>
<td>Attention Problems</td>
<td>7.00 (3.95)</td>
<td>6.50 (3.73)</td>
<td>6.14 (3.53)</td>
<td>3.4 (3.1)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Delinquent Behaviour</td>
<td>12.00 (2.83)</td>
<td>10.83 (6.05)</td>
<td>9.71 (2.36)</td>
<td>1.9 (2.4)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Aggressive Behaviour</td>
<td>17.83 (11.55)</td>
<td>22.83 (11.92)</td>
<td>17.00 (6.32)</td>
<td>7.0 (5.7)</td>
<td>n.s.</td>
</tr>
</tbody>
</table>

All figures accurate to two decimal places. n.a.-Not available. n.s.-Not significant at the 0.05 level.
Figure 4: Comparison of the psychopathology mean group scores
(External, Internal & Anxious/Depressed)

CBCL Subtests

- BSB
- CSB
- NSB
- Normal Population

Scores

- External
- Internal
- Depression
Figure 5: Comparison of the psychopathology mean group scores


CBCL Scores

<table>
<thead>
<tr>
<th>CBCL Subtests</th>
<th>Withdrawn</th>
<th>Somatic Complaints</th>
<th>Social Problems</th>
<th>Thought Problems</th>
<th>Attention Problems</th>
<th>Delinquent Behaviour</th>
<th>Aggressive Behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BSB</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CSB</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NSB</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal Population</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Legend:
- BSB
- CSB
- NSB
- Normal Population
3.5. Association between schemata and psychopathology

The correlations between the schemata and measures of psychopathology were carried out using Pearson r correlations. Table 10 summarises the outcome of the correlations of the psychopathology sub-scales, with the five different 'Self' schemata.

Table 10. Pearson r correlation values of psychopathology with 'Self' schemata

<table>
<thead>
<tr>
<th>CBCL scores</th>
<th>Schemata</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Self Esteem</td>
</tr>
<tr>
<td>External</td>
<td>.22</td>
</tr>
<tr>
<td>Internal</td>
<td>.21</td>
</tr>
<tr>
<td>Anxious/Depressed</td>
<td>.27</td>
</tr>
<tr>
<td>Withdrawn</td>
<td>-.03</td>
</tr>
<tr>
<td>Somatic Complaints</td>
<td>.13</td>
</tr>
<tr>
<td>Social Problems</td>
<td>.56**</td>
</tr>
<tr>
<td>Thought Problems</td>
<td>.26</td>
</tr>
<tr>
<td>Attention Problems</td>
<td>.21</td>
</tr>
<tr>
<td>Delinquent Behaviour</td>
<td>.12</td>
</tr>
<tr>
<td>Aggressive Behaviour</td>
<td>.22</td>
</tr>
</tbody>
</table>

All correlations are two tailed tests. **Significant at the 0.05 level.
All figures correct to two decimal places.
The first column contains factors which indicate psychopathology from the CBCL. The second to the sixth columns represent the Pearson r correlation values of the CBCL scores, with self schemata values.
The majority of the correlations between psychopathology and self schemata were positive, 4% of which were significant. Two significant correlations at the 0.05 level were found between Social Problems and Self Esteem and Self Intimacy. The remaining correlations were not statistically significant. In general, very low and low positive correlations existed between psychopathology and Self Esteem. Low positive correlations also existed between Self Control and psychopathology. However, these were not significant at the 0.05 level.

Table 11 provides a summary of the correlation values, between the 'Other' schemata and the psychopathology subtests, from the CBCL. Again, the first column contains the factors from the CBCL and the second to sixth columns contain the Pearson r correlation values with the 'Other Schema'.

59
## Table 11. Pearson r correlation values of psychopathology with 'Other' schemata

<table>
<thead>
<tr>
<th>CBCL scores</th>
<th>Schemata</th>
<th>Other Esteem</th>
<th>Other Control</th>
<th>Other Safety</th>
<th>Other Trust</th>
<th>Other Intimacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>External</td>
<td></td>
<td>.24</td>
<td>.17</td>
<td>.43</td>
<td>.20</td>
<td>.08</td>
</tr>
<tr>
<td>Internal</td>
<td></td>
<td>.09</td>
<td>.48**</td>
<td>.36</td>
<td>.21</td>
<td>.26</td>
</tr>
<tr>
<td>Anxious/Depressed</td>
<td></td>
<td>.04</td>
<td>.35</td>
<td>.31</td>
<td>.16</td>
<td>.15</td>
</tr>
<tr>
<td>Withdrawn</td>
<td></td>
<td>-.41</td>
<td>.27</td>
<td>.05</td>
<td>.09</td>
<td>.12</td>
</tr>
<tr>
<td>Somatic Complaints</td>
<td></td>
<td>.08</td>
<td>.61**</td>
<td>.48**</td>
<td>.12</td>
<td>.32</td>
</tr>
<tr>
<td>Social Problems</td>
<td></td>
<td>.30</td>
<td>.57**</td>
<td>.49**</td>
<td>-.02</td>
<td>.52**</td>
</tr>
<tr>
<td>Thought Problems</td>
<td></td>
<td>.07</td>
<td>.43</td>
<td>.17</td>
<td>-.05</td>
<td>.21</td>
</tr>
<tr>
<td>Attention Problems</td>
<td></td>
<td>.14</td>
<td>.34</td>
<td>.12</td>
<td>.23</td>
<td>.31</td>
</tr>
<tr>
<td>Delinquent Behaviour</td>
<td></td>
<td>.22</td>
<td>.07</td>
<td>.15</td>
<td>.41</td>
<td>-.01</td>
</tr>
<tr>
<td>Aggressive Behaviour</td>
<td></td>
<td>.21</td>
<td>.24</td>
<td>.48**</td>
<td>.08</td>
<td>.10</td>
</tr>
</tbody>
</table>

All correlation s are two tailed tests. **Significant at the 0.05 level. All figures correct to two decimal places.

Most of the 'Other' schemata, 92 percent, had positive correlations with the psychopathology sub-scales. The majority of the negative correlations, were between the Withdrawn subtest and the schemata. Fourteen percent of the correlation values between the 'Other' schemata and the psychopathology sub tests were statistically significant (p<0.05). The CBCL sub test for Social Problems correlated positively (to a significant level) with a total of five Self and Other schemata. These were; Self Esteem, Self Intimacy, Other Control, Other Safety and Other Intimacy (p<0.05). Both Other Control and Other Safety schemata correlated significantly, (p<0.05), with two other sub tests of the CBCL. (Other Control correlated significantly with Internal Problems and Somatic Problems.
Other Safety correlated significantly with Somatic Problems and Aggressive Behaviour.

For a number of tests, non-parametric assessments were carried out and the results were not significantly different from the analysis, using the parametric statistical tests. See Appendix xii.
4. Discussion

4.1. Interpretation of the findings

4.1.1. The identification of the two forms of self blame

Hypothesis 1. That adolescents who have experienced trauma have a tendency to experience BSB and/or CSB

Through the Attribution of Blame Questionnaire (ABQ), it was possible to identify two different types of self blame, in a population of adolescents, who had experienced trauma. Self blame, as measured by the ABQ, was experienced to a significant level by approximately 63% of the participants in the study. Characterological Self Blame (CSB), whereby an individual attributes responsibility for trauma to their character was experienced, to a significant level, by approximately 32% of the participants.

The second form of self blame, Behavioural Self Blame (BSB), whereby an individual blames a specific aspect of their behaviour, occurred in approximately two thirds of the sample. Of these participants approximately half also experienced CSB and the remaining half, 32% of the participants, experienced only the BSB form of self blame, to a significant level. The rest of the participants, 37% of the sample, did not experience either form of self blame to any significant level, as measured by the ABQ. There was no distinct pattern across the three groups of the other types of blame from the ABQ. In summary, we can accept Hypothesis 1 and conclude that it has proved possible to identify individuals, who experience two distinct forms of self blame.

These findings supported research by Anderson et al. (1994) and Janoff-Bulman (1979) who also found the existence of distinct forms of self blame. The proportion of individuals experiencing CSB was greater in this study, than in the study reported by Janoff-Bulman (1979). Individuals sometimes appear to attribute a combination of different forms of blame to themselves or others following trauma. CSB was accompanied by BSB on all occasions in this research. This phenomenon was also observed by Janoff-Bulman (1979), who offered the explanation that CSB was a global trait and consequently, an individual blames all aspects of themselves and their behaviour, as well as their character. The difficulty of distinguishing between CSB and BSB, as experienced by Miller and...
Porter (1983), can be overcome by accepting Janoff-Bulman's assumption that BSB is a property of CSB, when they occur together.

The proportion of the sample experiencing CSB in this study was larger than in Janoff-Bulman's study of victims of rape, where only 19% were reported to be experiencing CSB. This may be explained by the research of Overholser and Moll (1990) and Miller and Porter (1983), who found that CSB was more likely when the abuse was repetitive. In this study, the traumatic experiences of the adolescents would probably have been repetitive in nature, being largely a mixture of abandonment, neglect, abuse and rejection.

Caution should be taken when interpreting the results, to recognise that the ABQ was designed specifically for this study. As a new measurement tool it has not, as yet, undergone rigorous testing. The items measuring the two forms of self blame appear to demonstrate homogeneity following the process of item analysis (although a third item had to be removed from the scale). It should also be noted that the types of self blame demonstrate construct validity, by being designed in accordance with the theoretical definitions for the concepts (Anderson et al., 1994; Shapiro, 1989 and Janoff-Bulman, 1979). The reliability coefficients, Cronbach's alpha, of BSB and CSB approached the 0.7 to 0.9 recommended range.

There are a number of areas of potential experimental difficulties. The first area rests with the assumption that the participants were able to focus on the childhood traumas they had identified in the CTQ. However, as the participants were not asked to describe their experiences, it was not possible to verify that the adolescents were focusing on these events.

For the purpose of this study, the ABQ seems to be able to make tentative distinctions between two types of self blame.

The ABQ offers an alternative measure of self blame to the commonly used Attribution Style Questionnaire (ASQ) (Anderson et al., 1994). In contrast to the ASQ, the measure designed for this study offers a measure of self blame from actual experiences, rather than hypothetical situations. This may overcome the limitations of the ASQ in generalising to real life experiences. Potentially the ABQ could be employed in a variety of situations and over a range of traumas. If it can be assumed that the ABQ is a valid instrument for measuring the
attributions of self blame, then the implications of having identified two different forms of self blame can be explored.

4.1.2. The association of Self Blame with schemata

Hypothesis 2. That adolescents who have experienced trauma, and employ BSB only would have less maladaptive Self Esteem and Self Control schemata compared to those who employ CSB

Individuals employing BSB only, had lower (less maladaptive) Self Esteem schemata and this was found to be statistically significant in this study in comparison with those also experiencing CSB. It follows that individuals who use BSB had higher self esteem, seeing themselves as worthy and valuable. Others who used CSB experienced lower self esteem and lacked confidence in themselves and their abilities. These findings are in agreement with the definition of self blame, proposed by Janoff-Bulman (1979), who suggested that CSB was related to low self esteem.

If this relationship between Self Blame and Self Esteem schemata can be generalised, it would be important to consider the clinical implications. Self esteem influences the individual's development of sense of self. This is particularly important during adolescence, as the individual is laying the foundations for their future life. Weiner (1992) described adolescence as a period of continual development of self and personality. Thus if trauma is accompanied by the use of CSB, the individual's view of themselves will be more negative. McCann and Pearlman (1990) argued that low Self Esteem schemata, as with CSB, were linked to lack of confidence. During adolescence this may be reflected in areas of personal relationships or in academic achievement. McCann and Pearlman (1990) also suggested that lack of confidence could be linked to vulnerability to manipulation or abuse by other people. Such experiences would have the effect on the individual of reinforcing their view of themselves as less worthy.

The second aspect of the hypothesis was also found to be true, that BSB was associated with lower (less maladaptive) Self Control schemata and CSB was linked to higher (more maladaptive) Self Control schemata. This confirms the theoretical predictions made by Janoff-Bulman (1979) that BSB would be associated with an individual's perception of greater control over their
environment. Interpretation of the results must be made with caution, in the light of the issues raised about the ABQ and in respect of the relatively small sample.

If it is assumed that the findings can be generalised to the population of individuals who have experienced childhood abuse or neglect, then consideration must be given to the clinical implications of trauma. Control schemata are important in providing the individual with confidence about their ability to deal with situations in their environment. One of the implications of holding maladaptive Control schemata may be that the individual will experience social problems, have difficulty with authority figures, or feel anxious about being out of control in difficult or unfamiliar situations. In this way, they may actually withhold themselves from positive experiences, which could help to change their maladaptive schemata.

An inspection of the results also revealed that those who experienced BSB actually had lower mean schemata scores than those who experienced CSB. Taken individually, none of the differences in schema scores were significant, except the two already discussed (Self Control and Self Esteem). However, when they were considered together, there was a statistically significant probability that CSB was associated with more maladaptive schemata.

The implication of this finding is that the individual who experienced BSB has less maladaptive views about themselves and their world, whilst those using CSB have more maladaptive views. Cognitive Theory predicts that the individual will use schemata to interpret their present world and to anticipate future events. Thus individuals using CSB and maladaptive schemata may interpret potentially positive or neutral experiences in a negative way, which serves to confirm existing maladaptive schemata, and thus reinforces the use of CSB. Young (1990) predicted that maladaptive schemata would be self perpetuating and by attributing blame for trauma to themselves using CSB, the individual may compound this global negative view of themselves.

One of the assumptions underlying this study has been that the adolescents in the community homes will have maladaptive schemata. There is no normative data available to assess the nature of the schemata for the adolescent version of the Traumatic Stress Institute Belief Scale (TSI). However normative data does exist for the adult version. Although adult normative data is not directly applicable to the adolescent population, and some of the questions are different, both versions
of the TSI attempt to measure the same underlying factors. In the light of the
similarities, a rough comparison of the data in this study with the adult
normative data is justified. The mean schemata scores for the CSB and the NSB
groups were above that of the adult data for all of the schemata. The mean
schemata scores for the BSB group were also above that of the mean adult scores,
with the exceptions of Self Esteem, Self Control and Other Intimacy. This
suggests that the sample may have more maladaptive schemata than the normal
adult population.

The scope of this research does not allow us to identify whether a causal
relationship exists between self blame and the development of maladaptive
schemata following childhood trauma. From the findings there are four main
possibilities:
1) That self blame affects the nature of the schemata experienced by an individual,
following childhood trauma.
2) That maladaptive schemata develop following the experience of childhood
trauma. These schemata determine the nature of the self blame experienced.
3) That schemata and self blame exist in a dynamic relationship.
4) That the use of self blame and the nature of the schemata are independent of
each other but dependent on a third unknown factor.

Considering the first possibility, if it is the nature of the self blame which affects
the schemata, then whilst CSB has a negative impact on how the individuals view
themselves and their world, BSB will have a less severe effect on the individuals'
schemata. This might be explained by the link proposed by Shapiro (1989)
between CSB and 'Universal' hopelessness. He argued that, the individual may
feel unable to avoid future traumas, or to alter feelings of responsibility for the
past. In this way CSB may result in a tendency of the individual to ruminate
about issues of blame involving personal stable characteristics, and create a spiral
of negative cognitions about themselves. These negative cognitions could serve to
form and maintain negative schemata. On the other hand, individuals engaging
in BSB would attribute blame to specific or unstable factors within themselves or
their behaviour. These factors are perceived as capable of change. As a
consequence, the individual feels able to deal with future situations differently
and reduce the likelihood of developing maladaptive schemata.

The second explanation is that the schemata cause the individual to blame
themselves in a particular way. In this case, an individual with negative Self
Esteem schemata may view themselves as inadequate. Following difficult experiences, the individuals blame themselves (CSB) for their failings which they are unable to remedy. In contrast, an individual with positive Self Esteem schemata (BSB) would value their abilities. Following difficult situations, they might blame their behaviour (BSB), but see it as specific to one event and continue to perceive themselves as able to deal with future problems.

Thirdly, a combination of the first two options could exist. Self blame and schemata may be involved in a dynamic relationship, whereby the schemata influence the nature of self blame used by the individuals, and self blame feeds back and confirms the negative schemata.

However, a fourth possibility might exist whereby self blame and schemata are independent of each other, but dependent on a third variable. A number of variables has been suggested by the schema based model of trauma. These include previous experiences, the nature of the trauma, social support and relationships. Other variables which may be influential include: the individuals' resources; their personality and intelligence; their mental health and previous psychopathology.

An alternative explanation for the findings of this study may be the length of time in care. Demographic information revealed that the CSB group had been in care for a shorter length of time than the BSB group. A possible explanation for the discrepancies between these two groups may be that CSB and negative schemata improve in some individuals over time. This improvement may result from the length of time which has elapsed since the trauma or from the physical separation of the individual from the trauma. Alternatively, feelings of personal isolation for those who have experienced trauma, may be reduced with the realisation that their experiences are shared by others, changing the nature of the blame they attribute to themselves. Celano (1992) suggested that group therapy could be valuable in addressing the attribution of self blame for some. This could potentially be a fruitful area of study. It might be helpful to look at the sense of isolation in relation to types of self blame, for those who have experienced childhood trauma, but have not been in contact with others with similar experiences e.g. in foster homes.

Improvements in negative schemata over time would be in accordance with the findings of Fletcher (1988), who found that the negative schemata of Vietnam war
veterans improved over time in the majority of cases. There was however, a small group of veterans that failed to improve. It is a possibility that a similar pattern is applicable to this study. Whilst some people may be expected to improve with time, a minority may not and it would be important to identify this group.

There are a number of other factors which may contribute to the significant results which have been found in this study. The first factor is the effect of a stable, positive relationship within the individual's life and another would be the nature of their family relationships and amount of contact. The type of community home and the quality of relationships with peers and staff are likely to be influential factors.

4.1.3. Association of BSB and CSB with psychopathology

**Hypothesis 3.** That adolescents who have experienced trauma and employ BSB only will have lower levels of depression compared with those adolescents who employ CSB.

The findings of this study fail to show a significant difference between BSB and CSB in relation to depression, measured by the Child Behaviour Checklist (CBCL). Both groups experienced high levels of depression, compared to the standardised normal data for male adolescents. The mean depression scores for both groups were below the clinical cut off point proposed by Achenbach (1991). However, the depression scores were similar to the ninety-third percentile of the normal population. Depression was measured by the Anxious/Depressed scale of the CBCL provided by the adolescent's keyworker.

If these findings represent the true relationship between depression and schemata, then it appears to raise doubts about the theoretical and therapeutic implications of CSB and BSB. Janoff-Bulman's (1979) proposal that BSB has adaptive properties has not been supported by the present research. This has been an issue of considerable confusion, with research appearing to be both supportive and unsupportive of Janoff-Bulman's hypothesis.

The current findings agree with those of Meyer and Taylor (1986) who failed to find a distinction in the relationship between types of self blame with depression. The current study and that of Meyer and Taylor (1986) are similar, in that they both used a clinical population. However they differ as Meyer and Taylor's population had experienced a single incidence of trauma i.e. rape. In contrast to
the findings of this study, Anderson et al. (1994) found that CSB was linked to depression. This differed from the current study as they asked a non-clinical population to reflect on hypothetical situations.

There may be considerable difficulty in translating findings from hypothetical situations to actual situations. It is possible that individuals react differently to how they imagine they will and that hypothetical situations do not reflect real life. An alternative explanation may be that Anderson et al.'s (1994) study reflects the underlying relationship between depression with BSB and CSB, and that this is masked in real situations by other factors.

Individuals engaging in both forms of self blame experienced higher levels of depression than the normal population. A similar pattern was apparent across all of the areas of psychopathology, measured by the CBCL (except for thought problems where there is no normative data available). The findings suggest that in general, the adolescents in community homes had higher levels of psychopathology than the normal adolescent male population, supporting the findings of McCann et al. (1996). Thompson and Fuhr (1992) also recorded high levels of psychopathology with lower levels of depression in a sample in community homes. This suggests that psychological problems in this population may be manifested in symptoms other than depression.

In relation to this study, there are a number of alternative explanations for the failure to establish a difference between the two self blame groups, in terms of depression. The first is that the measure of psychopathology may have failed to give sufficient discrimination to allow distinction between the two self blame groups. The high level of psychopathology experienced by the participants in general, may have resulted in a ceiling effect, which served to mask any differences which existed between the groups. Secondly, the CBCL measured the keyworkers' subjective view of the participants. Verhulst and van der Ende (1991) found that the CBCL was less reliable than the Youth Self Report (YSR), which had originally been envisaged for this study. Finally, the small sample size has resulted in a high probability of Type II errors. See section 4.2.2. for a discussion on this point.
4.1.4. Association between schemata and psychopathology

Secondary Hypothesis 4. That less maladaptive Self Esteem and Self Control schema will be related to lower levels of depression

Neither Self Esteem or Self Control schemata correlated significantly with depression. Although this study has failed to show that a relationship exists between schemata and psychopathology, the fact that 85% of the total schemata and psychopathology correlations were found to be positive (the majority at a non significant level), hints that a relationship may exist. A larger study may be able to explore these issues further.

Out of all the correlations between the schemata and psychopathology scores, nine statistically significant correlations were found. In interpreting these results, consideration should be given to the number of significant correlations which would be expected to occur by chance. At a 0.05 significance level, five significant correlations would be expected between psychopathology and schemata. Thus the number of statistically significant correlations is similar to the proportion expected by chance.

There are a number of possible interpretations of the failure to find a significant relationship between schemata and depression. Firstly, there may be no real relationship between these two factors. This is contrary to the prediction of Beck (1979) and the evidence presented by Greenberg (1988).

An alternative explanation for this result may be that a relationship actually exists and that this study failed to identify it, a Type II error. This may reflect the complex nature of the relationship between depression and schemata, and the fact that this study has not sought to explore other factors which contribute to this relationship. Greenberg et al. (1988) found that non depression was associated with positive schemata, but that both mild and moderate depression were linked to a mixture of positive and negative schemata. Thus it follows that as the Anxious/Depressed scores for the sample, in general, were high, it is possible that there were no discernible patterns of schemata with a mixture of positive and negative schemata being present.

In summary, the null hypotheses is not rejected. The study found insufficient evidence that a relationship existed between schemata and depression.
4.1.5. Additional findings

A number of unexpected findings have come to light. Firstly, although a number of significant correlations between schemata and psychopathology was similar to that which would be expected by chance, the distribution of significant results requires consideration. Five out of the nine significant correlations were between the CBCL measures for social problems and five of the schemata. These findings suggest that a relationship may exist between maladaptive schemata and social problems. These may be explained by considering the nature of the childhood trauma experienced by these adolescents. It is anticipated that the types of traumas involved a high probability of disruption to the individual's most significant relationships. Consequently, is not unexpected that these adolescents have difficulties in establishing other relationships.

Low or negative correlations were found between 'Withdrawn' (as measured on the CBCL) and schemata scores. This suggests that the ability to withdraw from situations may be a protective mechanism for some people. Further research would be interesting to explore the use of withdrawal as a protective mechanism against the development of maladaptive schemata.

4.2. Criticism of the methodology

4.2.1. The measures

The ABQ is a new questionnaire, which has demonstrated some validity and reliability, but could be further improved by use and refinement. One area of adjustment would be to increase the number of statements on the CSB measure (following the loss of statement 11). Additionally, by increasing the sample size, greater reliability for the ABQ might be established.

Wider consultation with psychologists in the field might be useful, when considering the face and construct validity of the questions used. The ABQ could be compared with assessments made by therapists of blame experienced by their clients. Alternatively, the ABQ could be compared with other existing measures of blame e.g. the Attributional Style Questionnaire (Anderson et al., 1994). This would determine whether or not the two questionnaires measure the same underlying concept. This could also help to establish whether 'Attribution of Blame' exists as a trait as proposed by Anderson et al. (1994).
The final area of criticism of the ABQ lies in the means of accessing the trauma in childhood. The CTQ was used to facilitate this, identifying five general types of childhood trauma. This gave an indication of the trauma(s) experienced, without identifying the actual experience. There were a number of individuals who failed to indicate that they had experienced any trauma. This group was also asked to complete the ABQ. In light of this, the possibility exists that these individuals failed to attribute blame to a childhood trauma. There was no evidence that this problem occurred or that it affected the responses given by the participants. A future study may consider ways of linking the questionnaire to specific childhood trauma(s), which would need ethical consideration and the provision of therapeutic support.

The Traumatic Stress Institute Belief Scale (TSI) offered a means of measuring a range of underlying cognitive schemata. It assumes that individuals can access these schemata through the questions. These assumptions may be a source of experimental error. In general, the TSI was easy for the adolescents to complete, though some individuals struggled with its length. The TSI adolescent version was a newly developed scale and lacked reliability and normative data.

The sole use of the CBCL can be criticised on a number of levels. It was initially intended to use both the parental version and the adolescent version (YSR). In fact, only the CBCL was administered, as the YSR (computerised version) was unavailable. The CBCL has been criticised for providing a less reliable measure of internal problems compared to the YSR (Verhulst and van der Ende, 1991). The ability of the CBCL to discriminate between depressed and non depressed individuals was found to be lower than the combined YSR + CBCL scores (Rey and Morris-Yates, 1992). As the psychopathology levels of the whole sample were high, a more refined measure, demonstrating greater discrimination between degrees of psychopathology, could have been useful.

Finally the CBCL relied on the subjective accounts from the participant's keyworker and therefore was subject to bias. Relationships between adolescents and their keyworkers varied in terms of duration and quality. Hence the knowledge of each keyworker differed and this inevitably affected the reliability of the CBCL.
4.2.2. Type I and Type II errors

Type I* errors may have occurred in this study where significant differences were erroneously identified between CSB and BSB groups. The probability of such an error is 5%, as 0.05 significance levels have been employed throughout. Type II errors may have occurred where a significant difference existed between two groups, but was not detected by the study. The probability of Type II errors being present in this study is likely to be large as the sample size is relatively small.

Consider, for example, the t-tests used to compare BSB and CSB. If the 'Effect Size' (the degree to which the means of the two groups differ) is assumed to be large, the probability of Type II error is 74%. If a smaller 'Effect Size' existed this would result in a larger percentage of Type II errors. A future study may reduce Type II errors by increasing the sample size and thus reducing the variance. If it is assumed that the 'Effect Size' is large and the response rate is similar to this study, then the total sample of adolescents needed to reduce the probability of Type II errors to 20% would be approximately one hundred and twenty five. Alternatively if the 'Effect Size' was only moderate then a sample of three hundred and twenty would be needed. By making the assumption that the number of relevant adolescents in Local Authority care was of a similar distribution in other urban areas, and a medium 'Effect Size' existed between the two groups, BSB and CSB, approximately ten cities would be needed to reduce the Type II errors to 20%. This is outside the remit of this present research.

4.2.3. Response rate and generalisation of the findings

The response rate (62%) for this study was relatively good, but might have been improved by reducing the length of the assessments. In general the participants and nonparticipants showed similar demographic characteristics. However, there was a difference in respect of the length of time they had lived in the community home.

In estimating the degree of generalisability of the research findings, the demographic characteristics of the participants and nonparticipants were considered. These two groups differed in that a greater proportion of the

* Calculations involving Type I and Type II errors have been carried out in accordance with Howell (1997).
participants had resided in the community homes for less than seven months. A number of hypotheses may provide a possible explanation for the difference between the participants and nonparticipants living in community homes. The first is that living in community homes may lead to increased alienation, resulting in adolescents becoming less willing to take part in activities. The second hypothesis is that the length of time spent in community homes may be associated with increased absconding, leading to the adolescent being unable to take part in this study. In summary the participants differed from the nonparticipants which suggests that we must consider the generalization of the conclusions with caution.

If it were possible to establish similar effects in other studies by using a different population who had experienced trauma, e.g. adult survivors of abuse, support would be given for the generalization of these findings to the individuals, who have previously experienced childhood trauma.

4.2.4. Sources of bias

There were a number of potential sources of bias in this study. Firstly differences appeared to exist between the participants and the nonparticipants and this suggested that the research may have used a biased sample. Secondly, the responses given by the adolescents may have been affected by the concept of social desirability. Thus they may have given what they regarded as socially acceptable answers. This effect may have been reduced by the use of the laptop computer, a more impersonal medium. Thirdly, the level of literacy was found to vary across the sample and may have contributed to bias in some of the adolescent responses, as the questionnaire required reading.

Fourthly, the use of denial and minimisation were likely to have affected the responses of the participants. The CTQ contained a measure of this, which showed that the CSB group was involved in less minimisation than the other two groups. If the responses across the other measures (i.e. TSI and ABQ) were similar, it would suggest that these might not reflect their true attributions of blame and schemata. CSB could have been under reported. In a larger sample of a future study, one possibility would be to screen out individuals who engage in denial, and therefore reduce this area of bias. However, this could introduce an alternative form of bias, which would be undesirable.
Finally, as already discussed, the use of the CBCL by the keyworker may introduce bias, as their account contains a subjective view of the psychopathology of the adolescent. The presence and the characteristics of the interviewer may have influenced the responses of the participants and this could be further compounded by a second researcher collecting some of the data.

4.2.5. Age and gender bias

Consideration of the age of the participants in this study showed that the mean ages of the groups (CSB, BSB, NSB and Nonparticipants) appeared to be similar. Thus, the probability of bias resulting from age differences between the groups was small. Gender differences in the study were not considered, as the majority of the sample was male and the females were evenly distributed across the three groups.

4.3 Clinical implications

4.3.1 Clinical implications for adolescents in care

Adolescents in care typically live in an environment which is unusual in having frequent changes of carers, loose or inconsistent boundaries and lifestyles which may be chaotic. The findings of this study suggest that individuals who experience CSB will have a low self esteem. In the community home environment, the adolescent may lack a good parental figure to help overcome the difficulties of self esteem. Young (1990) proposed that new experiences would be interpreted using existing schemata, and where these were maladaptive (e.g. CSB) they would result in the young person perceiving neutral or positive experiences in a negative light. This negative perception of experiences could lead the adolescent to behave in an aggressive or withdrawn manner, which may be confusing for staff. As a result residential social workers may react by being defensive or rejecting. Thus, it is possible that the possession of negative schemata may result in a cycle of negative experiences, which serve to confirm the adolescent’s low self esteem.

Adolescents who exhibit CSB have been found by this study to have more maladaptive Self Control schemata. They may react as a result by becoming withdrawn, helpless or aggressive in situations when someone else is in a position of authority. In this way they may become isolated and rejected. McCann and
Pearlman (1990) suggested that maladaptive control schemata may lead to manipulation of the adolescent by others. For adolescents in care it is possible that this could lead to prostitution or other offending behaviour.

It would be advantageous to be able to identify all types of self blame found in the research for a number of reasons. It may be helpful for social workers to understand how adolescent perceptions of blame affects their behaviour. Also, consideration could be given to events and situations which might trigger the re-experiencing of a similar sense of blame, particularly for those experiencing CSB. Identification of these individuals may indicate where a therapeutic intervention would be beneficial.

4.3.2. Broader Clinical Implications

In the light of the author's findings it would be useful to re-examine Lamb's (1986) recommendations regarding the therapeutic interventions for children who had experienced childhood sexual abuse. She argued that, although responsibility for the abuse resides with the adult perpetrator, self blame for some aspects of the abuse experienced by the victim could be positive, as it led to a greater sense of control and self esteem. Lamb (1986) believed that it was detrimental to challenge the tendency of children to engage in self blame. The present study found some evidence to support this finding, in principal, in respect of BSB, as BSB was associated with less maladaptive schemata. In this study, CSB was associated with higher levels of maladaptive schemata, particularly Self Esteem and Self Control. Thus, individuals who experienced CSB felt less control and lower self esteem. The findings of this study suggest that precaution should be taken when working with children or with adolescents, to distinguish the nature of the self blame.

Celano (1992) refined this argument suggesting that only some forms of self blame were adaptive and recommended that non adaptive forms of self blame should be re-framed. Following this study it would be important to reframe attributions of CSB.

In therapy, Lamb (1986) suggested that the child should acknowledge the areas where they felt responsible and explore alternatives. This research suggests that the BSB group would fit Lamb's suggestion. However, individuals who experience CSB would not benefit from this approach. The traumatised individual who used CSB would tend to blame global and stable aspects of their
character and feel helpless about changing these characteristics. If a distinction was made between CSB and BSB, then Lamb's approach could be applied to those who experience BSB only. Caution would be needed to ensure that those who practised denial could be identified.

For individuals exhibiting blame, Celano (1992) suggests the use of group therapy to both elicit and reframe attributions. This approach appears appropriate for individuals experiencing CSB rather than BSB.

4.4. Conclusions

4.4.1. Is BSB adaptive?

This study provides some evidence that BSB is associated with lower schemata scores than CSB, particularly with respect to Self Esteem and Self Control schemata. If lower schemata scores are an indication of adaptability, then the study does provide evidence that the distinction of BSB from CSB will be valuable. However, it is not possible to determine the significance of the level of the schemata scores associated with BSB. This means that BSB may be adaptive. Alternatively, it may be less maladaptive than CSB.

As the BSB, CSB and NSB groups all have similar psychopathology, it indicates that factors other than self blame contribute to the schema based model of trauma, as would be expected. The involvement of additional factors may help to explain negative results for Hypotheses 3 and 4.
4.4.2. Summary of the findings

This study has explored some aspects of the schema based model of trauma. Focus has been on the tendency of adolescents to attribute blame to themselves in two distinct ways following trauma. The study devised a method to measure the attribution of two different forms of self blame to childhood trauma in a sample of adolescents. The two forms of self blame were Behavioural Self Blame (BSB) and Characterological Self Blame (CSB), originally proposed by Janoff-Bulman (1979). The study tested its hypothesis that BSB had adaptive properties and that CSB was maladaptive in comparison. The study demonstrated in accordance with Hypothesis 1 that the two forms of self blame were able to be identified. The study found evidence, in accordance with Hypothesis 2, that BSB was associated with significantly lower Self Esteem and Self Control schemata compared to CSB. The study failed to find evidence in support for Hypothesis 3 for a correlation between depression, as measured by the CBCL, and self blame. Similarly the study failed to find a correlation between schemata and depression (secondary Hypothesis 4). An additional finding was of a significant correlation between social problems and maladaptive schema. High levels of psychopathology were found in the whole sample. In summary, the research offered some evidence that BSB is either adaptive or less maladaptive than CSB. The research evidence to date continues to be unclear about the benefit of BSB.

4.5. Summary of potential areas of research

A number of areas for future research have emerged:

1) It could be beneficial to investigate whether or not BSB and CSB are changeable and under which circumstances this would occur.

2) To investigate why some people exhibit BSB rather than CSB.

3) A long term study would be helpful to investigate the hypothesis that the degree of self blame may change naturally with time.

4) A large scale multifactorial study would be advantageous to clarify the relationship which exists between self blame and psychopathology.
6. References


Secondary references


6. Appendices

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Definition of schemata relevant to trauma

Safety

**Self:** the need to feel one is reasonably invulnerable to harm inflicted by oneself or others

**Other:** the need to feel that valued others are reasonably invulnerable to harm inflicted by oneself or others

Trust/dependence

**Self:** the need to rely upon one's own judgement

**Other:** the need to rely upon others to meet one's needs

Control

**Self:** the need to manage one's feelings and behaviours in interpersonal situations

**Other:** the need to exert control over others in interpersonal situations

Intimacy

**Self:** the need to feel connected to oneself

**Other:** the need to feel connected to others

Esteem

**Self:** the need to feel valued by oneself and others

**Other:** the need to value others

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Ethical Issues

Ethical permission was given for the parent project and this project by Nottingham City Hospital Ethics Committee.

Consent was given by the participants, their keyworkers and approval for the project was received from Nottingham City Council Social Services Department.
Appendix iii

Young Person's Consent Form

Title of Project  The Assessment of Emotional and Physical Health Needs of Young People in Community Homes in Nottingham

Site  Radford Health Centre

Investigators  Dr Leon Polnay, Dr Paul Cawthon, Dr James Lang, Janet Coutts
Julia Pickering, Jennifer Goatly, Joanna Wood

The young person should complete the whole of this sheet himself / herself.

- Have you read and understood the information sheet
- Have you had the opportunity to ask questions and discuss the project
- Have all your questions been answered satisfactorily
- Have you received enough information about the project
- Who have you spoken to

Please cross out as necessary

YES / NO
YES / NO
YES / NO
YES / NO

Do you understand that you can withdraw from the project
at any time
without having to give a reason
without affecting your future care
Do you agree to take part in the study

Young Person's signature ................................................................. Date ..............................

NAME (IN BLOCK CAPITALS) .................................................................

I have explained the project to the above young person and he / she is willing to take part.

Signature of Health Team Member .................................................. Date ..............................

NAME (IN BLOCK CAPITALS) .................................................................
The Assessment of Emotional and Physical Health Needs of Young People in Community Homes in Nottingham

Health Team  Dr Leon Polnay, Dr Paul Cawthron, Dr James Lang, Janet Coutts, Julia Pickering, Jennifer Goatly, Joanna Wood

Site  Radford Health Centre. Telephone (0115) 942 0360

This sheet talks about the assessment of the health needs of the young person in your care and the two questionnaires which we would like you to complete about the young person. Ask any questions if there is anything you are unsure about.

The purpose of the assessment forms is to help us find out how healthy the young person is, and whether there is anything more you need from us to help the young person and yourself as a carer. You do not have to complete the forms if you don’t want to and you can stop doing them at anytime if you choose to. This will have no effect on any future health care of the young person.

All you have to do is to answer questions about the young person. One of the health workers will be available to answer any questions you are unsure about. The young person will fill in other questionnaires specifically designed for them on a computer.

Once all the questions are completed by the young person and yourself, the health worker will talk through them with the young person about what they mean. We will then ask the young person for permission to put the answers on their personal health record. Besides the young person, no one else will see the results unless the young person wants them to. If we need to speak to someone else about the answers, we will ask the young person first if this is okay and he or she can say no.

The information we gain from all young people will be used as part of a research project to help us to understand the health needs of young people looked after in community homes.

Please feel free to ask any questions at any time. You can contact any of the health workers on the phone number shown at the top of the page.

Thank you for your help,

The Health Team
Appendix v

Keyworker's Consent Form

Title of Project: The Assessment of Emotional and Physical Health Needs of Young People in Community Homes in Nottingham

Site: Radford Health Centre

Investigators: Dr Leon Polnay, Dr Paul Cawthon, Dr James Lang, Janet Coutts, Julia Pickering, Jennifer Goatly, Joanna Wood

The keyworker should complete the whole of this sheet himself / herself.

Please cross out as necessary

. Have you read and understood the information sheet YES / NO

. Have you had the opportunity to ask questions and discuss the project YES / NO

. Have all your questions been answered satisfactorily YES / NO

. Have you received enough information about the project YES / NO

. Who have you spoken to

. Do you understand that you can withdraw from the project YES / NO

. at any time YES / NO

. without having to give a reason YES / NO

. without affecting the young person's future care YES / NO

. Do you agree to take part in the study YES / NO

Keyworker's signature ........................................... Date ....................

NAME (IN BLOCK CAPITALS) .................................................................

I have explained the project to the above keyworker and he / she is willing to take part.

Signature of Health Team Member ........................................... Date ....................

NAME (IN BLOCK CAPITALS) .................................................................
CTQ

These questions ask about some of your experiences growing up as a child and a teenager. For each question, click the button that best describes how you feel.

Although some of these questions are of a personal nature, please try to answer as honestly as you can.

Example
When I was growing up someone took me to school

○ Never true  ○ Rarely true  ○ Sometimes true  ○ Often true  ○ Very often true

Copyright (c) 1998 by The Psychological Corporation, Harcourt Brace & Company, San Antonio, USA.
When I was growing up......

1 I didn't have enough to eat

2 I knew there was someone to take care of me and protect me

3 People in my family called me things like "stupid", "lazy", or "ugly"

4 My parents were too drunk or high to take care of the family

5 There was someone in my family who helped me feel important or special

6 I had to wear dirty clothes

7 I felt loved

8 I thought my parents wished I had never been born

9 I got hit so hard by someone in my family that I had to see a doctor or go to the hospital

10 There was nothing I wanted to change about my family

11 People in my family hit me so hard that it left me with bruises or marks

12 I was punished with a belt, a board, a cord, or some other hard object

13 People in my family looked out for each other

14 People in my family said hurtful or insulting things to me
When I was growing up ......

15 I believe that I was physically abused

16 I had a perfect childhood

17 I got hit or beaten so badly that it was noticed by someone like a teacher, neighbour or doctor

18 I felt someone in my family hated me

19 People in my family felt close to each other

20 Someone tried to touch me in a sexual way, or tried to make me touch them

21 Someone threatened to hurt me or tell lies about me unless I did something sexual with them

22 I had the best family in the world

23 Someone tried to make me do sexual things or watch sexual things

24 Someone molested me

25 I believe that I was emotionally abused

26 There was someone to take me to the doctor if I needed it

27 I believe that I was sexually abused

28 My family was a source of strength and support
Definitions of trauma used for the Childhood Trauma Questionnaire, Bernstein & Fink (1998)

Emotional Abuse- "verbal assaults on a child's sense of worth or well being, or any humiliating, demeaning, or threatening behaviour directed toward a child by an older person"

Physical abuse- "bodily assaults on a child by an older person that pose a risk of, or result in, injury"

Sexual abuse - "sexual contact or conduct between a child and older person; explicit coercion is a frequent but not essential feature of these experiences."

Emotional neglect- "the failure of the caretakers to provide a child's basic psychological and emotional needs, such as love, encouragement, belonging, and support.

Physical neglect - "the failure of caregivers to provide a child's basic physical needs including food, shelter, safety and supervision, and health."

(Bernstein & Fink, 1998, p2)
ABQ

Please answer the following questions about how you see the experiences you have described in the previous questions.

Click the button that describes your answer best.

Example

In general, when I think about what happened ......

If someone had helped me I could have avoided some of the things that happened

○ Disagree strongly  ○ Disagree a little  ○ Agree a little  ○ Agree strongly
Appendix viii

☐ Disagree strongly  ☐ Disagree a little  ☐ Agree a little  ☐ Agree strongly

1. People can’t change their destiny

2. If I had acted differently, I might have avoided some of the things that happened

3. The other people involved were too blame

4. Somehow I make bad things happen to me

5. If I had talked to someone earlier I could have avoided some of the things that happened

6. These things just happen

7. If I was a different person, I could have avoided some of the things that happened

8. If I had thought the situation through in a different way I could have avoided some of the things that happened

9. Other people shouldn’t have behaved the way they did

10. No one could have stopped the things that happened

11. Another person might have avoided some of the things that happened, but I don’t think there was any way I could have

12. The other people involved were in control
Please answer the following questions in regard to the experiences you have described in the previous questionnaire, the CTQ. Rate the statements from 1 to 6 on how much you agree that they apply to the experiences you have described.

For example: A rating of one indicates that you strongly agree that the statement applies to most of the experiences you have described.

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<thead>
<tr>
<th>Rating</th>
<th>Category</th>
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<tbody>
<tr>
<td>1</td>
<td>Agree Strongly</td>
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<tr>
<td>2</td>
<td>Agree Agree</td>
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<tr>
<td>3</td>
<td>Agree Agree</td>
</tr>
<tr>
<td>4</td>
<td>Disagree mildly</td>
</tr>
<tr>
<td>5</td>
<td>Disagree moderately</td>
</tr>
<tr>
<td>6</td>
<td>Disagree strongly</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>1</th>
<th>People can’t change their destiny</th>
</tr>
</thead>
<tbody>
<tr>
<td>_</td>
<td>Category 1=___</td>
</tr>
<tr>
<td>2</td>
<td>If I had acted differently I might have avoided some of the things that happened.</td>
</tr>
<tr>
<td>_</td>
<td>Category 2=___</td>
</tr>
<tr>
<td>3</td>
<td>The other people involved were to blame.</td>
</tr>
<tr>
<td>_</td>
<td>Category 3=___</td>
</tr>
<tr>
<td>4</td>
<td>Somehow I make bad things happen to me.</td>
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<tr>
<td>_</td>
<td>Category 4=___</td>
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<tr>
<td>5</td>
<td>If I had talked to someone earlier I could have avoided some of the things that happened</td>
</tr>
<tr>
<td>_</td>
<td>Category 5=___</td>
</tr>
<tr>
<td>6</td>
<td>These things just happen</td>
</tr>
<tr>
<td>_</td>
<td>Category 6=___</td>
</tr>
<tr>
<td>7</td>
<td>If I were a different person I could have avoided some of the things that happened.</td>
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<tr>
<td>_</td>
<td>Category 7=___</td>
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<tr>
<td>8</td>
<td>If I had thought the situation through in a different way I could have avoided some things that happened.</td>
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<td>Category 8=___</td>
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<td>9</td>
<td>Other people shouldn’t have behaved that way they did.</td>
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<td>Category 9=___</td>
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<tr>
<td>10</td>
<td>No one could have stopped the things that happened</td>
</tr>
<tr>
<td>_</td>
<td>Category 10=___</td>
</tr>
<tr>
<td>11</td>
<td>Even though other people might have avoided some of the things that happened I don’t think there was any way I could have.</td>
</tr>
<tr>
<td>_</td>
<td>Category 11=___</td>
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<tr>
<td>12</td>
<td>The other people involved were in control.</td>
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<tr>
<td>_</td>
<td>Category 12=___</td>
</tr>
</tbody>
</table>

Please write 'C' at the end of any statements that you found confusing.
TSI Belief Scale

This questionnaire is used to learn about how individuals view themselves and others.

As people differ from one another in many ways, there are no right or wrong answers.

Please click for each question the button you feel most clearly matches your own belief about yourself and your world.

Try to complete every item.

Examples

I feel happy most days

○ Disagree strongly ○ Disagree ○ Disagree somewhat ○ Agree somewhat ○ Agree ○ Agree strongly
Appendix x

1. I believe I am safe
2. You can’t trust anyone
3. I don’t feel like I deserve much
4. Even when I’m with friends and family, I don’t feel like I belong
5. I can’t be myself around people
6. I never think any one is safe from danger
7. I can trust my own judgment
8. People are wonderful
9. When my feelings are hurt, I can make myself feel better
10. I am uncomfortable when someone else is the leader
11. I feel like people are hurting all the time
12. If I need them, people will come through for me
13. I have bad feelings about myself
14. Some of my happiest times are with other people
15. I feel like I can’t control myself
16. I could do serious damage to someone
17. When I am alone, I don’t feel safe
18. Most people ruin what they care about
19. I don’t trust my instincts
20. I feel close to lots of people
21. I feel good about myself most days
22 My friends don't listen to my opinion
23 I feel hollow inside when I am alone
24 I can't stop worrying about others' safety
25 I wish I didn't have feelings
26 Trusting people is not smart
27 I would never hurt myself
28 I often think the worst of others
29 I can control whether I harm others
30 I'm not worth much
31 I don't believe what people tell me
32 The world is dangerous
33 I am often in conflict with other people
34 I have a hard time making decisions
35 I feel cut off from people
36 I feel jealous of people who are always in control
37 The important people in my life are in danger
38 I keep myself safe
39 People are no good
40 I keep busy to avoid my feelings
41 People shouldn't trust their friends
42 I deserve to have good things happen to me
O Disagree strongly  O Disagree  O Disagree somewhat  O Agree somewhat  O Agree  O Agree strongly

43 I worry about what other people will do to me
44 I like people
45 I must be in control of myself at all times
46 I feel helpless around adults
47 Even if I think about hurting myself, I won’t do it
48 I don’t feel much love from anyone
49 I have good judgment
50 Strong people don’t need to ask for help
51 I am a good person
52 People don’t keep their promises
53 I hate to be alone
54 I feel threatened by others
55 When I’m with people, I feel alone
56 I have problems with self-control
57 The world is full of people with mental problems
58 I can make good decisions
59 I often feel people are trying to control me
60 I am afraid of what I might do to myself
61 People who trust others are stupid
62 I am my own best friend
63 When people I love aren’t with me, I believe they are in danger
64 Bad things happen to me because I am a bad person
65 I feel safe when I'm alone
66 To feel okay, I need to be in charge
67 I often doubt myself
68 Most people are good at heart
69 I feel bad about myself when I need help
70 My friends are there when I need them
71 I believe that someone is going to hurt me
72 I do things that put other people in danger
73 There is an evil force inside me
74 No one really knows me
75 When I am alone, it's as if there is no one there, not even me
76 I don't respect the people I know best
77 I can usually figure out what's going on with people
78 I can't do good work unless I am the leader
79 I can't relax
80 I trust too many people
81 I have physically hurt people
82 I am afraid I will harm myself
83 I feel left out everywhere
84 If people really knew me, they wouldn't like me
85 I look forward to time I spend alone
## CHILD BEHAVIOR CHECKLIST FOR AGES 4–18

**For office use only**

### Child's Information

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>First</td>
</tr>
<tr>
<td>SEX</td>
</tr>
<tr>
<td>Boy</td>
</tr>
<tr>
<td>Girl</td>
</tr>
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**Today's Date**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
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</table>

**Child's Date of Birth**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

**Grade in School**

- [ ] Please fill out this form to reflect your view of the child's behavior even if other people might not agree. Feel free to print additional comments beside each item and in the spaces provided on page 2.

### I. Sports

**Please list the sports your child most likes to take part in.**

- [ ] None
- [ ] Baseball
- [ ] Basketball
- [ ] Soccer
- [ ] Tennis
- [ ] Swimming
- [ ] Other

**Compared to others of the same age, about how much time does he/she spend in each?**

- [ ] Don't Know
- [ ] Less Than Average
- [ ] Average
- [ ] More Than Average
- [ ] Don't Know
- [ ] Below Average
- [ ] Average
- [ ] Above Average

### II. Hobbies, Activities, and Games

**Please list your child's favorite hobbies, activities, and games, other than sports.**

- [ ] None
- [ ] Stamps
- [ ] Dolls
- [ ] Books
- [ ] Piano
- [ ] Crafts
- [ ] Cars
- [ ] Singing

**Compared to others of the same age, about how much time does he/she spend in each?**

- [ ] Don't Know
- [ ] Less Than Average
- [ ] Average
- [ ] More Than Average
- [ ] Don't Know
- [ ] Below Average
- [ ] Average
- [ ] Above Average

### III. Organizations, Clubs, Teams

**Please list any organizations, clubs, teams, or groups your child belongs to.**

- [ ] None

**Compared to others of the same age, how active is he/she in each?**

- [ ] Don't Know
- [ ] Less Active
- [ ] Average
- [ ] More Active

### IV. Jobs or Chores

**Please list any jobs or chores your child has.**

- [ ] None

**Compared to others of the same age, how well does he/she carry them out?**

- [ ] Don't Know
- [ ] Below Average
- [ ] Average
- [ ] Above Average

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**V. 1.** About how many close friends does your child have? □ None □ 1 □ 2 or 3 □ 4 or more  
(Do not include brothers & sisters)

**2.** About how many times a week does your child do things with any friends outside of regular school hours?  
(Do not include brothers & sisters) □ Less than 1 □ 1 or 2 □ 3 or more

**VI.** Compared to others of his/her age, how well does your child:

<table>
<thead>
<tr>
<th></th>
<th>Worse</th>
<th>About Average</th>
<th>Better</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Get along with his/her brothers &amp; sisters?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>b. Get along with other kids?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>c. Behave with his/her parents?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>d. Play and work alone?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

**VII. 1.** For ages 6 and older—performance in academic subjects. □ Does not attend school because ____________________________________________

<table>
<thead>
<tr>
<th>Subject</th>
<th>Failing</th>
<th>Below Average</th>
<th>Average</th>
<th>Above Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Reading, English, or Language Arts</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>b. History or Social Studies</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>c. Arithmetic or Math</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>d. Science</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>e. Other academic subjects—for example: computer courses, foreign language, business. Do not include gym, shop, driver's ed, etc.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

2. Does your child receive special remedial services or attend a special class or special school? □ No □ Yes—kind of services, class, or school: ____________________________________________

3. Has your child repeated any grades? □ No □ Yes—grades and reasons: ____________________________________________

4. Has your child had any academic or other problems in school? □ No □ Yes—please describe: ____________________________________________

When did these problems start? _______________________________

Have these problems ended? □ No □ Yes—when? _______________________________

Does your child have any illness or disability (either physical or mental)? □ No □ Yes—please describe: ____________________________________________

What concerns you most about your child? ____________________________________________

Please describe the best things about your child: ____________________________________________
Below is a list of items that describe children and youth. For each item that describes your child now or within the past 6 months, please circle the 2 if the item is very true or often true of your child. Circle the 1 if the item is somewhat or sometimes true of your child. If the item is not true of your child, circle the 0. Please answer all items as well as you can, even if some do not seem to apply to your child.

### Please Print

<table>
<thead>
<tr>
<th>Item Description</th>
<th>Circle 0</th>
<th>Circle 1</th>
<th>Circle 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acts too young for his/her age</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Allergy (describe):</td>
<td></td>
<td></td>
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<tr>
<td>Argues a lot</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Asthma</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Behaves like opposite sex</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Bowel movements outside toilet</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Bragging, boasting</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Can't concentrate, can't pay attention for long</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Can't get his/her mind off certain thoughts; obsessions (describe)</td>
<td></td>
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<tr>
<td>Can't sit still, restless, or hyperactive</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Clings to adults or too dependent</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Complains of loneliness</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Confused or seems to be in a fog</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Cries a lot</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Cruel to animals</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Daydreams or gets lost in his/her thoughts</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Deliberately harms self or attempts suicide</td>
<td>0</td>
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<tr>
<td>Demands a lot of attention</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Destroys his/her own things</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Destroys things belonging to his/her family or others</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Dishonest at home</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Disobedient at school</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Doesn't eat well</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Doesn't get along with other kids</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Doesn't seem to feel guilty after misbehaving</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Easily jealous</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Eats or drinks things that are not food—don't include sweets (describe):</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Fears certain animals, situations, or places, other than school (describe):</td>
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<td></td>
<td></td>
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<tr>
<td>Fears going to school</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Fears he/she might think or do something bad</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Feels he/she has to be perfect</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Feels or complains that no one loves him/her</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Feels others are out to get him/her</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Feels worthless or inferior</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Gets a lot</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Gets hurt a lot</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Gets in many fights</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Gets teased a lot</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Hangs around with others who get in trouble</td>
<td>0</td>
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<td>2</td>
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<tr>
<td>Hears sounds or voices that aren't there (describe):</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Impulsive or acts without thinking</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Would rather be alone than with others</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Lying or cheating</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Bites fingernails</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Nervous, highstrung, or tense</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Nervous movements or twitching (describe):</td>
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<tr>
<td>Nightmares</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Not liked by other kids</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Constipated, doesn't move bowels</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Too fearful or anxious</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Feels dizzy</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Feels too guilty</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Overeating</td>
<td>0</td>
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<tr>
<td>Overtired</td>
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<td>2</td>
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<tr>
<td>Overweight</td>
<td>0</td>
<td>1</td>
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<tr>
<td>Physical problems without known medical cause:</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>a. Aches or pains (not stomach or headaches)</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>b. Headaches</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>c. Nausea, feels sick</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>d. Problems with eyes (not if corrected by glasses) (describe):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Rashes or other skin problems</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>b. Stomachaches or cramps</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>c. Vomiting, throwing up</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>h. Other (describe):</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

Please see other side
### Appendix

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Total</th>
<th>Code 1</th>
<th>Code 2</th>
<th>Code 3</th>
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<tbody>
<tr>
<td>57.</td>
<td>Physically attacks people</td>
<td>0 1 2</td>
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<tr>
<td>58.</td>
<td>Picks nose, skin, or other parts of body</td>
<td>0 1 2</td>
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<td>59.</td>
<td>Plays with own sex parts in public</td>
<td>0 1 2</td>
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<td>60.</td>
<td>Plays with own sex parts too much</td>
<td>0 1 2</td>
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<td>61.</td>
<td>Poor school work</td>
<td>0 1 2</td>
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<tr>
<td>62.</td>
<td>Poorly coordinated or clumsy</td>
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<tr>
<td>63.</td>
<td>Prefers being with older kids</td>
<td>0 1 2</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>64.</td>
<td>Prefers being with younger kids</td>
<td>0 1 2</td>
<td></td>
<td></td>
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<tr>
<td>65.</td>
<td>Refuses to talk</td>
<td>0 1 2</td>
<td></td>
<td></td>
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<tr>
<td>66.</td>
<td>Repeats certain acts over and over; compulsions (describe):</td>
<td>0 1 2</td>
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<tr>
<td>67.</td>
<td>Runs away from home</td>
<td>0 1 2</td>
<td></td>
<td></td>
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<tr>
<td>68.</td>
<td>Screams a lot</td>
<td>0 1 2</td>
<td></td>
<td></td>
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<tr>
<td>69.</td>
<td>Secretive, keeps things to self</td>
<td>0 1 2</td>
<td></td>
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<tr>
<td>70.</td>
<td>Sees things that aren’t there (describe):</td>
<td>0 1 2</td>
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<tr>
<td>71.</td>
<td>Self-conscious or easily embarrassed</td>
<td>0 1 2</td>
<td></td>
<td></td>
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<tr>
<td>72.</td>
<td>Sets fires</td>
<td>0 1 2</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>73.</td>
<td>Sexual problems (describe):</td>
<td>0 1 2</td>
<td></td>
<td></td>
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<tr>
<td>74.</td>
<td>Showing off or clowning</td>
<td>0 1 2</td>
<td></td>
<td></td>
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<tr>
<td>75.</td>
<td>Shy or timid</td>
<td>0 1 2</td>
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<tr>
<td>76.</td>
<td>Sleeps less than most kids</td>
<td>0 1 2</td>
<td></td>
<td></td>
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<tr>
<td>77.</td>
<td>Sleeps more than most kids during day and/or night (describe):</td>
<td>0 1 2</td>
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<tr>
<td>78.</td>
<td>Smears or plays with bowel movements</td>
<td>0 1 2</td>
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<tr>
<td>79.</td>
<td>Speech problem (describe):</td>
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<tr>
<td>80.</td>
<td>Stares blankly</td>
<td>0 1 2</td>
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<tr>
<td>81.</td>
<td>Steals at home</td>
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<tr>
<td>82.</td>
<td>Steals outside the home</td>
<td>0 1 2</td>
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<td>83.</td>
<td>Stores up things he/she doesn’t need (describe):</td>
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<td>Strange behavior (describe):</td>
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<td>85.</td>
<td>Strange ideas (describe):</td>
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<td>86.</td>
<td>Stubborn, sullen, or irritable</td>
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<tr>
<td>87.</td>
<td>Sudden changes in mood or feelings</td>
<td>0 1 2</td>
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<td></td>
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<tr>
<td>88.</td>
<td>Suiks a lot</td>
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<td></td>
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<tr>
<td>89.</td>
<td>Suspicious</td>
<td>0 1 2</td>
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<tr>
<td>90.</td>
<td>Swearing or obscene language</td>
<td>0 1 2</td>
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<tr>
<td>91.</td>
<td>Talks about killing self</td>
<td>0 1 2</td>
<td></td>
<td></td>
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<tr>
<td>92.</td>
<td>Talks or walks in sleep (describe):</td>
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<tr>
<td>93.</td>
<td>Talks too much</td>
<td>0 1 2</td>
<td></td>
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<tr>
<td>94.</td>
<td>Teases a lot</td>
<td>0 1 2</td>
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<td>95.</td>
<td>Temper tantrums or hot temper</td>
<td>0 1 2</td>
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<tr>
<td>96.</td>
<td>Thinks about sex too much</td>
<td>0 1 2</td>
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<td>97.</td>
<td>Threatens people</td>
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<tr>
<td>98.</td>
<td>Thumb-sucking</td>
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<td>99.</td>
<td>Too concerned with neatness or cleanliness</td>
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<td>100.</td>
<td>Trouble sleeping (describe):</td>
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<td>101.</td>
<td>Truancy, skips school</td>
<td>0 1 2</td>
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<tr>
<td>102.</td>
<td>Underactive, slow moving, or lacks energy</td>
<td>0 1 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>103.</td>
<td>Unhappy, sad, or depressed</td>
<td>0 1 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>104.</td>
<td>Unusually loud</td>
<td>0 1 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>105.</td>
<td>Uses alcohol or drugs for nonmedical purposes (describe):</td>
<td>0 1 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>106.</td>
<td>Vandalism</td>
<td>0 1 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.</td>
<td>Wets self during the day</td>
<td>0 1 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>108.</td>
<td>Wets the bed</td>
<td>0 1 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>109.</td>
<td>Whining</td>
<td>0 1 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>110.</td>
<td>Wishes to be of opposite sex</td>
<td>0 1 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>111.</td>
<td>Withdrawn, doesn’t get involved with others</td>
<td>0 1 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>112.</td>
<td>Worries</td>
<td>0 1 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>113.</td>
<td>Please write in any problems your child that were not listed above:</td>
<td>0 1 2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Please Print**

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

Please be sure you have answered all items. Underline any you are concerned about.
Non parametric statistical tests

A sample of non parametric tests were performed.

<table>
<thead>
<tr>
<th>Schemata</th>
<th>Mean rank scores for BSB and CSB</th>
<th>Comparison of the BSB and CSB groups using the Mann Whitney U test</th>
<th>Statistical significance using a parametric assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Esteem</td>
<td>BSB = 4.33, CSB = 8.67</td>
<td>Z = -2.09, p&lt;0.05**</td>
<td>Statistically Significant, p&lt;0.05</td>
</tr>
<tr>
<td>Self Control</td>
<td>BSB = 4.25, CSB = 8.75</td>
<td>Z = -2.18, p&lt;0.05**</td>
<td>Statistically Significant, p&lt;0.05</td>
</tr>
<tr>
<td>Other Esteem</td>
<td>BSB = 5.50, CSB = 7.50</td>
<td>Z = -0.98, n.s.</td>
<td>Not significant</td>
</tr>
<tr>
<td>Other Control</td>
<td>BSB = 5.50, CSB = 7.50</td>
<td>Z = -0.97, n.s.</td>
<td>Not significant</td>
</tr>
<tr>
<td>Psycho-pathology</td>
<td>Anxious/Depression</td>
<td>BSB = 6.67, CSB = 6.33</td>
<td>Not significant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Z = -0.17, n.s.</td>
<td></td>
</tr>
</tbody>
</table>

n.s. = Not significant

Figures accurate to two decimal places
** Significant at the 0.05 level.