

# Identification of abuse histories in a community mental health centre: The need for policies and training

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## Abstract

In the context of studies finding low levels of enquiry about abuse by clinicians in the U.S.A. and the U.K., the medical records of 200 consecutive adult clients of a New Zealand Community Mental Health Centre were reviewed. All information regarding clients' abuse histories contained within the files was noted. The results suggest that enquiry about abuse is not routinely taking place. Assessments conducted using a form with an abuse section identified significantly greater prevalence rates of abuse than assessments conducted without the form. When notes in the current chart from previous contacts with mental health services were included, a prevalence rate of 46% for childhood and/or adulthood abuse was calculated. Only approximately half of this abuse, however, was identified in the notes of the current admission. Recommendations are proposed regarding the need for unit policies ensuring routine enquiry about abuse in standardised admission procedures, and for providing clinicians with training in how and when to enquire about abuse, and how to respond.

## Introduction

### Why it is necessary to know about abuse

A relationship between childhood abuse and many mental health problems in adulthood has been well documented, including depression, anxiety disorders, post-traumatic stress disorder, eating disorders, dissociative disorders, personality disorders, sexual dysfunction, and substance abuse (Beitchman, *et al.*, 1992; Boney-McCoy & Finkelhor, 1995; Briere, *et al.*, 1996). A growing number of studies also demonstrate a relationship between child abuse and schizophrenia (Briere, *et al.*, 1997; Read, 1997; Read & Argyle, 1999; Ross, *et al.* 1994). Furthermore it has been demonstrated that child abuse is posi-

tively related to measures of disturbance severity, including suicidality (Beitchman *et al.*, 1992; Briere *et al.*, 1996; Read, 1998; Read, *et al.*, 2001).

A recent review of 15 studies calculated that 64% of female psychiatric in-patients have suffered physical or sexual child abuse (Read, 1997). Male psychiatric in-patients have also been shown to have significantly higher rates of child abuse than men in the general population (Jacobson & Herald, 1990; Palmer, *et al.*, 1994; Rose, *et al.*, 1991). Sexual and physical assault in adulthood have also been found to be related to severe psychiatric disorders (Goodman, *et al.*, 1997; Ritscher, *et al.*, 1997). The hypothesis that these relationships may involve causality receives support

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from studies controlling for possible mediating variables (Briere *et al.*, 1997; Fergusson *et al.*, 1996; Mullen *et al.*, 1993). Regardless of the issue of causality many researchers have for some years recommended, on the basis of the sheer volume of abused individuals in contact with mental health services, that routine enquiry about abuse history be conducted in all mental health settings (e.g. Briere, 1999; Jacobson & Richardson, 1987; Read & Fraser, 1998a; Swett *et al.*, 1990).

Knowledge of a patient's abuse history can assist treatment in several ways. It enables the clinician to formulate the client's development and presenting problems more accurately, including an assessment of the impact of abuse (Jacobson & Richardson, 1987).

Abused clients may be slow to trust when entering a therapy relationship (Jacobson & Herald, 1990). An awareness of abuse history helps the therapist understand and tolerate the slow formation of therapeutic alliance and avoid misinterpreting it as an incapacity for relationships or 'resistance'.

Because abuse is so often denied, dissociated, or repressed, it may not be mentioned or connected with the presenting problem (Herman, 1992; Lundberg-Love *et al.*, 1992). The patient who is understood correctly has a much better chance of receiving an accurate diagnosis and appropriate treatment (Briere, 1989). Recalling and revisiting the experience, and understanding the role the abuse may have played in causing or maintaining current difficulties, are important elements of the recovery process (Briere, 1989; Herman, 1992).

### **Why it is necessary to ask about abuse?**

Fewer than half of abuse victims tell anyone at the time of the abuse and a large percentage, including many with extensive contact with mental health services, never reveal the victimisation until asked by re-

searchers (Elliott, 1993; Finkelhor, 1990). There are many possible reasons for this secrecy. Some people may be unaware that they were abused because of denial or dissociation. Others may feel pressure to keep their abuse secret, sometimes from a sense of family loyalty. They may fear stigmatisation and rejection, or have feelings of shame and guilt. They may have attempted to disclose in the past and been ignored, disbelieved or blamed by family or professionals; and they may have a deep distrust of other people (Herman, 1992; Jacobson & Herald, 1990; Lundberg-Love *et al.*, 1992). By asking about abuse clinicians demonstrate that they believe that an abuse history is important, and it demonstrates a capacity to deal with the subject matter, which is central to a therapeutic alliance (Jacobson & Richardson, 1987).

### **Are clinicians asking about abuse?**

Jacobson, *et al.* (1987) examined in-patient charts for any mention of abuse and compared the data with results from their research interviews. They found that 91% of assaults reported by their research were unrecorded in the charts; 85% for childhood physical abuse (CPA), 90% for adulthood physical abuse (APA), and 100% for adulthood and childhood sexual abuse (ASA, CSA). Wurr & Partridge (1996) found that while in-patient case notes in the UK documented a prevalence rate of 14% for CSA, direct investigation via questionnaire produced a rate of 46%. Lipschitz *et al.* (1996) found that the charts of only 29% of psychiatric out-patients who disclosed child abuse in a self-report questionnaire included documentation of the abuse. Goodwin *et al.* (1988) found an abuse prevalence rate of 50% among female in-patients who were asked about abuse but a rate of 10% among those who were not asked. Briere & Zaidi (1989) found that the rate of sexual abuse histories in female psychiatric

emergency room patients increased from 6% to 70% after clinicians were instructed to screen for sexual abuse. Such large discrepancies between rates of physical and sexual abuse found when clients were directly asked, and rates recorded in the charts, indicate that clinicians are either not asking clients about abuse histories or not recording such information in the files.

In a New Zealand survey of users of mental health services Lothian (1998) found that although many (65%) had been abused the majority (78%) were not asked about abuse by clinicians during initial assessment. The clients reported that the failure to ask about abuse greatly affected dialogue between them and clinicians about possible causal relationships. Sixty percent of consumers were unsure whether mental health workers saw a connection between their mental health problems and their experiences of abuse. Only 17% felt such a connection was recognised. This was in contrast to the 69% of consumers who believed that their experiences of abuse were connected to their present problems.

A New Zealand in-patient study compared abuse rates when the abuse section of an admission form was and was not used (Read & Fraser, 1998a). While the overall rate for all forms of abuse documented in the medical records (child and adult, physical and sexual) was 32%, the rate rose to 82% if an abuse history was taken on admission. In those cases where the abuse section of the admission form was not used the rate of documented abuse fell to 8%. Although use of the abuse section of the form significantly increased disclosure ( $p < 0.001$ ), the section was avoided in 68% of cases.

The aim of this study was to investigate whether the recommendations for routinely enquiring about abuse are being observed by clinicians in a Community Mental Health Centre (CMHC). It was hypothesised that in

an out-patient setting there would be more time to more thoroughly investigate psychosocial histories, including the gathering and integration of records from previous contact with mental health services where abuse may have been disclosed.

## Method

The files of 200 consecutive clients of a New Zealand CMHC were read in their entirety. Information on demographics, diagnosis, whether the standard initial assessment form was used or not, and disclosure of abuse, was recorded. As data was restricted to a file review the operational definition of sexual and physical abuse was based on what the client reported, and what the clinician considered abusive. In cases where there was strong evidence that abuse occurred but no documented conclusion, two researchers (KA & JR) independently rated the cases as to whether they were 'highly probable': the criterion being an individual subjective estimation of 95% certainty that abuse had occurred. Only when both researchers independently judged a case as 'highly probable' was that case included for analysis. Of 42 cases evaluated in this way 13 were included. An example of a case included as childhood sexual abuse is '... has made serious accusations about being the victim of sexual abuse... needs to be given as much support as possible' and, elsewhere in notes '... was living in a situation where apparently a whole group of boys lived with an older gentleman whose relationship with them was questionable.' An example of a case included as childhood physical abuse was: 'Depressed alcoholic father. Described a background of violence and physical abuse as a child'. An example of cases excluded is: 'raised from a babe in an abusive situation by an aunt' and 'abusive father'. The age cut-off for child-

hood abuse was 16 years inclusive.

All information regarding clients' abuse histories was noted, including the content recorded at initial assessment (with or without use of an admission form) or elsewhere in the notes covering the current admission, as well as abuse recorded in the notes in the current file that related to previous contact with mental health services.

Differences between proportions were tested for statistical significance with the Chi-Square test of independence. Independent Samples *t*-tests (two-tailed), and one-way analyses of variance (ANOVA) were used to analyse differences involving continuous variables.

### **Sample characteristics**

Of the 200 participants, 114 were women and 86 were men. The mean age was  $36.5 \pm 12.3$  years. One hundred and fourteen were European, 21 were Maori, 12 were Pacific Islanders, and 19 were classified as 'other'. Ethnicity was not recorded in four files. The diagnoses were depression for 85 participants, schizophrenia for 28, substance abuse for 20, bipolar disorder for 15, personality disorder for 10, anxiety for nine, adjustment disorder for seven, post traumatic stress disorder for seven, psychotic episode for five, schizoaffective disorder for five, psychotic disorder (not otherwise specified) for four, eating disorder for three, schizo-phreniform disorder for one, and six were classified as 'other'. No diagnosis was recorded for 33. The mean length of admission (continuous contact with the CMHC) was  $150.6 \pm 67.8$  days.

In 47.5% of the cases the clinician concerned with the assessment and care of the clients was male, and in 44.5% female. The gender of the primary clinician was not clear in 8% of the cases. In 54.5% of the cases the professional was a psychiatrist, in 18.5% a

psychiatric nurse, 10.5% a psychologist, 6.5% a social worker, and 1.5% an occupational therapist. For 8.5% the profession was unidentified.

### **Results**

Ninety-two of the 200 clients (46%) had one or more forms of abuse recorded somewhere in their files. Forty (20%) clients had CSA recorded, 34 (17%) had CPA recorded, 15 (7.5%) had ASA recorded, and 39 (19.5%) had APA recorded. There was a significant gender difference for CSA and APA. Thirty of the 114 females (26.3%) compared to 10 of the 86 males (11.6%) had CSA recorded ( $\chi^2=5.29$ ,  $df=1$ ,  $p<0.01$ ). Twenty-nine females (25.4%) compared to 10 males (11.6%) had APA recorded ( $\chi^2=4.79$ ,  $df=1$ ,  $p<0.05$ ). There was no significant gender difference in rates of CPA or ASA.

The gender and profession of the primary clinician were not significantly related to the amount of abuse identified overall or within any of the four abuse categories. Psychologists identified one or more forms of abuse in 57.1% of the cases for which they were responsible, compared to 53.8% for social workers, 45.9% for psychiatrists and 40.5% for psychiatric nurses. Male clinicians identified abuse in 47.4% of their cases and female clinicians in 46.1%.

### **Effects of using an admission form with an abuse section**

A new initial assessment form, which included an abuse section, was introduced part way through the period covered by the study. The admission dates for approximately half of the files were prior to the introduction of the standard initial assessment form. It was used at admission for 26 (13%) of the clients. For 136 (68%) clients an initial assessment was conducted without using the new form.

**Table 1:** Prevalence rates of abuse found, when the new assessment form was and was not used, and when the abuse section of the form was and was not used

	Any abuse	Childhood sexual abuse	Childhood physical abuse	Adulthood sexual abuse	Adulthood physical abuse
Form used (n=26)	12 (46.2%) *	3 (11.5%)	3 (11.5%)	3 (11.5%) **	4 (15.4%)
Form not used (n=136)	30 (22.1%)	16 (11.8%)	12 (8.8%)	2 (1.5%)	8 (5.9%)
Abuse section of form used (n=20)	12 (60.0%)	3 (15.0%)	3 (15.0%)	2 (10.0%)	4 (20.0%)
Abuse section of form not used (n=6)	1 (17.0%)	0	0	1 (17.0%)	0

\* $p < 0.05$ ; \*\* $p < 0.01$ ; ( $\chi^2$  coefficients).

(There was no documented initial assessment for 38 clients). The new form was used in 22 of the 85 cases (25.9%) where the primary clinician was female and three of the 95 cases (3.2%) involving male clinicians. The form was used in only one of the 109 cases where a psychiatrist was the primary clinician and 23 of the 74 cases (31.1%) involving other professions.

Table 1 shows that assessments in which the new assessment form was used identified a significantly greater amount of one or more forms of abuse ('any abuse') than assessments conducted without the form ( $\chi^2=4.96$ ,  $df=1$ ,  $p < 0.05$ ). Assessments using the form identified, in particular, more ASA ( $\chi^2=7.2$ ,  $df=1$ ,  $p < 0.01$ ) than assessments conducted without using the form.

Table 1 also shows that of the 26 cases where the new form was used, the abuse section of that form was completed in 20 cases (77%). Use of the abuse section resulted in a rate, for 'any abuse', of 60%, compared to 17% when the section was not completed, but this difference was not statistically significant, perhaps partially due to the small cell sizes.

Client gender was not significantly related to either use of the form or use of the abuse section of that form.

**Awareness of abuse recorded in notes of previous contact with mental health services**

Table 2 shows where in the file information about each type of abuse was recorded. The categories of 'current-assessment' and 'current-elsewhere' include all cases of abuse recorded in the file during the current admission, and the category 'previous' includes all cases of abuse that were found in notes in the file that were written prior to the current admission but not in notes from the current admission. Where abuse was recorded in both past and current clinical notes it was classified as either 'current-assessment' or 'current-elsewhere' as the abuse had been recognised by the clinicians in this CMHC.

CMHC clinicians recorded, either at the initial assessment, or later in the file, 60% of all CSA identified by the researchers anywhere in the file, 52.9% of the CPA, 46.7% of the ASA, and 53.8% of the APA. The remaining abuse was recorded in previous notes

**Table 2:** Proportions of all identified abuse which was recorded (i) at initial assessment or (ii) elsewhere in notes of current admission, or (iii) in notes in the current file relating to previous contacts with mental health services

Identified abuse	Current notes			Previous notes
	Assessment	Elsewhere	Total	
Child sexual abuse ( <i>n</i> =40)	19 (47.5%)	5 (12.5%)	24 (60%)	16 (40%)
Child physical abuse ( <i>n</i> =34)	15 (44.1%)	3 (8.8%)	18 (52.9%)	16 (47.1%)
Adult sexual abuse ( <i>n</i> =15)	5 (33.3%)	2 (13.3%)	7 (46.7%)	8 (53.3%)
Adult physical abuse ( <i>n</i> =39)	12 (30.8%)	9 (23.1%)	21 (53.8%)	18 (46.2%)

but not mentioned anywhere in the notes recorded during the current admission, including summary formulations, treatment plans, or therapy notes. If attention was paid only to information obtained and recorded within the notes and assessments of the current admission (i.e. excluding past clinical notes) the rate of abuse found in the files would be 12% for CSA, 9% for CPA, 3.5% for ASA, and 10.5% for APA.

Of the abuse that was identified during the current admission ('current-assessment' and 'current-elsewhere') the majority of the abuse was identified at the initial assessment. Child abuse seemed particularly unlikely to be 'picked up' later if not identified at the initial assessment. Of the 42 cases of child abuse (CSA and CPA combined) identified by CMHC staff, 34 (81.0%) were identified at initial assessment, compared to 17 of the 28 cases of adult abuse (60.7%).

## Discussion

### Study limitations

As documented earlier, abuse rates based on medical records have been found to consistently and significantly underestimate the true prevalence rates of abuse in psychiatric samples. The chart-based prevalence rates for the four abuse categories were all significantly lower than the rates cited earlier from

studies involving direct enquiry of an entire sample. Compared to in-patient samples, rates of abuse tend to be lower in out-patient samples due to differences in severity of illness (e.g. Herman, 1992) (although not always e.g. Lipschitz *et al.*, 1996), however, the 'non-abused' group in the current study would probably have included a significant number of clients who had been abused but whose abuse was not identified by clinicians.

On the other hand the information recorded in the file may not have represented the full extent of clinicians' knowledge of abuse histories. Some clinicians may not have recorded what they knew because they considered it either too sensitive or, alternatively, not relevant to current treatment goals. Abuse may not have been recorded because of denial of abuse by the client, or at the request of the client not to mention the abuse in the notes. Information may have been forgotten if retrospectively recalled after an appointment to record in notes. Future research could investigate clinicians' reasons for not recording information about clients' abuse histories.

### Effects of using an admission form with an abuse section

The results revealed that when an assessment form that includes a specific section for enquiring about and recording abuse histo-

ries is used at initial assessment, significantly more abuse is identified than when initial assessments are not guided by such a form. This is in contrast to the finding of the New Zealand in-patient study (Read & Fraser, 1998a) that the use of a form including a specific section for asking about abuse did not affect rates of abuse. The researchers' explanation was that clinicians had avoided using the abuse section in 68% of cases. In the out-patient setting of the current study this occurred in only 23% of cases.

A possible explanation for this important difference is the availability, in an out-patient service, of more time for history-taking because of fewer crisis-type entries into the service.

Read & Fraser (1998a) found that when the abuse section of the in-patient admitting form was used, significantly higher rates emerged for all four types of abuse, and for 'any abuse' (82% vs. 8%) than when the abuse section was avoided. The fact that the parallel difference in the current study (60% vs. 17%) did not attain statistical significance may be partially explained by the small cell sizes (20 and six).

Research has identified numerous reasons why clinicians may choose not to enquire about abuse including: poor rapport with the client and fears of disengagement with services, abuse not considered relevant to current therapeutic goals, time constraints, more immediate needs and concerns, severity of disturbance and fears of exacerbating disturbance, clinicians' beliefs regarding the reliability of clients' accounts (Briere & Zaidi, 1989; Lab *et al.*, 2000; Mitchell *et al.*, 1996; Pruitt & Kappius, 1992; Read & Frazer, 1998a; Sugg & Inui, 1992; Young *et al.*, 2001).

In such cases where it is considered inappropriate initially to ask about abuse clinicians may need to reformulate later in the

progress of therapy when issues of abuse may be more readily disclosed, more appropriate to higher level targets, or when the goals of therapy change.

### **Awareness of previous documentation of abuse**

If attention was paid only to information obtained and recorded within the notes and assessments of the current admission, that is, the amount of abuse identified by staff at this CMHC, the rates of abuse would be only 12% for CSA, 9% for CPA, 3.5% for ASA, and 10.5% for APA. Given the prevalence rates for similar populations based on direct enquiry of all patients it seems clear from this first study of New Zealand out-patient clinicians that their ability to identify and record abuse is no greater than that of their US and UK counterparts.

It is of particular concern that among 200 out-patients 58 cases of abuse noted in the current charts from previous contacts with mental health services (see Table 2) appeared not to have gained the attention of clinicians at the CMHC.

One possible explanation for not picking up on previous documentation of abuse is that the primary clinician did not read through the past notes, or skimmed and missed the information about abuse. In many cases, however, documentation of abuse was repeated several times through the notes or written up in assessments and summaries that might have been an important source of information about a client's previous assessments and treatment. Another explanation could be that the clinician did read the notes, saw documentation of abuse, and did not record abuse history for a variety of possible reasons, some being; that the clinician did not feel the abuse history needed to be repeated, they queried the veracity of the report, they had yet to deal with this sensitive issue with the client, the abuse was considered not rel-

evant to the treatment goals or presenting problems in the current admission, the staff were untrained at dealing with abuse, or that the issues were resolved for the client.

Of the abuse that was identified by clinicians during the contact with the CMHC, the majority of the abuse was identified at the initial assessment. CSA, CPA, and ASA were significantly more likely to be identified at initial assessment than later in the admission. This is possibly the first such analysis of the point in a client's treatment where abuse is most often identified, and the analysis warrants replication.

### **Clinical implications**

Such information could be used in the development of policy and training with regard to identifying the most effective time for identifying abuse histories. The current data suggest that if not identified on admission abuse histories are unlikely to be identified later. Sometimes it may be best to not ask a client about abuse at admission particularly if they are in crisis or acutely distressed. This must not, however, be used as an excuse for not asking that client about abuse later. The adoption of an assessment form including an abuse history section, with a related increase in abuse identification, appears to be a positive step that should be considered elsewhere in New Zealand and beyond.

### **Case examples**

Although generalization of case examples may be limited outside this CMHC they can highlight areas where practice and policy could be reviewed and enhanced. Clients' abuse histories can be assessed and addressed at a number of points in the time they have contact with a service and in a number of ways. These cases provide an example of how a client's history of abuse can be missed within, and between, services.

### *Good practice*

Examples of good practice include the 42 instances where a client's abuse was identified at initial assessment.

### *Practice that might be enhanced by unit policies and staff training.*

In 58 of the 128 instances of abuse (45.3%) found somewhere in the file (see Table 2) information about abuse was recorded in previous notes but not mentioned in notes recorded during current contact with the CMHC. Recorded in two recent previous clinical notes of one file was information that the client was having 'confused thoughts with preoccupation of past events e.g. sexual abuse' and had been 'thinking a lot about childhood – was sexually abused by uncle'. The abuse was not mentioned anywhere in current file notes. The person had not received an initial assessment, there was no documentation of previous disclosure of, and treatment for abuse, and no therapy or referral.

In another file, past CSA, involving rape, was recorded in the discharge summary of a previous unit. Despite this there was no documentation of enquiry, therapy or referral, or any mention of the possibility of abuse in the notes of the current admission.

One individual's 'father was sadistic and used to severely beat both the mother and the children'. This individual was also sexually abused as a child. Details of the abuse and its consequences were recorded repeatedly at various points in the previous clinical notes. The 'transfer of care' forms to the CMHC recorded that the individual was 'in psychotherapy to deal with past abuse issues and is showing slow gains there'. The only mention of the abuse in 17 pages of clinical notes covering more than 30 contacts with the CMHC over the period of a year was a copy of a letter from a CMHC psychiatrist to the individual's counsellor stating that 'the epi-

sodes of depression should be considered as a separate disorder which may not directly be caused by the abuse proper'.

An individual's alcoholic father was noted to have beaten the individual and the individual's mother and siblings 'black and blue'. The individual also experienced APA from an alcoholic partner. All this information was recorded in previous clinical notes. In the notes of the current admission there was no mention of any abuse, no documentation of anything to do with the abuse, and no therapy or referral for abuse-related treatment. It was not clarified whether the individual was still in the abusive adult relationship.

### Training and policy

Further progress would seem to be dependent on the training of staff. Briere (1999) found that clinicians given a brief orientation to trauma (including a structured trauma assessment interview) identified significantly more childhood sexual abuse, childhood physical abuse and adult sexual abuse than those given no orientation. In order to design effective training programmes future research needs to address the possible barriers to asking about abuse that would need to be overcome via the training. Such barriers to clinicians' enquiry about abuse include: fear of vicarious traumatisation, lack of knowledge about how and when to enquire, fear of planting false memories of abuse, and beliefs that abuse is not relevant to some forms of mental illness.

Training might also need to address how to respond to positive responses to enquiry, and to spontaneous disclosures. Studies in the USA finding inadequate responses from mental health professionals (Eilenberg *et al.*, 1996; Rose *et al.*, 1991) have been replicated by a New Zealand chart-review study in which 52 instances of documented abuse

among in-patients resulted in no documented abuse-related support while in hospital, no reporting to legal authorities (even where the abuse was recent or ongoing) and only three referrals for abuse-related therapy (Read & Fraser, 1998b). Lack of knowledge about how to respond may well influence whether one asks in the first place and might, therefore, also be a valuable component in training programmes. Unit policies, backing up such training packages, might beneficially address the importance of all clients being asked at some stage during assessment and offer guidelines about how to refer for abuse-focussed therapy. Clinicians will need to inform managers of the importance of ensuring that adequate resources are available for providing such therapy. This need will presumably expand as the training and policies uncover previously hidden cases of abuse.

Research might also be productively focussed on users of mental health services to determine their views on what might constitute effective abuse policies and training packages. A valuable step thereafter would be evaluation of the effectiveness of various approaches to unit policies and training in order to gradually develop a consensus regarding best practice in this area.

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