Asking about Abuse during Mental Health Assessments: Clients' Views and Experiences

Jan Lothian, John Read
University of Auckland

This study reports the perceptions of 74 members of mental health consumer groups in New Zealand regarding their first assessment. Two-thirds of the participants reported sexual, physical or emotional abuse at some point in their lives, but only 20% had been asked about abuse on assessment. However the likelihood of being asked about abuse was higher the more recently the assessment had occurred. The majority (69%) of those who reported abuse believed there was a connection between having been abused and their mental health problems, but few (17%) thought the clinician saw such a connection. Those reporting abuse were more likely than other participants to believe that their diagnosis was not an accurate description of their difficulties and to be dissatisfied with their treatment. Recommendations for staff training and routine abuse inquiry are offered.

Causal relationships between child abuse and adult psychological disorders have now been established, including: depression, anxiety disorders, post traumatic stress disorder, substance abuse, personality disorders, sexual dysfunction, eating disorders and dissociative disorders (Beitchman et al., 1992; Briere, Berliner, Bulkley, Jenny, & Reid, 1996). A New Zealand study found that even after controlling for mediating variables measuring other childhood disadvantages, the relationships between child sexual abuse [CSA] and a range of disorders at age 18 remain significant (Fergusson, Horwood, & Lynskey, 1996). Sexual and physical assaults in adulthood are also related to psychiatric disorders (Ritscher, Coursey, & Farrell, 1997).

A review of 15 studies, of a total of 817 female inpatients, calculated that 44% reported child physical abuse [CPA], 50% CSA and 64% either CSA or CPA (Read 1997). Male inpatients also report significantly higher rates of child abuse than men in the general population (Rose, Peabody, & Stratigeas, 1991). A community survey of New Zealand women found that the relationship between CSA and becoming an inpatient remains after controlling for other measures of disadvantage that might account for the relationship (Mullen, Martin, Anderson, Romans, & Herbison, 1993).

Child abuse seems to be particularly related to psychotic symptoms and diagnoses of schizophrenia (Bryer, Nelson, Miller, & Krol, 1987; Read, 1997; Read, Agar, Argyle & Aderhold, in press; Read, Perry, Moskowitz & Connolly, 2001; Ross, Anderson, & Clark, 1994). A New Zealand study found that 77% of adult psychiatric inpatients that reported either CSA or CPA experienced hallucinations, delusions or thought disorder, and that the content of about half of these symptoms appeared to be related to the abuse (Read & Argyle, 1999). Another New Zealand study, of 200 adult outpatients, found that child abuse is a significant predictor of hallucinations, and that a combination of childhood and adulthood abuse significantly predicts delusions and thought disorder (Read, Agar, Argyle, & Aderhold, in press). A study of American of women attending a psychiatric emergency service found that after controlling for "the potential effects of demographic variables, most of which also predict victimization and/or psychiatric outcome", CSA was related to "nonmanic psychotic disorders (e.g., schizophrenia, psychosis not otherwise specified)" (Briere, Woo, McRae, Foltz, & Sitzman, 1997).

A history of abuse is also related to severity of disturbance, including: suicidality, age at first admission, frequency and length of admissions, time spent in seclusion, likelihood and dosage of psychiatric medication, and global symptom severity (Beitchman et al., 1992; Briere et al., 1997; Bryer et al., 1987; Pettigrew & Burcham, 1997). Read (1998) found that of those New Zealand inpatients who reported either CSA or CPA, 64% were acutely suicidal on admission, compared to 22% of those who had not been abused. A study of 200 adult outpatients found that child abuse was a stronger predictor of current suicidality than a current diagnosis of depression (Read, Agar, Barker-Collo,

Davies, & Moskowitz, 2001).

The high proportion of abused people using mental health services has caused many researchers and clinicians to recommend that abuse histories be taken on a routine basis in all mental health agencies (e.g., Bryer et al., 1987; Lipschitz et al., 1996; Read, 2000; Rose et al., 1991). This is consistent with similar recommendations for other health services dealing with high numbers of abused people (Hurst, MacDonald, Say & Read, in press). However researchers have found that the proportion of the abuse reported to them which had been identified by mental health services ranges from 12% to 30% (Briere & Zaidi, 1989; Lipschitz et al., 1996: Wurr & Partridge, 1996). Other studies confirm that many people with extensive contact with mental health services never disclose their abuse until asked by researchers (Elliott, 1997; Rose et al.). Emotional abuse may be similarly unrecognized by mental health services (Thompson & Kaplan, 1999).

A study of a New Zealand inpatient unit (Read & Fraser, 1998a) found that even when the admission form included a section specifically for abuse history, only 17 of 53 patients were asked the abuse questions. Of those from whom an abuse history was taken on admission 82% disclosed some form of abuse. Of those not directly asked about abuse on admission only 8% spontaneously disclosed any form of abuse. (Men were less likely to disclose without being asked, and less likely to be asked.) A study of 200 New Zealand outpatients found, however, that similar inclusion of an abuse section in the admission form produced a more promising outcome, with 77% of clinicians asking about abuse when using the form. Doing so produced an abuse prevalence rate of 60%, compared to 22% when the form was not used (Agar, Read, & Bush, 2002).

New Zealand studies have also found that the response of clinicians following disclosures of abuse leaves much to be desired. The inpatient study found that there was no documentation in the medical records that any of the 32 patients who disclosed abuse received any abuse-related support or information during the hospitalization. Only three (9%) were referred for post-discharge abuse counselling (Read & Fraser, 1998b). The outpatient study (Agar & Read, 2002) found that of the patients for whom CSA had been identified, the abuse was mentioned in only 39% of their treatment plans, with this being the case for 31% of those with identified CPA. More outpatients (21%) gained access to abuse counseling than was the case for inpatients (9%). Nevertheless even innovative community-based services have been found, in New Zealand at least, to pay little or no attention to abuse issues (Allen & Read, 1997).

There is a paucity of literature on consumers' views and experiences concerning how mental health professionals deal with abuse issues. The 'People First' survey, conducted in the United Kingdom (Rogers, Pilgrim, & Lacey, 1993) found that only 10% of consumers described their problems in "mentally ill" terms, with 48% giving a range of etiological explanations of a more personal and contextual nature such as marital problems and work stress. A more recent study also found that whilst a third of consumers related their problems to a "chemical imbalance in the brain", 45% attributed them to "bad things that happened to me in the past," and 24% to the "result of the way I was raised" (Ritscher et al., 1997). Similarly, surveys from numerous countries (Read, 2002), including New Zealand (Read & Law, 1999; Read & Harre, 2001), show that the public tends to reject biological theories, favouring explanations that focus on negative life experiences.

The People First survey found that consumers expected their life experiences to be considered at length, and thought them crucial in diagnosing and treating them. Their experience, however, was that clinicians frequently conducted cursory interviews in the belief that their problems were "illnesses" requiring physical treatments. That is, "the patient's communications are only of interest to doctors in revealing symptoms, not in terms of them being personally meaningful and the basis for shared exploration in a therapeutic relationship" (Rogers et al., 1993, p.53).

This study aimed to provide New Zealand users of mental health services with a vehicle for the expression of their views and feelings about the initial assessment process. Kent and Read (1998) have reported that New Zealand mental health workers believe that a collaborative relationship already exists with clients both in assessment and treatment procedures. Another study found that the majority of New Zealand's psychologists and psychiatrists state that they are "highly likely" to ask clients about abuse, that they know whether or not most of their clients have been abused, and that only a third believe they need training in how to ask about or respond to abuse (Young, Read, Barker-Collo, & Harrison, 2001). The present study compares the beliefs of these clinicians with the views of some New Zealanders who use mental health services.

Method

The data reported here were gathered as part of a larger study to obtain information from service users about their experiences of their first contact with mental health services (Lothian, 1998). A questionnaire, involving "forced choice" questions (tick box and Likert scale formats), with space for comments after these questions, and "open-ended" questions, was supplemented by follow-up interviews with a selected sample of participants.

Participants

Participants were members of the 28 mental health consumer support groups identified by the Ministry of Health's "Guide to Effective Consumer Participation" (1995) as representing consumers for consultation and research purposes, or listed as consumer support groups by Aotearoa (New Zealand) Network of Psychiatric Survivors, which is itself listed in the Ministry's Guide.

Representatives of consumer support groups were contacted by telephone. The primary researcher (JL) visited several groups to explain the study. Due to the nature of distribution an accurate response rate was difficult to gauge. Each coordinator was asked to record how many consumers took a questionnaire. Coordinators were telephoned throughout the data collection period to see whether they needed more questionnaires, or if they had any

questionnaires that hadn't been distributed. A final call to all support groups was made to see how many questionnaires were left so that calculations could be made to estimate as accurate a response rate as possible. The final estimated response rate was 26% (74 out of 281).

Questionnaire

The questionnaire was designed in consultation with several consumer consultants and the Co-Director of the Research Unit for Maori Education at Auckland University. It included four items about abuse. The first required a Yes/No response to "A number of people have experienced emotional, physical and/or sexual abuse in their childhood and/or their adult life. During your first contact were you asked about possible abuse?" Only those who had experienced abuse were asked to respond to the next three statements. These participants were asked to respond, with 1-strongly agree, 2-agree, 3-neither agree nor disagree, 4-disagree, or 5-strongly disagree, to the statement: "Whether I was asked about abuse or not, the interview situation was comfortable enough for me to discuss the abuse I have experienced." Yes/No responses were then sought for "Did the mental health worker believe there may have been any connection between your experiences of abuse and any mental health problems you may have had as an adult?" and "Did/or do you see any connection between the abuse you experienced and any mental health problems you may have had as an adult?" Space was left after each of these three items for comments. Five-point Likert scales were used to measure the extent to which participants thought their diagnosis was an accurate description of their difficulties, and how satisfied they were with the treatment they received.

Interviews

Seventeen of the 74 questionnaire respondents volunteered to be interviewed. Eight lived outside the Auckland region so were excluded due to travel costs. One Auckland consumer's questionnaire arrived too late for an interview to be considered; another could not be contacted by telephone. Thus seven consumers were interviewed. All chose to be interviewed in their homes.

The aim of the interviews was to provide more freedom for consumers to express their views in detail. A semi-structured interview format was chosen to allow for a more flexible exploration of what was meaningful to each consumer whilst ensuring that all were asked the same key questions to provide for some degree of comparative analysis. "

Results

Sample Characteristics

Of the 65 participants who indicated their gender 36 (55%) were male and 29 (45%) were female. The average age of participants was 39.5 years. Of the 55 who gave their ethnicity 48 (87%) were of European descent, six (11%) were Maori and one was Niuean. The majority (73%) were ordinary members of their consumer group, with the other 23% holding more active leadership roles such as consumer advocate or consultant. Among the 28% who were in paid employment two were working as staff in mental health services. The seven interviewees, four of whom were women, were all European and aged between 29 and 48.

The professionals seen at first contact were: Psychiatrist 49%, General Practitioner 26%, Social Worker 10%, Psychologist 8%, Counsellor/Psychotherapist 4% and Other 3%. Twenty-five percent had their 'first contact' within the last five years; 47% in the last decade and 53% over 11 years ago. The most common diagnoses reported by participants were schizophrenia (45%), bipolar disorder (40%) and depression (19%), with 23% reporting multiple diagnoses. Only three received a diagnosis of post traumatic stress disorder. Seventy three percent were either advised or taken to see a mental health worker, while 23% sought help independently and 4% were both sent and sought help simultaneously.

Quality of the Interview Relationship

Among questions about the quality of the interview relationship in general four items measured the degree of agreement with four statements relating to past and present life experiences and discussion of possible causes of current problems (Table 1). Approximately half the participants (53%) felt that their past and present life experiences were not listened to carefully. More (44%) reported having been encouraged to express their opinion about causation than not (34%). However 60% thought that the clincian's views about causes were not fully explained.

Table 1. Consumers' Views on their Initial Interview

	Strongly Agree		Agree		Neither Agree nor Disagree		Disagree		Strongly Disagree	
	n	%	n	%	n	%	n	%	n	%
My views and life experiences were not listened to carefully	24	(34)	13	(19)	17	(24)	6	(9)	10	(14)
My current life experiences and level of social support were ignored	14	(21)	16	(24)	18	(27)	9	(14)	9	(14)
I was encouraged to express my views on possible causes of my problems	8	(12)	22	(32)	15	(22)	10	(15)	13	(19)
The mental health worker's views on possible causes for my problems were fully explained to me	5	(7)	13	(19)	9	(13)	19	(28)	22	(32)
My diagnosis was an accurate description of my problems	14	(21)	24	(37)	11	(17)	5	(8)	11	(17)
I was happy with the treatment I received	7	(10)	15	(22)	13	(19)	11	(16)	22	(32)

Abuse

All but two of the 74 participants responded to the item about whether they had been asked about abuse. Of these, 56 (78%) had not been asked, 15 (20%) had, and one could not remember. The next three items were to be responded to only by those participants who had been abused. Nearly two thirds (64%) responded. Table 2 shows the beliefs of the abused consumers about the connection between their abuse and their mental health difficulties and the consumers' perceptions of the mental health workers' beliefs. It is important to note that 28 of the participants (60%) were unsure what the worker thought on this point.

Thirty-one (66%) of the abused consumers disagreed (38% strongly) that the interview situation was comfortable enough for them to discuss their abuse. Ten (21%) agreed (none strongly).

Cross-tabs analysis found that those reporting abuse were less likely (47%) to agree that their diagnosis was an accurate description of their problems than those not reporting abuse (82%), Spearman 2-tailed, $rho = .38$, $p < .005$. Similarly those reporting abuse were less likely to have been happy with their treatment (21% vs 54%) $rho = .36$, $p < .005$. A weaker relationship was found between reporting abuse and feeling that one's views and life experiences were listened to carefully (15% vs 30%) $p < .05$. There was also a significant positive correlation between being asked about abuse and the recency of the assessment ($p < .01$).

Participants' Comments

The following quotes are drawn from the 'comments' sections following questionnaire items, the open-ended questions at the end of the questionnaire, and the interviews.

Connections between Past Abuse and Current Mental Health Problems:

The stress involved in being physically and sexually abused and surviving into adulthood burdened with all the shame and memories caused massive distress and crisis.

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.

My whole life has been a go back to my teens and my sexual abuse and other kinds of abuse.

I was aware of the incident at 12 which I believe had horrendous influence and impact on my wellness.

The multiple abuse which followed went on and on whilst I was going in and out of hospital. All of this (and the lack of professional counseling) has had immense ramifications.

Do not blame patients for their illness, specially when it's caused by sexual abuse

I think there was an assumption that I had a mental illness and, and you know, because I wasn't saying anything about my abuse I'd suffered no-one knew

Whether to Ask about Abuse:

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

Table 2. Consumers' Own Beliefs, and their Perceptions of Mental Health Workers' Beliefs, Regarding Connection Between Abuse and Mental Health Problems

	Connection		No Connection		Unsure	
	n	%	n	%	n	%
Consumers	33	(69%)	7	(15%)	8	(16%)
Mental Health Workers	8	(17%)	11	(23%)	28	(60%)

You know there was so many doctors and registrars and nurses and social workers and psychiatric district nurses in your life asking you about the same thing mental mental mental but not asking you why.

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?".

I've had four admissions to psychiatric hospitals, a long history of depression. It was a couple of years after my first contact that I disclosed the abuse.

I would walk past there [psychologists' office] every day and I'd think God I want to talk to these people yeh so I made myself quite known to them....He took charge of the situation and let me be me and talk. So I really appreciate that. But I don't actually think I had a formal referral to see him. Why couldn't they refer me? Because I was on medication you know, to shut me up, and yeh sedate me when all I wanted was to rant and rave about the past.

I think that questions could have been asked i.e. "has anyone done anything to you that you didn't like?"

Discussion

The finding that approximately two-thirds of participants reported abuse is consistent with the many studies, cited earlier, demonstrating that the majority of individuals coming into contact with mental health services indicate, when asked, that they have been abused at some point in their lives. Only about half of the participants felt that their life experiences were adequately listened to. This finding replicates the 'People First' survey (Rogers et al., 1993) where consumers expected to speak at length about their feelings, concerns, and life experiences, but were disappointed.

No consumers in this study felt strongly that they were comfortable enough to discuss any experiences of abuse and only 21% felt any degree of comfort whereas 66% felt too uncomfortable to discuss abuse issues, with more than half of them (38%) stating this strongly. Only one in five participants were asked about abuse. This is consistent with the studies reviewed earlier; in New Zealand and elsewhere, showing that clinical practice in this domain still leaves much to be desired. Nevertheless, the finding that the probability of being asked was related to recency of first contact is encouraging since it suggests that practice may be improving with regard to abuse inquiry.

Another survey from our research programme asked New Zealand psychologists and psychiatrists why they do not always take abuse histories. The two most commonly cited reasons were that there were more immediate concerns and that they thought asking might upset the client (Young et al., 2001). This contrasts with the comments of those participants who thought their abuse was the most immediate concern and who were upset by not being asked.

Less than half (44%) felt encouraged to express their views about causation, and even fewer (26%) felt that the clinicians had explained their own views about causation. However, most (69%) believed there were a connection between having been abused and their current difficulties. This contrasts with an earlier finding that only 16% saw such a connection (Wurr & Partridge, 1996). The earlier study asked only about connections with CSA (as compared to all abuse) and was conducted while people were inpatients (as compared to when living in the community). Further research is clearly indicated here, including a focus on variables influencing whether a connection is made. For instance, Wurr and Partridge found that women were more likely than men to see a connection.

If the consumers' perceptions of the workers' beliefs are accurate the consumers were four times more likely (69%) than the clinicians (17%) to see a connection. It seems worthy of note that most consumers (60%) didn't know whether the clinician had made the connection. Thus it is possible that many clinicians do consider abuse to be causally linked to current difficulties but choose not to make that view explicit. Sharing this information could be very valuable to clients.

The finding that having been abused was negatively related to perceived accuracy of diagnosis and to satisfaction with treatment underlines the importance of abuse inquiry. Not knowing whether a client has suffered potentially traumatic life experiences reduces the probability of an accurate formulation of the client's problems and needs. This in turn can reduce the likelihood of offering appropriate treatment such as abuse-focussed psychotherapy (Read, 2000).

Methodological Limitations

Although 25% of the participants had their first contact within the last five years, for 53% the first contact was 11 or more years ago. This raises the possibility that some of the participants' criticisms and recommendations are no longer relevant. Furthermore, recall after such long periods may not be entirely accurate.

Our self-report methodology carries with it all the limitations of dealing with perceptions, beliefs and attributions. Consumer groups may attract people who have strong views about mental health services. Similarly the group members who chose to participate may have had stronger views than those who did not take part. The research was transparently open to criticisms of mental health services, as well as things that consumers found helpful. Nevertheless it seems valuable to seek to redress the imbalance between the extent to which professional groups and consumer groups are given a voice in research journals and in decision making processes about mental health services.

Recommendations

The data generated by these consumers of mental health services support the recommendations of researchers and clinicians, cited earlier, that abuse histories should be taken on a routine basis in all mental health services. All units would benefit their clients by developing a unit policy covering when and how to ask about abuse, how to respond to disclosures, provision of therapy for abuse, and issues relating to reporting alleged crimes to the authorities.

Nevertheless New Zealand studies (Read & Fraser, 1998a, 1998b; Agar & Read, 2002, Agar et al., 2002) suggest that policies about routine inquiry may not be effective unless accompanied by staff training. In recognition of this finding the 'Trauma and Sexual Abuse' policy recently introduced by Auckland Healthcare Ltd.[#] not only recommends that all mental health clients are asked about abuse but mandates all mental health staff to undertake a one-day training programme in how and when to ask about, and how to respond to, abuse histories. The training programme has been summarised elsewhere (Young at al., 2001) and the content is available on request [#].

To assist the design of training programmes in different locations it would be helpful to first interview local clinicians about why they sometimes choose not to respond to abuse disclosures (Young et al., 2001). Policy on abuse-related practice may need to differ according to the client population, and evaluation of the effectiveness of unit policies and training programmes will be necessary. It will be helpful to include consumer groups, including Maori users of mental health services, in the development of policies and training programmes and in the design of their evaluations (Kent & Read, 1998, Lothian, 1988).

References

Agar, K., & Read, J. (2002). What happens when people disclose sexual or physical abuse to staff at a community mental health centre? *International Journal of Mental Health Nursing, 11*, 70-79.

Agar, K., Read, J., & Bush, J-M. (2002). Identification of abuse histories in a community mental health centre: The need for policies and training. *Journal of Mental Health, 11*, 533-543.

Allen, R., & Read, J. (1997). Integrated mental health care: Practitioners' perspectives. *Australian and New Zealand Journal of Psychiatry, 31*, 496-503.

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

Briere, J., Berliner, L., Bulkley, J., Jenny, C., & Reid, T. (Eds.). (1996). *The ASPAC handbook on child maltreatment.* Newbury Park, CA: Sage.

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.

Briere, J., & Zaidi, L. (1989). Sexual abuse histories and sequelae in female psychiatric emergency room patients. *American Journal of Psychiatry, 146*, 1602 -1606.

Bryer, J., Nelson, B., Miller, J., & Krol, P. (1987). Childhood sexual and physical abuse as factors in psychiatric illness. *American Journal of Psychiatry, 144*, 1426-1430.

Elliott, D. (1997). Traumatic events: Prevalence and delayed recall in the general population. *Journal of Consulting and Clinical Psychology, 65*, 811-820.

Fergusson, D., Horwood, J., & Lynskey, M. (1996). Childhood sexual abuse and psychiatric disorder in young adulthood: II. Psychiatric outcomes of childhood sexual abuse. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*, 1365-1374.

Hurst, C., MacDonald, J., Say, J., & Read, J. (in press). Routine questioning about non-consenting sex: A survey of practice in Australasian sexual health clinics. *International Journal of STD & AIDS.*

Kent, H., & Read, J. (1998). Measuring consumer participation in mental health services: Are attitudes related to professional orientation? *International Journal of Social Psychiatry*, 44, 295-310.

Lipschitz, D., Kaplan, M., Sorkenn, J., Faedda, G., Chorney, P. & Asnis, G. (1996). Prevalence and characteristics of physical and sexual abuse among psychiatric outpatients. *Psychiatric Services, 47*,189-91.

Lothian, J. (1998). *From paternalism to participation: Consumers' views and experiences of the initial assessment process in mental health.* Unpublished Masters' thesis, University of Auckland.

Ministry of Health. (1995). *Guide to effective consumer participation in Mental Health Services.* Wellington: Author.

Mullen, P. E., Martin, J.L., Anderson, J.C., Romans, S. E., & Herbison, G. P. (1993). Childhood sexual abuse and mental health in adult life. *British Journal of Psychiatry, 163*, 721-732.

Pettigrew, J., & Burcham, J. (1997). Effects of childhood sexual abuse in adult female psychiatric patients. *Australian and New Zealand Journal of Psychiatry, 31*, 208-213.

Read, J. (1997). Child abuse and psychosis: A literature review and implications for professional practice. *Professional Psychology: Research and Practice, 28*, 448 - 456.

Read, J. (1998). Child abuse and severity of disturbance among adult psychiatric inpatients. *Child Abuse & Neglect, 22*, 359-368.

Read, J. (2000). The role of psychologists in the assessment of psychosis. In H. Love and W. Whittaker (Eds.), *Practice issues for clinical and applied psychologists in New Zealand, 2nd ed.* (pp.277-292).. Wellington: New Zealand Psychological Society.

Read, J. (2002). The need for evidenced-based destigmatization programmes. *Incite: The Mental Health Journal of New Zealand, 1 (2)*, 10-16.

Read, J., Agar., Argyle, N., & Aderhold, V. (in press). Sexual and physical abuse during childhood and adulthood as predictors of hallucinations, delusions and thought disorder. *Psychology & Psychotherapy: Theory Research and Practice.*

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., & Argyle, N. (1999). Hallucinations, delusions, and thought disorder among adult psychiatric inpatients with a history of child abuse. *Psychiatric Services, 50*, 1467-1472.

Read, J., & Fraser, A. (1998a). Abuse histories of psychiatric inpatients: To ask or not to ask? *Psychiatric Services, 49*, 355-359.

Read, J., & Fraser, A. (1998b). Staff response to abuse histories of psychiatric inpatients. *Australian and New Zealand Journal of Psychiatry, 32*, 206-213.

Read, J., & Harre, N. (2001). The role of biological and genetic causal beliefs in the stigmatization of 'mental patients'. *Journal of Mental Health, 10*, 223-235.

Read, J., & Law, A. (1999). The relationship of causal beliefs and contact with users of mental health services to attitudes to the 'mentally ill'. *International Journal of Social Psychiatry, 45*, 216-229.

Read, J., Perry, B., Moskowitz, A., & Connolly, J. (2001). The contribution of early traumatic events to schizophrenia in some patients: A traumagenic neurodevelopmental model. *Psychiatry: Interpersonal and Biological Processes, 64*, 319-345.

Ritscher, J., Coursey, R., & Farrell, E. (1997). A survey on issues in the lives of women with severe mental illness. *Psychiatric Services, 48*, 1273-1282.

Rogers, A., Pilgrim, D., & Lacey, R. (1993). *Issues in mental health: experiencing psychiatry, users' views of services.* London: Macmillan.

Rose, S., Peabody, C., & Stratigeas, B. (1991). Undetected abuse among intensive case management clients. *Hospital and Community Psychiatry, 42*, 499-503.

Ross, C., Anderson, G., & Clark, P. (1994). Childhood abuse and the positive symptoms of schizophrenia. *Hospital and Community Psychiatry, 45*, 489-91.

Thompson, A., & Kaplan, C. (1999). Emotionally abused children presenting to child psychiatry clinics. *Child Abuse & Neglect, 23*, 191-196.

Wurr, C., & Partridge, I. (1996).. The prevalence of a history of childhood sexual abuse in an acute adult inpatient population. *Child Abuse & Neglect, 20*, 867-871.

Young, M. Read, J, Barker-Collo, S. Harrison, R. (2001). Evaluating and overcoming barriers to taking abuse histories. *Professional Psychology: Research and Practice, 32*, 407-414.

Note #: For a copy of the '*Recommended Best Practice – Trauma and Abuse*' document contact The Quality Manager, Mental Health Services, Auckland District Health Board, Private Bag 92-605, Symonds Street, Auckland, New Zealand.
For a copy of the training manual, or to enquire about arranging training sessions or a workshop to train trainers, contact Auckland Rape Crisis (rapeeduc@asiaonline.net.nz) or John Read (j.read@auckland.ac.nz).

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Address for correspondence:
Dr John Read
Director – Doctorate of Clinical Psychology
Psychology Department
University of Auckland
Private Bag 92019
Auckland
j.read@auckland.ac.nz
ph: +64-9-373-7599 ext 85011