

WHY, WHEN AND HOW TO ASK ABOUT CHILDHOOD ABUSE

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This article provides a brief summary of evidence that childhood abuse experiences are very common among those who develop serious mental health problems; argues that mental health services need to acknowledge this important area, and provides guidance on asking patients about childhood abuse based on experience from New Zealand.

The prevalence and effects of child abuse

A review of 46 studies ($n = 2604$) of female in-patients and out-patients, most of whom had psychoses, revealed that 48% reported having been subjected to sexual abuse and 48% to physical abuse during childhood. The majority (69%) had been subjected to one or the other (or both). The corresponding figures for men (31 studies, $n=1536$) were: childhood sexual abuse, 28%; childhood physical abuse, 50%; either one or the other (or both), 59% (Read *et al*, 2005).

Childhood abuse has been shown to have a causal role in many mental health problems, including depression, anxiety disorders, post-traumatic stress disorder (PTSD), eating disorders, substance misuse, sexual dysfunction, personality disorders and dissociative disorders (Mullen *et al*, 1993; Boney-McCoy & Finkelhor, 1996; Kendler *et al*, 2000).

Psychiatric patients subjected to sexual or physical abuse during childhood have earlier first admissions, longer and more frequent hospitalisations, spend longer in seclusion, receive more medication, are more likely to self-mutilate, and have higher global symptom severity (Mullen *et al*, 1993; Lipschitz *et al*, 1996; Read *et al*, 2001*b*). They are far more likely to try to kill themselves than are psychiatric patients who have not suffered such abuse (Lipschitz *et al*, 1996; Read, 1998). One study, of 200 adult out-patients, found that suicidality was better predicted by childhood abuse than by a current diagnosis of depression (Read *et al*, 2001*b*). A general population study found that women who had been sexually abused as children were between 8 and 25 times more likely (depending on the severity of the abuse) to have tried to kill themselves than women who had not been abused (Mullen *et al*, 1993).

The authors are also convinced by the evidence that childhood sexual and physical abuse are related to the symptoms of psychosis and schizophrenia, particularly hallucinations and paranoid delusions (Ross *et al*, 1994; Read & Argyle, 1999; Read *et al*, 2001*a*, 2003, 2004*b*, 2006*a*; Hammersley *et al*, 2003; Bebbington *et al*, 2004; Read & Hammersley, 2006).

Public beliefs and expectations

A recent review (Read *et al*, 2006c) found that the public in 16 countries believe that psychosocial factors such as childhood abuse, loss, poverty and problematic families play a greater role in the causation of mental health problems than do genes, brain dysfunction or chemical imbalance. This is also true for patients and their relatives (Read & Haslam, 2004).

The important point here, however, is that because the public, i.e. clients/patients, believe that their problems are caused predominantly by bad things that have happened to them, they probably expect to be asked about these by mental health professionals. A rare study of what users of mental health services think about being asked about childhood abuse found that although the majority (64%) had experienced such abuse in some form, 78% had not been asked about this at initial assessment. Those reporting abuse to the researchers were significantly less satisfied with their treatment, and less likely to believe that their diagnosis was an accurate description of their problems, than the non-abused participants (Lothian & Read, 2002). Furthermore, 69% of the abused participants believed that there was a connection between their having been abused and their mental health problems, but only 17% believed that the mental health staff thought there was a connection.

Waiting to be told?

Survivors of childhood sexual abuse are usually very reluctant to spontaneously tell anyone about it. A US study found that the average time before disclosure by individuals who had suffered childhood sexual abuse was 9.5 years (Frenken & Van Stolk, 1990). A New Zealand study of 252 women who had been sexually abused during childhood found that 52% waited at least 10 years to tell someone, and 28% had told nobody (Anderson *et al*, 1993). In another New Zealand study, of 191 women who had received counselling for childhood sexual abuse, the average time taken to tell anyone about it was 16 years (Read *et al*, 2006d).

People are no more likely to tell mental health professionals than to tell anyone else. Indeed, there is some evidence that psychiatric patients underreport childhood abuse (Dill *et al*, 1991). For example, when researchers conducted a survey of female in-patients after they returned to the community, 85% of those interviewed disclosed childhood sexual abuse, a rate far in excess of the 48% average reported earlier (Read *et al*, 2005) for female in-patients (when asked in hospital). Many people with extensive contact with mental health services never reveal their victimisation to clinicians (Finkelhor, 1990; Elliott, 1997).

A New Zealand study (Read & Fraser, 1998a) compared rates of disclosure when psychiatric in-patients were asked about past trauma on admission and when they were not asked on admission (i.e. either were asked later during the hospital stay or spontaneously disclosed the information). The results, which are shown in Table 1, were similar to those obtained in a replication of the study with psychiatric out-patients (Agar *et al*, 2002).

Table 1 Disclosure of abuse by psychiatric in-patients

<i>Disclosure of abuse, %</i>		
<i>Type of abuse</i>	<i>If asked on admission</i>	<i>If not asked on admission</i>
Childhood sexual abuse	47	6
Childhood physical abuse	30	0
Adult sexual assault	12	0
Adult physical assault	35	3
At least one of the four types of abuse	82	8

Current clinical practice

Asking

In-patient studies in the USA and the UK have found that clinicians identify fewer than half of the cases of abuse reported to researchers. The proportion identified by clinicians ranges from 48% to 0% (Jacobson *et al*, 1987; Craine *et al*, 1988; Mills, 1993; Muenzenmaier *et al*, 1993; Wurr & Partridge, 1996).

A study of 30 'heavy users' of acute in-patient and emergency services who disclosed to researchers that they had been sexually or physically abused during childhood found that none had ever been asked about abuse before (Rose *et al*, 1991). A survey of New Zealand women who had been sexually abused during childhood and were later treated by mental health services found that 63% had never been asked about childhood sexual abuse by mental health staff (Read *et al*, 2006d). These studies focus on sexual and physical abuse, but neglect and emotional abuse may be similarly unrecognised by mental health services (Thompson & Kaplan, 1999).

Responding

There has been little research on what mental health professionals do after a client discloses childhood abuse. In a self-report survey of British staff, only 5% of nurses, 10% of psychologists and 24% of psychiatrists said that they take no action when a male client discloses childhood sexual abuse (Lab *et al*, 2000). However, three studies of recorded behaviour in such situations, in New Zealand (Read & Fraser, 1998b; Agar & Read, 2002) and the USA (Eilenberg *et al*, 1996), found very low levels of response in terms of offering information or support, referring for counselling, documenting the abuse in the patients' files, asking about previous disclosure or treatment, including the

abuse in summary formulations or treatment plans, and considering reporting to legal or protection authorities.

Barriers to enquiry and to appropriate response

More important issues and not wanting to upset the patient

In preparation for designing a training workshop in Auckland, psychiatrists and psychologists were surveyed about their reasons for sometimes not asking about past abuse (Young *et al*, 2001). For both professions, the two most frequently endorsed reasons were 'too many more immediate needs and concerns' and 'patients may find the issue too disturbing, or it may cause a deterioration in their psychological state'. The first might be a sensible reason for delaying enquiry (e.g. when faced with acute psychosis or suicidal behaviour). The second is a good reason for learning how to ask sensitively and how to respond therapeutically. Of course remembering bad things that have happened can be distressing, especially if handled clumsily by the person asking about them, but there is no evidence that asking causes any serious or permanent damage, and some evidence (Lothian & Read, 2002) that not being asked can cause distress and anger.

Reliability and fear of inducing false memories

Not many clinicians gave as their reason 'my enquiring could be suggestive and therefore possibly induce false memories'. Nevertheless, this response was positively correlated, for both professions, with self-reported low probability of asking about abuse (Young *et al*, 2001). Similarly, the higher the percentage of childhood sexual abuse disclosures that a clinician thought were false (mean 4.9%), the lower the probability that the clinician would ask about abuse. This suggests that for some clinicians the frequent allegations in the media that mental health professionals are repeatedly asking about sexual abuse in a way that plants false memories may be inhibiting their capacity to do their job. The irony here is that, as we have seen, the reality is the opposite: staff rarely ask about abuse at all.

Reports of abuse by psychiatric patients, including those diagnosed with psychosis, are reliable (Meyer *et al*, 1996; Goodman *et al*, 1999). Despite the secrecy often surrounding childhood sexual abuse, corroborating evidence – providing various degrees of certainty – has been found in 74% (Herman & Schatzow, 1987) and 82% (Read *et al*, 2003) of cases reported by psychiatric patients. As already mentioned, psychiatric patients tend to under- rather than over-report abuse. In a New Zealand study involving multiple professions, participants believed that 7.3% of clients' disclosures of childhood sexual abuse were psychotic delusions (Cavanagh *et al*, 2004). A study directly addressing this issue, however, found that people with schizophrenia were no more likely to make false allegations of sexual assaults than the general population (Darves-Bornoz *et al*, 1995).

Who, when and how to ask

Ask everyone

It is essential, because of the high prevalence of abuse across nearly all diagnostic categories, to ask all patients. The temptation to ask only individuals with certain symptoms (e.g. of PTSD) reflects a restricted view of the impact of trauma. Given the very low spontaneous disclosure rate documented above, waiting for clients to disclose abuse does not work. Mental health professionals must actively elicit each person's narrative.

Ask at initial assessment

In the New Zealand survey of psychologists and psychiatrists (Young *et al*, 2001), 62% chose 'Once rapport has been established' as the most appropriate time to ask, but 47% chose 'Usually on admission/initial assessment unless the client is too distressed' (participants could select more than one response). The reason for asking at initial assessment is that if the question is not posed then it tends not to be asked later (Read & Fraser, 1998a). If clinicians conducting an initial assessment decide to delay the enquiry they should record clearly that a trauma history has not been taken (and why) and take responsibility for following up when the client is less distressed. Clinicians who are tempted to wait for some magic moment when rapport is just right should remember that, for many abused clients, asking may be a crucial act that encourages rapport rather than creates a barrier to it. For some clients, it might even be a prerequisite (Lothian & Read, 2002).

Context

Questions about abuse should not be asked near the outset of an assessment, nor should they come out of the blue with no preface or clear context. The obvious time to ask is when taking a comprehensive psychosocial history, which naturally includes childhood.

How to respond

For some clinicians, not being sure how to respond may be an additional reason for not asking in the first place (Young *et al*, 2001). Clinicians may feel under pressure to either gather all the details or try to fix the 'problem' immediately, or both. The first is unnecessary and undesirable. The second is unrealistic. A guiding principle is to focus more on the relationship with the patient than on the abuse. The important thing is to respond to the fact that a person has just revealed something important. Validation of the person's experience, and of their reactions to disclosure, will communicate both the understanding and the non-judgemental stance of the clinician.

Validation: affirm that telling was a good thing

It is important that the client feels that the staff member has understood the importance of what has been disclosed and that it will, if the client wishes, be returned to later. Clients have a range of responses to disclosing abuse. They might feel anger, shame, self-blame, fear, relief, a lack of connection with their

feelings, numb or ambivalent. What is important at this point is that what they have disclosed is met with a positive response.

The clinician should acknowledge that abuse can sometimes be difficult to talk about, but that it is a positive action to have told them about it. It is also important to gauge how the individual is feeling about disclosing, rather than making judgements about what they should be feeling. The kind of responses that might be helpful include: 'In my experience, people often find that, although it's difficult, it can often be really helpful to talk about it. How is it for you talking about this now?' People who have been abused often blame themselves. If self-blame does surface it is important to affirm that it is a common reaction and to state that abuse they experienced as a child was not their fault.

Do not try to gather all the details

It is not necessary, or desirable, on first being told by a client that they have been abused to immediately gather all the details (their age when it happened, the identity of the alleged perpetrator, specifics of the acts, etc.). This can all come later, if the person chooses to discuss it. However, clinicians may sometimes need to ask just enough to ascertain that they are talking about broadly the same thing as the client. If a client does start to give lots of details, it is obviously important to listen, but at some point the clinician might carefully suggest that this material can be returned to later, as there are some other things they would like to ask about now.

Ask whether the person has told anyone before – and how that went

There is a huge difference between a situation in which the patient told an adult at the time of the abuse, was believed and some appropriate action was taken and a situation in which the individual has never disclosed to anyone before. For those who have told someone before it is important to ask what the response was – including whether they received any help such as abuse counselling. If the clinician is the first person in whom the patient has confided it is very important to check the person's emotional state at the end of the session and offer immediate follow-up.

Offer support

It is important to discuss possible treatment and support for the effects of the disclosed abuse. The key word here is 'offer'. It is best not to imply that the person 'should' have treatment of any kind. The clinician should just describe what is available. This implies that they are familiar with the abuse-related services in their own agency and the broader community. Pamphlets summarising this information can be extremely helpful – to both the clinician and the patient. Not everyone will need or want psychotherapy. For some, simply making a connection between their life history and their previously incomprehensible symptoms may have a significant therapeutic effect (Fowler, 2000).

Ask whether the client relates the abuse to their current difficulties

Regardless of their own views about whether the abuse may be a causal factor in a patient's mental health problems, it is obviously important that clinicians find out the patient's views on this matter. It is the meaning for the patient, not the clinician, that matters. If there is disagreement, this might not be the best time to discuss it.

Check current safety

The clinician should ask whether the patient is still being abused. They should ask also whether the perpetrator might pose a risk to others. For example, if a teacher or priest is named as the perpetrator of childhood abuse, the clinician should ask whether that person is still in contact with children.

Check emotional state at end of session and offer follow-up/'check-in'

Before ending the session the clinician should ask the person how they feel after having talked about the abuse and, if possible, encourage them to stay calm: 'Telling someone about what happened can sometimes bring up a lot of feelings. How are you feeling about having told me?'. Clinicians should be able to give patients the name or telephone number of someone they can contact out of hours if they later become upset. They should also help clients to identify their own support systems.

Take good notes

It is important to record accurately what was said. Always use reported speech ('Anna said that her father often hit her', not 'Anna's father often hit her') or direct quotation (Anna said 'Dad often hit me'). Files may be used in legal proceedings later on.

Consider reporting to authorities

If there are current safety issues, for example if the patient says that they are still being abused or an alleged abuser still has access to children, decisions about whether to report to the police or child protection agencies should be made in accordance with unit policies on such matters. These policies should include procedures for situations in which confidentiality must be broken (patients should have been informed about these at the beginning of their engagement with the service). Clinicians must be aware of the law as it relates to mandatory reporting in their country. If there is no current safety threat, clients should be offered (but not necessarily immediately) a discussion about taking legal action with someone who fully understands the pros and cons.

Training and policies

Although we hope that the suggestions laid out above will be helpful, training workshops do need to be made available to all mental health professionals. Although the introduction of policies and guidelines is an essential step in

establishing a supportive culture for this challenging work, without training little is likely to change (Read, 2006).

References

* Recommended for follow-up reading.

- 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.
- Anderson, J., Martin, J., Mullen, P., *et al* (1993) The prevalence of childhood sexual abuse experiences in a community sample of women. *Journal of the American Academy of Child and Adolescent Psychiatry*, **32**, 911–919.
- Bebbington, P. E., Bhugra, D., Brugha, T., *et al* (2004) Psychosis, victimisation and childhood disadvantage. Evidence from the second British National Survey of Psychiatric Morbidity. *British Journal of Psychiatry*, **185**, 220–226.
- Boney-McCoy, S. & Finkelhor, D. (1996) Is youth victimization related to trauma symptoms and depression after controlling for prior symptoms and family relationships? *Journal of Consulting and Clinical Psychology*, **64**, 1406–1416.
- *Cavanagh, M., Read, J. & New, B. (2004) Childhood abuse inquiry and response. A New Zealand training programme. *New Zealand Journal of Psychology*, **33**, 137–144.
- Craine, L., Henson, C., Colliver, J., *et al* (1988) Prevalence of a history of sexual abuse among female psychiatric patients in a state hospital system. *Hospital and Community Psychiatry*, **39**, 300–304.
- Darves-Bornoz, J.- M., Lemperiere, T., Degiovanni, A., *et al* (1995) Sexual victimization in women with schizophrenia and bipolar disorder. *Social Psychiatry and Psychiatric Epidemiology*, **30**, 78–84.
- Dill, D., Chu, J., Grob, M., *et al* (1991) The reliability of abuse history reports. A comparison of two inquiry formats. *Comprehensive Psychiatry*, **32**, 166–169.
- Eilenberg, J., Fullilove, M., Goldman, R., *et al* (1996) Quality and use of trauma histories obtained from psychiatric inpatients through mandated inquiry. *Psychiatric Services*, **47**, 165–169.
- Elliott, D. (1997) Traumatic events. Prevalence and delayed recall in the general population. *Journal of Consulting and Clinical Psychology*, **65**, 811–820.
- Finkelhor, D. (1990) Early and long-term effects of child sexual abuse. An update. *Professional Psychology: Research and Practice*, **21**, 325–350.
- Fowler, D. (2000) Psychological formulation of early episodes of psychosis. In *Early Interventions in Psychosis* (eds M. Birchwood, D. Fowler & C. Jackson). Wiley.
- Frenken, J. & Van Stolk, B. (1990) Incest victims' inadequate help by professionals. *Journal of Child Abuse and Neglect*, **14**, 253–263.
- Goodman, L., Thompson, K., Weinfurt, K., *et al* (1999) Reliability of reports of violent victimization and PTSD among men and women with serious mental illness. *Journal of Traumatic Stress*, **12**, 587–599.

- Hammersley, P., Dias, A., Todd, G., *et al* (2003) Childhood trauma and hallucinations in bipolar affective disorder: preliminary investigation. *British Journal of Psychiatry*, **182**, 543–547.
- Herman, J. & Schatzow, E. (1987) Recovery and verification of childhood sexual trauma. *Psychoanalytic Psychology*, **4**, 1–14.
- Jacobson, A., Koehler, J. & Jones-Brown, C. (1987) The failure of routine assessment to detect histories of assault experienced by psychiatric patients. *Hospital and Community Psychiatry*, **38**, 386–389.
- Kendler, K., Bulik, S., Silberg, J., *et al* (2000) Childhood sexual abuse and adult psychiatric and substance use disorders in women. *Archives of General Psychiatry*, **57**, 953–959.
- Lab, D., Feigenbaum, J. & De Silva, P. (2000) Mental health professionals' attitudes and practices towards male childhood sexual abuse. *Child Abuse and Neglect*, **24**, 391–409.
- Lipschitz, D., Kaplan, M., Sorkenn, J., *et al* (1996) Prevalence and characteristics of physical and sexual abuse among psychiatric outpatients. *Psychiatric Services*, **47**, 189–191.
- Lothian, J. & Read, J. (2002) Asking about abuse during mental health assessments. Clients' views and experiences. *New Zealand Journal of Psychology*, **31**, 98–103.
- Meyer, I., Muenzenmaier, K., Cancienne, J., *et al* (1996) Reliability and validity of a measure of sexual and physical abuse among women with serious mental illness. *Child Abuse and Neglect*, **20**, 213–219.
- Mills, A. (1993) Helping male victims of sexual abuse. *Nursing Standard*, **7**, 36–39.
- Muenzenmaier, K., Meyer, I., Struening, E., *et al* (1993) Childhood abuse and neglect among women outpatients with chronic mental illness. *Hospital and Community Psychiatry*, **44**, 666–670.
- *Mullen, P. E., Martin, J. L., Anderson, J. C., *et al* (1993) Childhood sexual abuse and mental health in adult life. *British Journal of Psychiatry*, **163**, 721–732.
- Read, J. (1998) Child abuse and severity of disturbance among adult psychiatric inpatients. *Child Abuse and Neglect*, **22**, 359–368.
- *Read, J. (2006) Breaking the silence: learning why, when and how to ask about trauma, and how to respond. In *Trauma and Psychosis: New Directions for Theory and Therapy* (eds W. Larkin & A. P. Morrison), pp. 195–221. Brunner-Routledge.
- 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. & Hammersley, P. (2006) Can very bad childhoods drive us crazy? Science, ideology and taboo. In *Evolving Psychosis: Different Stages, Different Treatments* (eds J. Johannessen, B. Martindale & J. Cullberg), pp. 270–292. Brunner-Routledge.
- Read, J. & Haslam, N. (2004) Public opinion. Bad things happen and can drive you crazy. In *Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia* (eds J. Read, L. Mosher & R. Bentall), pp. 133–146. Brunner-Routledge.

- Read, J., Perry, B., Moskowitz, A., *et al* (2001a) The contribution of early traumatic events to schizophrenia in some patients. A traumagenic neurodevelopmental model. *Psychiatry*, **64**, 319–345.
- Read, J., Agar, K., Barker-Collo, S., *et al* (2001b) Assessing suicidality in adults. Integrating childhood trauma as a major risk factor. *Professional Psychology: Research and Practice*, **32**, 367–372.
- Read, J., Agar, K., Argyle, N., *et al* (2003) Sexual and physical assault during childhood and adulthood as predictors of hallucinations, delusions and thought disorder. *Psychology and Psychotherapy: Theory, Research and Practice*, **76**, 1–22.
- *Read, J., Goodman, L., Morrison, A., *et al* (2004b) Childhood trauma, loss and stress. In *Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia* (eds J. Read, L. Mosher & R. Bentall), pp. 223–252. Brunner-Routledge.
- *Read, J., van Os, J., Morrison, A., *et al* (2005) Childhood trauma, psychosis and schizophrenia. A literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica*, **112**, 330–350.
- *Read, J., Rudegeair, T. & Farrelly, S. (2006a) The relationship between child abuse and psychosis. Public opinion, evidence, pathways and implications. In *Trauma and Psychosis: New Directions for Theory and Therapy* (eds W. Larkin & A. P. Morrison). Brunner-Routledge.
- Read, J., Haslam, N., Sayce, L., *et al* (2006c) Prejudice and schizophrenia. A review of the ‘mental illness is an illness like any other’ approach. *Acta Psychiatrica Scandinavica*, **114**, 303–318.
- Read, J., McGregor, K., Coggan, C., *et al* (2006d) Mental health services and sexual abuse. The need for staff training. *Journal of Trauma and Dissociation*, **7**, 33–50.
- 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 positive symptoms of schizophrenia. *Hospital and Community Psychiatry*, **45**, 489–491.
- Thompson, A. & Kaplan, C. (1999) Emotionally abused children presenting to child psychiatry clinics. *Child Abuse and 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 and Neglect*, **20**, 867–872.
- *Young, M., Read, J., Barker-Collo, S., *et al* (2001) Evaluating and overcoming barriers to taking abuse histories. *Professional Psychology: Research and Practice*, **32**, 407–414.