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An independent academic psychologist, based in England, who has written extensively on different areas of psychology with an emphasis on the critical stance towards traditional ideas.

A complete listing of his writings at http://kmbpsychology.jottit.com.

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1. SOME REFLECTIONS ON LAPIERE (1934) SOME YEARS LATER

1.1. DETAILS OF LAPIERE (1934)

Prejudiced attitudes and beliefs are notoriously difficult to measure accurately, particularly with questionnaires. LaPiere (1934) was aware of this in the 1920s and 1930s [1] [2]. Individuals may not tell the truth when answering a questionnaire, either in terms of directly lying or that their response does not mirror/predict their actual behaviour.

LaPiere (1934) overcame this problem by measuring the attitude through a questionnaire, and the behaviour through observation of an actual situation. How would restaurant and hotel workers respond to Chinese guests in a time of anti-Chinese feeling in the USA?. LaPiere observed:

> Beginning in 1930 and continuing for two years thereafter, I had the good fortune to travel rather extensively with a young Chinese student and his wife. Both were personable, charming, and quick to win the admiration and respect of those they had the opportunity to become intimate with. But they were foreign-born Chinese, a fact that could not be disguised. Knowing the general "attitude" of Americans towards the Chinese as indicated by the "social distance" studies which have been made, it was with considerable trepidation that I first approached a hotel clerk in their company. Perhaps that clerk's eyebrows lifted slightly, but he accommodated us without a show of hesitation. And this in the "best" hotel in a small town noted for its narrow and bigoted "attitude" towards Orientals. Two months later I passed that way again, phoned the hotel and asked if they would accommodate "an important Chinese gentleman". The reply was an unequivocal "No". That aroused my curiosity and led to this study (1934/2010 p8).

[1] LaPiere (1928) had investigated the attitudes towards "dark-skinned people" in France and England in 1927. He collected the data in "casual conversations" while on a trip in Europe, and the conversations included with hotel proprietors. A forerunner to the 1934 study (Lee 2010).

[2] LaPiere (1934) said that "it is impossible to make direct comparison between the reactions secured through questionnaires and from actual experience" (p234).

Travelling with the Chinese couple [3], LaPiere was refused once out of 67 hotels, auto-camps, and "Tourist Homes", and "treated with what I judged to be more than ordinary consideration in 72 of 184 restaurants and cafes (figure 1.1). Overall, individuals in one out of 251 establishments showed prejudiced behaviour [4].

The Chinese couple were oblivious to LaPiere's "experiment", and he encouraged them in many cases to approach the hotel clerks and so on while keeping in the background [5].

(Data from LaPiere 1934/2010 table 2 p10)

Figure 1.1 - Number of response of staff to LaPiere and Chinese couple.

Six months after visiting the establishments, LaPiere sent a questionnaire about attitudes towards different nationalities as guests. The key question was: "Will you accept members of the Chinese race as guests in your establishment?" [6]. Of 81 restaurants and 47 hotels that replied, over 90% said "No" (which was similar to

[3] LaPiere hide the identity of the Chinese couple, but Lee (2010) speculated that it was a former collaborator (Cheng Wang) and his wife.

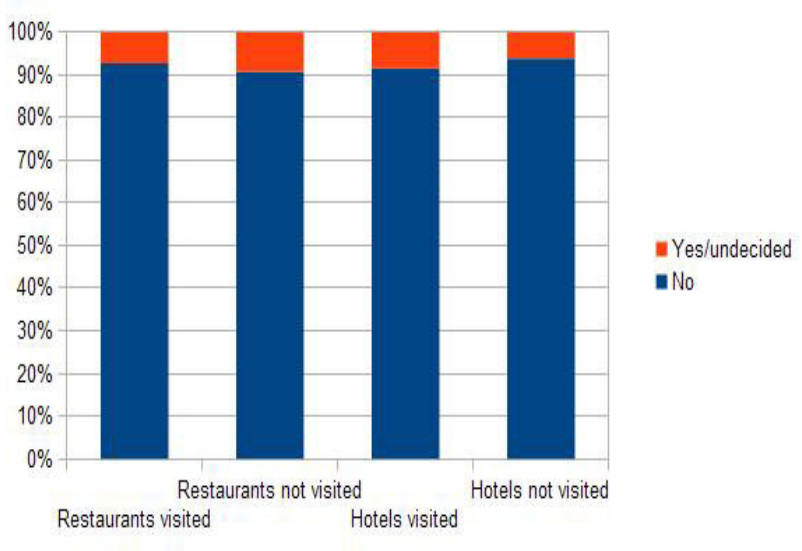
[4] The refusal was at an "inferior auto-camp" in California by a manager who said, "I don't take Japs!" (LaPiere 1934/2010 p8).

[5] The Chinese couple spoke good English, had good social skills, and smiled a lot. La Piere (1934) noted that "even where some tension developed due to the strangeness of the Chinese it would evaporate immediately when they spoke in unaccented English" (p232). If the Chinese couple had been by themselves, the reaction may have been different, but they were with an American.

[6] Sechrest (2010) felt that this attitude item was "closer to representing an inquiry into intentions rather than attitudes".

the replies from hotels and restaurants not visited) (figure 1.2).

La Piere (1934) also asked whether the same establishments would accept German, French or Japanese people as guests, and got similar results (table 1.1).



(Data from LaPiere 1934/2010 table 1 p9)

Figure 1.2 - Responses to the question, "Will you accept members of the Chinese race as guests in your establishment?".

Replies to question: "Will you accept members of the German, French or Japanese race as guests in your establishment?"

	Hotels and Restaurants: Visited	Not Visited
No	58	52
Yes/Undecided	5	5

(After La Piere 1934)

Table 1.1 - Number of replies to question about German, French and Japanese guests.

1.2. EVALUATION

This study is quoted as an example of the

inconsistency between attitudes and behaviour [7] [8]. Dockery and Bedeian (1989) disagreed: "In fact, the actual discrepancy uncovered was between true attitudes - the tendency to act in a certain way - and that which is measured by an attitude questionnaire" (p9).

Dockery and Bedeian (1989) outlined key criticisms of the validity of LaPiere's study:

i) Six months between visit and questionnaire - Though this was meant to give time for the visit to be forgotten, a lot can happen in that time to reduce the consistency between attitudes and behaviour.

ii) Who completed the questionnaire - It is quite possible, particularly in larger establishments, that a different person completed the questionnaire to who served LaPiere's group (Ajzen et al 1970). Campbell (1963) called this "pseudo-inconsistency" between attitudes and behaviour. What about the non-respondents to the questionnaire? What views might they have held? (Brewer 2006).

iii) Measurement of attitudes and behaviour - This was done by criteria with "unknown reliability". Furthermore, a specific attitude item should have been used - namely, "Would you accept a young, well-dressed, well-spoken, pleasant, self-confident, well-to-do Chinese couple accompanied by a mature, well-dressed, well spoken... educated European (sic) gentleman as guests in your establishment?" (Ajzen et al 1970 quoted in Dockery and Bedeian 1989 p13).

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[7] Sechrest (2010) took the position that "a social attitude is a behavioural disposition to respond in a consistent way to a social stimulus in the same way that, let us say, a habit of taking an aisle seat in a lecture hall or auditorium is a disposition to respond in a consistent way" (p22). Thus the verbal expression of an attitude and the behaviour being different is not inconsistency, but evidence of a "middling-level disposition".

Put another way, the contextual factors on behaviour are key: the Chinese couple "were personable and charming, spoke excellent English, were in the company of a Caucasian gentleman, and arrived by automobile, and so on. Moreover, the study was carried out during the Great Depression when times were hard, and business owners were probably eager for patronage. It would, then, likely have been very difficult for an individual owner of a motel or of a restaurant to face down LaPierre and his companions and refuse them accommodation or service" (Sechrest 2010 p23).

[8] "In their everyday lives, ordinary, everyday people know that verbal statements cannot always be expected to be congruent with other behaviours. We know from our own experience that we may say things that belie what we will do subsequently in other ways. And it works both ways. We may express a favourable opinion of a restaurant and never go there again; it may be too difficult to tell a friend that we do not like his favourite place. On the other hand, we may be silent or even assenting, if one of our own friends strongly disparages a movie we liked. But in both instances, were our attitude (disposition) stronger, we might find ourselves speaking out in a way more consistent with other behaviours. If a person feels strongly about a matter, that person may speak out strongly even when it is not in his or her best interests to do so. Or we may not act in some matter if we do not feel strongly, ie: have a strong attitude about it" (Sechrest 2010 p23).

iv) Predicting behaviour - Attitudes should have been measured before behaviour (not after) in order to use them to predict future behaviour (Wicker 1969). Furthermore, the acceptance of the Chinese couple as guests could have influenced the answers given on the questionnaire.

v) Questionnaire respondents - This was a self-selecting sample (but this problem was reduced by the use of a matched control group) (Dockery and Bedeian 1989).

vi) Selection bias - The choice of establishments to visit, and the fact that other types of establishments like shops were not included limits the generalisability of the findings.

vii) Experimenter bias - The presence of LaPiere when negotiating the accommodation etc may have influenced the reactions of the staff.

Herrera (2010) criticised the lack of informed consent for the "unannounced observation" [9] from the employees of the hotels and restaurants: "Living in a liberal democracy as we do, the freedom to decide what we participate in enjoys pride of place in most settings. Why should anything be different where scientific activity is underway? Were we to decide that LaPiere probably did not abuse the subjects of his research, it might still seem that scientists themselves would be somewhat annoyed to learn that they had been part of a study without their having been asked first" (p12).

Herrera wished for more information about how LaPiere justified his use of the method (ie: covert observation) [10], and wished more generally for the incorporation of research ethics into research reporting: "Greater attention to the linkage between ethics, methods and rhetoric could improve our ability to make the tough choices about the counter-factual (ie: 'what if...?') statements that we assume the scientists who are interested in social issues will ask anyway. Would LaPiere applaud the recent efforts to study, without obtaining consent, the traditionally private relationship between doctor and patient? Would LaPiere recommend that researchers go beyond the answers that jury members give when asked how they deliberated? My hunch is that he would, and that he would justify such recommendations on an assessment of the social and scientific merits of

[9] This is "methodological opportunism" which "involves the conscious and explicit exploitation of occasions to collect data relevant to a particular research question not necessarily originally envisaged as part of the research design" (Lee 2010 p17).

[10] Taylor (2007) noted the style of writing had a "journalistic tone which is personal, even jokey: this is not 'objective' writings" (p59). LaPiere also wrote fiction (Lee 2010) if this has any relevance.

having researchers sneak recording devices into the doctor's office or the jury chambers, possibly enlisting the services of undercover ethnographers as well" (p15).

Firmin (2010) outlined five reasons why LaPiere's study was seminal:

i) It inspired other studies (for example, on the relationship between attitudes and behaviour). Dockery and Bedeian (1989) felt that the criticisms of LaPiere "pale next to the contribution flowing the stream of research it has inspired".

ii) The questions that LaPiere studied remain today.

iii) The study is relatively robust - "In one sense, the elegance of LaPiere's research study was its simplicity. There were no statistics, data analysis or mathematical computations involved with the study. Its design was simple and straightforward. The results were so stark that they grab one’s attention" (Firmin 2010 p19).

iv) The study is not replicable today - both from the research ethics point of view, but also because it is illegal in the USA to deny services based on discrimination.

v) It measured real-world behaviour. Sechrest (2010) recorded that "LaPiere had the imagination and courage to 'experiment' with real life... Even after 75 years, it stands (so far as I know) alone in terms of its magnitude" (p22).

Since LaPiere's (1934) study there has been much discussion about the link between attitudes and behaviour, and many different explanations for the apparent inconsistency (Brewer 2006).

The strength of any attitude-behaviour linkage depends upon three factors (Friedkin 2010):

a) The behaviour is voluntary and not constrained or coerced [11].

b) The attitudes are specific. General attitudes are poor predictors of specific behaviours.

c) The existence of a behavioural intention. Attitudes are linked to behaviour via an intention to perform the behaviour (eg: theory of reasoned action;

[11] In the LaPiere study were the hotel clerks etc performing voluntary behaviour or were they constrained by their terms of employment, for example?

Fishbein and Ajzen 2009).

Recent research has added the influence of the group/others on behaviour and on the formation of attitudes (Friedkin 2010).

In a meta-analysis of 41 studies, Glasman and Albarracin (2006) found that accessible (easy to recall) and stable (over time) attitudes strongly predicted future behaviour. Direct experience of the attitude object, and reporting of the attitudes frequently were also important in accessibility of the attitudes.

1.3. REFERENCES

Ajzen, I.R.K et al (1970) Looking backward revisited: A reply to Deutscher American Sociologist 5, 267-273

Brewer, K (2006) The Relationship Between Attitudes and Behaviour, and Condom Use Orsett, Essex: Orsett Psychological Services

Campbell, D.T (1963) Social attitudes and other acquired behavioural dispositions. In Koch, S (ed) Psychology: A Study of a Science vol 6 New York: McGraw-Hill

Dockery, T.M & Bedeian, A.G (1989) Attitudes versus actions: LaPiere's (1934) classic study revisited Social Behaviour and Personality 17, 1, 9-16

Firmin, M.W (2010) Commentary: The seminal contribution of Richard LaPiere's attitudes vs actions (1934) research study International Journal of Epidemiology 39, 18-20

Fishbein, M & Ajzen, I (2009) Predicting and Changing Behaviour: The Reasoned Action Approach New York: Taylor & Francis

Friedkin, N.E (2010) The attitude-behaviour linkage in behavioural cascades Social Psychology Quarterly 73, 2, 196-213

Glasman, L.R & Albarracin, D (2006) Forming attitudes that predict future behaviour: A meta-analysis of the attitude-behaviour relation Psychological Bulletin 132, 5, 778-822

Herrera, C (2010) Commentary: Ethics and the rhetorical context of human research International Journal of Epidemiology 39, 12-16

LaPiere, R.T (1928) Race prejudice: France and England Social Forces 7, 102-111

LaPiere, R.T (1934) Attitudes versus actions Social Forces 13, 2, 230-237

LaPiere, R.T (1934/2010) Attitudes versus actions (reprinted) International Journal of Epidemiology 39, 7-11

Lee, R.M (2010) Commentary: LaPiere and methodological opportunism International Journal of Epidemiology 39, 16-17

Sechrest, L (2010) Commentary: Not all attitudes are created equal International Journal of Epidemiology 39, 21-24

Taylor, S (2007) Attitudes. In Langdridge, D & Taylor, S (eds) Critical Readings in Social Psychology Maidenhead: McGraw-Hill

Wicker, A.W (1969) Attitudes versus actions: The relationship of verbal and overt behavioural responses to attitude objects Journal of Social Issues 25, 41-78

2. SOME RISKS AND EFFECTS OF CHILDHOOD SEXUAL ABUSE

2.1. RISKS

Many studies look for individual risk factors for future problems or behaviours. But "ecological" theories also include risk factors outside the individual, like the family environment or local community (including socio-economic status/social class). For example, Garbarino (1977) proposed such a model in relation to child abuse [12].

Martin et al (2011) concentrated on maternal risk factors and offspring childhood sexual abuse using data from the Mater-University of Queensland Study of Pregnancy (MUSP). This is based upon 7223 pregnant women who gave birth to single babies at the Mater Misericordiae Hospital in Brisbane, Australia between 1981 and 1984. Data were collected at 3-5 days after birth, six months, and 5, 14 and 21 years old. Martin et al used the last follow-up which questioned 2664 young adults about their experiences of childhood sexual abuse (defined as forced sexual contact before age of 16 years).

Overall, 16% of the sample reported non-penetrative sexual abuse (defined as "exposure or masturbation"; "kissed or fondled at breasts or genitals"; "touched or masturbated the genitals of someone else") and 8.8% reported penetrative abuse (defined as sexual intercourse or oral sex). For women the rates were 20.2% and 10.2%, and 11.4% and 8.1% for men respectively.

Table 2.1 summarises the significant associations between individual factors and the risk of childhood sexual abuse, after controlling for other variables, found by Martin et al (2011).

Evaluative points

1. The reported prevalence of childhood sexual abuse - Lower than some other Australian studies (eg: 40% women

[12] Childhood sexual abuse is more likely in dysfunctional family environments with parental conflict, impaired parent-child relationships, and parental adjustment problems (Fergusson et al 1996).

FACTOR	NON-PENETRATIVE	PENETRATIVE
Gender	Being female	Being female
Maternal educational level	-	Less than higher education
Marital status at 6 months after birth	-	Any other than married
Smoking	Heavy (>20 cigarettes per day)	Any
Pre-pregnancy attitudes	Feeling positive about baby, but not having planned/wanted pregnancy	-
Maternal anxiety at 6 months after birth	Yes	-

Table 2.1 - Significant risk factors for penetrative and non-penetrative sexual abuse.

and 15% men; Najman et al 2005 [13]) (figure 2.1), but higher than in New Zealand (eg: 17.3% of women and 3.4% of men; Fergusson et al 1996; appendix 2A) (figure 2.2). The latter study interviewed their participants at 18 years old compared to 21 years old in Martin et al.

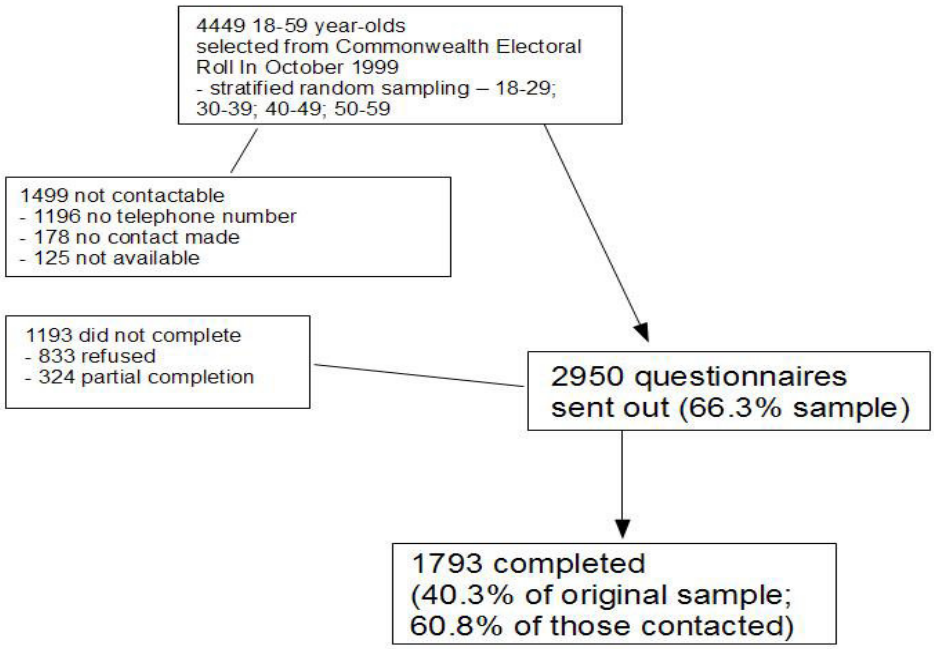


Figure 2.1 - Sampling details of Najman et al (2005).

[13] Non-penetrative abuse reported by 12% of men and 23% of women, and penetrative abuse by 4% and 12% respectively (based on 1793 18-59 year-olds).

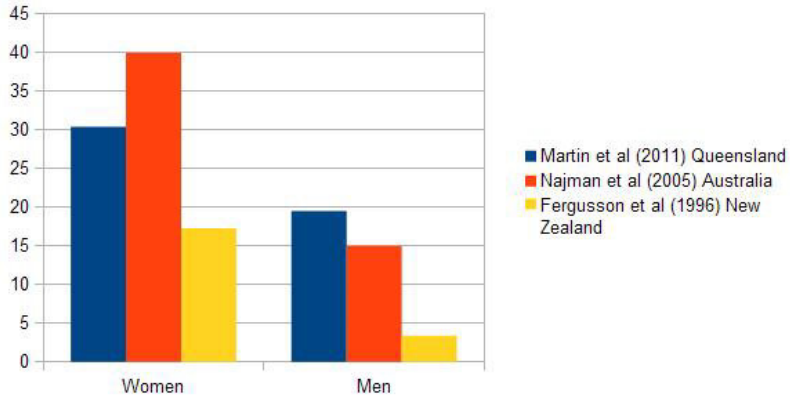


Figure 2.2 - Prevalence of childhood sexual abuse in three studies.

2. Maternal education level - Martin et al found an association of lower education with risk of penetrative sexual abuse, whereas Fergusson et al (1996) found no relationship with sexual abuse.

3. Marital status - Martin et al found that penetrative sexual abuse was associated with any status other than married (eg: single or living together). The key factor is the presence of a non-biological male in the household (Cicchetti and Valentino 2006).

4. Measurement of maternal variables - Most of them were single point measures at six months after birth, for example, and did not take account of changing circumstances.

5. Lack of paternal data, particularly as the vast majority of child sex offenders are male.

6. Self-reported retrospective accounts of childhood sexual abuse depend upon the honesty and recall accuracy of the victims. Maughan and Rutter (1997) argued that these are "adequately reliable accounts".

7. No data were collected on the frequency and severity of abuse, identity of perpetrators, and non-sexual types of abuse. Sexual abuse after age 16 was excluded.

8. Information was not collected about the neighbourhood and school experience of the participants.

9. As with any longitudinal study, there was a "loss to follow-up" of a large number of participants. The study began with 7223 women, and 3739 of them and their offspring were contactable after 21 years, but only 2664

offspring included in the study (36.9% of original sample). This is a potential bias because those who drop-out may have lower or higher prevalence of the behaviour being studied.

10. Key strengths of the study:

- Length of study (21 years).
- Distinguished between penetrative and non-penetrative sexual abuse.
- Large cohort.
- Prospective study.

11. Martin et al (2011) were interested in whether socio-economic status/social class is a risk factor for childhood sexual abuse. The previous studies were divided. This study could not give a definite answer. Certain variables, like heavy smoking, and lower education, that are signs of lower socio-economic status were related to sexual abuse, but other signs, like lower household income, and young maternal age at birth, were not.

2.2. ABUSE AND MENTAL ILLNESS

Victims of child abuse (physical [14] or sexual) are more likely as adults to attempt suicide, to experience more hospitalisation (earlier in illness, longer periods, or more often) for a mental disorder, and to have more severe symptoms of a mental disorder than non-victims (Read et al 2003). Among female sufferers of "serious mental illness", studies find rates of child abuse as high as 90%, but less for men (up to one-third) (Read et al 2003).

Retrospective studies that ask adults with mental

[14] The "battered-child syndrome" was a term coined for children who receive "serious physical abuse" (usually from a parent or carer) (Kempe et al 1985/1962). Typically the child is under three years old, and as well as the physical injuries there can be a failure to thrive. At one extreme it involves murder, and, at the other, the mother (usually) reports fantasies of hurting the child (Kempe et al 1985/1962).

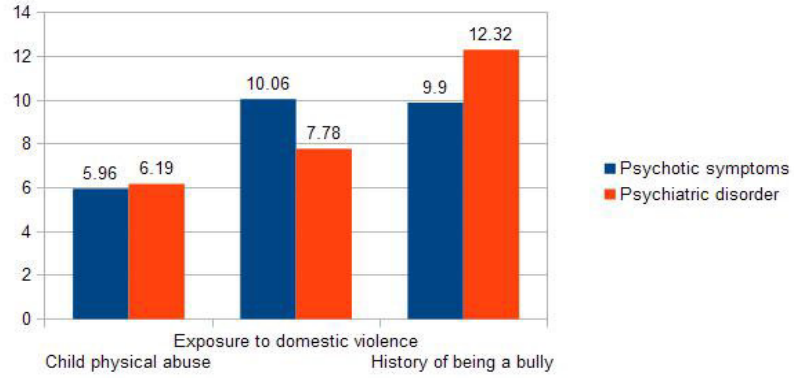
For example, in the UK, child-minder Keran Henderson was convicted of the manslaughter in March 2005 of 11 month-old Maeve Sheppard via "shaken baby syndrome". Though she was convicted, the evidence presented varied between "unqualified sympathetic mums" giving character references for a "perfect record as a child minder" versus "near-unanimous damning science from the experts" about a controversial condition known as "shaken baby syndrome". This is where the violent shaking of a baby causes brain damage and bleeding ("Panorama: Shaken Babies"; BBC TV; 10/3/08).

In the first study of "battered-child syndrome", Kempe et al (1962) surveyed 71 hospitals in the USA, which reported 302 cases, and 77 District Attorneys (reporting 447 cases) in one year.

health problems about their childhood experiences of abuse are prone to recall bias. Prospective studies that follow individuals from childhood to adulthood are better for establishing causality.

Welch et al (2009) synthesised the findings from 23 studies published between 1970 and 2008 involving more than 100 participants each over more than 10 years in length. They found almost complete agreement between the studies that severe child abuse and neglect (measured by parental interviews, observation, child interviews, or court records) predicted later depression and/or PTSD.

Among 211 Irish adolescents aged 12-15 years old (Challenging Times study) reporting a psychotic symptom [15] was significantly more likely among individuals who had experienced physical abuse, been exposed to domestic violence, and to be a bully (figure 2.3).



(Data from Kelleher et al 2008 table 1 p380)

Figure 2.3 - Odds ratios of significant associations.

Read et al (2003) investigated the relationship between child abuse (physical or sexual) or adult assault (sexual or physical), and three symptoms of schizophrenia (hallucinations, delusions, and thought disorders) in New Zealand. Information was ascertained from the medical records of 200 individuals at an urban community mental health clinic [16].

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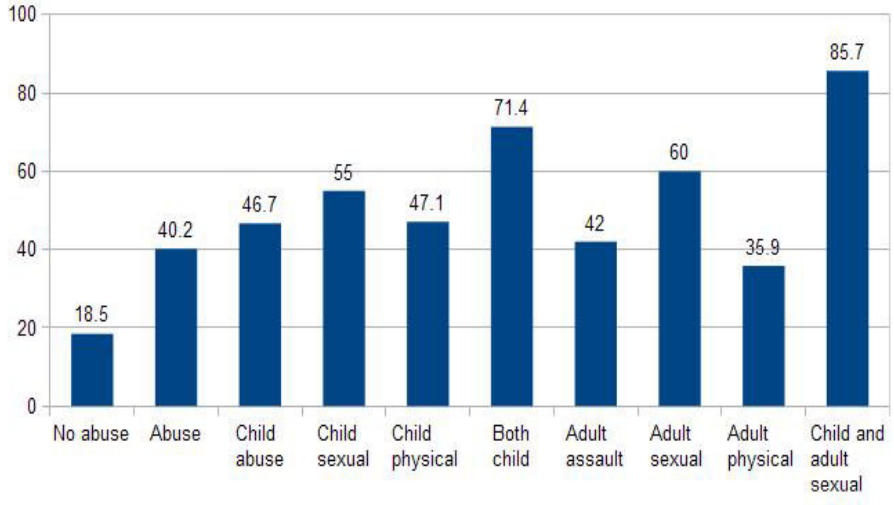
[15] This was measured by the Schedule for Affective Disorders and Schizophrenia for School-Aged Children, Present and Lifetime Versions (K-SADS) (Kaufman et al 1996). Example of questions asked to discover if individual has had delusions: "Do you know what imagination is? Tell me? Has there ever been a time your imagination played tricks on you? What kinds of tricks? Tell me more about them. Did you have ideas about things that you didn't tell anyone because you are afraid they might not understand? What were they? Did you believe in things that other people didn't believe in? Like what?" (Kelleher et al 2008 p382).

[16] Probably in Auckland, though this is not specified by the authors, but they are based at the University of Auckland.

Just under half (46%) of the individuals' records contained details of at least one form of the four abuses. Any abuse was significantly associated with hallucinations only (40.2% of victims vs 18.5% of no abuse group). This included auditory hallucinations, voices commenting, command hallucinations to harm or kill oneself, visual hallucinations, and tactile hallucinations, but not olfactory hallucinations.

Separately, all types of abuse except adult physical assault were significantly associated with hallucinations (figure 2.4). Adult sexual assault was significantly more common among delusion and thought disorder sufferers, and they had more symptoms than non-victims. Being a victim of both child and adult sexual abuse was associated with significantly more symptoms (mean 2.43).



(Data from Read et al 2003 table 1 p8)

Figure 2.4 - Percentage of individuals suffering from hallucinations based on type of abuse.

This study had two key limitations:

i) The use of medical records as the source of information including for diagnosis. This meant that it was a secondary source study (ie: researchers did not have contact with participants).

ii) The accuracy of abuse disclosure - both in terms of not reporting (underestimate) or delusional reporting (overestimate). Relative to other studies, the prevalence of abuse was lower here (Read et al 2003).

A traumagenic neurodevelopmental model (Read et al 2001) has been proposed to explain the relationship between child abuse and adult schizophrenia. The

childhood trauma affects the developing brain which makes the individual more sensitive to stress and vulnerable to schizophrenia developing.

2.2.1. Suicide Attempts

Though there may be a strong link between childhood abuse and adult problems, there are many individuals experiencing abuse who do not have mental health problems. Are there common factors that distinguish abused individuals who develop adult problems and those who do not?

Brezo et al (2008) investigated this question in relation to suicide attempts by young adults who reported childhood abuse. Data were analysed from 1631 individuals in a French-Canadian longitudinal study in Quebec from nursery school-age to their early 20s. Participants who reported having experienced childhood abuse when asked in their 20s were divided into three groups: contact sexual abuse (n = 162), physical abuse (n = 336), or both (n = 133); and compared to the non-abused group (n = 1000) on various socio-demographic and other variables.

Suicide attempts and suicidal ideation were more common among the abused than non-abused group, and among the abused group they were higher in the both types of abuse and sexual abuse sub-groups (figure 2.5).

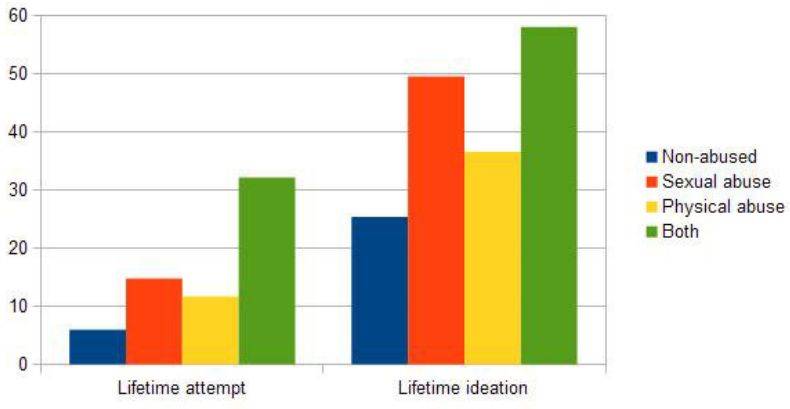


Figure 2.5 - Percentage of respondents reporting suicidal attempts or ideation based on abuse.

Individuals who had been abused repeatedly by an immediate family member (eg: father, stepfather, brother) had the highest risk of suicide attempt (five times greater than non-abused individuals). Individuals abused by an extended family member (eg: uncle, cousin) had over three times the risk, and over twice for non-related abusers (eg: acquaintance, stranger).

Externalising behaviours like disruptive behaviour, conduct problems, and childhood aggression by individuals in the abused group were associated with suicide attempts.

In terms of socio-demographic variables, only low parental education was associated with suicide attempts by abused individuals. Among the both types sub-group, women were more likely to attempt suicide than men.

Thinking about killing oneself was strongly associated with suicide attempts in all abused sub-groups.

All measures were self-reported in retrospect by the participants as adults using validated instruments like the Suicidal Intent Scale (Beck et al 1974) [17] and the Childhood Sexual Abuse Scale (Felitti et al 1998). Individuals who were not honest would have been misclassified.

2.3. APPENDIX 2A - FERGUSSON ET AL (1996)

This study interviewed 1019 18 years olds in the Christchurch Health and Development Study in New Zealand. Of these, 106 (10.4%) reported any type of sexual abuse before age 16 years old (based on three categories - non-contact; contact not involving attempted or completed intercourse; attempted or completed vaginal, oral or anal intercourse).

Having experienced any form of childhood sexual abuse was associated with increased risk of depression, anxiety, or alcohol abuse/dependence, but sexual abuse involving intercourse had a much greater risk including eight times more likely to be depressed, five times more likely anxiety, 4.5 times conduct disorders, three times alcohol abuse/dependence, five times other substance abuse/dependence, and twelve times more likely to attempt suicide.

Fergusson et al (1996) calculated that sexual abuse accounted for 10-20% of the prevalence of these mental disorders.

2.4. REFERENCES

Beck, R.W et al (1974) Cross-validation of the Suicidal Intent Scale Psychological Reports 34, 445-446

Brezo, J et al (2008) Predicting suicide attempts in young adults with histories of childhood abuse British Journal of Psychiatry 193, 134-139

Cicchetti, D & Valentino, K (2006) An ecological-transactional perspective on child maltreatment: Failure of the average expectable environment and its influence on child development. In Cicchetti, D & Cohen,

[17] This scale has twenty items about the intensity of the wish to die.

D (eds) Developmental Psychopathology Risk, Disorder and Adaptation (2nd ed) New Jersey: Wiley

Felitti, V.J et al (1998) Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) study American Journal of Preventive Medicine 14, 245-248

Fergusson, D.M.P.D et al (1996) Childhood sexual abuse and psychiatric disorder in young adulthood: I. Prevalence of sexual abuse and factors associated with sexual abuse Journal of the American Academy of Child and Adolescent Psychiatry 35, 1355-1364

Garbarino, J (1977) The human ecology of child maltreatment: A conceptual model for research Journal of Marriage and Family 39, 721-735

Kaufman, J et al (1996) Schedule for Affective Disorders and Schizophrenia for School-Age Children, Present and Lifetime Versions Pittsburgh: University of Pittsburgh, Western Psychiatric Institute and Clinic

Kempe, C.H et al (1985) The battered-child syndrome Child Abuse and Neglect 9, 143-154 (reprint from Journal of the American Medical Association 181, 17-24; 1962)

Kelleher, I et al (2008) Associations between childhood trauma, bullying and psychiatric symptoms among a school-based adolescent sample British Journal of Psychiatry 193, 378-382

Martin, A et al (2011) Longitudinal analysis of maternal risk factors for childhood sexual abuse: Early attitudes and behaviour, socio-economic status, and mental health Australian and New Zealand Journal of Psychiatry 45, 629-637

Maughan, B & Rutter, M (1997) Retrospective reporting of childhood adversity: Issues in assessing long-term recall Journal of Personality Disorders 11, 19-33

Najman, J et al (2005) Sexual abuse in childhood and sexual dysfunction in adulthood: An Australian population-based study Archives of Sexual Behaviour 34, 517-526

Read, J et al (2001) The contribution of early traumatic events to schizophrenia in some patients: A traumagenic neurodevelopmental model Psychiatry: Interpersonal and Biological Processes 64, 319-345

Read, J et al (2003) Sexual and physical abuse during childhood and adulthood as predictors of hallucinations, delusions and thought disorder Psychology and Psychotherapy: Theory, Research and Practice 76, 1-22

Welch, S et al (2009) Family relationships in childhood and common psychiatric disorders in later life: Systematic review of prospective studies British Journal of Psychiatry 194, 392-398

3. TRUMAN SYNDROME

"Truman syndrome" (or "Truman Show delusion"; TSD) is a form of delusion named after the film, "The Truman Show" [18], where there is a sense that the ordinary has changed or is different, and this has particular significance. In the case of a 26 year-old male sufferer, it was the "feeling there was something subtle going on around him that others knew about but he didn't. He had a vague sense that people around him were 'acting', he was the focus of their interest and they knew a secret that was being kept from him" (Fusar-Poli et al 2008 p168). Thus the preoccupation that he was the focus of something which he did not understand. It is a variation on delusions of grandeur.

Gold and Gold (2012) reported the cases of five patients at the Bellevue Hospital in New York with the delusion (table 3.1).

Patient	Details of delusion
Mr.A	Held belief for five years; believed he had cameras in his eyes.
Mr.B	He said: "I realised that I was and am the centre, the focus of attention by millions and millions of people... my [family] and everyone I knew were and are actors in a script, a charade whose entire purpose is to make me the focus of the world's attention".
Mr.C	A local newspaper reporter who believed that all news stories were written by his colleagues for his entertainment.
Mr.D	Working behind the screens on a reality TV show, he came to believe that he was the focus of the show really.
Mr.E	In hospital he believed that all the staff were actors in a programme about him.

Table 3.1 - Brief details of five cases of TSD.

Central to the TSD are persecution and grandiosity. Though these characteristics are common in other forms of delusion, Gold and Gold (2012) argued that, in one sense, the TSD is distinct, and is a "child of its time" as reality television has grown in popularity in the 21st century. Interestingly, Reiss and Wiltz (2004) reported a correlation between hours of watching reality television shows and feelings of self-importance in the general population.

[18] In "The Truman Show", a "world" has been created for one character, "Truman", and everybody else there is an actor playing out their lines. Only Truman does not know that it is a "reality television" show (taken to the maximum). Truman was born and raised in the television show-world.

Delusions can have local variations; for example (Gold and Gold 2012):

- Belief that one is chief disciple of Buddha in Buddhist country.
- Belief that one is being covered by sand in desert countries.
- Belief that one's telephone is tapped by the CIA in the USA while one's letters are read by Communist Party officials in China.

But Gold and Gold (2012) saw the local variations as no more than "novel manifestations of delusional forms that are unchanging across time and culture... never more than old wine in new bottles" (pp12-13). In reference to the TSD, "Although the feature of controlled reality is novel, the delusion remains a variant on persecution, grandiosity and reference" (Gold and Gold 2012 p12) [19] [20]. So delusions are both specific to the time and place (delusional content), and have universal elements (delusional form) (Gold and Gold 2012).

REFERENCES

Bentall, R (2009) Doctoring the Mind: Is Our Current Treatment of Mental Illness Really Any Good? New York: New York University Press

Frith, C (1992) The Cognitive Neuropsychology of Schizophrenia Hove, UK: Lawrence Erlbaum Associates

Fusar-Poli, P et al (2008) "Truman' signs and vulnerability to psychosis British Journal of Psychiatry 193, p168

Garety, P.A et al (2005) Reasoning, emotions and delusional conviction in psychosis Journal of Abnormal Psychology 114, 373-384

Gold, J & Gold, I (2012) The "Truman Show" delusion: Psychosis in the global village Cognitive Neuropsychiatry 1-18, iFirst

Reiss, S & Wiltz, J (2004) Why people watch reality TV Media Psychology 6, 363-378

Stompe, T et al (2003) Old wine in new bottles? Stability and plasticity of the contents of schizophrenic delusions Psychopathology 36, 6-12

[19] Stompe et al (2003) listed seven common themes in delusions - persecution, grandiosity, guilt, religion, hypochondria, jealousy, and love. Gold and Gold (2012) added reference, control, thought, nihilism, and misidentification.

[20] Three main theories have been proposed to explain the cognitive processes involved in delusions:
i) Theory of mind disorder (Frith 1992) - a disorder in the processes that make inferences about the mental state of others.
ii) Jumping to conclusions hypothesis (Garety et al 2005) - a bias in reasoning that leads the individual to jump to conclusions based on little evidence.
iii) Attributional bias hypothesis (Bentall 2009) - a tendency to attribute blame for negative events as external rather internal (eg: I was not promoted because the boss against me rather than may work is poor).