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Disturbing the Sound of Silence

Mental health services' responsiveness to people with trauma histories

by Debra Wells

This paper is dedicated firstly to those of us who have abuse in our backgrounds and have survived thus far. It is also dedicated to those of us who have chosen to take our own lives because yet another day was just too much to negotiate, whom the silence overwhelmed. As the author of this paper I would also like to dedicate this paper to psychiatrists in my life who do give a damn and who have walked a difficult and lonely path in standing up for people like me - Janet, Suzie and Mr Thom.

And in the naked light I saw

Ten thousand people, maybe more.
People talking without speaking,
People hearing without listening,
People writing songs that voices never share
And no one dare
Disturb the sound of silence
(Paul Simon, *The Sound of Silence*, 1964)

When someone sees at last, the shame is gone;
When someone hears, anguish may be composed,
And the long lucid listening is done.
(May Sarton, excerpt from *Death of a Psychiatrist*, 1974)

The purpose of this paper is to answer the question, 'are mental health services in New Zealand responsive to people with trauma histories'. When the Commission first asked me to write this document, my response was, 'well that's going to be a very short paper, the answer is NO'. They wanted a more informed discussion, understandably, and I have struggled to know how to present the following in a way that is not just a piece of academic writing. Instead, it needed to be alive and real and relevant. It needed to examine and answer the question in a way that reflects the human dimensions of distress and pain and silencing. It needed to dare to share the 'songs' in order to disturb the sound of silence. I do not apologise for the strong language I use in this paper; this issue has been ignored for too long and I, as one of many, say enough is enough.

For the purposes of this paper trauma is defined as a consequence of sexual, emotional and physical abuse. Trauma is not abuse, but is clearly a result or consequence of abuse for many people. This is in no way to minimise other types of trauma that people experience resulting from grief, loss, trauma resulting from wars, redundancies, mental health hospitalisation, dislocation and so on. I have chosen to only look at abuse as trauma, firstly because there is now a fairly substantial volume of research in this area which appears to be largely ignored by mental health services and secondly,

because as a person who has a trauma-based diagnosis and who has been and currently still is a user of mental health services, it is a topic I am very passionate about.

While this paper is written in a more conversational tone than is typical of such works, it covers the following areas:

1. What does the research say about the link between abuse and mental illness?
2. What do service users say about this same link?
3. What do national mental health documents say about trauma and mental health?
4. How are mental service services responding and why?
5. What are the next steps?

1. Research findings regarding abuse and mental illness

The opening lines of an Accident Compensation Commission document on therapy guidelines states in a highlighted box “Traumatised people are frequently misdiagnosed and mistreated in the mental health system. Because of the number and complexity of their symptoms, their treatment is often fragmented and incomplete” (cited in McGregor, 2001, pg 4).

Fairly damning words but are they true? Does research bear this out?

New Zealand research findings

- Studies (both New Zealand and international) consistently confirm a 50-80% prevalence rate of physical and/or sexual abuse among people who later acquire a mental illness diagnosis (Beitchman, Zucker, Hood, daCosta, Akman, Cassavia, 1992), (Briere, Woo, Mc Rae, Foltz, Sitzman. 1997), (Goodman, Rosenberg, Mueser, Drake, 1997), (Palmer, Bramble, Metcalfe, Oppenheimer, Smith, 1994), (Read, Agar, Barker-Collo, Davies, Moskowitz, 2001).
- Mental health service users who have been abused as children when compared to other mental health service users enter a psychiatric unit at a younger age, have longer and more frequent hospitalisations, spend more time in seclusion, are more likely to receive psychotropic medication, relapse more frequently, are more likely to attempt suicide and are more likely to engage in deliberate self harm (cited in Read, 1998).
- The diagnostic labels these people receive are wide and may change for one person a number of times over contact with mental health services. These include, but are not limited to major depression, panic and anxiety disorders, borderline personality disorder, post-traumatic stress disorder, dissociative disorders, eating disorders, substance abuse, sexual dysfunction, psychosis including schizophrenia, somatoform disorders (Risman, 2000, Young, Read, Barker-Coll, Harrison, 2001).
- Child abuse can be a stronger predictor of suicidality than a current diagnosis of depression (Lothain & Read, 2002).
- In one New Zealand study, 91% of cases in which service users had disclosed abuse, there was no evidence of them being offered abuse-related information, support or counselling (Young, Read, Barker-Collo, Harrison, 2001)
- A New Zealand inpatient study found that even when admission forms included a section for abuse history, only 32% of service users were asked the questions. While 59% of those who were asked disclosed abuse, only 6% of those who were not asked disclosed abuse (Young, Read, Barker-Collo, Harrison, 2001).

This paper by no means suggests that all mental illness is caused by abuse, it does however suggest that there is a strong link between abuse and mental illness for those who have been abused. I will not get into the causal versus contributory debate beyond what has been discussed, however I think that the general reader of this paper would agree that to imply that the relationship is purely coincidental is naive, and I would suggest perpetuates the abuse for those of us on the receiving end of mental health services.

2. What do service users say about this?

Kia Mauri Tau, a research project conducted out of the University of Waikato, interviewed 40 people from New Zealand about their recovery from mental illness. Most of these participants associated circumstances or events from their childhood or adolescence to their later mental illness, that is they did not understand their unwellness to be genetic or organic in origin. Eighteen of the 40 participants specifically mentioned sexual and/or physical abuse even though they were not directly questioned about this (Lapsley, Nikora & Black, 2002).

The following are quotes by service users within New Zealand about their understandings about the cause of their mental illness and about abuse histories within mental health services.

Causation

It was due to the child abuse, sexual abuse, that I had inflicted upon me as a child that caused my problems later on in life (Lothian & Read, 2002).

My whole life has been a go back to my teens and my sexual abuse and other kinds of abuse (Lothian & Read, 2002).

I know that my very difficult childhood and abuse history contributed greatly to my mental illness and I know it is the case for many others (personal communication to author).

As far as I am concerned, in regards to the relationship between trauma and later mental illness, I regard the sexual abuse that happened to me at the hands of my father at a preschool age, and other psychological and emotional abuse as I was growing up, to be the cause of my bi-polar disorder. I also know personally a significant percent of consumers that have trauma in their backgrounds (personal communication to author).

My experience has been that mental health professionals took no account of or interest in past and present stressful events. More interested in changing my behaviour by extortion or threat or accounting my distress to a mental illness which I am told is a 'chemical imbalance in the brain' and 'may have a genetic link' (personal communication to author).

On being asked

My life went haywire from thereon in...I went into a spiral of...I can't describe it...I just wish they would have said what happened to you, what happened - but they didn't (Lothian & Read, 2002).

It took 10 years, many admissions, a lot of different medication, ECTs. No one was able to draw out any abuse issues until my very last admission and I talked with a psychologist who asked me, "have you been abused?" (Lothian & Read, 2002).

It is my experience that generally mental health professionals have not initiated talk about my experiences. I have always been the one to bring up the subject, mainly because I have seen it relevant and refused to keep silent and keep secrets; the silencing of victims is how the abuse has power over us, and not just by the initial abuser. If the mental health professionals were not asking me the questions, and I know every time I talk about it etc it is not that comfortable for me, and that other consumers fear talking about it and bringing it up, how often is it ignored? (personal communication to author).

Not all service users that I spoke with had had a negative experience in this regard, though most had. Unfortunately though, positive experiences seemed to be a matter of good luck rather than good management. Some people found that the person or people they were working with were sympathetic to the impact of abuse and worked accordingly. While we, as service users, are theoretically allowed choice in the staff who work with us, the reality is that within many services this

is not possible due to staffing levels and caseloads. This would suggest that services as a whole need to be far more responsive to this issue. For service users to be at the mercy of luck is not good enough.

3. The stance of national documents

It is interesting, yet disturbing, to find that national mental health policy documents have almost nothing to say about this topic. When one considers the research about the prevalence of abuse histories for service users, this highlights that mental health policy makers in New Zealand have not taken this issue seriously. In fact, I would suggest they do not even formally recognise it as an issue that affects the lives of a significant number of service users.

This year service users wrote a vision document to “guide the development of the Ministry of Health’s second mental health plan and to influence the overall development of the sectors that affect people with mental illness” (Our Lives in 2014, 2004, pg 7). The document clearly articulates that services need to respond proactively to this issue. It says:

“Services [need to] recognise the social, psychological, spiritual as well as biological contributors to mental illness, including trauma, deprivation and loss” (pg 16)

“All people have access to health and social services that are culturally safe and responsive to our differing life experiences and needs including: people affected by trauma, deprivation and loss” (pg 18)

“Mental health services provide safe and effective resources and solutions and include: psychological therapies” (pg19).

Clearly service users do recognise trauma as an issue that must be addressed.

4. Mental health service response

In the course of writing this paper I spoke with a number of people who worked within mental health services across New Zealand and asked them what they were doing about this issue. All I spoke with acknowledged that there was a problem, but the general consensus was that they were not funded to deal with the issue.

I turned to the National Service Specification Guidelines for Mental Health Services (Ministry of Health) to see if there were any specific guidelines and therefore funding for trauma or psychotherapy services. There were only two, one for the refugee population (MHCS27) and one for Specialist Psychotherapy Services (MHCS10). However when one reads through the specifications for mental health, it appears that services are funded to work with people with abuse issues, if one takes a wider view. I have to admit, though, that the rationale behind some of the material was puzzling. In terms of exclusion clauses, child, adolescent and youth mental health service specifications clearly exclude people from services “whose problems are solely as a result of sexual abuse”. It is the only service specification to do this. In each of the service frameworks, there is a section that begins with, “service users accessing these services can expect, as a minimum, to be able to access all of the following processes” and then a list of processes follow that are clearly relevant to the particular service described. Almost all DHB provider arm inpatient and community services have ‘Therapy’ listed in this section. However supported accommodation specifications generally don’t. In the process description section of the framework, which provides definitions of what is meant by each of the processes, ‘therapy’ is defined as:

“Cognitive, behavioural, biological, and psycho-dynamic therapeutic interventions with proven efficacy including group and family treatment/therapy in respect of Service Users who fall within the Service User group described” (MOH, Process Descriptions, pg9).

Presumably then, the Ministry of Health acknowledges that people may require therapy and not just bio-medical interventions.

The issue of funding would seem to me to be irrelevant. If at least 50% of the people who use mental health services in this country have abuse histories and are more likely to be heavy users of mental health services, the effects of this abuse fall within the 3% range of funding. The Mental Health Commission has discussed the use of the 3% benchmark and notes that it has been used, or rather misused, and has led to diagnostic rationing and the assumption that severe mental illness means psychotic disorders (Mental Health Commission 2004). When one considers the wide range of diagnostic labels that people with abuse histories are given, it certainly falls within the 3%. It requires that services look past diagnostic labels to what people say has impacted on their mental health. It requires mental health in general to move beyond a bio-medical approach to treatment and to recognise that “diagnoses are not things people have inside them. We need to understand people, not diagnoses” (Risman, 2000, pg 466). It requires services to ask us, the people experiencing the distress, what do you think has caused this, and to respond to the answers given.

While I was unable to assess any New Zealand material regarding the costs of inappropriate mental health services treatment, I found this American case study which provides food for thought.

One victim of sexual, physical and emotional abuse whose life ended by suicide: her inpatient hospitalisation, alone, figured at \$640 a day, cost \$2,639,360. This figure does not include residential treatment, case management, legal, medical and other costs estimated to be over \$500,000, making a total cost of over \$3 million. In contrast, trauma-based psychotherapy, figured generously at \$150 a session, two sessions a week, for 17 years, would have cost \$265,000 (Maine Trauma Advisory Group 1997). The cost of this woman’s life is priceless and I apologise to her for reducing her suffering to dollars. It would seem to me, however, to be common sense that if services users were treated more appropriately in this country the costs also would be substantially reduced. Costs would not only be reduced but potentially the number of us who end our lives because we feel as if no one understands or gives a damn would also be reduced.

Service users have identified a number of practices within mental health that they find traumatising. This is true both of people who have and have not experienced previous trauma. These practices include seclusion and restraint, being labelled with a diagnosis, the silencing of abuse by either not asking in the first place or not responding to it when abuse is disclosed, the pathologising of psychological pain including the attempts to medicate it away.

In a powerful book *In Their Own Words* (Maine Trauma Advisory Group, 1997) the comments of 127 trauma survivors who were past or present users of mental health services in Maine also highlights these practices as damaging. While this publication is American, the conversations I have had with service users in New Zealand reinforce many of the comments. Another very powerful article in this regard is *About Trauma: Retraumatizing the Victim* (Jennings, 2003, in *Incite 2* (1). Pgs 15-20). Jennings, whose daughter was a victim of childhood sexual abuse and a user of mental health services who eventually suicided, parallels some mental health services’ practices to the actual experience of sexual assault.

One interesting response that I read suggested that if all people who entered mental health services were presumed to have trauma histories then many of the current practices within services would not be used and service delivery would be less traumatizing. It states “If trauma was presumed, anyone entering the system would be subject to a more humane, considerate and relevant approach. Interventions such as restraint and seclusion would be deemed too traumatising for anyone in crisis, not only for those whose trauma history is known...Indeed, the ‘trauma models’ often appear much more humane and respectful of the person than do traditional [bio-medical] approaches to people with psychiatric diagnoses” (Unknown).

What then, do service users with abuse histories want from mental health services?

We want:

- mental health services that look beyond diagnosis to the whole person, and practitioners who are willing to form therapeutic relationships with us
- training for ALL mental health staff in all aspects of trauma treatment and recovery, some of which would be provided by abuse survivors
- the creation of alternative services designed to diminish or eliminate the need for hospitalisation for those with abuse histories
- a stop to pathologising and medicating our distress
- mental health staff who ask about our histories and what we believe about what has created our distress, and who then work accordingly
- mental health services that do not perpetuate the abuse through its practices
- access to professionals who work effectively with people with trauma histories
- movement beyond a bio-medical approach to mental illness
- national recognition in mental health policy, planning and funding of the ongoing effects of abuse in peoples' lives
- national leadership in this area.

The discussion thus far raises the question of why mental health services seem to be generally unresponsive, or lack a commonsense approach, to the impact of abuse histories in service users.

A number of issues have already been alluded to. These include the lack of a national focus and commitment on the issue, the lack of response or acceptance of research that clearly shows that abuse and mental health issues are linked for a number of people and the misuse of the 3% benchmark.

While these can be seen as systemic issues, research indicates that there are also a number of factors which are barriers that individual clinicians face. These are:

- Fear of vicarious traumatisation
- Discomfort with discussing personal topics
- Concern about client embarrassment
- Time constraints
- Lack of training and confidence
- Severity of disturbance and fear of exacerbating disturbance
- Clinicians' beliefs regarding the reliability of clients accounts
- Concern about 'false memory syndrome'
- Clinicians' and clients' gender
- Having a bio-medical based theory of etiology.

(Young, Read, Barker-Collo, Harrison, 2001)

Clearly these issues need to be addressed if headway is to be made. Auckland District Health Board mental health services have introduced policy guidelines 'Trauma and Sexual Abuse' which outline recommended practice and are "designed to ensure that routine mental health assessments include appropriate questions about sexual abuse/trauma, and that disclosure is sensitively managed" (ADHB Mental Health Service Policy & Procedure Manual). Fionnagh Dougan, General Manager, said that the policy was designed to assist staff to be responsive to clients in a consistent way and to ensure that staff didn't feel on their own; that they knew there was support both within mental health

services and in the wider community to redirect people to appropriate services. The policy is guided by two principles. The first is that “assessment of mental health clients *must* include questions about possible trauma/sexual abuse to ensure that appropriate support and therapy is made available”. The second is “Clinicians should routinely ask about history of trauma, especially occurring during the client’s childhood”. Alongside this policy all mental health staff are required to attend a one-day workshop ‘Sexual Abuse and Trauma-Inquiry and Response’ run by Auckland Rape Crisis. The workshop is co-facilitated by Debra Lampshire, a consumer consultant with Mind and Body, and John Read, a lecturer from the University of Auckland. A follow-up study of the first seven workshops has been undertaken to assess the impact of the workshop on staff practice. It found that they had a “significant impact on confidence, and self-perceived abilities, in relation to both asking about abuse and responding to disclosures” (Cavanagh, Read, New, 2004). ADHB mental health services needs to be commended for their efforts in this regard.

Another reason why services are generally unresponsive, I believe after having spoken with clinicians who do work in a way that acknowledges peoples histories, is that there can be some backlash from peers and colleagues about the appropriateness of their stance and methods.

In Their Own Words also discusses this when trusted (by service users) mental health professionals discussed ‘what hurt’ in terms of professional attitudes, behaviours and practices. They said, “there can be resistance from untrained [in terms of trauma] staff because...as a new, unfamiliar mode of treatment, trauma-based practice does not fit the current treatment model and perceptions, only biological interventions are considered necessary; an understanding and treatment of trauma is not considered a needed approach” (pg 41).

I could liken this to a parallel process, they are silenced as we are silenced.

Whatever the reasons are for the lack of response, the current situation, I would strongly suggest, is abusive and needs to be considered and acted upon proactively. New Zealand must acknowledge that the current models of service delivery are generally unresponsive to people with abuse histories.

5. Where to from here?

From what I have been able to gather, the request for this paper is the first national mental health response to considering this issue. I wish to acknowledge the Mental Health Commission for this and thank them on behalf of all the service users that this affects, for taking some initiative.

At the end of the day, people and services need to make a commitment to not only disturb the sound of silence but totally dismantle it, or to ignore the issues raised in this paper and continue to be a part of the abuse cycle so many of us experience. The decision to do nothing is a decision to perpetuate the abuse.

The cry was heard; the rage was not refused...(Sarton, 1974, *Death of a Psychiatrist*)

It is up to you.

Bibliography

Beitchman, J.H., Zucker, K.J., Hood, J.E., deCosta, G.A., Akman, D. & Cassavia, E. (1992). A review of the long-term effects of child sexual abuse. *Child Abuse and Neglect*, 16, 101-118.

Briere, J., Woo, R., McRae, B., Foltz, J., Sitzman, R. (1997). Lifetime victimization history, demographics, and clinical status in female psychiatric emergency room patients. *Journal of Nervous and Mental Disease*, 185, 95-101.

Cavanagh, M., Read, J., New, B. (2004). *Sexual Abuse Inquiry and Response: A New Zealand Training Programme*. In press.

Everett, B. & Gallop, R. (2001). *The Link Between Childhood Trauma and Mental Illness: Effective Interventions for Mental Health Professionals*. Sage Publications: London.

Goodman, L., Rosenberg, S., Mueser, T. & Drake, R. 1997. Physical and sexual assault history in women with serious mental illness: Prevalence, correlates, treatment and future research directions. *Schizophrenia Bulletin*, 23, 685-696.

Jennings, A. (2003). About trauma: Retraumatizing the Victim. In *Incite 2 (1)*. Pgs 15-20.

Lapsley, H., Nikora, L. W., Black, R. (2002). "Kia Mauri Tau!" Narratives of recovery from Disabling Mental Health Problems. *Mental Health Commission: Wellington*.

Lothian, J & Read, J. (2002). Asking About Abuse during Mental Health Assessments: Clients' Views and Experiences. *New Zealand Journal of Psychology* 31 (2). Pgs 98-103.

McGregor, K. (2001). *Therapy Guidelines: Adult Survivors of Child Sexual Abuse*. ACC: Wellington.

Maine Trauma Advisory Board. (1997). *In Their Own Words: Trauma survivors and professionals they trust tell what hurts, what helps, and what is needed for trauma services*. Office of Trauma Services: Maine.

Mental Health Commission (2004). *Issues Paper: Applying the Blueprint*. Mental Health Commission: Wellington

Ministry of Health. *Nationwide Mental Health Service Framework*. www2@moh.govt.nz/nsfl

Mullen, P. E., Martin, J. L., Anderson, J. C., Romans, S. H., Herbison, G. P. (1993). Childhood Sexual Abuse and Mental Health in Adult Life. *British Journal of Psychiatry* 163. Pgs 721-732.

Our Lives in 2014. (2004). Mental Health Commission: Wellington.

Palmer, R., Bramble, D., Metcalfe, M., Oppenheimer, R. & Smith, J. 1994. Childhood sexual experiences with adults: Adult male psychiatric patients and general practice attenders. *British Journal of Psychiatry*, 165, 675-679.

Read, J. (1998). Child Abuse and Severity of Disturbance Among Adult Psychiatric Inpatients. *Child Abuse and Neglect* 22 (5). Pgs 359-368.

Read, J., Agar, K., Barker-Collo, S., Davies, E. & Moskowitz, A. 2001. Assessing suicidality in adults: Integrating childhood trauma as a major risk factor. *Professional Psychology: Research and Practice*, 32, 367-372.

Read, J., Mosher, L. R., Bentall, R. P. (Eds). (2004). *Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia*. Brunner-Routledge: East Essex.

Risman, J. (2000). The Consequences of Childhood Sexual Abuse. *Psychiatric Rehabilitation Skills* 4 (3). Pgs 448-479.

Ross, C. A. (2000). *The Trauma Model: A Solution to the problem of Comorbidity in Psychiatry*. Manitou Communications Inc: Texas.

Sarton, M. (1974). Death of a Psychiatrist In *Collected Poems 1930 – 1973*. W.W Norton & Co: New York. Pg 289-290.

Unknown. *The prevalence of abuse histories in the mental health system*.

Young, M., Read, J., Barker-Collo, S., Harrison, R. (2001). Evaluating and Overcoming Barriers to Taking Abuse Histories. *Professional Psychology: Research and Practice* 32 (4). Pgs 407-414.