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Do community mental health staff ask about and respond to adverse childhood experiences and attachment histories?

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Abstract

The links between adverse events, attachment, and mental health problems are well documented. However, there has been limited focus on clinicians' enquiry and response behaviour in the literature to date. This project had two main objectives: 1) To add to this limited field of research and 2) to function as a replication of 1997 file audit (Agar & Read, 2002). The current study examined 250 computerised medical files, to see if clinicians working in four community mental health centres (CMHC) in Auckland, New Zealand, routinely asked about adverse events and if they incorporated disclosed information into psychological case formulations and treatment recommendations. All files were read in their entirety, and information regarding adverse events in childhood, adulthood and attachment related experiences was recorded.

Results indicate that there have been significant improvements in both enquiry and response behaviours since the last audit. For instance, 20% of the files included recorded disclosures of child sexual abuse in the 1997 audit, compared to 32.4% in 2010. Furthermore, the inclusion of adverse events in clients' case formulations had increased by more than 300% since 1997. Despite these encouraging results, there were also some concerning findings. There had been no improvements in the proportion of individuals referred for psychological therapy or in the number of alleged crimes that had been reported to the authorities. Furthermore, men and individuals with a psychotic disorder diagnosis appear to continue to receive a less than satisfactory service regardless of efforts made by a training programme.

Findings from this study suggest that focus needs to be placed on assuring that more individuals are referred to and able to access trauma-focused therapy. Future CMHC training providers would benefit from considering ways to disseminate this information to minimise misunderstandings, misdiagnosis, and ineffective treatment recommendations, especially for males and clients experiencing psychosis. Furthermore, reporting of historical abuse to legal authorities also needs some future attention at policy level.

-This thesis is dedicated to my husband Andrew and daughter Emma, in appreciation of their love, patience, and support during this doctoral journey -

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"It is important to ask questions of patients because with the help of these questions one will know more exactly some of the things that concern disease, and one will treat the disease better"

Greek physician Rufus of Ephesus 1000 AD.
(Sigerist, 1951, pp 326-327)

CHAPTER ONE: INTRODUCTION

The Origins of a Medicalised Approach to Mental Health

The way society views the causes of 'madness' impacts on the way people interact with and treat individuals displaying behaviours seen as different to the 'norm'. To understand how modern views of mental health have developed, we need to consider the complex interaction between history, law, and social principles that have all helped to produce what is currently seen as 'normal' in many cultures. People have attempted to explain diversity and/or madness in many different ways over past centuries. For a very long time explanations of madness were centered on evil spirits or demons, resulting in treatments such as burning, exorcisms, or primitive brain surgery (Porter, 2002). Following these unsubstantiated views of 'madness' the world saw the rise of a scientific approach which enhanced knowledge in a wide variety of fields. During this era, the focus in psychiatry was on finding organic causes of 'madness' while psycho-social factors were rarely considered. This can be viewed as the early phases of the development of the 'medical model' and treatment was still often cruel and violent. Some of the favoured treatment methods were bloodletting, ice water dousing, or force-feeding (Porter, 2002).

During this time however, there was also a group of influential physicians, led by Phillipe Pinell in France and William Tuke in England, who were promoting a more humane way of treating individuals seen at the time as deviant or mad. They had become aware that many medical treatments had little success and searched for alternative ways to treat these problems. Their main focus was to impress 'morality' on individuals by means of kindness and humane treatment in an endeavour to gain social control (Weiner, 1992). Proponents of this 'moral' therapy were influenced by Lockean thinking (1844), seeing the mind as originally a blank slate that was affected by the individual's environment.

In 1856 two prominent men were born: Sigmund Freud in Austria and Emile Kraepelin in Germany. These physicians came to represent two sides in an ongoing debate. On one side was Kraepelin, a physician often seen as the founding father of the medical model and biological psychiatry as we know it today, and the author of the influential *Compendium of Psychiatry* (Kraepelin, 1927). Kraepelin argued that there were a small number of discrete mental disorders

that could be identified by observing symptoms which he believed were associated with various forms of 'brain disease' and different aetiologies such as genetic predisposition.

Clare (1979) proposed that the medical model is best defined as a scientific process, including inspection, description, differentiation, identification of disease aetiologies, and treatment of symptoms. A medicalised model of mental health argues that predominantly biological factors can withstand the scrutiny of such a scientific process, while social and psychological factors cannot. However, many authors have strongly argued against this medicalised view of mental health (Becker, 1974; Bentall, 2003; Simon & Wynne, 2006; Szasz, 2008), suggesting that:

> *"Psychiatry's crisis revolves around the question of whether the categories of human distress with which it is concerned are properly considered "disease" as currently conceptualized and whether exercise of the traditional authority of the physician is appropriate for their helping functions" (Engel, 1977, p1).*

On the other hand, Sigmund Freud, also a physician, specialising in clinical neurology, is commonly known as the founding father of psychoanalysis. He argued for the importance of memory to mental health, both on the development of symptoms and their management (Freud & Strachey, 1964). Moreover, he suggested that repression of memories of negative life events is a risk factor in the development of both physical and mental illness (Knafo, 2009). Freud's early writings were mainly based on traumatised women who had experienced early sexual abuse, leading to the development of the 'Seduction Theory' that he later famously publically retracted, but privately still endorsed (Knafo, 2009). Interestingly, more contemporary work on the effects of trauma also refers to the effect of storing traumatic childhood memories, concluding that this often results in somatisation disorders (van der Kolk, 1994). Such recent findings would indicate that Freud discovered something extremely influential a century ago, that cannot be explained by a purely medical approach to mental health.

It has also been suggested that the medical model adopts a statistical approach to define normality and that the source of difference from the mean is located within the individual. If this way of constructing reality were valid, both redheads and lefthanders would be seen as 'abnormal' (Becker, 1974). This medicalised view of mental health has and is still dominating a great deal of the knowledge in the field of mental health today.

A Move from a Medical Model to a More Psycho-Social Model

Research into mental health has, for many years, been dominated by this 'medical model', and efforts have continually focused on finding biological explanations for, and treatments of, mental health problems (Bentall, 2003). However, over the past 20 years researchers have repeatedly shown that psycho-social factors such as childhood abuse, attachment related events, and poverty are significant predictors of adverse psychological outcomes in adulthood (Finklehor, 1990; Mullen, Martin, Anderson, Romans, & Herbison, 1996; Fergusson, Boden, & Horwood, 2008; Grossman, Grossman, & Waters, 2005; Moffit et al., 2007).

George Engel is commonly credited for formulating the Bio-Psycho-Social (BSP) model of mental health. He proposed that a new model was needed for more successful care, taking into account social (including cultural) and psychological factors in concurrence with biological aspects (Engel, 1977). Evidence has shown that both social and psychological experiences can influence changes in brain development and function (Read, Perry, Moskowitz, & Connolly, 2001), making it difficult to uphold a brain-body split. Given the strong evidence of the impact of childhood adversities on psychological wellbeing, it is important to investigate if clinicians enquire about their clients' childhood experiences. Engel (1997) emphasised the significance of conducting rigorous and meaningful medical interviews not only focusing on biological contributors to the client's distress but also making connections between the past and current presenting problems.

However, research has found that clinicians do not commonly include a comprehensive list of psycho-social factors in their initial assessments (Agar, Read, & Bush, 2002; Meyer, 2009; Eilenberg, Fullilove, Goldman, & Mellman 1996). Increasing the emphasis on psycho-social factors during the interview would enhance the possibility of comprehensive formulations, best possible treatment recommendations, and ultimately successful outcomes for clients and the mental health systems (Meyer, 2009). The subsequent literature review will include current and significant research in the fields of childhood adversities, attachment, and enquiry behaviours of mental health workers.

CHAPTER TWO: LITERATURE REVIEW

The main aim of this literature review is to give an overview of various factors that may contribute to an individual's psychological wellbeing, both in childhood and adulthood. The hope is that this will demonstrate the complexity of the origins of human wellbeing, and the need for clinicians to undertake comprehensive assessments, devoid of pre-set assumptions, in order to deliver accurate formulations of the origin of clients' problems and best possible treatment recommendations. The key areas that will be reviewed are: Childhood and adulthood adversities and their consequences; Attachment Theory and its implications for psychological wellbeing; current enquiry practices; and best recommended practices.

Adversity

Research findings inform us that salient childhood experiences can leave memories and physical and psychological scars that can last into adulthood (Edwards, Holden, Felitti, & Anda, 2003; Felitti et al., 1998; Fergusson, Boden, & Horwood, 2008). Other research findings indicate that salient experiences in adulthood, especially traumatic experiences, are associated with an increased utilisation of psychological services (Dorn, Yzermans, Spreeuwenberg, Schilder, & van der Zee, 2008; Fergusson, Horwood, & Ridder, 2005). The association between adverse childhood experiences and child and adult mental health problems such as depression, eating disorders, anxiety disorders, psychosis, and substance abuse are well documented (Afifi, Brownridge, Cox, & Sareen., 2006; Alloy, Abramson, Walshaw, Keyser, & Gerstein., 2006; Bebbington et al., 2004; Courtney, Kushwaha, Johnson., 2008; Everett & Gallop, 2001; Fergusson et al., 2008; Moffitt et al., 2007; Read, van Os, Morrison, & Ross, 2005). It is also important to point out that it is not only the type of adverse experiences that can lead to mental health problems later in life. Variables such as what age the experience(s) happened (Kaplow & Widom, 2007), the severity and the frequency of the experiences (Fisher & Regan, 2006), and individuals affected by multiple forms of childhood adversities (Edwards et al., 2003, Felitti et al., 1998) are important to consider. One study investigating maltreatment in participants drawn from the Minnesota longitudinal study found that 49% of cases identified as maltreated had experienced more than one type of maltreatment. These individuals presented with the greatest number of behavioural or emotional problems later in life and as many as 74% met diagnostic criteria for a clinical disorder (Shaffer, Huston, & Egeland, 2008).

For the purpose of this study a number of experiences discussed in the literature will be considered. These include childhood sexual abuse (CSA), childhood physical abuse (CPA), childhood physical neglect (CPN), childhood emotional abuse (CEA), childhood emotional neglect (CEN), adult sexual abuse (ASA), adult physical abuse (APA), adult emotional abuse (AEA), and poverty. A summary of some of the recent and/or influential research around the effects of specific adverse childhood experiences on mental health later in life is presented below.

Childhood Adversities: Definitions, Prevalence Rates, and Effects

Defining experiences such as abuse and neglect has proven to be complicated (Finkelhor & Hotaling, 1984; Russell, 1984; Wyatt & Peters, 1986). Discrepancies in definitions provided by various researchers are likely to impact how prevalence rates are calculated in different studies. For example, if participants are excluded if they only experienced non-contact abuse or if the upper age limit for inclusion is lowered, prevalence rates are likely to be lower. In addition to variations in definitions, it is also important to consider what is meant by prevalence. In prevalence studies researchers aim to estimate the proportion of the population that has had a certain experience in their lifetime. This differs from incidence studies, which calculate the number of incidences during a given time (Wyatt & Peters, 1986). The following section presents working definitions for this study, prevalence rates from recent research, and possible effects of such events.

Childhood sexual abuse

CSA can range from non-contact (e.g., indecent exposure) to sexual penetration. Earlier research suggested that a definition of CSA should include elements of coercion, age discrepancies of five years or more, and the type of act imposed (Finkelhor, 1979). Subsequently, definitions were extended to include abuse by peers (Finkelhor & Hotaling, 1984). For the purpose of this study, CSA will be defined as, "Sexual contact that occurs to a child as a result of force, threat, deceit, while unconscious, or exploitation of an authority relationship, no matter what the age of the partner" (Finkelhor & Hotaling, 1984; pp. 31).

The exact numbers of individuals who have been sexually abused are unlikely to ever be known. However, research has indicated high prevalence rates of CSA in New Zealand and the rest of the world. Two recent studies suggest that for New Zealand women, exposure to CSA prior to the age of 15 could be as high as 35.1% (Fanslow, Robinson, Cregle, & Perese, 2007; Fergusson, Boden, & Horwood, 2008). Fanslow and her colleagues (2007) conducted a survey on a random sample of 2855 women in two regions of New Zealand. They found that women in rural regions reported a

higher rate of sexual abuse and Māori women living in a rural environment reported the highest rate of CSA. Recent data from a New Zealand longitudinal health and development study indicated that 14.1% of the birth cohort had been exposed to CSA (Fergusson et al., 2008). These studies highlight the scale of the problem of CSA within New Zealand.

A review of CSA around the world found that prevalence varies depending on definition and population studied. Findings suggested that frequency ranging from 2-62% of women and 3-16% of men (Johnson, 2004). An extensive international review suggested that rates of CSA cluster around 42% for women and 12% for males in clinical populations (Everett & Gallop, 2001). However, it is important to note that research suggests that CSA is regularly under-reported, thus calling into question the accuracy of these figures (Johnson, 2004).

A growing body of evidence over the past decade indicates a strong relationship between CSA and a range of mental health concerns both in childhood and adulthood (Afifi et al., 2007; Brier, Woo, McRae, Foltz, & Sitzman, 1997; Browne & Finklehor, 1986; Fleming, Mullen, Sibthorpe, & Bammer, 1999; Janssen et al., 2004; Molnar, Buka, & Kessler, 2001; Mullen et al., 1993; Najman, Nguyen, & Boyle, 2007; Read, 1998; Read et al., 2005; Spataro, Mullen, Burgess, Wells, & Moss, 2004). Depression is the most frequently reported diagnosis by survivors of CSA (Brier et al., 1997). Rates of depression among women who have experienced CSA have been reported to be higher than 50% (Mullen et al., 1993), rising to as high as 89% for women who had been victims of incest (Pribor & Dinwiddie, 1992). Similar rates have been found for eating disorders (Messman-Moore & Garrigus, 2007), substance abuse (Zink, Klesges, Stevens, & Decker, 2009), self-injurious behaviour (Yates, Carlson, & Egeland, 2008), and psychosis (Bebbington et al., 2004). Overall, evidence is overwhelming for the negative consequences of CSA, with evidence suggesting that CSA is a powerful predictor of future mental health concerns (Brier et al., 1997; Agar & Read, 2002). Research findings also suggest that the more severe and frequent the abuse is the more likely is the development of psychological problems (Mullen et al., 1993). Moreover, a recent review of forty-six studies found that 69% of female inpatients had suffered either CPA or CSA (Read et al., 2005). Thus, there is little doubt that growing up in an abusive environment and/or with an abusive caregiver can have deep effects on individuals' physical and psychological wellbeing, and on the development of a secure attachment style (discussed later in this chapter). Another associated risk of CSA is an increased rate of adult rape, further impacting on psychological wellbeing (Balsam, Lehavot, & Beadnell, 2011).

Childhood physical abuse

The definitions of CPA greatly depend on social, cultural, and personal norms. Physical ways of punishing children can be seen either as normative or as a childhood adversity depending on where in the world and within which culture the child is raised. Definitions of childhood physical abuse commonly include factors such as acts taking place before the age of 18, perpetrated by a more senior assailant, not interpreted by the individual as sibling rivalry, an act that produces severe pain (e.g., repeated slapping, kicking, biting, choking, burning), and threatening with or using a weapon (Brown & Anderson, 1991; Goodman, Rosenberg, Mueser, & Drake, 1997). Including words such as ‘repeated’, potentially excludes severe single incidents. However, to be consistent with other research a stringent criterion was adopted for this study.

Seventy-eight percent of the sample in the Christchurch longitudinal study (Fergusson et al., 2008) reported that at least one of their parents regularly used physical punishment and 4.5% reported that the punishment was harsh and abusive. Afifi and her colleagues (2006), in a Canadian study, found that 48% of a sample of 5,838 participants in the U.S. had experienced physical punishment (minor physical assault) and 16.5% reported that they had experienced physical abuse (kicked, bitten, hit with closed fist or object, or choked). Results indicated that even the use of ‘light’ physical reprimand was associated with increased risks of major depression, externalising problems, and alcohol abuse later in life. Results also indicated that the likelihood of experiencing mental health problems and/or alcohol dependence later in life progressively increased as the severity of the physical punishment/abuse increased (Afifi et al., 2006). Other research suggests that minor physical punishment at the hand of a non-abusive parent has little or no negative consequences for the child (Larzelere, 2000).

Results from a longitudinal study in New Zealand indicated a weak and inconsistent association between CPA and mental health problems later in life. However, findings did show that children who had been exposed to harsh or abusive physical punishment had 1.5 times higher rates of mental health disorders than those who had experienced only occasional or no physical punishment. Moreover, there was a strong association between CPA and depression during childhood (Fergusson et al., 2008). Fergusson and his colleagues (2008) suggested that the association between CPA and mental health is mediated by confounding family factors, such as parental attachment, parental education, and living standards. As previously discussed, childhood adversities do not occur in isolation, thus effects are mediated and moderated by numerous variables in a child’s environment.

Several studies have also shown that the use of physical punishment or abuse predicts insecure attachment relationships (e.g., Muller, Gragtmans, & Barker, 2008; Weinfield, Sroufe, & Egeland, 2000). A more complete discussion of Attachment Theory and its implications will follow at the end of this section.

Childhood physical neglect

Much less attention has been given to childhood physical and emotional neglect, perhaps because it is less obvious and more difficult to measure. Moreover, what is seen as neglect today would not have been acknowledged as such in previous times (e.g., the Industrial Age) or in many of the developing countries of the world. An ongoing challenge when considering neglect is the distinct lack of a unified research definition (Dubowitz, 2006). This lack of clarity may have led to reluctance to research effects and potential interventions, leading to what is often referred to as "neglect of neglect" (Slack, Holl, Altenbernd, McDaniel, & Stevens, 2003). However, even these less visible signs of maltreatment can have extremely negative effects (Allen, 2008).

The following statement captures the essence of neglect and its consequences and is perhaps especially fitting for emotional neglect. "Neglect is an insidious form of maltreatment. It starves the developing mind of stimulation. It denies the child information and interest about self and others" (Howe, 2005, p.111). A recent New Zealand report (2010) on neglect identified a range of risk factors including family violence, fewer parenting skills, poverty, and poor knowledge about child development.

Definitions of neglect often contain two categories: Failure to provide basic physical care, such as clothing, cleanliness, healthcare, and food; and failure to provide age and need appropriate supervision of children (Horwath, 2007; May-Chahal & Cawson, 2005). Horwarth's definition of neglect is one of the more inclusive:

> *"Child neglect is a failure on the part of either male and/or female caregiver or pregnant mother to complete the parenting tasks required to ensure that the developmental needs of the child are met. This should take into account the age, culture, religious beliefs and particular needs and circumstances of the individual child. This failure may be associated with parenting issues. It has occurred despite reasonable resources being available to enable the caregiver(s) to complete the parenting tasks satisfactorily. Whilst neglect is likely to be ongoing, one off incidents and episodic neglect can affect the health and the development of a child" (Horwath, 2007, p. 38).*

Physical neglect may be both easier to describe and identify than emotional neglect. Although CPN is commonly acknowledged it is, however, difficult to estimate CPN without considering factors that may underlie neglect, such as stress and poverty.

Various types of neglect are often referred to as one the most frequently identified forms of child maltreatment. For example 78.3% of cases investigated by child protective services (CPS) in the U.S. were found to have experienced some form of neglect (U.S. Department of Health and Human Services, 2009). A population-based study from the United Kingdom reported a 6% lifetime prevalence of physical neglect, with serious lack of care experienced by 10% of the sample that had caregivers in semi or unskilled occupations. Similar findings emerged from a Canadian population study that indicated that 'failure to supervise' was the largest form of verified neglect (48%) in cases where neglect was of primary or secondary concern (Trocme, Tourigny, Maclaurin, & Fallon, 2003).

The effects of physical neglect have been found to vary depending on the extent of the neglect, from developmental delay to significant long-term effects and in some cases death (Sinclair & Bullock, 2002; Hildyard & Wolfe, 2002). As with many of the other adverse experiences discussed, the severity, frequency, and onset of the physical neglect all contribute to how severe the short-and long-term effects maybe. For an extensive literature review of child neglect see Hildyard and Wolfe (2002). To a large extent, research on physical neglect centres around delayed cognitive and behavioural development (Erikson & Egeland, 2002) due to its impact on brain development (Glaser, 2000), attachment security (Cassidy & Shaver, 2008), and physical development (Horwath, 2007). There is very little doubt that physical neglect can have profound effects on the developing child. Thus, assessing the mental health of an adult without enquiring about childhood neglect may lead to incomplete formulations and treatment recommendations.

Childhood emotional abuse

Relatively little research has been conducted into childhood emotional abuse and neglect, partially due to the previously described inconsistency of research agreements about definitions. However, reports have increased over the past decade, suggesting that CEA and CEN are frequent forms of child maltreatment (Glaser, 2002). The American Professional Society on the Abuse of Children (APSAC) provide a working definition of CEA as, "a repeated pattern of caregiver behaviour or incident(s) that convey to the child that they are worthless, flawed, unloved, unwanted, endangered, or of value only in meeting another's needs" (APSAC, 1995). They include six forms of maltreatment: Spurning, terrorising, exploiting, denying, isolating and mental health, medical, and educational neglect (APSAC, 1995). This definition was adopted for this study.

As noted previously for other types of abuse, prevalence rates of CEA vary depending on the definition and population studied. One U.S. study based on a community sample of 8,667 adults indicated that 34.6% of individuals reported having experienced more than one type of childhood maltreatment. Those who had experienced CEA had significantly more adverse psychological outcomes in adulthood (Edwards, Holden, Felliti, & Anda, 2003). Another study reporting on childhood emotional maltreatment during two years in a community of American army families found emotional abuse in 26% of the families (Jellen, McCarroll, & Thayer, 2001).

A growing body of evidence suggests that CEA is associated with an increased likelihood of developing symptoms of depression later in life (Alloy et al., 1999; Courtney, Kushwaha, & Johnson, 2008). Findings from a community based study of 8,667 adults in the U.S. found that individuals who reported CEA or CEN had lower mental health scores than individuals that did not report CEA or CEN (Edwards et al., 2003).

Emotional abuse has often been studied in individuals who have also experienced other forms of abuse or neglect. Spertus (2003) and her colleges investigated a non-clinical sample who had not received any treatment for psychiatric illness and had a comparatively low rate of physical or sexual abuse. They also aimed to investigate the effects of early emotional abuse or trauma in the context of subsequent trauma exposure. They found that both CEA and CEN were associated with increased rates of depression, anxiety, and post traumatic stress symptoms. In addition, results indicated that CEA and CEN predicted higher rates of lifetime trauma exposure and that CEN and CEA were risk factors for post-traumatic stress symptoms later in life (Spertus, Yehuda, Wong, Hallingan, & Seremetis, 2003).

Childhood emotional neglect

Iwaniec (1995, 2006) suggests that the difference between emotional abuse and emotional neglect may be the degree of intent, describing emotional abuse as a deliberate act. According to Iwaniec (2006), emotional neglect involves non-intentional acts by the caregiver, commonly originating from caregivers' lack of awareness and knowledge, and/or ignorance of the child's emotional needs. It has been suggested that neglect takes place when a child's basic needs are not sufficiently met, resulting in real or probable harm (Dubowitz, Black, Starr, & Zuravin, 1993). For the purpose of data collection, emotional neglect will be defined as: Ongoing failure to meet a child's emotional needs. This definition was used in a recent report by the New Zealand Ministry of Social Development (2010).

Research on the prevalence of child maltreatment from the United Kingdom indicates that over one-third of their sample (N=2,869) had experienced some form of emotional maltreatment, such as humiliation, threat, and domination (May-Chahal & Cawson, 2005).

The impact of ongoing neglect can be severe. Effects are well described by MacMillan and colleagues (2009) including delayed language and cognitive development. As with other forms of adversity, research has suggested that emotional neglect may predict various emotional adjustment problems throughout childhood and in adulthood (Allen, 2008). Findings have shown that many emotionally abused or neglected children have experienced dismissive, harsh, and neglectful parenting styles which impact on the formation of attachment bonds (Prior & Glaser, 2006: Iwaniec, 2006).

Poverty

Since ground-breaking work in the 1950's (Hollingshead & Redlich, 1958) there have been an extensive number of studies focused on the inverse relationship between socioeconomic status (SES) and adverse psychological outcomes (e.g., Robbins, Dollard, Armstrong, Kutash, & Vergon, 2008; Siegel, 2008). Poverty is usually defined according to income. However, the World Health Organisation (WHO) suggests that poverty is characterised by much more diverse deprivations, including marginalisation and social exclusion (2004). UNICEF's overview of child wellbeing in rich countries in 2007 indicated that as many as one in five children in New Zealand are living in poverty (UNICEF, 2007). Poverty rates are even higher for subgroups in New Zealand: 42 % of children living in sole-parent families, 25% of Pacific Island children, and 33% of Māori children live in homes below the poverty line (Ministry of Social Development, 2011). The U.S. Census Bureau (2011) reported that 21.6% of all children in the United States live below the poverty threshold, and this increases to 38.2% for children identified as Black and 32.2% for children identified as Hispanic.

The relationship between economic status and mental health has received a lot of attention in recent literature (Das, Do, Friedman, McKenzie, & Scott, 2007; Dashiff, DiMicco, Myers, & Sheppard, 2009; Read, 2010; Robbins et al., 2008; Siegel, 2008). It has been suggested that higher rates of mental health concerns among lower SES- groups are the result of a downward drift for individuals in the socioeconomic hierarchy due to mental health concerns (Aro, Aro, & Keskimaki, 1995), suggesting that low SES is an outcome of mental health problems not a cause (Munk-Jorgensen & Mortensen, 1992). On the other hand, research suggests that youth growing up in low SES environments may be as much as 50% more likely to develop adverse psychological problems later in life than those living in higher SES environments (e.g., Heflin &

Iceland, 2009). Others have found that there is little evidence for an association between income inequality and mental health (Bockerman, Johansson, Helakorpi, & Uutela, 2009). The link between poverty and mental health problems is undoubtedly complex and mediated by variables associated with low SES including unemployment and ethnicity (Barker-Collo & Read, 2003) In addition, research has indicated that it is the relative poverty of a country (difference between the rich and poor) that is particularly predictive of poor mental health outcomes (Carroll, Casswell, Huakau, Howden-Chapman, & Perry, 2011; Powell-Jackson, Basu, Balabanova, McKee, & Stuckler, 2011; Wilkinson & Pickett, 2006; Wilkinson &Pickett, 2009).

In New Zealand, historical processes have left those of Māori heritage exposed to socioeconomic disadvantages, resulting in higher rates of mental health concerns (Marie, Fergusson, & Boden, 2008). As research has shown however, children and adolescents are disproportionately represented among the poor, thus making investigating potential interactions between childhood poverty and adverse psychological outcomes both valid and important.

Links between Adverse Childhood Experiences and Specific Disorders in Childhood

As already demonstrated, a number of research studies have consistently shown a strong link between childhood adversities and poor overall mental health later in life. There is also substantial evidence linking specific disorders with adverse childhood experiences. For the purpose of this review, a small selection of disorders commonly diagnosed in childhood will be discussed, specifically: Attention Deficit Hyperactivity Disorder (ADHD), and Depression and Anxiety Disorders (American Psychiatric Association (APA), 2000).

ADHD

ADHD is commonly diagnosed in childhood. In the last decade, influential organisations such as the American Academy of Child and Adolescent Psychiatry and the American Academy of Paediatrics (AAP) have acknowledged the association between child abuse and neglect and behaviour presenting as ADHD, recommending in their assessment and treatment guidelines to screen for psychological trauma (AAP, 2001). Studies have suggested that adverse experiences in childhood may place children at an increased risk of developing post-traumatic stress symptoms, some of which correspond with symptoms of ADHD (e.g., Ford et al., 2000; Becker-Blease & Freyd, 2008). Results from a large longitudinal population based study in the U.S. of adolescent health showed a significant association between physical neglect, physical abuse, contact sexual abuse, and inattentive-type ADHD (Ouyang et al., 2008). Another study found that children with a

record of maltreatment (e.g., emotional, sexual, physical abuse or neglect) were diagnosed with ADHD inattentive-type more frequently than any other DSM diagnosis (Coleman, 2007). Similar links have also been indicated between childhood depression and maltreatment, which will be discussed next.

Depression

It has been suggested that adverse events in childhood may contribute to the development of depression through three main pathways: The development of negative internal working models of self and others; disturbances in neural pathway development affecting the hypothalamic-pituitary-adrenal (HPA) axis; and activation of the onset of depression through stressful traumatic events such as abuse (Harkness & Lumley, 2008). Most of the research in this area has been carried out with adolescent samples (e.g., Harkness, Bruce, & Lumley, 2006). In a large-scale study of adolescents' mental health Kilpatrick and colleagues (2003) found that adolescents who had been exposed to physical or sexual violence were almost three times more likely to experience depression than adolescents without a history of maltreatment. Another prospective study found that children who had experienced sexual abuse were nine times more likely to be treated for childhood disorders such as depression at public mental health services (Spataro et al., 2004).

Furthermore, research has also shown that children exposed to multiple abusive events are more likely to experience depression than those who had been victimised only once. Additionally, children abused by a known or related perpetrator in their home and female adolescents were found to be more likely to experience depression (Danielson, de Arellano, Kilpatrick, Saunders, & Resnick, 2005). A longitudinal study of young maltreated children indicated that children affected by chronic neglect are significantly more likely to suffer from depression or anxiety symptoms than those affected by more transient maltreatment (Éthier, Lemelin, & Lacharité, 2004).

Anxiety

Childhood anxiety symptoms and disorders have also been associated with adverse experiences such as abuse and neglect (Beidel & Turner, 2005; Chaffin, Silovsky, & Vaughn, 2005; Wright, Crawford & Del Castillo, 2009). There is no single explanation for the development of any mental health problem including anxiety disorders. Environmental, psychological, and biological factors are all thought to play a part in the aetiology of anxiety, and are conceptualised as working in conjunction with each other (Carr, 2000). For example, not every child responds in the same way to the same situation. Their reaction will depend on their previous experiences, resilience, parenting practices, and their perceived control of the situation (Beidel &Turner, 2005).

In addition to traumatic events such as child abuse, research has indicated that other negative life events such as parental separation, family members with mental health problems, and loss of a close friend or caregiver are associated with increased levels of anxiety disorders in children (Tiet et al., 2001). Numerous studies have also shown a link between childhood adversities and PTSD (e.g., Maikovich, Koenen, & Jaffee, 2009; Famularo, Fenton, Augustyn, & Zuckerman, 1996). For a comprehensive review of anxiety disorders in childhood see Muris (2007).

These findings highlight how children react differently to similar adverse experiences and thus demonstrate how imperative it is that clinicians go into initial assessments without assumptions and pre-set ideas of what may have contributed to an individual's current difficulties. It is unfortunate that both clinical assessment and treatment have been and still are so focused on finding biological explanations and treatments for mental health problems, as one may imagine that children struggling with the enduring effects from childhood experiences may respond better to early psychological interventions. Without early intervention, effects of adverse childhood experiences can often be seen in adulthood. Additionally, adversities do not exclusively occur during childhood. A sample of adult adversities and their effects will now be discussed.

Adulthood Adversities: Definitions, Prevalence Rates, and Effects

Adult sexual abuse

Definitions of ASA or sexual victimisation are often focused around rape or attempted rape. Rape is often referred to as an act of sexual or non-sexual penetration (vaginal, oral, or anal) that has been attained by force and/or threat in a situation where the victim is unable to resist or give consent (Kolivas & Gross, 2007). A complete definition of ASA needs to include both sexes, all sexual orientations, and take into account more recently exposed sexual phenomena such as acquaintance rape (Fisher, Cullen, & Diagle, 2005). These more inclusive criteria will be adopted for this study.

Official statistics from the U.S. report incidence rates for rape or attempted rape of 0.5 attempts/rapes per 1000 adult females, compared to 1.3% in New Zealand (Rape victims by country, UNICRI (United Nations Interregional Crime and Justice Research Institute), 2002). However, rape is significantly underreported, thus it is difficult to make accurate estimates of actual prevalence rates (Clay-Warner, Burt, & Harbin 2005; Gavey, 1991). Fisher and her colleagues (2006) found that fewer than 1 in 20 incidents of sexual victimisation were reported to the police or other authorities in the U.S., while as many as 7 in 10 disclosed the incident to a

friend. Similar results were found in a New Zealand study (Gavey, 1991) where 51.6% of the participants disclosed an experience of sexual victimisation when directly asked by the researcher, indicating that the prevalence of ASA may be much higher than some official data may suggest. It is therefore important that the clinician ask clients about these events directly.

Experiencing ASA has been associated with numerous negative psychological outcomes including depression, PTSD, attempted suicide, and substance abuse (Jordan, Campbell, & Follingstad, 2010). The majority of research has been focused on heterosexual women. While men in the general population are affected by rape less than women, this is not the case for gay men (Tjaden & Thoenness, 2000). Not surprisingly, gay men and lesbian women experience similar adverse consequences as heterosexual women (Balsam, Lehavot, & Beadnell, 2011) highlighting the importance of asking everyone about adverse events in the past.

Adult physical abuse

Research into APA is often focused on heterosexual domestic or intimate partner violence (IPV) against females. Definitions of domestic and intimate partner violence include physical, psychological, and sexual abuse by a current or former partner (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; Mercy, Butchart, Dahlberg, Zwi, & Krug, 2003). For the purpose of this study APA will be defined (in line with CPA) as acts that produce severe pain (e.g., repeated slapping, kicking, biting, choking, burning), and threatening with or using a weapon.

The majority of research in this field has focused on the prevalence and effects of physical violence. Prevalence rates among women internationally range between 10 and 34% (Howard et al., 2010; Krug et al., 2002). Much less is known about IPV experienced by males in heterosexual or homosexual relationships. However, one recent study found that 4.6% of men had experienced IPV in the last year and 10.4% over the past five years. Less than 3.5% of the study sample were in homosexual relationships (Reid et al., 2008). A New Zealand cohort study found that domestic conflict was present in 70% of relationships, ranging from minor psychological abuse to severe physical assault, with both genders showing comparable patterns of violence and victimisation (Fergusson, Horwood, & Ridder, 2005).

A recent National Epidemiology Study, in the U.S., found that new onset of axis I disorders (APA, 2000) were significantly more common among individuals who reported experiencing APA during the last 12 months (Okuda et al., 2011). Approximately 20% had been diagnosed with a new onset disorder. Moreover, increased frequency and severity contribute to an increased risk of developing

mental health problems. Findings showed that APA was associated with the onset of PTSD, GAD, depression, substance abuse, and bi-polar affective disorder (Okuda et al., 2011).

Adult emotional abuse

As with CEA, researchers differ on how to define adult emotional or psychological abuse. Murphy and Hoover (1999) suggested that emotional abuse be defined as: “Coercive or aversive behaviours intended to produce harm or threat of harm, often resulting in fear, increased dependency, and/or a diminished sense of self worth”. O’Leary and Maiuro (2001) proposed that emotional abuse include: Denigration of partner’s self-esteem, passive-aggressively withholding emotional support, threatening behaviour (explicit and implicit), and restricting personal freedom. More recently the term ‘psychological aggression’ has been suggested as an alternative (Follingstad, 2009). O’Leary and Maiuro’s (2001) definition was adopted for this study.

Due largely to inconsistency in definition, and coexisting abuse, prevalence rates of AEA are varied. A large population survey (n=6,790) of adult males and females showed that 12.1% of women and 17.3% of men had experienced AEA without experiencing any other form of abuse. However, more that 90% of those who had experienced sexual abuse and physical abuse also reported experiencing emotional abuse, suggesting this is a prevalent problem within the general population and within a clinical sample (Coker et al., 2002). A recent New Zealand study (Fanslow & Robison, 2011) reported that 55% of women had experienced some form of IPV during their lifetime. Notably, almost all of these women reported experiencing emotional abuse, and women who only reported one form of abuse were most likely to have experienced emotional abuse. These findings highlight the importance of clinicians asking about different kinds of abuse and neglect during assessment interviews.

Follingstad (2009) reviewed the literature on emotional abuse and described a range of negative consequences experienced by women reporting emotional abuse including: Depression, PTSD, and generalised anxiety disorder. Other negative consequences included reduced self-esteem, stress, and poor physical health. The author also summarised research suggesting that emotional abuse elevates personality traits such as antisocial attitudes, persecutory feelings, and interpersonal sensitivity. Qualitative research found that more than 70% of women reported that emotional abuse had a more negative impact on their life than physical abuse (Follingstad et al., 1990).

Links between Adverse Experiences and Specific Disorders in Adulthood

It may be comparatively easy to see the link between childhood adversities and specific childhood disorders due to their temporal relationship. However, what makes this project so important is that these childhood experiences often result in enduring poor social adjustment and mental health in adulthood. There is once again a large body of research convincingly showing this delayed and/or prolonged response to adverse childhood experiences. Research supporting this connection exists for the majority of disorders identified in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR) (APA, 2000). However, only a few disorders will be discussed in more detail to illustrate this connection, specifically Depression, Eating Disorders, and Psychosis.

Depression

As with childhood depression, an extensive research literature indicates that adverse experiences in childhood are linked to depression in adults (e.g., Fergusson et al., 1993; Fergusson et al., 2008; Harkness & Lumely, 2008; Mazure, 1998; Molnar et al., 2001; Spataro et al., 2004). Some studies suggest that exposure to CSA or CPA is associated with up to five times the risk of developing depression as an adult (Harkness & Lumely, 2008: Kendler, Kuhn, & Prescott, 2004). It has been proposed that adversities such as CSA and CPA heighten an individual's sensitivity towards future stress, thus increasing the likelihood of depression when new stress is encountered in adulthood (Post, 1992).

A large-scale National Comorbidity Survey in the U.S. found that the percentage of women reporting depression among those that had experienced CSA was 39.3% compared to 19.2% of those that had not experienced CSA. Figures were similar for men, whereby 30.3% of those who had experienced CSA reported depression compared to 11.4% of those who did not (Molnar et al., 2001). A longitudinal study in New Zealand found that both CSA and CPA were significantly associated with an increased incidence of major depression (Fergusson et al., 2008).

Eating disorders

Another group of disorders often discussed in relation to environmental influences and adverse childhood experiences are Eating Disorders (ED) (APA, 2000). Findings into links between EDs and child abuse are conflicting (Hund & Espelage, 2005). The aetiology of EDs is complex. Some researchers argue that there may be an indirect relationship between abuse and EDs, as EDs traditionally develop during adolescence or early adulthood (Hund & Espelage, 2005). However, this temporal association exists in many mental health problems and there is a significant body of

evidence supporting an association between EDs and adverse childhood experiences (e.g., Kong & Bernstein, 2009; Mazzeo, Mitchell, & Williams, 2008; Messman-Moore et al., 2007; Murray, MacDonald, & Fox, 2008). For instance, a recent study of a clinical population found that emotional abuse, sexual abuse, and physical neglect were all significant predictors of disordered eating, and 90.4% of participants reported experiencing some form of trauma during their formative years (Kong & Bernstein, 2009). Moreover, research has found that individuals suffering from disordered eating with an abuse history more frequently fail to complete treatment and relapse compared to those without a trauma history (Rodriguez, Perez & Garcia, 2005), making enquiry behaviour important to understand and inform the therapeutic process and treatment recommendations. Furthermore, emotional abuse has been suggested to play a significant role in the development and maintenance of eating disorders (Waller, Corstorphine, & Mountford, 2007).

Psychosis

There continues to be an intense debate over the influence adverse childhood experiences may have on the development of psychosis. It would not be unfair to say that out of all mental health problems treated by mental health professionals today, psychosis is consistently associated with a biological cause. However, there has been an increased resistance to this theory over the last decade, with many researchers arguing for, and empirically demonstrating environmental causes (e.g. Anda et al., 2006: Bentall, 2003; Janssen et al., 2004; Read, 2004; Read et al., 2005; Read, Fink, Rudegeair, Felitti, & Whitfield, 2008; Rosenberg, Mueser, Jankowski, & Cournos, 2007; Whitfiled, Dube, Felitti, & Anda, 2005). Focus has often been on the link between CSA, CPA and psychosis (Read et al., 2005). However, other adverse life experiences, such as poverty (Read, 2010) and emotional neglect or abuse (Mullen et al., 1996; Whitfield et al., 2005), have also been found to be as influential on the development of psychosis. For a comprehensive discussion on the association between environmental factors and the development of psychosis see articles by Read and his colleagues (2005, 2008, 2010). Read (2010) conducted a review of research indicating that there is a causal relationship between poverty and psychosis, suggesting that the relationship between poverty and psychosis may be best thought of as " being a result of the greater exposure to a range of risk factors, in both childhood and adulthood, which are disproportionately experienced by poorer people" (Read, 2010, p11). A recent meta-analysis (Varese et al., 2012) of 36 prospective, cross-sectional and patient-control studies exploring the link between childhood adversities and increased risk of psychosis indicated that childhood adversities, including sexual, physical, and emotional abuse, neglect, parental death, and bullying significantly increased the risk of experiencing psychosis. Moreover, no specific type of adversity or trauma was more strongly

related to psychosis than others, suggesting that variables such as frequency of exposure and age of onset may be more predictive of the risk of psychosis.

Resilience

The preceding discussion has highlighted significant negative effects on peoples' lives as a result of adverse childhood experiences. However, it is important to point out that evidence also shows that far from everyone who has experienced childhood adversities goes on to develop mental health difficulties later in life (Iwaniec, Larkin, & Higgins, 2006; Mullen et al., 1993; McGolin & Windom, 2001). Resilience is an area of psychology that has prompted numerous investigations. As with various psychological concepts, there has been extensive debate regarding a working definition of resilience. However, it is generally agreed that such a definition needs to cover two main points. Initially, the individual must have been exposed to a risky or stressful situation. Secondly, resilience should be evident over an extended period of time (Rutter, 2006). Resilience has been defined as the capacity to adapt despite traumatic or unfortunate circumstances (Waller, 2001), a dynamic process including biological, social and psychological factors (Luthar & Cicchetti, 2000).

An extensive overview of resilience is out of the scope of this thesis, for a more complete discussion see Taylor and Wang (2000). However, this discussion would be incomplete without mentioning resilience and the body of evidence indicating that a considerable minority of individuals appear to be comparatively unaffected by adverse childhood experiences (Collishaw et al., 2007; McGloin & Widom, 2001). McGolin and Widom (2001) interviewed 676 participants with a history of substantiated abuse or neglect. They measured functioning across eight domains (education, social activity, employment, substance use, homelessness, psychiatric disorders, and two measures of criminal behaviour) as a measure of 'overall resilience'. Results found that 22% of their participants met their criteria for resilience. More females met criteria and scored higher across a greater number of the eight domains measured. Moreover, results indicated that sexual abuse had a negative impact on resilience; this was not evident for physical abuse (McGloin &Windom, 2001). A long-term follow-up of a community sample in the U.K. found similar levels of resilience among their participants. Results also indicated that resilience was associated with certain factors, such as perceived parental support, personality style, peer relationships during adolescence, and quality of adult romantic relationships (Collishaw et al., 2007).

The preceding discussion has highlighted the significant impact of adverse childhood and adulthood experiences and the need for a comprehensive approach towards initial assessments and treatment recommendations in mental health settings. Moreover, as mentioned previously, adverse

experiences cannot be considered in isolation of other contextual factors. One theory that is pertinent in this discussion is John Bowlby's Attachment Theory (1958, 1960, 1969, 1973, 1980). The following section will briefly outline Attachment Theory and its implications for mental health.

Theoretical Background to Attachment Theory

Attachment Theory was initially developed by John Bowlby (1958, 1960, 1969, 1973, 1980). Born in 1907 in England, Bowlby followed in his father's footsteps and became a physician, specialising in psychiatry. However, his interest in children, and especially 'disturbed' children, started when he worked as a volunteer at a school for 'maladjusted' children. His experiences there initiated his interest in early childhood interactions (Bretherton, 1992). Bowlby's early work on attachment was also inspired by classical work from Lorenz, Hinde, and Harlow (Cassidy & Shaver, 2008). Prior to introducing the concept of attachment, Bowlby (1944) investigated 44 young thieves, their characters, and home lives. This investigation made him consider that comparatively serious disturbances in the mother-child relationship could play a formative role in child development and were salient antecedents for future psychopathology.

The most elementary aspects of Attachment Theory are focused on the biological foundations for human attachment behaviour. Bowlby suggests that infant behaviours such as crying, smiling, and vocalising all have the function of increasing the proximity of the child to the primary attachment figure, usually the mother (1958). Even though much of the existing research focuses on the primary attachment figure, young children can develop attachment relationships with more than one individual during the early stages of their lives (Bowlby 1969/1980; Ainsworth, 1967). In most western cultures these may include the father, siblings, or grandparents; in other more collective cultures these may be members of the extended family or close friends with whom the children have close and continual contact (Grossmann, Grossmann, & Keppler, 2005). Attachment Theory suggests that seeking security from and proximity to attachment figures is biologically anchored and serves as a survival mechanism for children (Brisch, 2002). Moreover, the child is thought to be biologically predisposed to seeing the primary attachment figure as a 'safe' base from where they can explore the environment (Bowlby, 1969/1980). This innate biological mechanism of protection is considered to be a healthy characteristic of human development and, if disrupted, may result in psychological disturbances. Bowlby described attachment as, "any form of behaviour that results in a person attaining or maintaining proximity to some other differentiated and preferred individual, usually conceived as stronger and wiser" (1973).

According to Attachment Theory, it is thought that attachment behaviours are structured into an "attachment behavioural system" that leads to foreseeable behavioural outcomes. Furthermore, findings suggest that this behavioural system is not determined by only pleasurable encounters, as children appear to become attached to abusive as well as warm and sensitive parents (Bowlby, 1958). Bowlby also suggests that through early interaction with the primary caregiver during the first year of a child's life, they develop mental representations which he refers to as 'internal working models' of human interactions and their own sense of self (Bowlby, 1969/1980).

Bowlby (1969/1980) proposed that attachment bonds have several defining characteristics, including 'separation distress', 'safe haven', 'secure base' and 'proximity maintenance' all of which are easily observable in the interaction between the infant and the caregiver. A securely attached infant tends to protest when they are separated from their primary caregiver, returns to them for reassurance during exploration and retreats back to them if they sense any risk of danger or harm. The child's desire for proximity to the primary attachment figure may vary under different circumstances, such as context, emotion, cognition, and individual differences. Bowlby (1969/1980) depicted two classes of contextual differences that contributed to activation of the attachment system in the individual: Either signalling danger or a threat for the child. There are circumstances within the child, (e.g., illness or pain) and others in the child's environment (e.g., the presence of threatening or dangerous stimuli) that may activate this system. This balance between exploration and attachment needs is considered by Bowlby (1969/1980) to be a central part of human behaviour throughout their life span.

Similarly, the child's innate and developing emotions are also strongly linked with attachment. Bowlby suggested that children are predisposed to experience positive emotions in interactions with their primary attachment figure and negative emotions when they experience loss (short- or long-term) of that attachment figure. He suggested that emotions are a vital regulatory system within the attachment relationship (1973). This relationship between attachment and emotions has received much interest from current attachment researchers (e.g., Cassidy & Shaver, 2008; Collins, Ford, Guichard, & Allard, 2006) because of suggestions that individual differences in attachment security serve as the base for how individuals respond, regulate, and communicate their emotions.

Attachment Theory also proposes that there is a cognitive element in the development of human attachment behaviour. Bowlby suggested that recurring attachment encounters will lead to the development of 'internal working models' of how to best behave/react in certain situations (for an extensive review of these models see Main, Kapland, & Cassidy, 1985). Individual difference is thought to affect the organisation of attachment-related behaviours leading to differences in the

quality of the attachment relationship (Sroufe & Waters, 1977). These individual differences are most easily detected in the balance between exploration and need for proximity to the primary attachment figure (Wienfield, Sroufe, Egeland, & Carlson, 2008). Research into Attachment Theory and concepts has become extremely diverse and extensive (e.g., Birsch, 2002; Cassidy & Shaver, 2008) but a full review of all the literature is beyond the scope of this inquiry. Thus a more limited focus is adopted here. For a more extensive overview of Attachment Theory and associated concepts see Birsch (2002), Cassidy and Shaver (2008) and Mikulincer and Shaver (2007).

One of Bowlby's colleagues, Mary Ainsworth, became instrumental in the development and recognition of Attachment Theory with her work on identifying and categorizing different types of attachment behaviour (1967, 1978). Mary Ainsworth (nee Salter) trained at the University of Toronto prior to World War II, where she was introduced to Security Theory (Blatz, 1940). One of the major concepts in this theory is that infants need to develop a secure reliance on their parents prior to exploring new unknown situations:

> *Familial security in the early stages is of a dependent type and forms a basis from which the individual can work out gradually, forming new skills and interest in other fields. Where familial security is lacking, the individual is handicapped by the lack of what might be called a secure base from which to work (Salter, 1940. p. 45).*

This quote gives some insight into her early interests and ideological beliefs. Mary, now Ainsworth, joined Bowlby's research unit at the Tavistock Clinic in 1950 to undertake work on separation and reunion. Even though Ainsworth left Bowlby's research team in 1953 to undertake a study with infant-maternal relationships in Uganda, their working relationship continued (Bretherton, 1992). After leaving Uganda in 1955 Ainsworth moved to Baltimore where she continued her studies on infants' ties to their mothers culminating in what is now seen as the 'gold standard' (Crowell & Waters, 2005) of attachment assessment: The 'Strange Situation' (Ainsworth, Blehar, Waters, & Wall, 1978).

The 'Strange Situation' is a series of three minute interactions between 12 to 18 month old infants and their primary attachment figures, developed to evaluate the quality of the attachment relationship. The experiment is conducted in a playroom filled with interesting toys to elicit exploration while the attachment figure leaves the room and a stranger appears in order to try and elicit fear or wariness on the part of the infant (Ainsworth et al., 1978). Ainsworth initially identified three distinct behavioural/attachment clusters: Secure, Avoidant, and

Resistant/Ambivalent attachment styles. In later research, a fourth behavioural cluster was suggested, known as Disorganised attachment, which represented many of the children that initially were unclassified in Ainsworth's original classification system (Main & Solomon, 1986). As a result, attachment patterns are mainly classified as one *secure* and three *insecure* patterns, with a 'standard' global distribution in non-clinical samples of 62% secure, 15% avoidant, 9% ambivalent and 15% disorganised. This distribution seems to exist across a range of cultures (van Ijzendoor & Sagi-Schwartz, 2008; van Ijzendoor & Kroonberg, 1988).

A Secure attachment style in infants is characterised by clear signals of distress when their primary attachment figure leaves the room and then reacting with warmth and joy upon the return of the attachment figure (Ainsworth et al., 1978). Secure attachment is associated with normative development and a reduced risk of adverse mental health outcomes (Cassidy & Shaver, 2008). Infants who display Avoidant attachment patterns display little or no protest during separation from the caregiver and display no direct joy upon the attachment figure's return (Ainsworth et al., 1978). Ambivalently attached children, on the other hand, tend to be visibly distressed after separation from the caregiver, fail to engage in exploration, and react with the need for closeness while simultaneously displaying aggressive behaviours upon the return of their caregiver (Ainsworth et al., 1978).

Research into attachment and psychopathology often focuses on individuals who are classified as having Disorganised attachment styles at different stages of their lives (Main & Solomon, 1986). Infants with Disorganised attachment patterns display secure behaviours upon the caregiver's return, alongside contradictory behaviour such as happily running towards the caregiver followed by a fearful response such as anger or running away. They may also display characteristics of all the other attachment styles (Main & Solomon 1986). It has been suggested that infants could find it difficult to maintain closeness to a caregiver they may find frightening or associate with fearful stimuli (Liotti, 1992). A Disorganised attachment style is often found to occur significantly more frequently in clinical samples (van Ijzendoorn, Schuengel, & Bakersman-Kranenburg, 1999). Due to this disproportionately higher percentage in clinical samples, much attention has lately been given to Disorganised attachment patterns, as it has been shown that this pattern correlates with adverse events such as neglect and various types of abuse (Holmes, 2003). It has also been suggested that Disorganised attachment is best understood as two distinct types: Disorganised-Secure and Disorganised-Insecure attachment, based on the type of attachment their behaviour most closely resembles (Lyons-Ruth & Spielman, 2004).

Research has also shown that Ainsworth's classification system is reliable from birth to six years of age (Main & Cassidy, 1988). During middle childhood (ages 7-12) peers begin to take on a more favoured role than attachment figures for most children (Kerns, Tomich, & Kim, 2006). Attachment Theory suggests that there may be a decline in the frequency and intensity of attachment behaviours during middle childhood, as the child's attachment system progresses towards greater self-reliance (Bowlby, 1982). Recent research has indicated that this is the case; children seek out their parents less, but do not perceive them to be less available and tend to turn to them for attachment needs, while their peers fill their companionship needs (Kerns, Tomich & Kim, 2006).

Adolescence is another transitional period in life; this is also the case in reference to the attachment system. Attachment Theory suggests that representations or 'internal working models' of human interactions guide our social behaviour throughout life (Bowlby, 1988). This process is thought to influence interactions in new relationships, both with peers and romantic partners as they begin to guide representations, feelings, and information processing (Bowlby, 1980). Indeed, research has indicated that there is a strong relationship between attachment styles and relationship behaviours in adolescence (Berlin, Cassidy, & Appleyard, 2008; Furman, 2001). In their study of attachment generalisation Feeney, Cassidy, and Ramos-Marcuse (2008) reported that insecurely attached adolescents may be guided by negative expectations in regards to others' good and bad intentions. Adolescents with an Anxious attachment style were more likely to strongly reciprocate negative affect, and were less likely to reciprocate positive affect (Feeney, Cassidy & Ramos-Marcuse, 2008).

Attachment behaviours in adulthood are somewhat more complicated, being influenced by variables such as resilience, stability of the family environment, loss of attachment figure, and both peer and romantic relationships (Grossman, Grossman, & Waters, 2005; Mikulincer & Shaver, 2007). However, longitudinal studies have shown that generalised models of attachment are very stable: If there is any change in attachment style it is usually associated with challenging life events, such as loss or abuse (Grossman, Grossman, & Waters, 2005). Other prominent authors in the attachment field also suggest that attachment styles can be stable over life and that change only occurs if there are significant changes in the family environment (Waters, Weinfield, & Hamilton, 2000).

A model of attachment activation in adulthood proposed by Mikulincer and Shaver (2007) suggests that activation of the attachment system in adulthood is a process of three 'if then' conditions: If threatened, seek protection and proximity; if the attachment figure is supportive and

available, relax and enjoy the feeling of being loved; and finally, if the attachment figure is unavailable, either increase attachment seeking efforts or deactivate the system and rely on yourself (Mikulincer & Shaver, 2007). These 'if then' propositions gradually become relatively stable 'internal working models' of social experiences. For example, a diary study with couples (Collins, Ford, Guichard, & Allard, 2006) found that, in line with Attachment Theory, adults tend to seek more support from their partners on days when they experience more stress.

The majority of research into adult attachment has been focused on romantic relationship dynamics (Feeney & Collins, 2001; Hazan & Shaver, 1987; Mikulincer & Shaver, 2007; Treboux, Cronwell, &Waters, 2004). Bowlby (1980) suggested that attachment bonds created in infancy laid the foundations for adults' interactions in their close romantic relationships. Hazan and Shaver (1978, 1990) were among the first to argue that romantic love could be seen as an attachment process and proposed what is often referred to as romantic attachment styles based on Ainsworth's (1978) infant attachment categories. They found that the distributions among adult attachment styles were almost the same as for children and that the difference in attachment style predicted the way individuals experienced romantic love (Hazan & Shaver, 1987, 1990).

This work into adult romantic love and attachment led to the development of a new four-group model of adult attachment (Bartholomew, 1990). Bartholomew suggests that working models of self and others can be divided into positive and negative, resulting in four different adult attachment styles: Secure, Preoccupied, Dismissing, and Fearful. Securely attached adults tend to be comfortable with intimacy and have developed autonomy. Preoccupied adults, on the other hand, tend to be overly dependent on their partner and individuals. Dismissing attachment behaviours are characterised by self-reliance and independence at the expense of intimacy. Finally, Fearfully attached adults desire intimacy and romantic love but tend to be unable to trust others often resulting in rejection and/or loss (Bartholomew & Horowitz, 1991).

Adult attachment is often measured by the Adult Attachment Interview (AAI), a semi-structured interview developed by Main, Kaplan, and Cassidy (1985). In the AAI the individual is interviewed about their general views on relationships with parents, peers, and partners. The final AAI classification is based on two scales: The 'state of mind' and the 'parental behavioural scale'. Individuals can be classified into five major classifications: Secure; Dismissing; Preoccupied; Unresolved/Disorganised; and Cannot Classify (Hesse & Main, 2000). Ainsworth's (1978) 'strange situations' classification and the AAI have been shown to be significantly related to each other by a number of researchers (e.g., Behrens, Hesse, & Main, 2007; Ward & Carlson, 1995).

Although the vast majority of work on adult attachment has been done with heterosexual adults, some recent research has investigated romantic attachment in same-sex partnerships (Kurdek, 2005; Ridge & Feeney, 1998; Wells, 2003). Results generally replicate findings from studies of heterosexual relationships. That is, they indicate that same sex partners have the same distribution and attachment styles as heterosexual partners.

Up to this point this review has considered gradual development of attachment through the life span. However, some noteworthy events have been shown to have a significant impact on the development of individual attachment. A brief review of some of these events follows.

Attachment Related Events

Positive attachment related events may be daily phenomena such as bedtime stories, warm caring embraces after a fall, or simply being available when the child is exploring his/her surroundings. However, a number of specific attachments related events have been shown to have a negative impact on the development of individuals' attachment styles (Cassidy & Shaver, 2008). Thus, a more detailed discussion of some of these events is warranted here, specifically, child abuse, parental loss, adoption, foster care, separation/divorce, and the mental health of the primary attachment figure will be explored.

Abuse

The earlier literature review has already highlighted the effects of different types of abuse on individuals' mental health, both in childhood and adulthood. This section reiterates this association and draws attention to its link with attachment (Afifi et al., 2007; Edwards, Holden, Felliti, & Anda, 2003; Everett & Gallop, 2001). The impact of severe abuse on developing attachment relationships may seem self-evident. If a growing child seeks safety and security from a caregiver only to be meet by harsh physical punishment or sexual molestation, maladaptive 'internal working models' regarding one's self, others, and the world are likely to form. Children who experience sexual and/or physical abuse are more likely to develop insecure attachment styles (e.g., Disorganised attachment) (Main & Solomon, 1986) associated with increased risk of mental health problems both in childhood and adulthood (Brown, 2009; Carlson, 1998; Cassidy & Shaver, 2008). Riggs and her colleagues (2007) found that an insecure attachment style was a significant predictor of several mental health problems including, substance abuse, anxiety disorder, and PTSD among adults who had experienced abuse during their childhood. Similarly children experiencing abuse and/or neglect often develop an insecure attachment to their care giver(s),

associated with an increase risk of childhood mental health problems (e.g., Claussen, Mundy, Mallik, & Willoughby, 2002; Shipman, Zeman, Penza, & Champion, 2000). For a comprehensive review on child abuse, neglect and attachment see Howe (2005).

Loss of caregiver

Bowlby's third volume in his trilogy addressed the psychological consequences of loss (1980). It stressed the impact on an individual's attachment systems when they are affected by death or other loss (e.g., adoption, incarceration). However, Bowlby's interest in the effects of loss of a key attachment figure began long before he wrote *Attachment and Loss* (1980). In his early work with juvenile delinquents he suggested that the loss of a key attachment figure may in fact be a predisposing factor for adolescent criminal behaviour (Bowlby, 1944).

Given the frequency at which children experience loss of a caregiver and the subsequent breaking of an attachment bond, examining potential consequences is important. A recent UK study of individuals experiencing a first episode of psychosis found that they were 12.3 times more likely to have lost their mother in childhood (Morgan et al., 2007). However, research also indicates that vulnerability to the effects of loss depends on the quality of attachment experiences prior to the loss (Crowell & Waters, 2005). Longitudinal work has shown that the loss of a parent during adulthood can similarly have problematic effects on the psychological and physical wellbeing of the individual (Marks, Jun, & Song, 2007). Given the dramatic impact death can have on an individual's wellbeing, both in childhood and adulthood, enquiring as to its occurrence may aid in assuring that best possible treatment is recommended. Death of a significant person may represent definitive loss that can be extremely difficult to replace. However, a more indefinite loss such as the effect of adoption, foster care, and institutionalised care also warrants attention.

Foster care and adoption

Many children in New Zealand and around the world are growing up in foster care or are adopted during the time that attachment bonds are formed. According to New Zealand government statistics, 5,095 children out of a population of 4 million people were in foster care in June, 2006 (Child, Youth and Family, 2006). In the United States, children in foster care exceed 420,000 (U.S Department of Human Services, 2006).

Apart from when children are placed in foster care at birth, foster care inevitably involves separation from the primary attachment figure. Even though most children placed in foster care come from a home environment of abuse and/or neglect attachment still forms within this environment and subsequently separation from a primary attachment figure can be fraught with

challenges (Mennen & O'Keefe, 2004; Pearce & Pezzot-Pearce, 2001). One study, for instance, found that children in foster care had approximately as many externalising and internalising problems as children in community mental health centers and that 70% of the children in foster care ended up having lifelong mental health problems (Stein, Evans, Mazumdar, & Rae-Gran, 1996). This is not to say that all these difficulties can be explained by Attachment Theory, and certainly an insecure attachment style is only one of various risk factors contributing to poor social adjustment and mental health problems. However, it is likely that the combination of growing up in a fearful and/or anxiety provoking environment with subsequent removal from the primary caregiver is likely to have significant effects on the developing child.

Divorce and separation

Another event that may affect attachment and is linked to poor mental health status both in childhood and adulthood is divorce and separation (Sirvanli-Ozen, 2005). Given that divorce can result in separation from at least one of the primary attachment figures, potentially disrupting that vital attachment bond, attachment related challenges can be expected. It has been suggested that the effect of divorce/separation on children is often cumulative due to a number of divorce related stressors such as financial hardship, moving school, and re-marriage, to name a few (Amato, 2000). As previously discussed in regards to loss and foster care, temporary or permanent loss of a primary caregiver at a young age can have prolonged effects on a child's development and subsequent psychological health. There are some studies indicating that divorce may be associated with positive adjustment for children (e.g., Crosnoe & Elder, 2004). However, the majority of empirical evidence indicates that divorce is in fact associated with a wide range of psychological difficulties, for example lower self esteem, conduct problems, developmental delays, and depression and anxiety problems (Feeney & Monin, 2008). Longitudinal studies have also indicated that divorce may have lasting effects, predicting poor psychological wellbeing both in adolescents and adults (Amato & Sobolewski, 2001; Wallerstein & Lewis, 2004). Given that divorce/separation is a regularly occurring event in modern society and it clearly has implications on individuals' psychological wellbeing, both in the short and the long-term, routine enquiry would ensure a more complete picture of an individual's current challenges.

History of mental health problems in a significant attachment figure

Another area worth considering is whether there could be potential consequences on the attachment relationship if the primary attachment figure was suffering from poor mental health. Links to parental mental health are frequently focused on genetics and biological predispositions. However, given that Attachment Theory assumes that children are predisposed to seek proximity

to their primary caregiver, and that this caregiver's role is to provide a 'secure base' for the child to explore the world, it is easy to appreciate how difficult it may be for a young child if their caregiver was unavailable or unable to provide this support due to their own challenges at the time.

Top-down and bottom-up studies have consistently indicated that parental psychopathology is a significant risk factor for childhood depression (Essau & Sasagawa, 2008). One recent study indicated that children of depressed caregivers are three times more likely to develop affective disorders than children of caregivers without mental health problems (Weissman et al., 2006). It has been suggested that the origins of cognitive vulnerability may lie in early attachment experiences. This has significant implications, both for research and clinical work. For an extensive review on implications see Moran and colleagues (2008).

Childhood Mental Health and Attachment Theory

As noted previously, research suggests that attachment behaviours impact on individuals' mental health during childhood and later in life (Duggal, Carlson, Sroufe, & Egeland, 2001). This impact may be even more significant if the individual is exposed to neglect, sexual, physical, or emotional abuse from their primary attachment figure (Sroufe, 2005; Sroufe, Egeland, Carson, & Collins, 2005). Several studies have indicated that attachment insecurity is only predictive of problematic behaviour in high risk samples (Belsky & Feron, 2002; Dallaire & Weinraub, 2007). However, it is important to remember that risk factors are not operating in isolation of protective factors (Rutter, 2006). Some of the more important protective factors identified by researchers include: individual factors (e.g., temperament, intelligence), ecological factors (e.g., school, SES), and the quality of the relationships with peers, parents, or other influential attachment figures (Dallaire & Weinraub, 2007; Wood, McLeod, Sigman, Hwang, & Chu, 2003).

Affective disorders

Childhood anxiety and affective disorders may, in many ways, fit the framework of Attachment Theory best as insecure mental representations of human interactions would likely lead to anxious and insecure feelings. Several studies have gone on to show this link. One of the more recent studies found that school children with insecure attachment styles are significantly more likely to receive anxiety diagnoses (Rapee, Kennedy, Ingram, Edwards, & Sweeny, 2005). Another recent study from a large, diverse sample of children indicated that children classified as Securely attached coped better with adverse events, displayed fewer symptoms of depression, and anxiety, and displayed less aggressive behaviours. However, children classified as Insecure displayed more

anxious and aggressive symptoms at four-and-a-half years of age (Dallaire & Weinraub, 2007). Research has also proposed that Insecurely attached children more frequently develop social and behavioural deficits, have problems forming and maintaining positive relationships, and have difficulty forming adaptive 'internal working models' increasing their vulnerability to depression (Rudolph, Flynn, & Abaied, 2008). Data from the Dunedin longitudinal study in New Zealand supports this argument, indicating that low perceived attachment to caregivers was linked with high levels of affective disorders, conduct disorders and inattention in adolescence (Nada Raja, McGee, & Stanton, 1992).

Externalising behaviour

Externalising problems in childhood are those that manifest as actions or behaviours readily visible to others (e.g., aggression). These have received a considerable amount of research attention in attachment research (e.g. Allen et al., 2002; Levinson & Fonagy, 2004; McElhaney, Immele, Smith, & Allen, 2006). Indeed, Bowlby's original interest in attachment began with his work with juvenile thieves (1944), leading him to conclude that the hostility, disregard, lack of empathy, and intense anger he found in many of the boys led to conduct problems and criminal behaviour. The link between insecure attachment and conduct problems can be thought of as individuals' inability to use constructive attachment strategies as they have not had the opportunity to learn such strategies. Furthermore, a number of research projects have also indicated that there is a link between adolescent attachment styles and mental health. Wallis and Steele (2001) found that adolescents requiring residential care were significantly more likely to be assessed as Insecure-Disorganised attachment style.

Substance abuse

Research has indicated that insecure attachment is associated with an increased likelihood of substance abuse in adolescence as well as later in life (McNally, Palfai, Levine, & Moore, 2003). Because these problems are over-represented within clinical populations, some argue that as many as 80% of the children in clinical settings could be classified as insecurely attached (Speltz, Greenberg, & DeKlyen, 1990; Speltz, DeKlyen & Greenberg, 1999). However, data is inconsistent and more research is needed in this area. It would therefore be far from accurate to imply that insecure attachment on its own is a form of psychopathology, though it can, in association with other external conditions, lead to mental health concerns from an early age (DeKelyn & Greenberg, 2008).

Adult Mental Health and Attachment Theory

The association between adverse childhood experiences and later utilisation of mental health services has been documented by several comprehensive reviews (e.g., Everett & Gallop, 2001; Read, Goodman, Morrison, Ross, & Aderhold 2004). The preceding discussion has illustrated how adverse childhood experiences are likely to impact on a child's attachment security and how insecure attachment styles are likely to increase the risk of developing psychiatric conditions during childhood. There are similar findings supporting the link between childhood attachment behaviours and adult mental health problems. For instance, longitudinal studies exploring the relationship between infant attachment and adult psychopathology suggest that early distortions in interpersonal experiences can place children on the path to future behavioural and emotional disturbances in adulthood (e.g., Carlson, 1998; Grossman et al., 2005).

The most influential of these studies include the Minnesota study and the Bielefeld and Regensburg studies, which together followed more than 230 children from infancy to adulthood (Grossmann et al., 2005). Findings from these studies have indicated that a variety of attachment experiences and insecure attachment styles are associated with less favourable outcomes later in life. It is therefore important to also consider specific attachment-related events in childhood and their association with adult psychopathology.

Affective disorders

Insecure attachment has been linked to affective disorders such as depression and generalised anxiety disorder (APA, 2000) in adolescence (Duggal, Carlson, Sroufe & Egeland, 2001) and in adulthood (Bifulco, Moran, Ball, & Bernazzani, 2002; West & George, 2002). Epidemiological studies have indicated that anxiety disorders are the most common psychiatric disorders in childhood and in adolescence (Fergusson, Horwood, & Lynskey, 1993). Results from the Minnesota longitudinal study indicated that insecure attachment relationships in childhood were predictive of poor peer relationships in adolescence, and increased anxiety symptoms in adolescence and adulthood. More than 100 studies have investigated the links between insecure attachment styles and depressive and/or anxiety disorders. Significant associations have been found in both non-clinical and clinical samples (for a review see Mikulincer & Shaver, 2007). Additionally, several studies have shown that the death of a parent during childhood is associated with an increased risk of developing depression later in life (e.g., Shoelson Meyers, 2005; Takeuchi et al., 2003). A recent Dutch study (Bekker & Croon, 2010) compared adult clients accessing primary mental health care with a non-clinical group. Results suggested that anxious attachment style was a particularly strong predictor of both anxiety and depression. Research has

also suggested that adults diagnosed with depression often describe their parents/caregivers as more rejecting and less supportive than individuals without diagnosed depression (Fonagy et al., 1996).

Eating disorders

Eating Disorders (EDs) (APA, 2000) are another group of clinical disorders often associated with early maladaptive attachment experiences, along with over-controlling, rejecting parents (Back, 2011). In one study 95% of individuals diagnosed with EDs were found to be insecurely attached (Ward et al., 2001). Attachment Theory would suggest that dysfunctional eating behaviours and associated difficulties in interpersonal relationships and negative self-representations stem from a history of insecure interactions with attachment figures (Cole-Detke & Kobak, 1996). Cole-Detke and Kobak (1996) suggest that behaviours associated with EDs develop as defensive methods to avoid feelings of vulnerability and helplessness. Pearlman (2005) found several commonalties in attachment experiences in her work with women suffering from EDs. She reported that many of her clients had either a mother who was anxious and unsupportive or an absent father. Many also spoke of traumatic separations from their mothers in early childhood. An added complication for many studies investigating the relationship between EDs and depression is that over half of women with EDs also report suffering from depression (Cassidy & Shaver, 2008), which still fits with Attachment Theory.

Dissociation

Some have also argued that there is a relationship between dissociation in adulthood (APA, 2000) and infant attachment style, with the strongest predictor of dissociative tendencies being a Disorganised attachment style (Lyons-Ruth, Dutra, Schuder, & Bianchi, 2006). According to Main and Hesse (1990) and Lotti (1992), dissociative tendencies are intensified by frightening or frightened caregiver behaviour during childhood, which results in disorganisation of the child's attachment behaviour, subsequently leading to dissociative disorders in adulthood. Longitudinal research has suggested that a Disorganised attachment style in particular has long-term implications for the development of dissociative symptoms later in life (Carlson, 1998). Significant correlations between insecure attachment and dissociation have also been found in a non-clinical sample (Calamari & Pini, 2003). On the whole, research into attachment and dissociation tends to support van der Kolk's (1996) hypothesis that secure attachment relationships in childhood work as a shield for individuals, protecting them from developing dissociative symptoms in adulthood.

PTSD and Psychosis

Individual differences in attachment style have also been found to play an important role in the development of post-traumatic stress disorder (PTSD) (APA, 2000). For example, several authors investigated the effects on individuals of the attack on the World Trade Center in New York in 2001. These authors found that those classified as insecurely attached suffered from more severe symptoms of PTSD (Fraley, Fazzari, Bonanno, & Dekel, 2006; Twaite & Rodriguez-Srednicki, 2004). Additionally, in recent studies, negative attachment experiences in childhood as a result of trauma and abuse (sexual, emotional, and/or physical) have been linked to the development of disorders in the schizophrenic spectrum (Janssen et al., 2004; Read, van Os, Morrison, & Ross, 2005). Compelling support for this link has been found in a large scale prospective study in the Netherlands (Janssen et al., 2004), which found that individuals who had suffered severe child abuse were 48 times more likely to develop 'pathology level psychosis' than individuals who had not been abused during childhood. Studies have also found that both positive and negative characteristics of schizophrenia (see Read et al., 2004 for a description) are associated with Insecure attachment styles (Berry, Wearden, Barrowclough, & Liversidge, 2006). A link between attachment style and 'schizophrenia' is discussed in depth by Liotti and Gumley (2008) in a recent book on psychosis, trauma, and dissociation (Moskowitz, Schäfer, & Dorahy, 2008).

Some authors go so far as to suggest that the explanation offered by Attachment Theory for how individuals develop 'internal working models' may be the best way to understand how abuse and trauma in childhood can lead to the development of psychosis in adulthood (e.g., Read & Grumley, 2008). These authors highlight meta-analytical evidence indicating that Insecure attachment patterns such as Disorganised attachment do not arise from the child's own temperament (van Ijzendoorn, Schuengel, & Bakersmans-Kranenburg, 1999) or other genetically predisposing variables (Bakersmans-Kranenburg, van Ijzendoorn, & Kroonenberg, 2004), but from interpersonal experiences such as trauma and abuse. It is argued that the latter are extremely likely to affect individuals' perceptions of themselves and others, potentially resulting in serious mental health concerns including psychosis.

Overall, research provides convincing support for the hypothesis that infant attachment and attachment-related events play a role in the development of child and/or adult psychopathology, indicating that attachment and adverse childhood experiences are very much linked. It would therefore be unwise to investigate one without also considering the other. As already discussed, although the awareness of a more bio-psycho-social approach to mental health has increased over the last century, it would be fair to say that the trend towards more psychodynamic thinking such

as Attachment Theory is still foreign to many clinicians working in mental health today. Given the arguments presented above, it is therefore necessary to consider what actually occurs in clinical practice. Do clinicians ask about these variables when they see clients in initial interviews, and if so, do they recommend treatments that may address some of these concerns? The importance of clinical enquiry practice is outlined below.

Why is it Important to Ask about Adverse Experiences in Childhood?

If we accept that there is a relationship between adverse childhood experiences and adult mental health, and that treatment is enhanced by understating the development of the presenting problem, we would expect clinicians working in mental health services to routinely elicit this information during the initial interview. Research shows that many victims of abuse are extremely hesitant to spontaneously talk about their experiences (Acierno, Resnick, & Kilpatrick, 1997; Elliott & Brier, 1994; Read, McGregor, Coggan & Thomas, 2006). There are several likely reasons for this hesitation including shame, guilt, and previous attempts of disclosure may have been ignored or disbelieved. One New Zealand study found that only 4% told someone straight away following sexual abuse, and over half (54%) took more than 10 years to disclose the abuse (Read et al., 2006). Moreover, individuals predominantly disclosed abuse to family or friends (71.6%) and only 4% reported telling a health professional first (Read et al., 2006). However, and importantly, disclosure rates increase significantly when clients were asked directly about their adverse experiences by mental health workers (Wurr & Partridge, 1996). Research has also shown that if clinicians are directed to enquire about adverse childhood experiences such as CSA and/or CPA disclosure rates increase significantly (Brier & Zaidi, 1989). It is therefore, the clinician's responsibility to ask directly about this in order to ensure accurate formulation of the aetiology of the presenting problems, which informs recommendations of best possible treatment plans and interventions.

In the late 1980's, Bryer and his colleagues pointed out the importance of initiating a discussion of abuse because failing to do so increased the likelihood of the client denying or not disclosing the reality of the incident(s) (Bryer, Nelson, Miller & Krol, 1987). However, research has found that an overwhelming majority of clients in the public mental health system were never asked about adverse experiences such as child abuse in their initial interview (Mitchell, Grindel, & Laurenzano, 1996; Agar, Read, & Bush, 2002; Read et al., 2006). When patients in New Zealand were asked about their experiences of mental health assessments, only 20% reported that they had been asked about adverse experiences in their childhood (Lothian & Read, 2002). Of equal

concern, studies have shown that when clients do disclose childhood abuse most clinicians did not take any further action (Agar & Read, 2002; Eilenberg et al., 1996; Posner, Eilenberg, Friedman, & Fullilove, 2008).

There are a number of possible reasons why clinicians might fail to ask about adverse childhood events. These have been found to include not wanting to upset the client, not knowing how to respond to the disclosure, fear of creating 'false memories', and the client's gender and age (Young, Read, & Baker-Collo, 2001). On the other hand it has been shown that the majority of the general public, in numerous countries, believe that mental health problems are caused primarily by psycho-social factors such as adverse events (Angermeyer & Dietrich, 2006: Jorm, Christensen, & Griffiths, 2005), making it likely that people may expect to be asked. Moreover, research has also shown that individuals with an abuse history who were not asked during an assessment interview reported being less satisfied with their treatment and less convinced of the accuracy of their diagnosis (Lothian & Read, 2002).

Even if enquiring about abuse during the initial interview is complicated and difficult for some clinicians, it is essential to do so in order to minimise the risk of misdiagnosis or inappropriate treatment recommendations. There are multiple implications of misdiagnosis, both for the individual and the mental health system. It is, therefore, critical to expand the research into clinicians' enquiry behaviour to ensure that best possible practice is followed.

Why is it Important to Ask about Attachment Related Events?

The aim of this review thus far has been to show that childhood experiences can play a significant role in the mental health of both children and adults. It is fair to say that awareness around the effects of salient events or experiences such as CSA and severe physical abuse has increased dramatically over the last decade or two. However, this does not appear to be the case for less salient events such as emotional abuse, loss, or less severe physical or psychological abuse, even though all of these events can have a significant impact on a developing child's attachment to their caregiver(s) and result in a range of mental health difficulties.

Attachment Theory has attracted a large amount of attention over the years. Most of this attention has been focused on classifications and research into developmental psychology, not in the diagnosis and treatment of patients in clinical practice. One of the reasons for this may be that most psychological treatments associated in any way with a psychodynamic approach to mental health went out of vogue for a long time, while medication and other more structured approaches

like cognitive behaviour therapy (CBT) (Beck, 1963,1964) and medication (Alanen, Finne-Soveri, & Leinonen, 2008; Snowden, 2011).

According to Bowlby (1988), Attachment Theory is often underutilised both in diagnosis and in the treatment of mental health problems. This sentiment has been echoed by many in the attachment field. Karl Brisch initially qualified as a psychiatrist, and then subsequently trained in psychotherapy because he found that many of his patients could not be helped by a purely medical model approach (Brisch, 2002). In his book, *Treating Attachment Disorders,* he proposed a classification scheme of attachment disorders that map onto existing attachment classifications and which can be applied throughout an individual's life. He suggested six different categories of attachment disorder: No sign of attachment behaviour; undifferentiated attachment behaviour; exaggerated attachment behaviours; inhibited attachment behaviours; aggressive attachment behaviours; and attachment behaviours with role reversal (Brisch, 2002). These categories can be mapped onto many of the existing disorders described in the DSM-IV-TR (APA, 2000). Thus, increased awareness for alternative explanations of mental health problems can be beneficial to individual clients and mental health systems. Awareness of Attachment Theory and its implications is also important for the therapeutic relationship and potential engagement in treatment, as it will help inform how clients may interact with the clinician.

Engagement

Given the current dominance of the 'medical model' in mental health, it is easy to appreciate how clinicians might interpret an individual's problematic behaviours both in childhood and adulthood as an 'illness' that can only be treated with pharmacological resources without any need for investigating further as to the reasons for the problems. If health professionals fail to enquire into an individual's history when they assess clients, they not only run the risk of misdiagnosis but may also disengage the individual from their own recovery process. In Attachment Theory psychopathology is seen in terms of difficulties in relation to others. Potential attachment difficulties are viewed as likely to have an impact on the relationship between the mental health professional and their client and the client's willingness to seek and continue treatment often depend on attachment security (Slade, 2008). Increasingly, research indicates that a secure therapeutic bond or alliance is a pivotal aspect of treatment engagement, compliance, and outcome, independent of the treatment modality (Dundon et al., 2008; Marmarosh et al., 2009).

A therapeutic relationship between the client and therapist often represents a new attachment relationship, where the therapist is frequently seen as the stronger/wiser party offering support and a safe environment to explore difficulties (Doizer & Bates, 2004). Clients who have experienced

maltreatment and consequently developed insecure attachment styles are likely to anticipate similar patterns from any new relationship, including a therapeutic relationship (Birsch, 2002; Doizer & Bates, 2004; Marmarosh et al., 2009; Pearce & Pezzot-Pearce, 1994; Sable, 1997). An objective of therapy is often to modify clients' attachment-related processes, leading to improvements in interpersonal relationships with others and 'internal working models' of self (Doizer & Bates, 2004).

Clinicians who consider attachment histories in their assessment and treatment recommendations may not only gain a better understanding of their clients' difficulties but can also aid in forming new, more adaptive ways of relating to others. Secure attachments in clients have been shown to aid in engagement and in creating a positive therapeutic alliance (Kivlighan, Patton & Foote, 1998). However, considering that most clients presenting at CMHC tend to be insecurely attached (Khaleque, 2003), it may be beneficial to examine the impact of insecure attachment on the therapeutic alliance. Findings suggest that clients with Preoccupied attachment style may experience strong fluctuations in alliance during treatment, whereas clients with Dismissing attachment styles often experience a decrease in alliance towards the end of therapy (Kanninen, Salo, & Punamaki, 2000). Therapists' own attachment security/insecurity is also likely to impact on the therapeutic relationship (Black, Hardy, Turpin, & Parry, 2005). In contrast to insecure therapists, securely- attached therapists were more likely to cope with demands of insecure clients and be more responsive to the clients' underlying needs. Conversely, therapists with Anxious attachment reported poor therapeutic alliance and more problems in therapy. In light of these findings and the previous discussion on attachment, enquiring into clients' psycho-social history and attachment relationships can ensure a more inclusive approach to assessment, minimise misdiagnosis, and increase engagement and therapeutic alliance between the clinician and the client. This will ultimately maximise the treatment benefits for the individual.

Clinical Enquiry Behaviours

As this review has shown, without asking the right questions, clients may be subject to incomplete formulation of their problems and/or not given appropriate treatment. Yet research in the area of enquiry behaviour is limited. Interest in routine enquiry for trauma and abuse is a relatively late addition to the growing body of literature investigating childhood adversities. The following section will review previous findings on clinicians' enquiry behaviour in New Zealand and internationally. These studies are summarised in Table 1.

In the late 1980's, Jacobson and her colleagues at the University of Washington examined inpatients' files to evaluate if clinicians routinely enquired about physical and/or sexual abuse during the clinical assessment (Jacobson, Koehler, & Jones-Brown, 1987). They compared information from files with information gained from research interviews with the same 100 inpatients. Only 9% of the physical or sexual abuse that was mentioned in the interviews was documented in the clients' charts. Interestingly, broken down into type of reported assault, 15% of physical assault as a child, 10% of physical assault as an adult, and none of sexual assault as an adult or child were recorded in the files. They concluded their findings by recommending that all clinicians incorporate enquiry into sexual and physical abuse history as part of their routine clinical assessment (Jacobson et al., 1987). This recommendation was made over 30 years ago, and since then several other authors have made similar recommendations (e.g., Agar, Read, & Bush, 2002; Cusack et al., 2004; Read, Hammersley, & Rudegeair, 2007; Rose et al., 1991). However, as this review will show, research repeatedly indicates that there is some resistance to enquiring about maltreatment such as sexual and physical abuse during clinical assessments.

Another early study examining initial assessment files was completed by Briere and Zaidi in the U.S. (1989). They also undertook a file review where they randomly selected 50 initial assessment files of non-psychotic patients attending emergency rooms in the US and 50 files from clinicians who had been instructed to ask about sexual abuse. Results showed that only 6% of the randomly selected sample spontaneously disclosed a history of sexual abuse. While on the other hand, 70% of the files from patients that had directly been asked about abuse reported a history of sexual abuse. These early findings highlight the importance of direct enquiry and not waiting for the client to spontaneously disclose without prompting. Other studies have also shown reluctance to disclose sensitive information such as abuse histories (Finkelhor, Hotaling, Lewis, & Smith, 1990).

At around about the same time as Brier and Zaidi's investigation (1989), Cole (1988), also in the U.S., undertook an investigation into clinical assessment procedures. In this study, the author attempted to maximise clinicians' enquiry rates by informing them of the intent of the study and giving them suggestions on how to best enquire about clients' abuse history. Data was recorded from 406 psychiatric inpatient files. Results showed that over half of the clients reported a history of sexual or physical abuse, while 25% had experienced severe or multiple forms of abuse. These rates of recorded abuse are considerably larger than many other inpatient studies conducted at a similar time (Mills, 1993; Rose, Peabody, & Stratigeas, 1991). It is likely that Cole's (1988)

attempt to maximise enquiry by educating staff about the study and how to best enquire had significant impact on the behaviour of the clinicians.

Another American inpatient study from the late 1980's by Goodwin and colleagues (1988) found that 50% of females disclosed CSA when asked compared to 10% if not asked. Other research from inpatient units in the US and the UK indicates that clinicians failed to identify many cases of abuse that were disclosed to researchers (Elliott, 1997; Mills, 1993; Rose, Peabody, & Stratigeas, 1991). One study investigating the prevalence of an abuse history at an intensive inpatient programme showed that 34% of the clients had a history of sexual abuse (of which 26% was incest) and 35% had experienced physical abuse. However, none had ever been asked about their abuse history, and among those who reported that they had spontaneously disclosed historical abuse only three had received some form of response (Rose, Peabody, & Stratigeas, 1991). Their main conclusion was to strongly encourage routine enquiry as they suggested it helped validate the individual's experiences and facilitate appropriate treatment recommendations. Another prevalence study found that 51% of clients in an inpatient unit had experienced sexual abuse. However, 56% had never been asked about abuse and only 11% reported receiving sufficient support/treatment for their abuse experiences (Craine, Henson Colliver & MacLean 1988). How, and if, clinicians respond to abuse disclosures will be discussed later.

In the UK, researchers administered a self-report questionnaire to 126 inpatients at an acute psychiatric ward (Wurr & Partridge, 1996). Forty-six percent of the entire sample reported CSA, 39% of males and 52% of females. In addition to prevalence data, Wurr and Partridge (1996) also examined the clients' case notes to see if there had been any previously documented disclosure of CSA. This file review found that only 14% of the incidents disclosed in the questionnaire had disclosures documented in their medical files. Similarly, under-reporting of CSA and CPA in medical charts was found in another study (Lipschitz et al., 1996). Lipschitz and her colleagues found that 28% of files of clients with reported CSA included written documentation, while 29% of files reported CPA (1996). This may indicate that either clients were not asked or alternatively chose not to disclose their abuse to clinicians at that time, leaving a substantial number of clients with a history of unrecognised childhood abuse.

Another study into sexual abuse assessment was a questionnaire sent to all hospitals in the U.S. that offered a psychiatric inpatient unit, asking about their current assessment practices (Mitchell, Grindel, & Laurenzano, 1996). Four hundred and sixty-six units out of 1410 approached responded, and the majority of those were adult units. Although more than two thirds of the hospitals (69%) reported that they believed that abuse enquiry ought to be included in the

admission assessments, only 43% of the sample actually included abuse in their admission assessment.

Eilenberg and colleagues (1996) in the U.S. conducted a chart review investigating how thoroughly clinicians recorded abuse histories when instructed to ask. They found that mandating enquiry resulted in a 40% identification of historical abuse. Indentified prevalence rates were slightly higher in a 10-year follow-up study (Posner, Eilenberg, Friedman, & Fulilove, 2008). These studies will be discussed in detail in the responding to disclosure section.

A New Zealand study by Read and Fraser (1998) conducted a file audit in which they reviewed 100 consecutive new admission records at an acute psychiatric inpatient unit. The unit was in the process of introducing a new admission form that included a section specifically asking about clients' abuse histories. However, the use of this form was not mandated. This section explicitly stated to record whether clients had been asked and no abuse history was noted, or if clients had not been asked. The main aim of this audit was to examine the rate of sexual or physical abuse that had occurred at some point either in childhood or in adulthood, among clients who had been asked compared to those who had not been asked. The new form was used in 53 out of 100 cases and of these 53 only 17 (32%) were asked about any potential abuse in their past. Results also showed that there was a significant difference in rates of disclosure for those who were asked on admission compared to those who were not asked (e.g., 47% of those asked disclosed CSA compared to 5.5% of those not asked). As the majority of clinicians apparently avoided asking about abuse even when the admission form specifically stated to ask, the authors concluded that some training and/or guidelines as to how to ask about abuse might be needed (Read & Fraser, 1998). These guidelines will be described in more detail later in the review.

A survey exploring clinicians' attitudes, in a teaching hospital in London, towards male sexual abuse (Lab, Feigenbaum, & De Silva, 2000) found that 33% of clinicians' never asked and 49% only asked every fourth client. Only 15.3% of the clinicians thought that males should routinely be asked about sexual abuse. However, out of these 15.3% only one clinician reported that they actually routinely asked male clients about sexual abuse. Almost 29% of nurses believed that men should always be asked, compared to 7.3% of psychologist and 4% of psychiatrists.

A study investigating what general practitioners in New Zealand (Wilson & Read, 2001) asked depressed women found that amongst the least mentioned issues asked about were abuse history, interpersonal violence, and rape (5%). However, when asked to rate the relevance of 35 known risk factors, rape and childhood sexual abuse were rated among the highest, suggesting that even if

clinicians are aware of the impact of these adverse events on individuals' mental health they seem reluctant to actually ask.

Agar, Read, and Bush (2002) subsequently undertook a study in a Community Mental Health Centre (CMHC) serving out-patients in New Zealand. The main aims of this study, similar to the 1998 inpatients study, were to investigate if clinicians working in community mental health settings asked about their clients' abuse history and, if so, how they responded to disclosures about abuse. The study audited 200 files for both sexual and physical abuse disclosures. Information was also recorded as to whether clinicians had used an admission form. Records were read in their entirety, to examine if abuse related information existed in the file prior to the current admission. Almost half (92) of the 200 files had recorded one or more form of disclosed abuse somewhere in the notes. Half-way through the period investigated, the admission form used for the initial assessment was changed to a new format including a section prompting the clinician to ask about clients' abuse history. This resulted in the identification of significantly more abuse during the initial intake assessment (Agar et al., 2002). Seventy-seven percent of clinicians who completed the admission form indicated that they had asked about abuse, identifying an abuse history in 60% of the files compared to 22% of files for those who had not used the form. Agar's research (2002) formed the basis for the current thesis as a 10-year follow-up replication project. A more detailed comparison of demographics and prevalence rates will therefore be included in the Results chapter.

In another New Zealand study (Lothian & Read, 2002), 74 members of mental health consumers' support groups were asked about their experiences during their initial assessment in a questionnaire. Almost two thirds (64%) of the participants reported that they had experienced sexual or physical abuse during their life. However, only 20% of the participants reported being asked about abuse during the initial assessment. Out of those who had experienced some form of abuse, (66%) felt uncomfortable during the assessment in a way that made it unlikely that they would disclose any form of past abuse and 53% reported feeling that their clinician had not taken careful note of their psycho-social history (Lothian & Read, 2002). There was a 'comment' section at the end of the questionnaire asking about the connection between historical abuse and mental health problems; these are a few of the quotes,

> "*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?*"

Another client said,

> "*You know there as so many doctors and registrars and nurses and social workers and psychiatric district nurses in your life asking you about mental mental mental but not asking why*"

Cusack and colleagues (2004) in the U.S. administered a brief self-report trauma screen to all 505 clients seen for an initial assessment at a CMHC during a nine-month period. Clinician's undertook a one-hour training session on trauma and PTSD, and were instructed to administer the self-report measure to all clients. They found that 91% had been exposed to some form of adverse life event, including 55% had experienced sexual abuse, 58% physical assault, and 37% had witnessed violence. They then conducted a chart review of 97 charts comparing these to the self-reported screen. Eight-six (89%) out of the 97 sampled files included trauma information. While these results are encouraging and the introduction of a trauma screen likely improved the rate of recording adverse events in files, their findings around treatment recommendations were less favourable. Their chart review found that none of the clients diagnosed with PTSD, all reporting an extensive trauma history, had a treatment plan that was focused on symptoms of PTSD.

As an extension of their trauma screen study Cusack and colleagues (2006) randomly selected 142 clients from a psychosocial rehabilitation programme at a CMHC. Clients were asked to complete a battery of self-report measures, followed by a chart review for each participant in order to investigate if disclosed trauma was documented in the client's file. They found that 87.2% of clients reported experiencing some form of trauma, including abuse, natural disasters or witnessing someone being killed. However, only 28% had these events were recorded in their medical files.

A postal survey was sent to 191 women in New Zealand who were receiving private counselling for CSA (Read, McGregor, Coggan, & Thomas, 2006). Thirty-three percent of the women had been in contact with a public mental health service and out of those only 22% reported that they had been asked about CSA. Moreover, the average time taken for these women to tell anyone about their CSA was 16 years and the most common (38%) person they confided in was another female member of the family (Read et al., 2006).

Recently, Meyer (2009) examined notes from the first four sessions of 162 adult files from three different counselling centres in Wisconsin to evaluate the extent to which clinicians (psychotherapists) used a comprehensive bio-psycho-social approach in their intake assessment. Nearly all (91%) of the clinicians had enquired about childhood abuse history and 63% about other forms of psychological traumas. These proportions are significantly higher that other reported

studies. This could partly be explained by the setting, and differences in training between psychotherapist and more medically trained clinicians. Moreover, this is a recent study and there may have been a general increases in public awareness of the effects of childhood abuse, also contributing to these high inquiry rates.

Most of these studies have focused on enquiry into historical events such as CSA. Less research attention has been given to asking about current abuse, such as inter-partner violence. A survey of American psychiatric residents found that 59% of American clinicians do not ask about domestic violence unless they suspect a problem, and an additional 15% reported not asking even when they suspect a problem (Currier, Barthauer, Begier, & Bruce, 1996). These findings suggest that reluctance to ask about adverse events may generalise across domains.

Taken all together, these findings do not paint a very reassuring picture of the enquiry behaviour of clinicians in New Zealand or internationally. One would hope that salient findings like these would have a major impact on mental health clinicians' enquiry behaviour. Despite the tide turning in the 'don't ask don't tell' atmosphere that has prevailed in mental health care for some time, there remains room for much improvement, and certainly for more research. This is especially as research into clinicians' enquiry behaviour is minimal, with only seven published studies or dissertations since 2000. While, it remains essential to continue education and research around enquiry behaviour, it is also important to understand how clinicians use information once they have asked. The following section will review research on clinicians' responses including if they identify adverse events in the formulation and recommended appropriate treatment.

Table 1. *Summary of research into enquiry behaviour***.**

Study	Country	*N*	*% F*	Main Findings
Jacobson et al., 1987	U.S.A.	100	50%	9% of identified incidents of abuse noted in file
Cole,1988	U.S.A.	406	63%	52-60% identified abuse, clinician directed to ask
Goodwin et al., 1988	U.S.A.	80	100%	50% reported SA when asked, 10% if not asked
Brier & Zaidi,1989	U.S.A.	100	100%	70% abuse noted when asked, 6% if not
Rose et al., 1991	U.S.A.	89	78%	0% asked, when asked 34% reported SA and 35% PA
Mills, 1993	U.K.	X		Most men not asked about childhood abuse
Eilenberg et al., 1996	U.S.A.	180	77%	Instructed to ask, 40% identified abuse history
Lipschitz et al., 1996	U.S.A.	120	72%	70% self-reported childhood or adult abuse
Mitchell et al., 1996	U.S.A.	466 #		43% of facilities included abuse history in assessment
Wurr et al., 1996	U.K.	133	47%	14% of identified abuse included in files
Read & Fraser, 1998	N.Z.	100	43%	82% reported abuse when asked directly
Lab et al., 2000	U.K.	111 *		15.3% routinely asked male clients about CSA
Wilson & Read, 2001	N.Z.	86	100%	Adverse events e.g., abuse and rape, only asked by 5%
Agar et al., 2002	N.Z.	200	57%	46% prevalence of CA/AA
Lothian & Read, 2002	N.Z.	74	81%	2/3 reported abuse, 20% had been asked
Cusack et al., 2004	U.S.A.	505	63%	91% self-reported trauma, 89% noted in file
Read et al., 2006	N.Z.	191	100%	22% asked, 16 years *m* time of disclosure
Posner et al., 2008	U.S.A.	107 *		Instructed to ask, 50% identified abuse history
Meyer, 2009	U.S.A.	162	38%	91% of clinicians reported asking about CA

* Participants did not indicate their gender; CA=childhood abuse; AA= adult abuse; *m*=mean; #=mental health services; x= no *n* reported

Responses to Disclosures of Adverse Events

Research is scarce into how clinicians respond to disclosures. The following section summarises existing literature (see Table 2).

None of the clients, attending an intensive case management programme, in Rose and colleagues' U.S. study (1991) had been asked directly about abuse experiences and it is unclear exactly how many spontaneously disclosed historical abuse. However, only three of those who brought up their abuse history reported being given some form of response, although none related to extra support or trauma focused treatment. The authors astutely noted in their conclusion that merely asking about abuse without follow-up facilities solves few problems. As this review will indicate, this is an ongoing challenge that has seen little improvements over the years.

Eilenberg and colleagues (1996) undertook a chart review of 180 outpatients already receiving some form of therapy at a teaching hospital in the U.S. At this location, trauma and abuse enquiry was mandated as part of the intake assessment. Thus the focus of this study was to investigate the quality of information recorded and if information was utilised in formulations and treatment recommendations. Assessments were conducted by intern psychologists, psychiatric registrars, or third-year medical students, all overseen by a senior psychiatrist. Results showed that 40% of the files had identified historical sexual or physical abuse. Out of these, 42% involved only physical abuse, and 22% involved only sexual abuse, and 8% involved some other form of abuse or trauma. A thorough description of traumatic events was recorded in 60% of the files, although, the severity and the frequency of the trauma was only recorded in 15% of the identified cases. In addition, even if trauma was identified, 56% did not include this information in the formulation or in the treatment recommendations. Trauma was simply noted in 35% of the treatment plans, without any relevant treatment recommendations. In fact, only 10% of the files that mentioned sexual or physical abuse had treatment plan recommendations that addressed their abuse history, and 5% were reported to have a 'high quality formulation'. The authors concluded that the gap between asking, recording, and actually offering appropriate treatment is large and in need of attention (Eilenberg et al., 1996).

A ten-year replication of this study was recently undertaken (Posner et al., 2008). This time, 107 files from the same clinic were audited, and interviews still conducted by trainees. They found that, in comparison to the original study, these files contained more detailed descriptions of the frequency and severity of the abuse, with 56% compared to 15% in 1996. Nevertheless, there were no significant improvements in treatment recommendations or in diagnostic formulations, indicating that the gap between identification and treatment recommendations still exists. Until the

current study this is the only published report of a prospective study designed to assess progress in clinical practice over time.

As an extension of their inpatient study on enquiry behaviour in New Zealand, Read and Fraser (1998) examined how staff responded to clients' disclosures of abuse. From the original 100 admission forms, 32 had recorded disclosed abuse. Staff responses were recorded regarding: enquiry into previous treatment, provision of counselling, or support during the stay at the unit, and if the information had been reported to legal authorities, or referred for continuing trauma/abuse counselling. Findings showed that no incidences of disclosed abuse were reported to the authorities, nor were there any reports of specific trauma/abuse focused therapy or counselling during the clients' stay at the unit. Only three of the 32 patients (9%) were referred for outpatient trauma/abuse focused therapy (Read & Fraser, 1998).

Lab and colleagues (2000) in the U.K. found that the most regular response to abuse disclosure by clinicians working in a teaching hospital was to talk to another mental health professional (59.8%), followed by a referral to community resources or refer on to an in-house psychologist (34%). Only 16.8% of the staff reported that a sexual abuse disclosure would significantly change their treatment plan, and 65.3% stated that it would 'somewhat' change their treatment plan.

Findings from the New Zealand CMHC file review (Agar & Read, 2002) described earlier, found that 32.6% of identified abuse was mentioned in the treatment plan, 36.4% included in formulations, 21.7% of clients were referred to or received some form of therapy, and 5.4% were coded as receiving trauma-related therapy. Rates were even lower for male clients or for those who had a psychotic disorder diagnosis. They also found a significant difference in recording rates dependant on profession, as psychiatrists documented significantly less abuse than other professions such as nurses, psychologists and social workers. In addition, none of the alleged offences were reported to legal authorities.

Results from Cusack and colleagues' (2004) U.S. community based study were encouraging as recording rates of disclosed trauma were in line with self-report measures. However, results were less encouraging in their 2006 study (Cusack, Grubaugh, Knapp, & Frueh, 2006) where only 28% of self-reported trauma was recorded in clients' files. In addition, their 2004 chart review found that none of the clients with an extensive trauma history and a diagnosis of PTSD had a treatment plan including specific trauma counselling. They recommended that trauma screening ought to be routine, and even if further training is needed in how to assess trauma, focus needs to shift towards training clinicians in how to treat trauma-related symptoms.

Meyer's (2009) review of notes from the first four sessions found that although 91% of psychotherapists asked their clients about childhood adversities, only 3% of the files showed some integration of the psycho-social information gathered into treatment recommendations. These findings highlight the complexity of trauma assessment and intervention, suggesting that clinicians have, over time, become more aware of the need for more comprehensive initial assessments. However, even if clinicians' make enquiry explicit, it seems unlikely to lead to comprehensive formulations or adequate treatment recommendations. Reviewed research is summarised in Table 2.

Table 2. *Summary of research into response behaviour.*

Study	Country	*N %F*	Main Findings
Rose et al., 1991	U.S.A.	89 78%	10% of identified abuse included a treatment plan
Eilenberg et al., 1996	U.S.A.	180 77%	10% of identified abuse included in treatment plan
Lipschitz et al., 1996	U.S.A.	120 72%	28% of reported CSA and of 29% CPA noted in the files
Read & Fraser., 1998a	N.Z.	100 43%	32% disclosed abuse, 9% referred for treatment
Lab et al., 2000	U.K.	111*	16.8% reported that SA disclosure would change the treatment plan
Agar & Read, 2002	N.Z.	200 57%	21.7% referred for treatment, 5.4% trauma-related
Cusack et al., 2004	U.S.A.	505 63%	0% of severe identified abuse included in treatment plan
Cusack et al., 2006	U.S.A.	142 44%	87.2% self-reported, 28% noted in files
Posner et al., 2008	U.S.A.	107 *	9% of identified abuse included in treatment plan
Meyer, 2009	U.S.A.	162 38%	3% included psycho-social information in treatment plan

* did not report gender

What Prevents Clinicians From Asking About Abuse?

To further increase the likelihood of clinicians asking about adverse events in childhood or adulthood we need to understand what barriers might prevent clinicians from asking. There are a few studies that have investigated what some of these contributing factors may be (Engel, 2008; Lab et al., 2000; Mitchell et al., 1996; Young et al., 2001).

Mitchell and colleagues (1996) found that although nurse managers at general hospitals in the U.S., identified the importance of asking about abuse, they also noted several barriers. They included: "The patient may not be willing to discuss the issue", "Staff members are uncomfortable about the topic of sexual abuse", "Discussion of sexual abuse may prolong treatment", "Staff members are inexperienced in dealing with sexual abuse", "The issue is too sensitive to raise within the first few hours of patient contact", or "This information is not necessary for treatment and stabilisation of patients". They also asked the managers how comfortable their staff felt enquiring about sexual abuse. The majority (73.8%) of respondents reported that staff felt comfortable asking about abuse. However, only 43% reported that their facility included abuse enquiry as part of the initial assessment. Although respondents in this study reported that their staff felt comfortable to discuss abuse, other studies have indicated that this is not the case (Young et al., 2001). In fact, the fear of how to ask and what to do if someone discloses abuse may prevent many mental health workers from asking (Read et al., 2007).

Other research has shown that males were being asked about abuse less frequently than females (Lab et al., 2000; Read & Fraser, 1998). The three most frequently quoted barriers for asking men about sexual abuse were: 1) Too intrusive to ask and it may obstruct engagement, or 2) it's not appropriate to ask when clients' presenting problems are unrelated to abuse, or 3) if the client is too upset or experiencing psychotic symptoms (Lab et al., 2000).

A New Zealand study (Young, Read, Barker-Collo, & Harrison, 2001), summarised responses from 51 psychiatrists and 63 psychologists as to what factors contribute to their disinclination to ask about abuse. Only 15% of clinicians reported that their workplace had a policy in place for abuse enquiry. The most frequently reported barrier for asking was: "There are too many more immediate needs and concerns". Other reasons given were: "Clients may find the issue too disturbing, or it may cause a deterioration of their psychological state", "Lack of time", "My inquiring could be suggestive and therefore possibly induce false memories", "Clients would rather be asked by clinicians of the same gender"," I am not sure how to ask appropriately", and "Abuse is of little relevance to prognosis or treatment". From these findings, the authors presented some practice guidelines for improving the enquiry rates which included asking routinely in the

context of recording psycho-social history, preferably during the initial assessment, (see Young et al., 2001 and Read et al., 2007 for a full list of their recommendations).

When Engel (2008) asked a group of obstetric nurses about barriers to asking about domestic violence when patients were admitted to hospital their responses were similar to Young et al's (2001) findings. Qualitative analysis identified seven main themes including: "It is hard to ask about abuse when patients' friends and family are with the patient", "If I ask, then what", "I am too busy to get involved", "I don't really want to know and it really is none of my business", It's not a problem here", and" It's not my job". A summary of barriers to enquiry can be found in Table 3.

Rose and her colleagues (2011) in the U.S. also explored possible barriers to disclosure of domestic violence from a client and clinician perspective. Their results further supported previous findings. Clinicians reported numerous boundaries for enquiring about domestic violence, including:"Lack of knowledge/experience about domestic violence", "Personal discomfort with the topic", "Gender", "Fear of consequences", and "Lack of confidence in approaching the topic". Clients reported barriers to discourse include: "Shame and embarrassment", "Fear of social service involvement", "Psychological distress", Fear disclosure will not be believed", and "Perpetrator's actions prevent disclosure".

These results may indicate that it is difficult to enquire about any form of adverse experience that society has conditioned us to see as a private event not to be talked about. The following sections will discuss differences in enquiry rates depending on characteristics of clinicians' or clients, current practice, and what is currently seen as best recommended practice.

Table 3: *Summary of barriers to asking and responding*

Other more immediate needs
Fear of vicarious traumatisation
Fear of inducing ‘false memories’
Not wanting to distress the client
Client being male
Client over 60 years of age
Client having a diagnosis of suggestive of psychosis
Clinician being a psychiatrist
Dominance of the medical diagnostic and treatment model
Clinician being male
Not sure how to ask or respond
Lack of training
Lack of time
Clinician uncomfortable with the topic
Too complex and issue
Enquiry not part of their role
Culture
Fear of consequences

From: Young et al., 2001; Read et al., 2007; and Rose et al., 2011

Difference in Enquiry Rates Depending on Gender, Profession, Diagnosis, and Training

Gender

Read and Agar's (2002) CMHC audit did not find a significant difference in enquiry rates depending on the clinician's gender. However, female clinicians were found to respond differently following abuse disclosures. They were more likely to include abuse-related information in the treatment plan and refer the client on for appropriate treatment. An American study found that female clinicians are more likely to detect sexual violations than male clinicians (Currier & Briere, 2000). Findings appear to be more conclusive when discussing clients' gender. Several studies have noted that male clients are significantly less likely to be asked about abuse compared to female clients (Lab et al., 2000; Mills, 1993; Read & Fraser, 1998a). Mills (1993), a nurse working in an inpatient unit with individuals admitted, was one of the first to identify this gender discrepancy. He had noticed that most of the men admitted had a history of sexual abuse that was often unnoticed, and speaking to him was the first time many of the men had disclosed their abuse history to anyone. Muenzenmaier and her colleagues' (2010) also found that childhood trauma in men diagnosed with 'serious mental illness' remain especially under assessed and identified. A New Zealand inpatient study found that only 25% of men had been asked about abuse, compared to 42.9% of women. However, this difference was not significant perhaps due to a small sample size (Read & Fraser, 1998a). These differences may in part be explained by a greater reluctance from clinicians to suspect that male clients may have been sexually abused as boys or as adults (Holmes & Offen, 1996).

Another indication of this possible bias was found in a study noting that 24 % of clinicians self-reported that they were less likely to ask a male client about historical abuse (Cavanagh at el., 2004). Even though socio-cultural discourse around masculinity varies across the world, research is predominately conducted in a western paradigm, likely influencing both clinicians' enquiry behaviour and men's inclination to disclose. In addition to gender, research has shown that males from minority ethnic groups are less likely to receive abuse-related therapy (Grossman, Sorsoli, & Kia-Keating, 2006). Overall it seems appropriate to consider gender as a risk-factor for fewer enquiries subsequently leading to more infrequent trauma-focused treatment recommendations.

Profession

Some studies have found no significant difference between professions in enquiry rates but differences in how clinicians respond to abuse disclosures (Agar et al., 2002; Agar & Read, 2002; Lab et al., 2000; Young et al., 2001). Lab and his colleagues (2000)found that overall nurses, psychiatrist and psychologist were similar in their attitudes towards asking male clients about

abuse, except that 28.9% of nurses reported that they thought males should 'always' be asked about abuse compared to 4% of psychiatrists and 7.3% of psychologists. Profession was not related to abuse inquiry in Agar's CMHC (2002) study. However, results showed that 26% of psychiatrists included abuse history in their formulations, 21% in treatment recommendations, and only 12.5% referred clients for abuse-related therapy. These rates were significantly lower that other professions (nurses, psychologist and social-workers), for 66.7% of nurses included abuse history in their formulations, 50% in treatment recommendations, and 47.7% referred clients for abuse-related therapy (Read & Agar, 2002). It may be that aetiological beliefs and the dominance of a medical-model of mental health play an instrumental role in this difference. Young and her colleagues (2001) found that self-reported intention to ask about abuse was high, but was negatively correlated with stronger adherence to a biological model of mental health. These beliefs and associated effects tend to become even stronger in relation to psychotic diagnoses (Bentall, 2003).

Diagnosis

Prior to undertaking abuse enquiry training, more that 40% of clinicians stated, that clients' diagnosis sometimes influences their decision to ask about adverse events, suggesting diagnosis such as PTSD and BPD would increase the likelihood of asking, while a diagnoses of a psychotic disorder or BPAD would decrease the likelihood (Cavanagh et al., 2004). This bias can also be seen in other findings (e.g., Agar & Read, 2002). Even though current guidelines for abuse enquiry suggest to refrain from asking individuals experiencing *acute* psychosis (Read, 2006), evidence indicates that individuals with an inactive psychotic disorder are significantly less likely to be asked or receive abuse-related therapy. For instance in Read and Fraser's (1998) inpatient study, only 5% of individuals with psychotic diagnoses were referred for trauma-related therapy, compared to 67% of those not being diagnosed with a psychotic disorder. Findings were similar in Agar and Read's (2002) CMHC study, where none of those diagnosed with a psychotic disorder had their abuse history included in the formulation compared to 48% of the rest of the sample. Biological causal beliefs remain strong, especially in relation to psychotic disorders, despite overwhelming evidence of the link between trauma and psychosis (Read, van Os, Morrison, & Ross, 2005). This likely contributes to clinicians not asking about abuse for clients who experience psychosis.

Training

In addition, research has found that even a small amount of increased training time on adverse childhood events and associated symptoms were associated with significantly higher rates of

detection during initial assessments in psychiatric emergency rooms (Cavanagh et al, 2004; Currier et al, 1996; Currier & Briere, 2000, Cusack et al., 2004). In the U.S. researchers found a significant difference between psychiatric residents that had received domestic violence-training compared to those who had not, in their ability to detect domestic violence, 88% compared to 48% (Currier et al, 1996). Moreover, clinicians the U.S. who received an hour long 'trauma orientation' lecture, including prevalence rates, effects, sensitivity of abuse assessment, and impact of abuse, where significantly more likely to detect sexual (37% vs. 14%) and psychical abuse (45% vs. 30%) compared to those who did not attend the lecture (Currier & Briere, 2000). In Cusack's (2004) CMHC study all clinicians received one hour of trauma training and were instructed to administer the Trauma-Assessment for Adults-Self-Report Version (TAA) to all clients. Results showed that 91% of clients reported some form of trauma and a subsequent chart review showed that 89% of detected trauma was identified in clients' medical-files. In another study Cusack and her colleagues (2006) did not include a training component. Clients were randomly selected from a waitlist, and asked to complete the TAA. Prevalence rates remained high (87.2%), however, only 28% of detected trauma was included in medical files. Auckland District Health Board added a new training programme in abuse and trauma inquiry in 2000. An evaluation of this programme found if to be effective in improving knowledge and confidence in abuse inquiry (Cusack et al., 2004). A brief summary of best recommended practice is reviewed next.

What is the Best Recommended Practice?

Partly as a result of the Read and Fraser (1998), Agar, Read, and Bush (2002) studies, and other international studies previously reviewed, Auckland District Health Board (ADHB) introduced in 2000 new best practice recommendations on how to enquire into clients' abuse/trauma history (Cavanagh, Read, & New, 2004). The ADHB added a section in their Manual of Mental Health Service Policy and Procedures, "Recommended best practice: Trauma and sexual abuse" (ADHB, 2000). This document states that its purpose is "To ensure that routine mental health assessments include appropriate questions about sexual abuse/trauma, and that discourse is sensitively managed" to ensure that the best possible treatment can be made available.

In 2007 the programme designers were invited to present the training programme, and the research on which it was based, in the profession journal of the U.K.'s Royal College of Psychiatrists (Read et al., 2007).

In 2008 the National Health Service (NHS) in the U.K. introduced guidelines similar to those introduced eight years earlier by the ADHB in New Zealand. Stating that "Violence and abuse is a

core mental health issue”, “All service users should be asked about abuse in assessments, after appropriate staff training, and that survivors of abuse receive appropriate care”. They listed nine suggested actions to support this policy including: Adding a specific abuse question in the assessment document “Have you experienced physical, sexual or emotional abuse anytime in your life?”, and providing “effective staff support and supervision”, “establish opportunities for staff to develop their clinical practice” (NHS, 2008).

Since the introduction of this new policy, the ADHB have mandated mental health staff to undertake a training course in how to best enquire about adverse childhood experiences. A new training programme was developed with the aim of increasing effectiveness and frequency of abuse enquiry (Young et al., 2001; Read, 2006; Read et al., 2007). This one-day programme is delivered to small groups several times a year by staff at Auckland Rape Crisis. It has now been operating in Auckland for over eight years, after a promising initial evaluation (Cavanagh, Read, & New, 2004). This training programme has been adopted by the University of Manchester and offered to early intervention teams in the Manchester area (Read, Hamersley & Rudegeair, 2007).

There are three overarching principles guiding this programme:

1) Training should be mandatory for all mental health staff,
2) Both knowledge and skills based (including role-play and research findings),
3) Take into account local conditions where it is delivered at the time.

With these basic principles in mind, eight other more specific principles form the basic outline for this programme:

1) Ask everyone, as research has shown that it does not work to wait for the client to disclose without prompting,

2) Then ask specific questions in regards to behaviours or events that may have taken place in their childhood,

3) Make sure to ask during the initial assessment,

4) Knowledge of incidence of abuse,

5) Understanding of both the short- and long-term effects of abuse,

6) Education on current clinical practice,

7) Learning how to respond to disclosure of abuse,

8) Gain awareness of how to handle vicarious traumatisation.

For a full outline of this programme see Read (2006, 2007).

In relation to the asking phase, five guiding principles are suggested:

1) Always explain to your client what will happen to the information they disclose and explain the limits of confidentiality,

2) Attempt to establish rapport prior to asking and attempt to not ask out of context,

3) If you are unable to gain information from general questions, you will need to ask more specific questions,

4) Always record reasons for not asking, and

5) Ideally all files should contain a section documenting that the client had been asked, including notes.

Although this programme stresses the importance of early enquiry, it also suggests that there are some good reasons for delaying the questions until the client is in a more stable state. Two such occasions may be if the clinician judges the client to be acutely suicidal or in a period of acute psychosis.

One reason frequently given by clinicians for not asking about childhood maltreatment is that they do not know how to respond to abuse disclosure (Engel, 2008; Young et al., 2001). Seven guiding principles on how to respond to abuse disclosure are suggested by the programme:

1) Validate the client for disclosing and recognise the importance of the client feeling that he/she is believed,

2) Offer support and treatment options (e.g., counselling) and ask about any previous disclosure and treatment,

3/4) Verify if there is any ongoing abuse and/or potential safety concerns for the client or others,

5) If your client discloses that they are currently abusing others, encourage the client to self-report or take appropriate action, and

6/7) Check on the clients' emotional state before ending the session and offer a time for them to be seen again.

In addition to detailed advice on how to ask and respond to abuse disclosures, this programme also covers issues such as how to take clinical notes, legal implications and/or obligations, understanding of cultural differences, and vicarious traumatisation of staff (Read, 2007). A evaluation was conducted following the first seven groups that had completed the training (Cavanagh, Read, & New, 2004). The majority of participants were females (73%). Participants completed an evaluation form at the end of the training and were then posted a follow-up questionnaire six weeks later. The initial questionnaire found that 94% of clinicians reported finding the training beneficial. Thirty-one clinicians returned the six-week follow-up questionnaire. Result indicated that clinicians felt more confident both in how to ask about childhood abuse and how to respond to disclosures. More than 65% also reported that the training had changed their clinical practice, including asking more frequently. A larger, more comprehensive evaluation is planned in the UK. Awaiting that evaluation data, the current programme appears to have good face validity, and to address most of the major fears described by mental health clinicians (Engel, 2008; Young et al., 2001).

This Thesis

As this review has shown, there are numerous research projects showing a significant relationship between childhood adversities and poor mental health later in life. Furthermore, experiences such as abuse and/or neglect in childhood can be initially traumatic for individuals who then often go on to endure negative consequence throughout life. As empirical evidence for this association is mounting it seems appropriate and important that clinicians working in the mental health field enquire about potential abuse and/or neglect in their clients' pasts in order to help inform understanding of their current presentation. However, there appears to be some reluctance to enquire about these experiences in mental health settings, both in New Zealand and around the world.

The primary purpose of this study was to investigate enquiry behaviours of clinicians working at four CMHCs in Auckland, New Zealand. More specifically, it evaluated: 1) Whether or not clinicians routinely ask about adverse experiences (i.e., emotional, physical, and sexual abuse in childhood and adulthood, and attachment related events such as loss of attachment figure and adoption) during the initial interview; 2) whether these factors were considered in psychological formulations and treatment recommendations; 3) whether there are any specific characteristics of the client or the clinician that impact on the rate of enquiry; and finally 4) to ascertain whether there had been any significant change in the rates of enquiry since a similar study was undertaken in 1997, since when the mediating training programme just described has been in place.

CHAPTER THREE: METHOD

Rationale for Methodology

A file audit was selected for this project for several reasons. First, the main focus of this project was to investigate the extent to which mental health professionals (i) enquire about and document clients' psycho-social histories, (ii) document and recommend treatment plans in response to identified abuse histories, and (iii) enquire and document attachment relationships and attachment-related events in the psycho-social history of their clients. This information is best gathered by reading and recording information mental health professionals actually document. Given that electronic files are currently the main source of documentation utilised by clinicians working within Auckland District Heath Board (ADHB), auditing information in these files was an obvious methodology to employ. Another aim of this study was to compare current enquiry rates with a similar study carried out ten years ago (Agar, Read, & Bush, 2002). Thus, adopting a comparable methodology was desirable. Moreover, in order to gain statistical power to detect significant statistical differences a relatively large sample was needed, limiting the use of other research methods. Thus, a file audit was judged to be the most appropriate approach for this study.

Procedure

Consultation

Three preliminary meetings were held with senior clinicians and management at the proposed site for data collection which was one of the four CMHCs involved in the study. These meetings were to discuss logistics, explain rationale for the study, respond to any questions and/or concerns, and seek endorsement for the study. The consultation process was then repeated with ADHB management, who represented all four CMHCs. In addition to our own requirements, staff and management were asked if there was any information they would require from the files for their own interests, which would be able to be collected simultaneously with data for this study. They asked to have data regarding adoption and divorce included.

Ethical approval

Accessing personal information from medical records in New Zealand is legally protected by the Health Practitioners Competency Assurance Act 2003 (HPCA), the Privacy Act 1993, and the Official Information Act 1982. However, the Official Information Act 1982 also states that information can be used for educational and research purposes as long as all information is kept anonymous. Ethical guidelines for research in New Zealand suggest that audits and observational studies are distinguished from interventions and experimental studies in regards to relevant ethical characteristics. As in both audits and observational studies the researcher has no control over the outcome, they merely record outcomes. These types of research projects are deemed appropriate for expedited ethical approval. This process included supplying documentation such as project protocol, data collection form, storage procedures of confidential information, budgetary requirements, and any possible risks and benefits to the project participants. Ethical approval for this study was obtained from ADHB, the Northern Y Regional Ethics committee, and the University of Auckland. This study was approved until the 30 of December 2011, Ethics Ref: NTY/09/51/EXP.

Development of recording instrument

A data collection form was developed specifically for this study. The form was amended several times during the consultation process. The main aim was to capture a range of information about the Initial Assessment (IA) and information that was recorded in the file prior to and after the IA. Initially, a copy of the recording instrument utilised by Agar and her colleagues (2002) in a similar study ten years ago was obtained. Variables from that recording instrument functioned as a platform for the development of a recording instrument for this project. It was deemed vital to capture similar variables as the preceding project as one of the main aims of this study was to investigate if enquiry rates had changed since the last study was carried out. This original form was then added to by the researcher, her supervisor, ADHB staff, and the management at the CMHCs to address a more comprehensive set of variables often researched in the abuse and attachment literature. A more detailed description of the final version of the instrument follows (see Appendix A for a copy).

Data collection

Electronic files for 250 individuals were read in their entirety by two researchers, the principle investigator and her thesis supervisor (Professor Read). Both researchers signed a confidentially agreement with ADHB and were subsequently granted access to ADHB's electronic clinical information system operating under the name of Health Care Community (HCC). Both researchers were granted "break glass" access, allowing them to read closed files. The principle investigator read and coded, 238 (95%) of the files. It took, on average, 140 minutes to read and record information from each file, (representing a total of 580 hours). All data was collected at one site, utilising ADHB's computers to access records from all four CMHCs.

Data entry

All data was transferred from the manual data collection form into a SPSS v17.0 data file by the primary researcher for analysis. A portion (15%) of randomly selected files were doubled keyed (entered a second time) to avoid data entry errors. There was over 99.9% agreement in data entry. Errors noted were double checked in the hard copy file and revised.

Sample

A sample of 250 adult consumers' (18 years of age and over) electronic files from four New Zealand urban CMHCs were drawn from a large computer generated pool of 850 potential files, supplied by ADHB's IT department. Files were generated at random, with a requested exclusion criteria of: Files opened prior to the 1st of January 2001 or after the 1st of June 2009, or files that had been active in the system for three days or less. Files prior to the 1st of January 2001 were excluded to avoid sampling the same records as a previous study (Agar, Read, & Bush, 2002). Files opened after the 1st of June 2009 were excluded as staff at all four CMHCs had been informed about this project by then, possibly influencing clinicians to enquire, record, or recommend treatment more frequently than usual. After consultation with CMHC's management it was agreed that files that had been active in the system for three days or less were very unlikely to include any face-to-face contact or an IA, thus these were excluded in the initial list of potential files. During the data collection process it was found that several files dated back prior to the 1st of January 2001. In these cases, files were closed and no information was recorded. Both currently open and closed files were included in this initial list. However, no information from currently open files that was recorded in HCC after the 1st of June 2009 was included in this study.

Additional exclusion criteria were added at the time of reading including: Files without any face-to-face contact, or when the only face-to-face contact was in a crisis situation (e.g., at a police station), or when the only face-to-face contact was with non-CMHC staff. For ethical reasons a final exclusion criteria was added. It was agreed that if either of the investigators were to encounter the file of a family member, personal friend, or acquaintance they would exit that file and pass it on to the other researcher, or exclude the file where it involved an individual known personally by both researchers. This final exclusion criterion was only employed in one instance. The sample was set at 250 to attain satisfactory statistical power in all cells for different sub-types of abuse, gender, diagnosis, attachment variables, et cetera during analysis. A total of 391 files were accessed to reach the desired sample size, with 141 excluded based on the exclusion criteria.

General Information

Demographics

Demographics recorded were age (at assessment), gender, ethnicity, marital status, employment status, and level of education.

Assessment date and duration of engagement with CMHC

The date of the Initial Assessment (IA) was recorded so that no IA prior to the 1st of January 2001was included, to ensure that we did not resample the same files as previously audited. Data was also collected to determine how many individuals had had an IA within three face-to-face meetings. If a file had more than one IA, the first IA after the 1st of January 2001 was used in the data collection process. Information from subsequent IAs was recorded as post-IA information. The number of days each file had been open was supplied by ADHB's IT department. This was calculated from the date of the first entry in the electronic files after the 1st of January 2001 to the cut-off date for data collection (1st of June 2009). However, it was discovered during data collection that the number of days that each file had been open as reported by the electronic files was unreliable. This electronic system begins re-calculating days open, as day one, each time a file is closed. For example, several files stated that they had been open for less than ten days, while in fact that client had been a service user of the CMHC for several years. One reason for closing a file is when a client relocates and subsequently becomes a client of a different CMHC still within ADHB. Due to the inconsistency in the recording of duration of engagement it was decided that we would abandon collecting this data during the audit. In an earlier study duration

of engagement was used as a mean to establish severity of presentation. Severity was gauged by other measures in this study, such as diagnosis and the number of psychotropic medications prescribed.

Diagnosis at assessment

For the purpose of this study, broad categories were created to record the primary diagnosis at the IA, such as 'Depression'. Included under this category were diagnoses recorded in the files as major depressive disorder, major depressive episode, depression, mood disorder, reactive depression, postnatal depression, dysthymic disorder, dysthymia, depressive disorder not otherwise specified, and mood disorder due to a general medical condition. A specific category was created for Bipolar Disorders including disorders recorded as bipolar disorder, BPAD, bipolar depression, and bipolar recurrent manic episode. The category of "Anxiety Disorders" included panic attacks, any type of panic disorder, any phobia, obsessive-compulsive disorder, and any type of anxiety disorder. A specific category was created for Post-Traumatic Stress Disorder (PTSD). Disorders categorised as a "Psychotic disorder" included schizophrenia, psychosis, schizoaffective disorder, delusional disorder, brief psychotic episode, and psychotic disorder not otherwise specified. Substance-related diagnoses such as substance dependence, alcohol abuse, substance induced mood disorder, and poly-substance dependence/ abuse were recorded in a separate category. A residual category named 'Other' was created for diagnoses not suitable for recording under any of the previous categories. This included eating disorders, a primary diagnosis of an axis II or III disorder, sexual or gender disorders, dissociative disorders, and sleep disorders. Many files had multiple diagnoses recorded in the notes from the IA, and some had up to five diagnoses recorded.

Five axis DSM diagnosis

The DSM system of diagnosing (APA, 2000) suggests that mental health professionals assess the individual's presenting problem(s) on five separate axes, including clinical disorders (Axis I), personality disorders (Axis II), general medical conditions (Axis III), psycho-social and environmental problems (Axis IV), and a global assessment of functioning (GAF) (Axis V). Information was recorded as to the extent to which mental health professional had recorded a separate DSM-IV-TR diagnosis (APA, 2000) in the records, and if so, if they had recorded information on all five axes. Information from each axis was recorded separately, as it appeared in the file.

Medication

Recorded information regarding psychotropic medication was included if the individual had been prescribed any medication prior to or subsequent to the IA, as well as the number and type of medication prescribed. Up to six different medications were recorded.

Risk

Level of risk was recorded under two separate headings. First, suicide attempts were categorised as documentation of any previous attempts or documentations of multiple attempts. Secondly, information was drawn from ADHB's electronic risk assessment form. It is obligatory for mental health professionals to complete this form as part of an IA. In this form risk is classified as 'low', 'medium' or 'high' in two sub-categories "risk to self" and "risk to and/or from others".

Gender and profession of mental health worker

Gender and profession of the mental health worker conducting the IA was recorded. Gender was assumed on the basis of the clinicians' name. If the name recorded in the file appeared ambiguous, management was approached for clarification. In those instances where there was no recorded IA, details for the key worker assigned to the individual during the first three face-to-face assessments were recorded. An 'unknown' category was used when there were no details in the file indicating gender and/or profession.

What Mental Health Workers Recorded

For operational definitions of childhood sexual abuse, childhood physical abuse, childhood physical neglect, childhood emotional abuse, childhood emotional neglect, adult sexual abuse, adult physical abuse and/or neglect, and adult emotional abuse and/or neglect for this study see Chapter One. However, as all the information collected for this study was gathered by reading computerised medical records it was decided that whatever the client and/or the mental health worker considered as abuse in the records was deemed sufficient. For example, medical records stating "sexually abused as a child" or "client reported frequently being physical assaulted by her ex-husband" were recorded as abuse having occurred.

Childhood and adulthood abuse

Information regarding how individuals' abuse history had been recorded was captured in several ways:

1. Whether one of ADHB's standard computerised IA forms (CMHC Initial Assessment (CMHCIA) or Core Adult Assessment (CAA), (CAA is an updated version of CMHCIA) had been used, and if so, whether or not the abuse section had been filled out. The CMHCIA form has specific 'tick boxes' for physical, sexual, and emotional abuse. The CAA also provides a 'tick box' for neglect and family violence. Both forms provide a large space for documenting more detailed information regarding current and historical abuse and/or neglect.

2. Records indicating whether the mental health worker had asked about the individual's abuse history. Any supportive information such as "denied any childhood abuse" or any type of documentation regarding abuse were recorded as evidence that an abuse history was taken. Due to the nature of this audit it was deemed inappropriate to attempt to evaluate whether clients had spontaneously disclosed abuse or if they had been prompted. Files without any written information or statements such as "not asked about past history during this interview" were recorded as "no abuse history taken". If clinicians had documented an explanation as to why they had not asked about their client's abuse history at that specific time this information was also captured, for example, "client too distressed to discuss his/her past". The location of recorded abuse history was divided into three sections: In the IA notes, in notes prior to, or following the IA.

3. Types of individual abuse were recorded under the following categories: Childhood sexual abuse, childhood physical abuse, childhood physical neglect, childhood emotional abuse, childhood emotional neglect, adult sexual abuse, adult physical abuse and/or neglect, and adult emotional abuse and/or neglect (for adults, physical and emotional abuse and neglect were recorded under the same heading).

4. Information regarding duration, perpetrator, age the abuse commenced, other documented details about the abuse (such as type of sexual abuse, i.e., penetration, oral, touching, non-contact) and severity of physical abuse (e.g., by hand, tool used, medical attention) was also recorded.

Previous disclosure

Recorded information around previously disclosed childhood and/or adulthood abuse included: Any recording of previous disclosure; any previous response to disclosure (e.g., supportive, unhelpful, and/or referred); if the individual had received any previous abuse-related treatment prior to engaging with the CMHC (privately or publicly founded).

Current disclosure

Information regarding mental health workers' responses to identified abuse histories were recorded in several ways:

1. Whether or not the abuse was mentioned in their formulation.
2. Information indicating that the identified abuse had been included as part of a treatment plan. However, there were no attempts made to record the amount of treatment individuals received or what type of treatment was recommended as it was deemed out of the scope of this project.
3. Information indicating that the client had been referred for abuse-related treatment beyond the CMHC e.g., Accident Compensation Claim (ACC), (a publicly founded insurance policy providing some funding for sexual abuse claims in New Zealand).
4. Information indicating that the client had been asked if he/she thought that there was any connection between their psycho-social history and them presenting at a CMHC.
5. Whether or not the abuse had been reported to the police or other authorities, or if there had been any recorded discussion of the possibility of such reporting.

Alcohol and drug abuse

Information indicating that individuals had been asked about their alcohol and drug use was recorded in three categories: At the IA, prior to the IA, and after the IA. Additional information recorded included type of substance (e.g., alcohol, cannabis, prescription medication) and if the mental health worker had deemed the level of consumption as problematic at the time of assessment.

Attachment information

Information recorded regarding individuals' attachment history included:

1. Whether or not individuals were asked about their relationship with their parent(s)/caregiver(s) prior and after 18 years of age. Responses were divided into four main categories: close/secure relationship, close to one parent/caregiver but conflictual with the other(s), conflictual, estranged from parent(s)/caregiver(s), and not asked. There was no attempt made to evaluate specific attachment styles as this was deemed impossible to infer from written records alone.
2. Whether individuals were asked about attachment related events (see point 3). The point of information-collection about attachment related events was divided into three categories: At IA, prior to, or subsequent to the IA.
3. Information about specific attachment-related events was divided into: Experienced prior to 18 years of age, and/or experiences subsequent to 18 years of age. Specific attachment-related events recorded were: Death of caregiver/parent, adoption or foster care, separation or divorce, recorded history of mental illness of a parent/caregiver, recorded history of alcohol and/or drug abuse of a parent/caregiver, domestic violence, bullying, poverty, or any other adverse events (e.g., loss of a sibling) recorded.

Inter-Rater Reliability

In some files information suggestive of abuse and/or neglect was deemed inconclusive by the researcher who initially read the file. In these incidents exact quotes from the file were recorded verbatim as well as other information, such as the frequency of this information in the file. These files were then coded as 'uncertain'. All 'uncertain' files were then rated independently by both researchers for the probability of abuse or neglect being experienced. A similar rating system used by a previous file audit was adopted (see Agar, Read, & Bush, 2002 for a more detailed description). For a case of possible abuse or neglect to be included in the statistical analysis both researchers had to rate the case as '95% or more probable' to have occurred. This rating was done independently. If one of the researchers rated the case as less than 95% likely to have occurred, that case was entered as "no abuse or neglect noted". Thirty-two files were recorded as 'uncertain' (12.8% of the total sample). Overall the researchers were in agreement in 29 cases (Inter–Rater Reliability (IRR) = 91%, $\kappa = 0.81$). Out of the 32 cases coded as uncertain, 14 (44%) were rated as 95% or more likely by both researchers and consequently coded as "yes, abuse or neglect was noted". Fifteen (47%) cases were rated as less than 95% likely by both

researchers and consequently coded as "no abuse or neglect noted". In the three (9%) cases where there were disagreements cases were also coded as "no abuse or neglect noted".

An example of a case where abuse was rated as less than 95% likely to have occurred by both researchers was a file stating, "violent and abusive father". This information was deemed vague as one could not be certain that the father was violent and abusive to the client. Another file in the same category stated, "reported traumatic childhood". Examples of cases rated as 95% or more likely to have occurred by both researchers stated, "father began to drink heavily and took up the use of severe and frequent corporal punishment", and "made to watch sexual activities as a child". One example of a case where the two researchers disagreed in their rating was a file stating "traumatic childhood, fostered at four due to familial alcoholism". Only one researcher had rated this file as '95% probable' for emotional and/or physical neglect, and it was therefore excluded.

Data Analysis

Analysis of data for this study was quantitative. Both continuous and categorical data were examined. For analysis of categorical data, the Chi-Square test of independence was used. This test investigates if there is any statistically significant difference between proportions. Continuous data was analysed by independent sample t-tests (two-tailed) and a repeated measure of analysis of variance (MANOVA). T-tests are used to investigate if there were any statistically significant differences between two independent means. A MANOVA made it possible to examine if there was any significant main effect or interactions between several variables, while saving statistical power. For example, do some professionals (psychiatrists versus. psychologists) enquire about abuse more than others, and if so, does this depend on any client characteristic such as age, gender, and/or diagnosis? Results were considered to be statistically significant if the p values were less than or equal to .05.

CHAPTER FOUR: RESULTS

This chapter will report the results of the file audit, including prevalence rates for childhood and adult abuse and neglect, enquiry rates, response to documented abuse, comparisons of the present data to the last audit (Agar et al., 2002), and will conclude with case examples of commendable, and less than optimal, practice. Information regarding individuals' abuse/neglect and attachment history has been captured in different ways including: (i) Recorded prevalence rates of individual abuse/neglect and attachment related events; and (ii) any records indicating that the clinician had asked the individual about their abuse /neglect history, alcohol and drug use, and their relationships with their caregivers. A more detailed description of the difference between recorded prevalence rate and records indicating that the clinician had asked about adverse experiences can be found in Chapter Three. In addition, the rate of completion of standard computerised assessment forms was recorded. For all results potential effects of ethnicity were analysed for New Zealand European, Māori, and Pacific Island clients (due to small numbers in other ethnic groups). Thus, the total sample size for ethnicity calculations is 236 not 250.

Sample characteristics

The sample characteristics are summarised in Table 4. Of the 250 files, 77 (30.8%) came from one CHMC, 70 (28.0%) from a 2nd, 54 (21.6%) from a 3rd, and 49 (19.6%) from the 4th. 125 (50%) were men and 125 (50%) were women. The mean age across the sample was 35.6 years of age with a standard deviation of 12.3 years. One hundred and thirty nine individuals (55.6%) were identified as New Zealand European, 60 (24%) were Māori, 22 (8.8%) were Pacific Islanders, and 28 (11.6%) were classified as 'Other'. Information regarding ethnicity was not recorded in one (0.4%) file. One hundred and twenty six individuals were identified as single (50.4%), 46 (18.4%) as married, 38 (15.2%) as separated or divorced, 37 (14.8%) were in a de-facto relationship, 2 (0.8%) were widowed, and this information was unavailable in one (0.4%) file.

The majority of individuals were described as unemployed 131 (52.4%), followed by 74 (29.6%) employed full-time, 23 (9.2%) part-time, and 20 (8%) were described as students. Information regarding employment status was not recorded in two (0.8%) files. Sixty-five (26%) individuals were identified as having no formal qualifications, 44 (17.6%) as having qualifications sufficient for university entrance, 31 (12.4%) had achieved School Certificate (lowest recognised high

school qualification in New Zealand), 42 (16.8%) had a University Degree or Diploma, 8 (3.2%) had a Trade Certificate, four (1.6%) had a Masters degree, and one (0.4%) had a Doctoral qualification. Level of education was not recorded for 55 (22%) individuals.

Primary diagnosis at the Initial Assessment (IA) were most frequently depressive disorders, for 88 individuals (35.2%), followed by psychotic disorders for 64 (25.6%), bipolar affective disorder for 27 (10.8%), substance abuse for 14 (5.6%), anxiety disorders for 13 (5.2%), and post-traumatic-stress disorder for nine (3.6%), 16 (6.4%) individuals were classified as 'Other'. There was no diagnosis documented for 19 (7.6%) individuals (see Table 4). In many cases individuals had been given more than one diagnosis. Thus, statistical analyses were conducted on more than one and/or multiple diagnoses. In 217 (86.5%) of the files an IA was conducted within three face-to-face meetings. This was not the case in 33 (13.2%) of the files.

For 155 (62%) of the files, the primary mental health professionals conducting the IA were female and in 92 (36.8%) of the cases they were male. This information was unclear in three (1.2%) files. One hundred and eighty seven (74.8%) IAs were conducted by psychiatrists, 50 (20%) by CHMC nurses, seven (2.8%) by psychologists, two (0.8%) by psychotherapists, one (0.4%) by an occupational therapist, and one (0.4%) by a social worker. Information regarding profession was unclear in two (0.8%) of the files (see Table 5).

Table 4. *Sample characteristics*

	N (250)	Weighted% or M (SD)
Gender		
Men	125	50%
Women	125	50%
Age		35.6 (12.3)
Ethnicity		
New Zealand European (NZE)	139	55.6%
Māori	60	24%
Pacific Islander (PI)	22	8.8%
'Other'	29	11.6%
Marital status		
Single	126	50.4%
Married	46	18.4%
Separated/divorced	38	15.2%
De-facto	37	14.8%
Widowed	2	0.8%
Unknown	1	0.4%
Education		
No-formal qualification	65	26.0%
School Certificate	31	12.4%
University entrance (UE)	44	17.6%
Trade Certificate	8	3.2%
University degree or diploma	42	17.6%
Masters degree	4	1.6%
Doctoral qualification	1	0.4%
Unknown	55	22.0%
Employment status		
Full-time	74	29.6%
Part-time	23	9.2%
Unemployed	131	52.4%
Student	20	8.0%
Unknown	2	0.8%
Primary diagnosis		
Depressive disorder	88	35.2%
Psychotic disorder	64	25.6%
BPAD	27	10.8%
Substance abuse	14	5.6%
Anxiety disorder	13	5.2%
PTSD	9	3.6%
Other	16	6.4%
No diagnosis	19	7.6%

Table 5. *Characteristics of clinicians conducting IAs*

	N (250)	Weighted %
Gender		
Male	92	36.8%
Female	155	62.0%
Unknown	3	1.2%
Profession		
Psychiatrist	187	74.8%
Nurse	50	20.0%
Psychologist	7	2.8%
Psychotherapist	2	0.8%
Occupational therapist	1	0.4%
Social worker	1	0.4%
Unknown	2	0.8%

IA= Initial assessment

Recorded Abuse and Neglect Prevalence Rates

Overall rates

Of the 250 files examined, 233 (93.2%) had some form of abuse, neglect, and/or attachment-related event documented. One hundred and sixty (64.0%) files had some form of adult or childhood abuse or neglect recorded. One hundred and eighteen files (47.2%) had multiple forms of childhood and /or adult abuse and neglect noted. Examining rates in relation to age, gender, and ethnicity was accomplished using Chi-Square and t-test, with findings presented in Table 6. Females were significantly more likely to have abuse or neglect recorded in their files compared to men (χ^2 (1) = 12.8, p<.001). There were significant differences in abuse rates dependent on ethnicity. There were no significant differences in recorded abuse rates by age. However, prevalence rates for abuse and neglect increased significantly when clients were asked about abuse and neglect, from 64% prevalence in all files to 86.5% (χ^2 (1) = 7.56, p<.01) in files indicating that clients had been asked. Among those 34.8% of files that had no indication of any enquiry, abuse and neglect prevalence rates reduced to 17.2 %.

Table 6. *Recorded prevalence rates for multiple forms of childhood and adult abuse/neglect with significant differences for gender and ethnicity*

	N	**1 or more**	2 or more	3 or more	4 or more	5 or more	6 or more	7 or more	8
All	250	**160 (64.0%)**	118 (47.2%)	82 (32.8%)	53(21.2%)	33 (13.2%)	22 (8.8%)	11 (4.4%)	2 (0.8%)
Gender									
Female	125	**96 (76.8%) *** **	75 (60.0%) ***	61 (48.8%) ***	39 (31.2%) ***	30 (24.0%) ***	20 (16.0%) ***	11 (8.8%) **	2 (1.6%)
Male	125	**64 (51.2%)**	43(34.4%)	28 (22.4%)	14 (11.2%)	3 (2.4%)	2 (1.6%)	0	0
Ethnicity									
NZE	154	**97 (63.0%)**	72 (46.7%)	51(40.8%)	29 (18.8%)	15 (9.7%)	10 (6.5%)	5 (3.2%)	1 (0.6%)
Māori	60	**43 (71.7%)**	33 (55.0%)	29 (48.3%) **b	18 (30.0%) **a	12 (20.0%) ***a	8 (13.3%)**a	4 (6.7%)	1 (1.7%)
PI	22	**14 (63.6%)**	10 (45.5%)	7 (31.8%)	7 (31.8%) **a	5 (22.7%) ***a	4 (18.2%) ***a	2 (9.1%) ***a	

NZE = New Zealand European, PI = Pacific Island, * = p < .05. ** = p <. 01. *** = p <.001, *a=compared to NZE, b= compared to PI*

Childhood abuse and neglect

As seen in Table 7, 141 (56.4%) files had some form of childhood abuse or neglect recorded. Eighty-one (32%) files had childhood sexual abuse documented, 91 (36.4%) had childhood physical abuse documented, 88 (35.2%) had childhood emotional abuse documented, 22 (8.8%) had childhood physical neglect documented, and 55 (22%) had childhood emotional neglect documented.

Female clients were significantly more likely than male clients to have childhood sexual abuse (χ^2 (1) = 17.55, p<.001), emotional abuse (χ^2 (1) = 4.49, p=.034), physical neglect (χ^2 (1) = 6.08, p=.048), and emotional neglect (χ^2 (1) = 5.24, p=.022) recorded in their files. There was no significant difference in the recorded rate of childhood physical abuse between female and male clients (p>.05). Clients identified as Māori were significantly more likely to have experienced all recorded forms of childhood abuse and neglect compared to clients identified as New Zealand European and/or Pacific Islanders (see Table 7).

As seen in Table 8, more than a third of the 250 files (38.4%) had two or more forms of childhood abuse or neglect recorded. Seven files (2.8%), all females, had all five forms of childhood abuse/neglect documented. Females were significantly more likely than males to have two or more forms of childhood abuse/neglect recorded in their files (χ^2 (1) = 8.42, p=.01). Clients identified as Māori were also significantly more likely than New Zealand European and Pacific Island clients to have two or more and three or more forms of childhood abuse/neglect recorded in their files.

Table 7. *Recorded prevalence rates of childhood abuse and neglect with significant differences reported for gender and ethnicity*

	N	**Any Childhood Abuse/Neglect**	Childhood Sexual Abuse	Childhood Physical Abuse	Childhood Emotional Abuse	Childhood Physical Neglect	Childhood Emotional Neglect
All	250	**141 (56.4%)**	81 (32.4%)	91 (36.4%)	88 (35.2%)	22 (8.8%)	55 (22%)
Gender							
Female	125	**82 (65.6%)** **	56 (44.8%) ***	49 (39.2%)	52 (41.6%)*	16 (12.8%)*	35 (28%)*
Male	125	**59 (47.2%)**	25 (20%)	42 (33.6%)	36 (28.8%)	6 (4.8%)	20 (16%)
Ethnicity							
NZE	154	**84 (54.5%)**	43 (30.9%)	49 (35.3%)	50 (36%)	10 (7.2%)	28 (20.1%)
Māori	60	**41 (68.3%)** *b	27 (45%) **a	28 (46.7%) **a	25 (41.7%) **b	8 (13.3%) *c	17 (28.3%) *b
PI	22	**11 (50.0%)**	6 (27.3%)	7 (31.8%)	5 (22.7%)	2 (9.1%)	4 (18.2%)

NZE= New Zealand European, PI= Pacific Island, *= p < .05. ** = p <. 01. ***= p<.001. , *a= compared to both NZE and PI, b= compared to PI, c= compared to NZE*

Table 8. *Recorded prevalence rates of multiple forms of childhood abuse and neglect with significant differences reported for gender and ethnicity*

	N	**1 or more**	2 or more	3 or more	4 or more	5 forms
All	250	**141 (56.4%)**	96 (38.4%)	57 (22.8%)	36 (14.4%)	7 (2.8%)
Gender						
Female	125	**82 (65.6%) ****	58 (46.4%) **	35 (28.0%) *	25 (20.0%) ***	7 (5.6%) *
Male	125	**59 (47.2%)**	38 (30.4%)	22 (17.6%)	11(8.8%)	0
Ethnicity						
NZE	154	**84 (54.5%)**	57 (37.0%)	33 (21.4%)	22 (14.2%)	4 (2.6%)
Māori	60	**41 (68.3%) **b**	30 (50.0%) *a	19 (31.6%) *a	11 (18.3%)	3 (5.0%)
PI	22	**11 (50.0%)**	6 (27.3%)	14 (18.2%)	3 (13.6%)	0

NZE = New Zealand European, PI = Pacific Island, *= p < .05. ** = p <. 01. ***= p<.001, *a= compared to both NZE and PI, b= compared to PI*

Adult abuse and neglect

As seen in Table 9, 88 files (35.2%) had some form of adult abuse or neglect recorded. Thirty-six (14.3%) clients had adult sexual abuse documented, 61 (24.4%) had adult physical abuse or neglect documented, and 54 (21.6%) had adult emotional abuse or neglect documented. Chi-Square (χ^2) tests found that all recorded rates of adult abuse and/or neglect were significantly higher for females than for males (e.g., any adult abuse rate, ($\chi 2$ (1) = 120.77, p< .001)). Pacific Island clients were significantly more likely to have experienced adult physical and emotional abuse and neglect compared to both New Zealand European and Māori clients. There were no significant differences in recording rates of adult abuse and/or neglect depending on age.

Table 9. *Recorded prevalence rates of adult abuse and neglect with significant differences reported for gender and ethnicity*

	N	**Any Adult Abuse/neglect**	Adult Sexual Abuse	Adult Physical Abuse/ neglect	Adult Emotional Abuse/ neglect
All	250	**88 (35.2%)**	36 (14.3%)	61 (24.3%)	54 (21.5%)
Gender					
Female	125	**70 (56.0%) *****	32 (25.6%) ***	52 (41.6%) ***	43 (34.4%) ***
Male	125	**18 (14.4%)**	4 (3.2%)	9 (7.2%)	11 (8.8%)
Ethnicity					
NZE	154	**51 (33.1%)**	17 (12.2%)	29 (20.9%)	25 (18%)
Māori	60	**24 (40.0%)**	11 (18.3%)	18 (30%)*c	15 (25%)
PI	22	**10 (45.4%)*b**	5 (22.7%) **b	10 (45.5%) **a	8 (36.4%) *a

NZE = New Zealand European, PI = Pacific Island, * = p < .05. ** = p<. 01. *** = p<.001, *a=compared to NZE and Māori, b= compared to NZE, c= compared to NZE and PI*

As seen in Table 10, 46 (18.4%) out of the 250 files had two or more forms of adult abuse and/or neglect recorded. Women were found to be significantly more likely to experience two or more forms of adult abuse and/or neglect than men (χ^2 (1) = 154.13, p<.001). There were no significant differences dependent on age (p>.05). Pacific Island clients were found to have experienced two or more forms of adult abuse and neglect significantly more compared to both New Zealand European (χ^2 (1) = 54.00, p<.001) and Māori clients (χ^2 (1) = 9.85, p<.01). This finding was different than that for childhood abuse and neglect.

Table 10. *Recorded prevalence rates of multiple forms of adult abuse and neglect with significant differences reported for gender and ethnicity*

	N	**1 or more**	2 or more	3 forms
All	250	**88 (35.2%)**	46 (18.4%)	17 (6.8%)
Gender				
Female	125	**70 (56.0%) *****	40 (32.0%) ***	17 (13.6%) ***
Male	125	**18(14.4%)**	6 (4.8%)	0
Ethnicity				
NZE	154	**51 (33.1%)**	21 (13.6%)	8 (5.2%)
Māori	60	**24 (40.0%)**	15 (25.0%)	5 (8.3%)
PI	22	**10 (45.4%) *b**	9 (40.7%) ***a	4 (18.2%) ***a

NZE = New Zealand European, PI = Pacific Island, *= p < .05. ** = p <. 01. ***= p <.001, *a= compared to NZE and Māori, b= compared to NZE*

Enquiry Rates

Enquiry for abuse and/or neglect

As seen in Table 11, 163 (65.2%) files indicated that the client had been asked about abuse and/or neglect at some point. Thus, there was no evidence of any enquiry for 87 (34.8%) clients. One hundred and fifteen files (46%) indicated that an enquiry had taken place during the IA, and 116 (46.4) were asked after the IA. Seventy-seven files (30.8%) indicated that an abuse-related enquiry had taken place prior to the IA. Of these 77, 57 (74%) were asked again during the IA. Forty-six files (18.4% out of the total sample) indicated that the individual had been asked at all three time points (prior to, during, and after the IA). Out of the 135 files that had no evidence of any abuse/neglect enquiry during the IA, 36 (26.7%) were asked about abuse/neglect subsequent to the IA.

Females were significantly more likely to be asked about abuse or neglect prior to the IA ($\chi2$ (1) = 9.93, *p*=.002), during the IA ($\chi2$ (1) = 13.54, *p*<.001), and following the IA

($\chi2\ (1) = 14.48$, p<.001). Female clinicians were more likely to ask about abuse and neglect during the IA ($\chi2\ (1) = 6.44$, p=.040),(clinicians' gender was only recorded for the IA, thus, this could not be evaluated for information recorded before or after the IA). Clients recorded as being of Pacific Island ethnicity were significantly less likely to be asked about abuse prior to the IA compared to clients identified as either New Zealand European ($\chi2\ (1) = 8.31$, p<.01) or Māori ($\chi2\ (1) = 26.11$, p<.001). This significant difference was only present between Pacific Island and Māori clients during the IA ($\chi2\ (1) = 4.86$, p<.05). There were no significant differences in enquiry rates according to age or recorded risk to self, problematic alcohol and/or drug use, or the clinician's profession (p>.05).

Table 11. *Comparisons of enquiry rates into abuse and neglect prior to, during, and after the IA with significant differences reported for gender and ethnicity*

	N	**Any time**	Prior to IA	During IA	Post IA
All	250	**163 (65.2%)**	77 (30.8%)	115 (46%)	116 (46.4%)
Gender of clients					
Female	125	**100 (80.0%)** ***	50 (40.0%) **	72 (56.6%) ***	73 (58.4%) ***
Male	125	**63 (50.4%)**	27 (21.6%)	43 (34.4%)	43 (34.4%)
Gender of clinicians					
Female	155	#	#	81 (52.3%) **	#
Male	92	#	#	33 (35.9%)	#
Ethnicity					
NZE	154	**96 (62.3%)**	47 (30.5%)	68 (44.2%)	68 (44.2%)
Māori	60	**44 (73.3%)**	24 (40.0%)	33 (55.0%)*b	34 (56.7%)
PI	22	**15 (68.2%)**	4 (18.2%) **a	9 (40.9%)	9 (45.5%)

IA = Initial assessment, # = gender unknown, NZE = New Zealand European, PI = Pacific Island, * = p < .05. ** = p <. 01. *** = p <.001, *a= compared to NZE and Māori, b= compared PI*

Gender differences in abuse enquiry rates

As seen in Table 12, female clinicians were significantly more likely to enquire about abuse and/or neglect during the IA than male clinicians ($\chi2(1) = 6.44$, p=.04). This was true for both female and male clients. Furthermore, both male ($\chi2\ (1) = 4.88$, p=.028) and female clinicians ($\chi2 = 8.63\ (1)$, p=.003) were significantly more likely to ask female clients than male clients about abuse and/or neglect.

Table 12. *Proportion of clients asked about abuse and/or neglect during the initial assessment with significant differences reported for gender of clinician*

	Client		
Clinician	All	Female	Male
Female N=155	81 (52.3%) *	53 (63.1%) *	28 (39.4%) *
Male N=92	33 (35.9%)	19 (48.7%)	14 (26.4%)

* = p < .05.

Differences in enquiry rates dependent on clients' diagnosis

As seen in Table 13, clients' primary diagnosis during the IA was significantly related to the rate of abuse/neglect enquiry ($\chi 2\ (9) = 27.45,\ p$<.001). Further analysis found that clients diagnosed with a psychotic disorder were significantly less likely to be asked about abuse and neglect compared to clients diagnosed with any of the other diagnostic categories (e.g., Psychotic disorders compared to alcohol and drug ($\chi 2\ (1) = 16.08,\ p$<.001)). On the other hand, clients with a primary diagnosis of PTSD were significantly more likely to be asked about abuse and neglect $(\text{e.g., PTSD compared to MDD/MDE}\ (\chi 2\ (1) = 21.54,\ p < .001))$ compared to clients diagnosed with any of the other diagnostic categories. There was no significant difference in the rate of enquiry about alcohol and drug use related to diagnosis (p>.05).

Table 13. *Proportion of enquiry rates into abuse/neglect during the IA dependent on diagnosis*

Diagnosis	N	Asked abuse/neglect
MDD/MDE	86	47 (54.6%)
BPAD	27	15 (51.8%)
PND	2	0
GAD	13	7 (53.8%)
PTSD	9	8 (88.9%) ***
Psychotic disorders	64	15 (23.4%) ***
Alcohol & Drug	14	6 (42.8%)
Other	17	10 (58.8%)
No Diagnosis	18	8 (44.4%)

IA = Initial assessment, MDD/MDE= Major depressive disorder (or episode), BPAD= Bipolar affective disorder,
PND= Post-natal depression, GAD= Generalised anxiety disorder,
PTSD= Post-traumatic stress disorder, *** = p < .001.

Enquiry into connection between abuse and current presentation

Information was recorded regarding the proportion of clinicians who had documented that they had asked their clients if they thought there was any connection between current or past abuse/neglect and their present challenges. Seventeen (10.6%) of the files indicated that the client had been asked about this at some point prior to the IA, 11 (6.9%) were asked during the IA, and 16 (10.0%) were asked at some point after the IA. Thus a total of 44 (17.6%) were asked at some point. There were no significant differences depending on ethnicity, age, gender of clients, gender of clinicians, or profession of the clinician.

Enquiry into alcohol and drug use

As seen in Table 14, 232 (92.8%) of the clients who had been asked about their alcohol and drug use at some time point during their contact with the CMHC. In total, 224 (89.6%) of the 250 clients had information recorded in their files indicating that they had been asked about their alcohol and drug use during the IA, 210 (84%) had been asked at some point prior to the IA, and 200 (80.0%) were asked subsequent to the IA. Out of the 224 clients that were asked about their alcohol and drug use during the IA, 114 (50.9%) were assessed as having current or recent problematic use. The mean age at the time of the IA of those who were asked was 34.63, which was significantly lower than the mean age of those who were not asked, 44.15 ($t(248) = 3.83$, $p<.001$). There were no significant differences in enquiry rates according to the ethnicity of the client, gender of the client, recorded risk to self, gender of the clinician, or clinician's profession (p>.05).

Table 14. *Proportion of enquiry rates into alcohol and drug use*

	N	**Any time**	Prior to IA	During IA	Post IA
All	250	**232 (92.8%)**	210 (84%)	224 (89.6%)	200 (80%)
Gender of clients					
Female	125	**114 (91.2%)**	103 (82.4)	110 (88%)	96 (76.8%)
Male	125	**118 (94.4%)**	107 (85.6%)	114 (91.2%)	104 (83.2%)
Gender of clinicians					
Female	155	#	#	139 (89.7%)	#
Male	92	#	#	83 (90.2%)	#
Ethnicity					
NZE	154	**142 (92.2%)**	128 (83.1%)	134 (87.0%)	121 (78.6%)
Māori	60	**60 (100%)**	56 (93.3%)	59 (98.3%)	53 (88.3%)
PI	22	**18 (81.8%)**	15 (68.2%)	19 (86.4%)	16 (72.7%)

IA = Initial Assessment, # = gender unknown, NZE = New Zealand European, PI = Pacific Island

Enquiry into relationship with parent(s)/caregiver(s)

One hundred and eighty-one (72.4%) clients had information recorded in their files indicating that they had been asked about their relationships with parent(s) or caregiver(s) during the IA (see Table 15). The mean age of clients who were asked was 33.85 years, significantly lower than those not asked, who had a mean age of 40.01 years ($t = 3.61\ (247)$, $p<.001$). There was no significant difference in enquiry rates depending on clients' gender or ethnicity or clinicians' gender.

As seen in Table 16, 82 (32.8%) clients had their relationship described as conflictual, 57 (22.8%) as close to one parent but in a conflictual relationship with another, 34 (13.6%) as close or good, and 8 (3.2%) as estranged from their caregiver(s) (see Chapter Three for definitions of relationship categories). There were no significant differences in the quality of the reported relationship with caregiver(s) depending on gender, age, or ethnicity of the client ($p>.05$).

Table 15. *Enquiry rates into relationship with parent(s)/caregiver(s)*

	N	During IA
All	250	181 (72.4%)
Gender of clients		
Female	125	93 (74.4%)
Male	125	88 (70.4%)
Gender of clinicians		
Female clinicians	155	117 (75.5%)
Male clinicians	92	63 (68.5%)
Ethnicity		
NZE	154	111 (72.1%)
Māori	60	43 (71.7%)
PI	22	18 (81.8%)

IA = Initial Assessment, NZE = New Zealand European, PI = Pacific Island

Table 16. *Description of relationship with parent(s)/caregiver(s)*

	N	Close	Close to one	Conflictual	Estranged
All	250	34 (13.6%)	57 (22.8%)	82 (32.8%)	8 (3.2%)
Gender					
Female clients	125	16 (12.8%)	28 (22.4%)	46 (36.8%)	3 (2.4%)
Male clients	125	18 (14.4%)	29 (23.2%)	36 (28.8%)	5 (4.0%)
Ethnicity					
NZE	154	20 (13%)	42 (27.3%)	46 (29.9%)	3 (1.9%)
Māori	60	4 (6.7%)	10 (16.7%)	25 (41.7%)*b	4 (6.7%)
PI	22	6 (27.3%)***a	4 (18.2%)	7 (31.8%)	1 (4.5%)

NZE = New Zealand European, PI = Pacific Island, a= compared to NZE and Māori, b= compared to NZE

Difference in enquiry rates depending on Community Mental Health Centre

Files were read from four different CMHCs during this file audit (see Table 17, Table 18 and Table 19). However, Chi-square analysis showed that there were no statistically significant differences. Enquiry rates into abuse and neglect varied between 50.6 % and 38.9 %. Enquiry into alcohol/drug use varied from 95.9% to 81.4% and enquiry into the relationship with caregiver(s) varied between 79.2% to 63% across the four centers. There were also no significant differences in the recorded prevalence rate of childhood or adult abuse and neglect between the four CMHCs ($p>.05$).

Table 17. *Enquiry rates during the IA into abuse/neglect, alcohol and drug use, and relationship with parent(s)/caregiver(s)*

	N	Abuse/ neglect	Alcohol/drug	Relationship with caregiver(s)
All	250	115 (46.0%)	224 (89.6%)	181 (72.4%)
CMHC 1	77	39 (50.6%)	73 (94.8%)	61 (79.2%)
CMHC 2	70	34 (48.6%)	57 (81.4%)	51 (72.9%)
CMHC 3	54	21 (38.9%)	47 (87.0%)	34 (63.0%)
CMHC 4	49	21 (42.9%)	47 (95.9%)	35 (71.4%)

IA = Initial assessment ,CMHC = Community Mental Health Centre

Table 18. *Recorded prevalence rates of childhood abuse and neglect at any time point*

	N	Childhood Sexual Abuse	Childhood Physical Abuse	Childhood Emotional Abuse	Childhood Physical neglect	Childhood Emotional Neglect
All	250	81 (32.4%)	91 (36.4%)	88 (45.2%)	22 (8.8%)	55 (22%)
CMHC 1	77	27 (35.1%)	32 (41.6%)	18 (23.4%)	10 (11.3%)	18 (23.4%)
CMHC 2	70	18 (25.7%)	27 (38.6%)	26 (37.1%)	6 (8.6%)	15 (21.4%)
CMHC 3	54	16 (29.6%)	15 (27.8%)	18 (33.3%)	2 (3.7%)	11 (20.4%)
CMHC 4	49	20 (40.8%)	17 (34.7%)	15 (30.6%)	4 (8.2%)	11 (22.4%)

CMHC = Community Mental Health Centre

Table 19. *Recorded prevalence rates of adult abuse and neglect at any time point*

	N	Adult Sexual Abuse	Adult Physical Abuse or Neglect	Adult Emotional Abuse or Neglect
All	250	36 (14.4%)	61 (24.4%)	54 (21.6%)
CMHC 1	77	11 (14.3%)	21 (27.3%)	19 (24.7%)
CMHC 2	70	10 (14.3%)	13 (18.6%)	11 (15.7%)
CMHC 3	54	7 (13.0%)	10 (18.5%)	12 (22.2%)
CMHC 4	49	8 (16.3%)	17 (34.7%)	12 (24.5%)

CMHC = Community Mental Health Centre

Summary of enquiry rates

A sign-test indicated that overall, clients were asked about their alcohol and drug use significantly more (89.6%) than abuse and/or neglect (46%), (Z= 9.51, p <.001). Clients were also asked about relationships with their caregiver(s) (72.4%) significantly more frequently, than about abuse or neglect (Z= 6.63, p <.001).

Use of standard assessment forms

During the period covered by this study Auckland District Health Board used two standard computerised IA forms, the CMHCIA form and the CAA form. Either of these forms were used in 153 (61.2%) of the 250 files to record information from the IA. Ninety-seven (38.8%) files had information from an IA recorded without using either of these forms. Out of those 153 individuals who had their IA recorded in one of the computerised forms, 74 (48.4%) were asked about abuse and/or neglect. The rate of abuse enquiry was not significantly different (p>.05) from those who had their IA information recorded elsewhere in their files 41 (42.3%).

Both of these forms include a specific abuse section. This section was completed in 69 (45.1%) files, and left blank in 84 (54.9%) of the 153 files that had used either form. The rate of recording childhood physical abuse was significantly higher for those who had completed the computerised forms than those who had not ($t\ (1) = 16.13$, p<.001). Significant increases were also noted for adult physical abuse/neglect, and adult emotional abuse/neglect. Recording rates increased significantly again when the specific abuse section was filled in. This increase was noted for all recorded forms of abuse and neglect except childhood physical neglect (see Table 20 and Table 21).

Table 20. *Comparisons of recorded prevalence rates of childhood abuse and neglect during the IA depending on use of computerised assessment form*

	N	Any Childhood Abuse/Neglect	Childhood Sexual Abuse	Childhood Physical Abuse	Childhood Emotional Abuse	Childhood Emotional Neglect	Childhood Physical Neglect
All Cases	250	141 (56.4%)	81 (32.4%)	91 (36.4%)	88 (35.2%)	55 (22%)	22 (8.8%)
Form							
Used	153	92 (60.1%)	38 (24.8%)	43 (28.1%) ***	35 (22.9%)	24(15.7%)	10 (6.5%)
Not used	97	49 (50.5%)	19 (19.6%)	13 (13.4%)	16 (16.5%)	9 (9.3%)	4 (4.1%)
Abuse section							
Used	69	64 (92.7%) ***	29 (41.0%) ***	35 (50.7%) ***	32 (46.4%) ***	21 (30.4%) ***	7 (10.1%)
Not used	84	28 (33.3%)	9 (10.7%)	8 (9.5%)	3 (3.6%)	3 (3.6%)	3 (3.6%)

IA = Initial assessment , *** = P<.001.

Table 21. *Comparisons of recorded prevalence rates of adult abuse and neglect during the IA depending on use of computerised assessment form*

	N	Any Adult Abuse or Neglect	Adult Sexual Abuse	Adult Physical Abuse or Neglect	Adult Emotional Abuse or Neglect
All cases	250	88 (35.2%)	36 (14.4%)	61 (24.4%)	54 (21.6%)
Form					
Used	153	56 (36.6%)	13 (8.5%)	24 (15.7%) **	24 (15.7%) *
Not used	97	32(33.1%)	7 (7.2%)	5 (5.2%)	6 (6.2 %)
Abuse section					
Used	69	53 (76.8%) ***	12 (17.4%) **	15 (21.7%) **	18 (26.1%) ***
Not used	84	18 (21.4%)	1 (1.2%)	9 (10.7%)	6 (7.1%)

IA = Initial assessment , *= p < .05. **= p <. 01. *** = P<.001.

Response to Documented Abuse and Neglect

Formulations, treatment plans, referrals, and reporting

Information was gathered as to which files had included the documented abuse and/or neglect in: (i) Formulation, (ii) treatment plan, and/or (iii) whether the responsible clinician had referred the person for further abuse/neglect-related treatment. Of the 81 files in which childhood sexual abuse was recorded, 46 (56.8%) had this mentioned in the formulation, 36 (44.4%) had abuse-related treatment plans, and 19 (23.5%) clients were referred for further abuse-related treatment. Females had childhood sexual abuse recorded in their formulations ($\chi2\ (1) = 4.15$, $p<.042$), treatment plan ($\chi2\ (1) = 10.12$, $p<.01$), and were referred for abuse related treatment ($\chi2\ (1) = 4.15$, $p<.042$) significantly more frequently than males. Females had more forms of abuse and neglect, except childhood emotional neglect, recorded in their formulations, treatment plans, and referral significantly more frequently than men (see Table 22).

Overall, with a few exceptions (CSA, ASA, and APAN), clinicians recorded clients' abuse and/or neglect history in the formulation more frequently than in treatment plans and in referral documentation (see Table 22). This difference was significant for CPA ($\chi2\ (1) = 22.05$, $p<.001$), CEA ($\chi2(1) = 14.41$, $p<.001$), CPN ($\chi2\ (1) = 6.09$, $p<.05$), CEN ($\chi2\ (1) = 22.84$, $p<.001$), and for AEAN ($\chi2(1) = 6.66$, $p<.01$).

In addition there was a significant difference between the type of childhood abuse or neglect and the likelihood of being mentioned in the formulations ($\chi2(4) = 76.38$, $p<.001$), in the treatment plans ($\chi2(4) = 55.07$, $p<.001$), and in the referral documentation ($\chi2(4) = 31.56$, $p<.001$). CPN was less likely to be included in the formulation than all other reported forms of childhood abuse and neglect (see Table 23). ASA was recorded in treatment plans

and referrals significantly more frequently than both adult physical abuse/neglect adult emotional abuse/neglect ($p<.05$), (see Table 24). Adult sexual abuse was significantly less likely to be mentioned in the formulation compared to childhood sexual abuse ($\chi2\ (1) = 22.43$, $p<.001$). This difference was also found to be significant between CPA and APAN ($\chi2\ (1) = 8.44$, $p<.01$), and CEA and AEAN ($\chi2\ (1) = 8.54$, $p<.001$) (see Table 25).

Table 22. *Proportion of files where abuse and/or neglect was recorded in the formulation, treatment plan, and/or were referred for further treatment with significances differences compared to recording rate in formulations by client gender*

	N	Recorded in formulation	Recorded in treatment plan	Referred for treatment
CSA	**81**	**46 (56.8%)**	**36 (44.4%)**	**19 (23.5%)** a***
Female	56	36 (64.3%) b***	28 (50.0%) b**	16 (28.6%) b***
Male	25	10 (40.0%)	8 (32%)	3 (12%)
CPA	**91**	**43 (47.3%)**	**22 (24.2%)** a***	**18 (19.8%)** a***
Female	49	25 (51.0%)	14 (28.6%) b*	12 (24.5%) b**
Male	42	18 (42.9%)	8 (19%)	6 (14.3%)
CEA	**88**	**40 (45.5%)**	**23 (26.1)** a***	**16 (18.2%) a*****
Female	51	26 (50.0%) b*	16 (30.8%) b**	10 (19.2%)
Male	37	14 (37.9%)	7 (19.4%)	6 (19.7%)
CPN	**22**	**5 (22.7%) c*****	**3 (13.6%) a***	**3 (13.6%) a***
Female	16	4 (25.0%) b*	3 (18.8%) b***	0
Male	6	1 (16.7%)	0	0
CEN	**55**	**18 (32.7%)**	**8 (14.5%) a*****	**6 (10.9%) a*****
Female	35	10 (28.6%)	5 (14.3%)	5 (14.3%) b***
Male	20	8 (40.0%) b*	3 (15%)	1 (5%)
ASA	**36**	**11 (30.6%)**	**13 (36.1%)**	**7 (19.4%) a***
Female	32	11 (34.4%) b ***	12 (37.5%) b*	6 (18.8%)
Male	4	0	1 (25%)	1 (25%)
APAN	**61**	**19 (31.1%)**	**14 (23%)**	**7 (11.5%) a*****
Female	52	18 (34.6%) b***	13 (25%) b***	7 (13.5%) b***
Male	9	1 (11.1%)	1 (11.1%)	0
AEAN	**54**	**16 (29.6%)**	**10 (18.5%) a****	**6 (11.1%) a*****
Female	43	14 (32.6%) b***	9 (20.9%) b***	6 (14.0%) b***
Male	11	2 (18.2%)	1 (9.1%)	0

CSA = Childhood sexual abuse, CPA = Childhood physical abuse, CPN = Childhood physical neglect, CEA = Childhood emotional abuse, CEN = Childhood emotional neglect, ASA = Adult sexual abuse, APAN = Adult physical abuse or neglect, AEAN = Adult emotional abuse or neglect, a= recorded significantly less than in the formulation, b =significant difference in gender, c= significantly less than other childhood abuse and neglect, *= p < .05. **= p <. 01. ***= p<.001.

Table 23. *Comparing proportions of recording rates according to type of childhood abuse or neglect with significant differences by gender of clinician and ethnicity*

% Recorded	N	CSA	CPA	CEA	CPN	CEN
Formulation		**56.8%**	**47.3%**	**45.5%**	**22.7%***a**	**32.7%**
Gender of clinicians						
Male	92	47.8%	40.0%	37.0%	33.3%***b	26.3%
Female	155	62.5% *b	51.7%	49.2%*	15.4%	37.0%*b
Ethnicity						
NZE	154	50.0%	45.3%	42.9%	33.3%***c	27.3%
Māori	60	59.3%	53.6%	50.0%	12.5%	52.9%***c
PI	22	100%***c	42.9%	60.0%*c	0	0
Treatment Plan		**44.4%**	**24.2%**	**26.1%**	**13.6%***a**	**14.5**
Gender of clinicians						
Male	92	56.5%*	20.0%	18.5%	22.2%***b	15.8%
Female	155	41.1%	27.6%	30.5%**b	7.7%	14.3%
Ethnicity						
NZE	154	32.6%	18.9%	23.2%	16.7%	9.1%
Māori	60	59.3%	35.7%***c	37.5%**c	12.5%	29.4%***c
PI	22	50.0%**c	14.3%	20.0%	0	0
Referred on		**23.5%**	**19.8%**	**18.2%**	**13.6%**	**10.9%***a**
Gender of clinicians						
Male	92	17.4%	20.0%	14.8%	22.2%***b	10.5%
Female	155	26.8%*b	20.7%	20.3%	7.7%	11.4%
Ethnicity						
NZE	154	19.6%	17.0%	16.1%	16.7%	9.1%
Māori	60	29.6% **c	25.0%**c	25.5%*c	12.5%	17.6%**c
PI	22	16.7%	14.3%	20.0%	0	0

a= significant difference between type of childhood abuse or neglect, b= significant difference in gender, c= significant difference in ethnicity, *= P < .05. **= p <. 01. ***= P <.001.

Table 24. *Comparing proportions of recording rates according to type of adult abuse or neglect*

% Recorded	N	ASA	APAN	AEAN
Formulation		**30.6%**	**31.1%**	**29.6%**
Gender of clinicians				
Male	92	22.2%	33.3%	42.9%***
Female	155	33.3%*	31.1%	25.0%
Ethnicity				
NZE	154	26.3%	21.9%	27.6%
Māori	60	36.4%*	44.4%***	40.0%*
PI	22	40.0%**	40.0%***	25.0%
Treatment Plan		**36.1%**a**	**23.0%**	**18.5%**
Gender of clinicians				
Male	92	44.4%	33.3%**	42.9%***
Female	155	33.3%	20.0%	10.0%
Ethnicity				
NZE	154	47.4%***	18.8%	24.1%
Māori	60	27.3%	27.8%*	20.0%
PI	22	20.0%	30.0%*	0
Referral		**19.4%*a**	**11.5%**	**11.1%**
Gender of clinicians				
Male	92	22.2%	20.0%***	28.6%***
Female	155	18.5%	8.9%	5.0%
Ethnicity				
NZE	154	21.1%	9.4%	13.8%
Māori	60	18.2%	11.1%	13.3%
PI	22	20.0%	20.0% **	0

*= P < .05. **= p <. 01. ***= P <.001, *a= Significantly more than both APAN and AEAN*

Table 25. *Comparing proportions of recording rates between childhood and adult abuse/neglect*

% Recorded in	CSA	ASA	CPA	APAN	CEA	AEAN
Formulation	56.8%	30.6%***	47.3 %	31.1% **	45.5%	29.4% **
Treatment plan	44.4%	36.1%	24.2%	23.0%	26.1% -	18.5%
Referral	23.5%	19.4%	19.8%	11.5% *	18.2%-	11.1% *

*= P < .05. **= p <. 01. ***= P <.001.

Recording of DSM axis four

Almost half (48.4%) of all files had a full DSM diagnosis. In 42.8% of the files clinicians had recorded information in axis four (psychosocial and environmental problems). Documenting problems with primary social support in 32 (12.8%) files, problems with social environment in 19 (7.6%) files, occupational problems in 16 (6.4%) files, abuse in 12 (4.8%) files, other psychological or environmental problems in 7 (2.8%) files, legal problems in 4 (1.6%) files, housing problems in 4 (1.6%) files, educational problems in 3 (1.2%) files, and problems with access to health-care in 2 (0.8%).

Reporting of criminal offences to authorities

In 11 (6.8%) of the 160 files that had documented abuse information it was recorded that there had been some discussion about the possibility of reporting of a current or historical criminal offence. Three (1.9%) files stated that the clinician had reported the alleged offence to the legal authorities.

Rates of Recording Attachment-Related Experiences

Prevalence rates of attachment-related experiences

Prevalence rates were collected for recording of eight specific attachment-related experiences (ARE): Death of parent/caregiver, adoption/foster-care, separation or divorce, history of mental illness of a significant attachment figure, witnessed domestic violence, bullying, and poverty. One hundred and four clients (41.6%) experienced divorce or separation of their caregivers/parents, 101 (40.4%) had a caregiver who had a history of mental illness, 95 (38%) had witnessed domestic violence, and 72 (28.8%) had a caregiver who had a history of alcohol or drug abuse prior to their 18th birthday.

As seen in Table 26 and Table 27, females were significantly more likely to have witnessed domestic violence ($\chi2(2) = 8.85$, $p<.012$) and to have had a caregiver who had a history of alcohol and/or drug abuse ($\chi2(2) = 6.63$, $p<.036$) prior to 18 years of age. Thirty-four clients (13.6%) experienced death of a caregiver/parent, 43 (17.2%) were placed in foster-care or permanently adopted, 53 (21.2%) experienced bullying, and 35 (14%) experienced poverty. In the poverty category the unknown group was represented by 67 (26.8%) files. Records also indicated that 58 (23.2%) had been exposed to other adverse experiences prior to their 18th birthday. There were statistically significant differences in adoption/foster-care rates ($\chi2(8) = 26.13$, $p<.001$), and poverty ($\chi2\ (8) = 40.24$, $p<.000$) depending on ethnicity.

Table 26. *Prevalence rates of specific experiences with significant differences for gender and ethnicity*

	N	Divorce or separation prior to 18	Caregiver history of mental illness prior to 18	Domestic violence prior to18	Caregiver history of alcohol or drug abuse prior to 18
All	250	104 (41.6%)	101 (40.4%)	95 (38%)	72 (28.8%)
Gender					
Female	125	48 (38.4%)	50 (40.0%)	58 (46.4%) **	45 (36.0%)*
Male	125	56 (44.8%)	51 (40.8%)	37 (29.6%)	27 (21.6%)
Ethnicity					
NZE	154	65 (42.2%)	68 (44.2%)	56 (36.4%)	39 (25.3%)
Māori	60	29 (48.3%)	19 (31.7%)	28 (46.7%)	26 (43.3%)
PI	22	6 (27.3%)**a	6 (27.3%)**b	7 (31.8%)*c	5 (22.7%)***c

NZE = New Zealand European, PI = Pacific Island, * = p < .05. ** = p <. 01*), a= compared to both NZE and Māori, b= compared to NZE, c=compared to Māori*

Table 27. *Prevalence rates of specific experiences with significant differences for gender and ethnicity*

	N	Death of caregiver prior to 18	Adoption or foster care prior to 18	Bullying prior to 18	Poverty Prior to 18
All	250	34 (13.6%)	43 (17.2.4%)	53 (21.2%)	35 (14.0%)
Gender					
Female	125	16 (12.8%)	16 (12.8%)	22 (17.6%)	21 (16.8%)
Male	125	18 (14.4%)	27 (21.6%)	31 (24.8%)	14 (11.2%)
Ethnicity					
NZE	154	18 (11.7%)	17 (11.0%) **b	35 (22.7%)	10 (6.5%) ***b
Māori	60	12 (20.0%)*a	20 (33.3%)	11 (18.3%)	19 (31.7%)
PI	22	4 (18.2%)	5 (22.7%)	2 (9.1%) **c	6 (27.3%)

NZE = New Zealand European, PI = Pacific Island, * = p < .05. ** = p <. 01, *a= compared to NZE, b= compared to both Māori and PI, c= compared to Māori and NZE*

Attachment Related Experience(s) (not including abuse or neglect), were divided into two categories for further analysis: (i) Attachment-related experiences that occurred prior to the persons 18th birthday will be referred to as Childhood Attachment Related Experience (CARE), and (ii) attachment-related experiences that occurred after the persons 18th birthday will be referred to as Adult Attachment-Related Experiences (AARE).

Of the total sample, 200 (80%) files identified at least one CARE, while 146 (58.4%) clients had multiple CAREs recorded (see Table 28). One hundred and eighty five (74.0%) files indicated that the client had experienced at least one AARE, and 101 (40.4%) clients had experienced multiple AAREs

Of the 200 files that indicated at least one CARE, 158 (79%) experienced at least one AARE, and 98 (49%) experienced multiple AAREs after their 18th birthday. In comparison, of those 50 (20.0%) files that did not indicate any CARE, 27 (54%) had one AARE recorded and 3 (6%) files had multiple AAREs recorded.

Females were significantly more likely to have AAREs recorded in their files ($p<.05$). There were also significant differences depending on ethnicity, where both Māori and Pacific Island clients were significantly more likely to have multiple CAREs and AAREs recorded in their files (see Table 28).

Table 28. *Prevalence rates of attachment related experiences with significant differences reported for clients' gender and ethnicity*

	N	One CARE	Multiple CAREs	One AARE	Multiple AAREs
All	250	200 (80.0%)	146 (58.4%)	185 (74.0%)	101 (40.4%)
Gender					
Female	125	102 (81.2%)	79 (63.2%)	100 (80.0%) *	59 (47.2%) *
Male	125	98 (78.4%)	67 (53.6%)	85 (68.0%)	42 (33.6%)
Ethnicity					
NZE	154	121 (78.6%)	89 (57.8%)	112 (72.7%)	58 (37.7%)
Māori	60	53 (88.3%)	42 (70.0%)	50 (83.3%)	35 (58.3%) **c
PI	22	15 (68.2%)*a	8 (36.4%) **b	18 (81.8%)	7 (31.8%)

CARE = Childhood attachment related experience, AARE= Adult attachment related experience, NZE = New Zealand European, PI = Pacific Island, * = p < .05. ** = p <. 01, a= *compared to Māori, b= compared to both NZE and Māori, c= compared to both NZE and PI*

Comparisons to Previous Audit

The previous file audit of clinicians' enquiry behaviours at a CMHC was carried out in 1997. Then, 200 files were audited from a single CMHC. In the current study, 250 files were audited from all four CHMCs in the District Health Board (DHB). During the previous audit, emotional abuse, and physical or emotional neglect were not recorded. As such, this audit is unable to compare these variables over time.

Demographics

As can be seen in Table 29, the present sample had a significantly higher proportion of Māori clients ($\chi2\ (1) = 17.36,\ p<.001$), and psychiatrists made up a greater proportion of mental health workers responsible for IAs ($\chi2\ (1) = 40.24,\ p<.001$) in the present sample as compared to 1997. In 1997 there were significantly more psychologists ($\chi2\ (1) = 21.17,\ p<.001$) and social workers ($\chi2\ (1) = 93.02,\ p<.001$) responsible for the IA. The two samples did not differ significantly in terms of clinician's gender (p>.05).

Table 29. *Comparing demographic of the 1997 and 2010 samples*

	1997	2010
N	200	250
Clients		
Gender		
Female	114 (57%)	125 (50.0%)
Male	86 (43%)	125 (50.0%)
Ethnicity		
NZE	114 (72%)	154 (61.6%)
Māori	21 (10.5%)	60 (24.0%) ***
PI	12 (6%)	22 (8.8%)
Clinicians		
Gender		
Female	89 (44.5%)	155 (62.0%) ***
Male	95 (47.5%)	92 (36.8%)
Profession		
Psychiatrist	109 (54.4%)	187 (74.8%) **
Nurse	37 (18.5%)	50 (20.0%)
Psychologist	21 (10.5%) ***	7 (2.8%)
Social Worker	13 (6.5%) ***	1 (0.4%)
Occupational Therapist	3 (1.5%)	1 (0.4%)

NZE = New Zealand European, PI = Pacific Island, ** = p <. 01. *** = p <. 001.

Prevalence rates

Prevalence rates of recorded sexual and physical abuse have increased for both childhood and adult abuse since 1997. As seen in Table 30 and Table 31 these increases were statistically significant for childhood sexual abuse ($\chi2\ (1) = 7.69,\ p<.01$), childhood physical abuse ($\chi2\ (1) = 22.14,\ p<.001$), and for adult sexual abuse ($\chi2\ (1) = 6.35,\ p<.05$). Significant increases for childhood and adult abuse were also noted for gender groups and ethnicity.

Table 30. *Comparing the overall recorded prevalence rates of childhood sexual and physical abuse between1997 and 2010 with significant differences reported by gender and ethnicity*

	CSA		CPA	
	1997	2010	1997	2010
All	(20.0%)	(32.4%) **	(17.0 %)	(36.4%) ***
Gender				
Female	(26.3%)	(44.8%) ***	(17.5%)	(39.2%) ***
Male	(11.6%)	(20.0%) *	(16.3%)	(33.6%) ***
Ethnicity				
NZE	(20.8%)	(30.9%) *	(18.1%)	(35.3%) ***
Māori	(23.8 %)	(45.0%) ***	(33.3%)	(46.7%) *
PI	(16.7%)	(27.3%) **	(8.3%)	(31.8%) ***

CSA= childhood sexual abuse, CPA= childhood physical abuse, NZE = New Zealand European, PI = Pacific Island,
* = p < .05. ** = p <. 01. *** = p<.001.

Table 31. *Comparing the overall recorded prevalence rates of adult sexual and physical abuse between 1997 and 2010 with significant differences reported for gender and ethnicity*

	ASA		APA	
	1997	2010	1997	2010
All	(7.5%)	(14.4%) *	(19.5%)	(24.4%)
Gender				
Female	(8.8%)	(25.6%) ***	(25.4%)	(41.6%) **
Male	(5.8%)	(3.2%)	(11.6%)	(7.2%)
Ethnicity				
NZE	(8.3%)	(12.2%)	(16.7%)	(20.9%)
Māori	(4.8%)	(18.3%) ***	(42.9%) *	(30.0%)
PI	(0%)	(22.7%) ***	(16.7%)	(45.5%) ***

NZE = New Zealand European, PI = Pacific Island, * = p < .05. ** = p <. 01. *** = p<.001

Use of standardised assessment forms

A standardised assessment form was used for 13% (N=26) of clients in 1997 versus 61.2% (N=153) in 2010. This is a significant increase ($\chi 2\ (1) = 178.71$, $p<.001$). This increase was also reflected in recorded rates of abuse within these forms, i.e. recording rates of childhood sexual abuse increased from 20% in 1997 to 32.4% in 2010($\chi 2(1) = 7.69$, $p<.01$) (see Table 32).

Table 32. *Recorded prevalence rates in 1997 compared to recorded rates in 2010*

	1997	2010
Form		
Used	26 (13.0%)	153 (61.2%) ***
Not used	174 (87.0%)	97(38.8%)
Abuse section		
Used	20 (76.9%) ***	69 (45.1%)
Not used	6 (23.1%)	84 (54.9%)

* = p < .05, ** = p <. 01. *** = p <.001

Inclusion of abuse/neglect history in the formulations and treatment plans

Without exception, clinicians recorded clients' physical and sexual abuse history more frequently in formulations and treatment plans in 2010 than in 1997. All of these differences were significantly different at the $p<.001$ level of significance (see Table 33).

Table 33. *Proportion of files where the recorded abuse was documented in the formulation and treatment plan in 1997 compared to 2010*

	Formulation			Treatment plan		
	1997	2010	χ^2	1997	2010	χ^2
All	17.4%	56.4% ***	87.41	16.3%	42.3% ***	41.47
CSA	22.5%	56.8% ***	52.29	8.7%	44.4% ***	146.49
CPA	11.7%	47.3% ***	108.32	4.3%	24.2% ***	92.09
ASA	6.6%	30.6% ***	87.27	3.2%	36.1% ***	338.25
APA	15.4%	31.1% ***	16.01	4.3%	23% ***	81.32

*** = p <.001

Identified abuse/neglect history referred on for therapy

There had been no significant increases in identified abuse and/or neglect cases that were referred on for trauma focused therapy since 1997.

Table 34. *Proportion of files where clients had been referred for treatment in 1997 compared to 2010*

	Referral	
	1997	2010
CSA	22.5%	23.5%
CPA	17.6.7%	19.8%
ASA	20.0%	19.4%
APA	15.4%	11.5%

Reporting of criminal offenses

No files indicated that any of the documented abuse had been reported to legal authorities in 1997. In 2010 6.8% of all files that had documented abuse indicated that there had been some discussion regarding reporting and 1.9% (N=3) of the files stated that the alleged crime had been reported to legal authorities.

Case Examples

Commendable practice

There were numerous files with commendable practice. The following section presents a selection of examples. This is by no means an exhaustive list, merely some illustrations of some of the impressive work done by many of the clinicians.

One individual, in their mid-fifties was referred for an IA to the CMHC as he/she was experiencing auditory hallucinations. A history of childhood physical abuse, childhood emotional abuse, and childhood emotional neglect had been identified prior to the IA, and these were once again assessed during this IA. It was found that this client had been experiencing insomnia and nightmares for some time, often replaying memories from the abuse they had encountered during their childhood. All this information was documented in detail, the client was asked if he/she thought that their past had impacted on his/her current difficulties, and different treatment options were discussed. The formulation identified the impact of the historical abuse and the client was referred on for 'psychological interventions' including stress management.

Another client was referred, subsequent to a suicide attempt, experiencing depressive symptoms. This individual had been sexually abused by a babysitter at eight years of age. This information had been noted prior to assessment at the CMHC. As a result of a thorough IA, childhood physical abuse, childhood emotional abuse, and childhood emotional and physical neglect were also noted. In addition, repeated rape and emotional abuse by a close relative during adulthood were recorded. The clinician conducting the IA asked the client if he/she thought that there was any connection between their experience of prolonged abuse and their current presentation. All notes were detailed and the formulation specified multiple forms of abuse, including severity, and duration. This client was offered a range of treatment options and the plan included: A safety plan, referral to ACC for sexual abuse counselling,

psychological input, psychotropic medication, respite, follow-up, and an opportunity to take part in a 'dealing with distress' group.

A third individual had an extensive history of childhood sexual, physical, and emotional abuse noted in their records prior to referral to the CMHC. However, he/she had never received any specific abuse-related counselling. This individual had been under the care of several different mental health agencies over the past five years, and had received a range of diagnoses. They were currently taking a wide variety of psychotropic medications for "depressive symptom with psychotic features", sleep disturbances, and anxiety. Following an assessment at one of the CMHCs the impact of their historical abuse was discussed, and the potential of reporting historical events to legal authorities was also discussed. There were clear identifications in the formulation and the treatment recommended abuse-related counselling to help lessen the impact of prolonged childhood abuse.

A fourth client was referred for the first time to a CMHC. The referral suggested an assessment for depression. After documenting a comprehensive IA the summary formulation read: "Twenty year old part Māori woman/man presenting with a six month history of depressive symptoms in the context of heavy ETOH abuse. There is a likely early history suggestive of insecure attachment to his/her mother who suffered from affective dysregulation. The experience of prolonged sexual abuse by a family member and associative guilt, simultaneously with separation of his/her parents has likely lead to the formation of core beliefs about him/herself as being unlovable, unworthy, and others as being abusive and abandoning. He/she has externalised some of this as grief in his/her adolescence which has lead to academic failure and further loss of self-esteem. His/her current presentation cannot be distinguished from a substance induced mood disorder given the timeline of heavy alcohol use. The complicated grief of his/her recent loss of his/her father and history of suicide attempts leaves him/her particularly vulnerable to self-harm". This client was referred to ACC for abuse-related counselling following the IA.

Less than optimal practice

There were many files where abuse enquiry and IA practices were less than optimal. These can be divided into some subcategories: (i) clinicians who appear to over-look previously recorded information during the current IA; (ii) clinicians who do not ask about abuse and/or neglect during the IA; (iii) clinicians who asked about abuse and/or neglect without noting this information in formulations and/or treatment recommendations.; (iv) or finally, as

occurred in 30 (12%) cases, clinicians did not record any psycho-social history at all during the IA. A further 80 files (32%) had a very limited psycho-social history recorded, often one line or one sentence such as “difficult childhood” or “left school in 3rd form” The following section does not include examples of the worst cases. Instead, those which are representative of common practice have been selected.

Oversight of previously recorded information

One client, 20 years old at the first contact with a CMHC, and diagnosed with “schizophrenia and chronic paranoia” was under the care of a CMHC for over six years before a formal assessment was recorded. During these six years there was no information indicating that he/she had been asked about abuse or neglect at any time point. However, information in a psychological report from another service stated “reported having flashbacks of memories of violence against him/her by family members, including being burnt”. Moreover, their mother reported that the father was verbally abusive and a “heavy user of drugs and alcohol”. Following the parents’ divorce he/she stayed with the father for a year prior to being moved to the mother for “refuge” despite her expressing wishes to the contrary. This individual was treated exclusively with psychotropic medication.

Another client in their mid-forties had an extensive history of abuse and neglect recorded prior to his/her referral to the CMHC. Prior documentations noted childhood sexual abuse by father and brother from five years of age, childhood physical abuse, childhood emotional abuse, physical neglect, being raped multiple times as an adult, and adult physical and emotional abuse. Nine months after the IA a note stated “client considers his/her mental problems stem from his/her abusive past” followed by, “client reports bringing this up on almost every contact with a mental health service”. A core adult assessment form was completed during the IA for this client. However, the abuse section was left blank. This IA also noted the presence of visual and auditory hallucinations both with explicitly sexual content. Three years later an entry in the clinical notes recommended a referral for ACC counselling, although there was no information suggesting that any treatment had actually been accessed.

Not asked about abuse and/or neglect during the IA

One client was initially referred to one of the CMHCs as a 33 year-old. During their IA there was no psycho-social information at all recorded in their file and the client was discharged with a prescription of psychotropic medication. Following this initial IA, the individual began

on-and-off contact with several of ADHB's CMHCs. He/she was hospitalised at one point due to severe adult physical abuse, and Child, Youth, and Family Services took over the care of his/her children. One entry from an agency stated, "Something happened when X was a child - but X does not want to talk about it. Talk to the psychologist." Six years later, this individual was admitted to an inpatient ward as he/she was hearing voices. At this point, a clinician took a full psycho-social history discovering that the individual had been sexually abused by two different assailants from seven years of age, physically and emotionally abused during their childhood, and had become involved in several violent and abusive relationships as an adult. At no point had this individual been offered any abuse-related treatment. Following this assessment, treatment was finally offered.

Another client referred to a CMHC in their late forties was given an extensive assessment covering many aspects of his/her history and an initial formulation stated "Childhood disturbed, parental separation at three, death of father at eight, illness and hospitalisation of mother at nine. Grandmother significant attachment figure, family schism resulted in estrangement from grandmother". However, no one asked about abuse specifically. Eighteen months later the sister of this client was asked about abuse in the home, during a family meeting. She reported that she and the client had experienced both verbal and physical abused in the home by both her parents from a young age. Subsequent to this information being noted the client was offered cognitive behavioural therapy.

Recorded abuse/neglect not included in the formulation or treatment recommendations

One individual had been assessed for an ACC sensitive claim for sexual abuse counselling eight years ago. However, they had not received any abuse-related treatment. During the initial assessment at the CMHC, severe childhood physical and emotional abuse was noted, as well as adult sexual and physical abuse. Childhood physical and emotional neglect were then recorded subsequent to the initial assessment. This client was frequently referred to as suffering from "low grade psychotic symptoms" and alcohol dependency. This individual repeatedly asked to get help with "my PTSD symptoms and with my depression". There were no records of any abuse or neglect being recorded in the formulation or any abuse-related treatment being offered at any time. After almost 10 years in the CMHC system the manager requested an investigation due to the client's "non-responsiveness" and the extended length of time this file had been open.

Another client was initially assessed in 2006. At that time the IA recorded a longstanding violent adult relationship, including rape and physical and emotional abuse. This individual

had been raped brutally and repeatedly over five years of marriage, between the ages of 18 to 24. The assailant had been charged and jailed. The client was initially diagnosed with "Chronic PTSD". However, there was no formulation recorded at the time and the treatment that was offered was exclusively psychotropic medication. Two years later this client was diagnosed with "schizophrenia", and childhood physical and emotional abuse had been included in the notes. During an inpatient admission six months later the clinician in charge wrote, "X has a history of sexual abuse. I explained that X is here under the MHA S.13 which means X is here for treatment, X has to take the medication".

No psycho-social history recorded during the IA

One client was referred to the CMHC for "family problems". There was no information in the notes indicating that the client was asked for any further information to clarify what "family problems" might refer to. Nor were there any other details from this client's psycho-social history recorded. One note stated "got counselling for family problems as a teenager and got over it". This individual was prescribed anti-depressants, and the summary formulation read, "X is experiencing depressive symptoms as a result of current relationship problems. If his/her relationship improves his/her current symptoms will be resolved".

Another client was seen for low mood. The only information recorded during the IA refers to the client's current alcohol abuse. A later entry stated, "X has been homeless for long periods of his/her life". That was the only piece of psychological history available in this client's file. Following the IA there were notes referring to experiences of hallucinations and delusions, although no further psycho-social history was recorded.

CHAPTER FIVE: DISCUSSION

Introduction

Over the last few decades a large body of empirical research has established that abuse and neglect can have negative effects on individuals' well-being, both in the short-and long-term. The literature review in Chapter One, provided convincing evidence that adverse experiences during childhood and/or adulthood can have a significant impact on individuals' psycho-social wellbeing and their mental health (e.g., Felitti et al., 1998; Kessler et al., 2010). Interestingly, when asked, most people tend to think that it is life experiences and/or life circumstances that contribute to mental health problems and therefore probably expect to be asked about the social causes of their problems during assessment interviews (Angermeyer & Dietrich, 2006). Thus, gathering a comprehensive psycho-social history from clients seeking help from mental health services seems essential in ensuring that inclusive formulations and effective treatment plans can be made. Research has also demonstrated that many individuals who have experienced adversity during childhood or later in life benefit from addressing that adversity as part of their recovery process (Briere & Scott, 2006).

The preceding literature review also suggested that findings from the attachment literature may provide some insight into how adverse childhood experiences can develop into mental health problems. Hence, enquiring about individuals' relationships with caregiver(s) as well as asking directly about abuse and/or neglect appears to be essential. Omitting this information could lead to misunderstandings, faulty formulations, and ineffective treatment recommendations. However, research into clinicians' enquiry behaviour has been limited. The limited body of existing research in this area has indicated that enquiry rates into abuse and neglect are low, and only a small number of clients appear to be offered abuse-related treatment. Mental health services at Auckland District Health Board (ADHB) have developed a best practice protocol and recommended staff training as a response to these research findings (Read, 2007).

The main aims of this training initiative were to increase the rate of abuse-related enquiry by clinicians employed in the mental health sector of ADHB, improve how they responded to abused related information (e.g., including abuse information in formulations and treatment

plans), and ensure that individuals were referred on for abuse-related therapy where appropriate (Briere & Scott, 2006; Grossman, Sorsoli, & Kia-Keating, 2006).

The primary purpose of this thesis was to investigate if there has been a significant increase in abuse enquiry and referral rates since the 1997 study (Agar et al., 2002), as well as to consider future clinical and research implications. Information was collected from 250 computerised files across four CMHCs in an urban area. Most previous research has focused on childhood sexual and physical abuse, neglecting many other salient experiences impacting on wellbeing and mental health. Therefore variables such as emotional abuse, neglect, and attachment-related information, which were not addressed in the 1997 study, were included.

Overall, results revealed that recorded prevalence rates and inclusion of abuse information in formulations and treatment plans have increased significantly since data collection in 1997. This chapter will summarise key findings and the relationship of these to international research and particularly to the 1997 comparison study. It will also discuss implications for future clinical practice, training, research, and social policy.

Limitations

The most important limitation of this study, as in any file audit, is that it is possible that clinicians actually enquired about their clients' abuse and/or attachment history without recording these conversations in their files. Clinicians may have chosen, or been asked, to leave out sensitive information, perhaps to protect the privacy of their clients. However, it seems unlikely that clinicians would choose to not record referrals for abuse-related treatment in clients' files. Additionally, other support, such as informed psychoeducation and counselling, may have been offered without being recorded in the file. However, one of the main aims of this study was to explore to what extent clinicians actually record this information in their clients' files, ensuring that future clinicians have access to vital information. Despite some findings, in this study, many clinicians do read previously recorded information. Thus, increasing the recording of all relevant information remains an important goal.

Another possible limitation of these findings is that in some cases individuals may have disclosed abuse or neglect while being asked about other aspects of their psycho-social history, possibly resulting in data not being recorded appropriately.

Limitations related to file audits are frequently linked to: Quality of information recorded in the files, lack of clinical knowledge amongst the researchers, difficulties with inter-rater reliability, and validity of the data. All efforts were made to minimise the effect of these methodological limitations. The quality of the information recorded was part of the purpose of undertaking this project. Both researchers had clinical knowledge, and a previously utilised inter-rater reliability protocol was employed (Agar et al., 2002) increasing the overall validity of the data. Moreover, a significant proportion (95%) of the data was collected by the primary researcher, minimising difference that can arise when multiple researchers are involved.

Although data collection was carried out with predetermined definitions of all recorded variables, clinical notes were sometimes unclear in their description, resulting in events being coded as 'uncertain' and subjected to an inter-rater reliability analysis. A previously tested IRR process was adopted (Agar et al., 2002). Despite being utilised in previously published research, this IRR protocol was subjective in nature (see Chapter Three for a detailed description of this protocol). However, criteria for inclusion were stringent, and it is more likely that actual cases of abuse and/or neglect were omitted from this study resulting in an under-reporting of abuse rates. Furthermore, only a small percentage (12.8%) of files had to undergo this IRR process, with only three files (1.2%) resulting in a disagreement between researchers, making it unlikely that results would change significantly.

Furthermore, collection of attachment-related variables was included in this project to explore a more comprehensive range of childhood adversities. As far as I am aware these variables have not been collected in previous file audits making them difficult to compare with other findings or used to draw conclusions. However, as the previous literature review has indicated many different adverse events contribute to distress and mental health problems making it important to extend research beyond sexual and physical abuse variables. In addition, it is important to recognise that individuals who have developed a more secure attachment system may in fact feel more confident to discuss adversities in their past and/or decribe realtiosnhips with caregivers as conflictual. Thus, caution is warranted when interpreting results indicating insecure attachment based on information gleaned from case notes.

The design of the study does not allow for definite conclusions about the causes of the improvement between 1997 and the current study. These may, perhaps, have been the result of a general increase in public awareness of child abuse and neglect as much as the result of

the new guidelines, training and/or data collection practices of the DHB (see Recommendations for future research p. 116).

It is also important to acknowledge my own personal beliefs and biases. As a doctoral student in clinical psychology, I have predominately been exposed to psycho-social explanations of the aetiology of human distress. My own childhood did not include personal experience of severe abuse or trauma. As an adult I have been privileged to have had the opportunity to work with clients throughout my training whose personal histories reflect many aspects discussed in this study. It is these experiences, in conjunction with a significant body of literature challenging a purely biological aetiology of mental 'illness', that has informed my personal belief that it is experiences in our life, including trauma, abuse, and neglect, frequently in the context of insecure attachment, that contribute to a range of mental health difficulties. These beliefs could have resulted in me making over-inclusive attributions of abuse when reading the files. However, data was recorded with clear definitions to minimise this risk.

Comparison of Main Findings to Previous Literature, Particularly the 1997 New Zealand Study

Overall prevalence rates

It is likely that prevalence rate calculations based on medical files under-estimate the actual occurrence of abuse and neglect. However, more than 93% of clients had some form of adverse experience during their childhood and/or adulthood recorded in their file. This is higher than recorded in other studies. However, this study recorded a more extensive range of variables, likely contributing to this finding. One of the more compatible findings is that of Felitti and colleagues (1998), who found that over 70% of the clients presenting at a general health clinic had experienced adversities (including CEA, CPA, CSA, violence within the home, substance abuse within the home, caregiver diagnosed with a mental illness, or imprisoned) during their childhood. Considering that this study investigated a clinical sample and included abuse in adulthood, it seems unsurprising that a significant majority reported experiencing adverse events during their lifetime. Different types of adverse experiences will now be discussed separately as they frequently are addressed separately in the research literature.

Abuse and neglect prevalence rates

Sixty-four percent of participants had one or more forms of abuse and/or neglect recorded in their files. This is comparable to findings in a similar study in the U.S. (Posner et al., 2008). Almost half (47.2%) of the files included multiple forms of abuse or neglect. This suggests that the various forms of abuse and neglect tend not to occur in isolation from each other, especially in a clinical population. These findings are in line with Kessler and colleagues' (2010) data from 21 countries suggesting that "childhood adversities" are very prevalent and interconnected. They also found that maladaptive family functioning (including childhood abuse and neglect, inter-family violence, and parental substance abuse) was the strongest predictor of all classes of mental health problems throughout life in all 21 countries.

Close to a third (32%) of the files had noted childhood sexual abuse. This was true for 44% of women and 20% of men. This is in line with a recently published literature review where, on average, 46.9% (range 12-100%) of women seen in an inpatient or community setting and 28.7% (range 10-57%) of men had experienced CSA. Fanslow and colleagues' (2007) recent research from New Zealand also supports these findings.

Another interesting finding was that 35.2% of files had documented CEA and 22% had CEN noted, but only 8.8% had recorded CPN. These variables were not recorded in the previous audit (Agar et al., 2002) disallowing a direct comparison, and, as far as I am aware, neglect has not been included as a variable in any similar audits. However, recorded prevalence rates are similar to other large population studies (e.g., May-Chahal & Cawson, 2005). Other reviews have noted higher averages for CEA (46.7%), CEN (51.1%), and CPN (41.2%) in samples of people experiencing psychosis (Read at el., 2008). It is interesting that childhood physical neglect seems overlooked by clinicians compared to other variables including emotional neglect. However, it is encouraging to note that clinicians record an extensive range of adverse events in their clients' files, possibly suggesting that awareness of the impact of childhood adversities has extended beyond events such as CSA or CPA.

Comparisons to the 1997 study

This project collected a more extensive range of variables including emotional abuse, neglect, and attachment-related experiences, only allowing comparisons to be made to the original variables used in Agar and Read's study (2002). Overall, incidents of recorded adverse events have increased significantly since the last data collection in 1997. This overall increase could be explained by the inclusion of emotional abuse, neglect, and attachment variables omitted

by the previous studies. However, rates for specific forms of abuse and neglect have also increased. In 1997, 20% of the files identified CSA, compared to 32.4% in 2010. The increase was even greater for CPA, from 17% in 1997 to 36.4% in the current audit. Findings were similar for adult abuse. Interestingly, adult physical abuse was the only variable to not increase in recorded prevalence rates since the last audit (Agar et al., 2002). These increases were noted across ethnicities and gender, although there was no difference in the recorded prevalence rates of ASA and APA for men. As is it unlikely that the actual prevalence of abuse has changed significantly over a decade, these increases can likely be attributed to improved enquiry rates.

This suggests that mandating enquiring and recording of abuse-related information and recommending training probably does result in increased rates of enquiry. Currier and Briere (2000) found that as little as one hour of training increased enquiry rates significantly. This may also be important in the light of findings suggesting that it is unlikely that individuals spontaneously disclose historical abuse or neglect if they are not asked directly (Read at al., 2006). It is also possible that a graduated increase in general awareness of the impact of childhood adversities may have contributed to these improvements. The use of computerised forms, all including a special section prompting clinicians' to record abuse related information, may also have had a positive impact on recording behaviour. Inclusion of a specific abuse section did not lead to an improvement in recoding rates in a previous inpatient study (Read & Fraser, 1998) but did result in some improvement in Agar's outpatient study (2002). However, data from these two studies (Read & Fraser, 1998; Agar et al., 2002) were collected almost 15 year ago and increased awareness may make this prompting tool more effective now. Nevertheless, a significant number of clinicians (34.8%) still did not ask and/or record information regarding abuse in their clients' files in the current study, likely resulting in a continuing under estimation of actual prevalence rates within this clinical population. These findings highlight how important it is that clinicians ask clients directly about abuse and neglect. This will be discussed further throughout this chapter.

Enquiry Rates

Almost two-thirds (65.2%) of all files indicated that individuals had been asked about potential abuse or neglect at some point. However, only 46% were asked during the IA even if enquiry at first assessment has been suggested as best practice in numerous previous publications (e.g., Agar et al., 2002; Read et al., 2007) and the district health board (ADHB,

2000) guidelines state that abuse enquiry should take place in the context of collecting general psycho-social history, usually gathered during an assessment interview. These findings are higher than many others (Lab et al., 2000, Read et al., 2006; Wilson & Read, 2001). For instance, other studies have found that 15.3 % of clinician's routinely asked males about sexual abuse (Lab et al., 2000) and only 5% of primary care clinicians asked about adverse event when their clients presented with symptoms suggestive of depression (Wilson & Read, 2001). On the other hand, Meyer (2009) found that 91% of psychotherapists asked about sexual abuse and 63% about other psychological traumas.

Furthermore, in over a third (34.8%) of the files in the current study there was no indication that the individual had been asked about abuse or neglect at any time. This is concerning, as we know that individuals are disinclined to spontaneously disclose abuse experiences. Some client barriers to disclosing frequently discussed in the literature are: shame, fear of not being believed, being in a relationship with the offender, no consequences for the offender, belief that the abuse was not serious enough, and not wanting to get the offender in trouble (Sable, Danis, Mauzy, & Gallagher, 2006; Thompson, Sitterle, Clay, & Kingree, 2007). It is possible that individuals were asked about adverse events without this enquiry being recorded in their file. However, there is a specific box in the computerised assessment form to tick to indicate that an enquiry has been made without any adverse events being disclosed.

During this audit, ADHB utilised two computerised forms to record information from IAs. Both of these forms included a specific 'abuse' section with a place to indicate that enquiry had taken place. Abuse enquiry was slightly higher among clinicians who recorded their clients' information in one of the standardised assessment forms compared to a generic note, although this difference was not significant. However, the rates of recorded childhood and adult physical abuse and adult emotional abuse increased significantly among clinicians who used the computerised form. Most training and research to-date has focused on sexual and physical abuse enquiry, likely contributing to clinicians becoming aware and more inclined to ask specifically about these forms of abuse and record their findings. It is clearly important to ask about sexual abuse, though it seems to have taken over 30 years for this to become routine during IAs. However, it is equally important to not overlook other forms of abuse and neglect. It seems plausible that computerised forms would prompt clinicians to record abuse information, increasing the overall rate. It could also be possible that clinicians who follow mandated enquiry protocol are more inclined to fill in the required forms.

Although these figures are encouraging, there are still up to 54% of clients seen at CMHCs who are not asked about abuse during the IA, and over a third appear to have never been asked. Clients diagnosed with PTSD were asked about abuse significantly more (88.9%) than others, and individuals diagnosed with a psychotic disorder significantly less (23.4%). These findings likely reflect possible biases (e.g., the assumption that psychosis has a bio-genetic aetiology) described by several previous researchers (Agar et al., 2002; Read & Fraser, 1998) and remains concerning. Of even more concern is that if clinicians remain unaware of clients' abuse history they may not be referred for appropriate treatment such as trauma-focused therapy.

Abuse enquiry rates varied from 38.9% to 50.6% between the four CMHCs audited. However, these differences were not statistically significant. Individual clinicians were not coded. Only 10.6% of all the files indicated that clients had been asked what they thought may have contributed their current problems.

Enquiry into alcohol and drug use

Over-use of alcohol and non-prescription drugs may both be caused by and contribute to many psycho-social stressors. However, the connection to mental health remains disputed. Some mental health problems may be induced by non-prescription drugs (Tucker, 2009), while on the other hand, substances may be used to avoid emotional pain (Vujanovic, Marshall-Berenz, & Zvolensky, 2011). Most clients (92.8%) were asked about their substance use at some time, and the majority during the IA (89.6%). These proportions are higher than what is found in primary care settings, where 70.5% of males and 64.8% of females were asked about their alcohol consumption (Volk, Steinbauer, & Scott, 1996). Other findings suggest that physicians working in primary care settings remain reluctant to ask about alcohol consumption, due to the sensitivity of the topic, lack of intervention tools, and doubt about the effectiveness of these interventions (Aira et al., 2003).

One possible reason for this high enquiry rate for alcohol and drug use may be that it is comparatively easy to access specific alcohol and drug treatment, compared to trauma-related therapy. In addition, some of the reported barriers for asking about abuse (e.g., apprehension of inducing 'false memories' and not knowing how to respond to abuse disclosures (Young et al., 2001) may not apply as much to alcohol and drug enquiry.

Interestingly, only 50.9% of those asked during the IA were assessed as having a current or recent alcohol and/or drug problem, compared to 86.5% who reported some form of abuse or

neglect when asked. Even if it seems unlikely that all clients who experience abuse or neglect would see their experience as problematic or contributing to their mental health problems, it illustrates a reluctance to ask about events that may be seen as socially objectionable.

Responding to Abuse Disclosures

Results examining how clinicians respond to clients' disclosures of abuse and neglect were encouraging, with the important exception of treatment referrals. Response variables collected during this project were: (i) whether clinicians included abuse and neglect information in the formulations of clients' presenting problems, (ii) in the treatment plans, (iii) referral for abuse-related therapy, and (iv) reporting of alleged crimes to appropriate authorities.

Formulation

Of the 81cases with identified CSA in the file, 46 (56.8%) had this mentioned as part of the formulation. Findings were similar for both CPA (47.3%) and CEA (45.5%), suggesting that approximately half of clinicians take such experiences into consideration when they hypothesise what may have contributed to clients' mental health difficulties. Overall, results indicate a significant improvement compared to other published finings (Agar et al., 2002: Eilenberg et al., 1996; Posner et al., 2008). Interestingly, however, childhood physical neglect was only included in 22.7% of formulations, the lowest proportion for any variable. This supports the notion that researchers and clinicians often overlook the impact of neglect (Slack at el., 2003). Other forms of childhood abuse, including CSA and CPA, have been given more attention both in academic journals and the media, likely contributing to increased awareness. Moreover, people living in poverty may find it more difficult to provide these needs, while others simply prioritise different needs independent of their financial situation. Another contributing factor may be that the training guidelines provided by ADHB omit discussing effects of physical neglect, another indication of how neglect often gets overlooked compared to other forms of abuse.

Compared to forms of childhood abuse and neglect, adult abuse and neglect were only noted in clients' formulations in approximately one third of the files with previously identified abuse (30.6% of ASA, 31.1% of APA, and 29.6% of AEA). This is likely another indication of how beliefs and attitudes of mental health workers influence how and what they regard as relevant to clients' mental health problems. It may be that both academic and media focus

have placed emphasis on adversity during childhood, resulting in reduced attention towards adult experiences. However, research has continued to show that abuse experienced during adulthood can have a considerable impact on individuals' mental health (Jordan et al., 2010; Okuda et al., 2011). Furthermore, individuals who report experiencing childhood abuse are more likely to be victims of further abuse as adults (Balsam et al., 2011), making it important to ask about a range of adverse events throughout life.

Comparisons to the 1997 study

The inclusion of abuse-related information in formulations has increased significantly across all comparable variables (CSA, CPA, ASA, and APA) since the last audit. For example, in 1997 only 17.4% of all noted abuse was included in clients' formulations, and this had increased by more than 300% in 2010 to 56.4%. This improvement is encouraging as it may indicate that clinicians place more emphasis on adverse events as a contributor to mental health problems. Regrettably, this possible shift in aetiological beliefs has not yet translated into improvements in treatment referrals for abuse-related therapy.

Treatment plans

The proportion of files including previously documented abuse or neglect in their treatment plans was less encouraging than other results. Childhood sexual abuse and adult sexual abuse were the most frequently included forms of abuse and neglect in treatment plans. However, only 36 files with (44.4%) of documented CSA and 13 (36.1%) files identifying ASA included this information in the treatment plan. Other forms of abuse and neglect were included in treatment plans less frequently. For instance CEN was only included in 14.5% of treatment plans (refer to Table 21 for all results). Even though these results are concerning, they are an improvement compared to international research. Eilenberg and her colleagues (1996) found that 35% of all recorded abuse was mentioned in treatment plans, most without any relevant treatment recommendations. In fact, only 10% of files documenting sexual or physical abuse had this included in the treatment plan. They found no improvements in their 10-year replication study (Posner et al., 2008).

Comparisons to the 1997 study

The inclusion of abuse-related information in treatment plans has also increased significantly across all comparable variables (CSA, CPA, ASA, and APA) since the last audit. For instance, 16.3% of all recorded abuse was included in the treatment plan in 1997 compared to

42.3% in 2010. The greatest increase was noted for CSA, where only 8.7% were included in treatment plans in 1997 compared to 44.4% in 2010. Once again these results are encouraging and interestingly, similar improvements have not been found internationally (Posner et al., 2008).

Referral for trauma-focused therapy

One of the most significant findings of this project is that even if enquiry rates and recording of abuse-related information in formulation and treatment plans have improved significantly over the last decade, the number of clients referred for trauma-focused therapy has remained unchanged. No attempt was made to record if referrals were made within the CMHC or to other agencies such as ACC. Only 23.5% of all files documenting CSA and 19.8% of all documented cases of CPA and ASA (19.4%) recorded a referral for abuse-related therapy. Proportions were even smaller for CPN (13.6%), CEN (10.9%), APA (11.5%), and AEA (11.1%). Posner and colleagues (2008) found similarly lacking treatment referrals in their replication study. However, others have found that more than a third of all clinicians who identified abuse during their assessments reported that they would refer clients on to a community source or an internal psychologist (Lab et al., 2000).

Comparisons to the 1997 study

The proportion of clients being referred for abuse-related therapy has not improved since 1997. For instance, 22.5% of clients with an identified history of CSA were referred for treatment in 1997, compared to 23.5% in 2010. Additionally, 15.4% of clients with an identified history of APA were referred for treatment in 1997 compared to 11.5% in 2010. While these findings are concerning, there may be several explanations for this ongoing lack of appropriate treatment recommendations.

One reason may be differences in aetiological beliefs. Even if clinicians are mandated to ask about abuse and to recommend best possible treatment, those who subscribe to a more medical model may see psychotropic medication as the best treatment for their clients, making it less likely that they would recommend abuse-focused therapy. Naturally, this does not apply to all psychiatrists, but is likely a more dominant view among medically trained clinicians. In addition, monetary restraints can result in reduced access to therapy and the option of a private therapist is often too costly for many clients seen by a CMHC.

Reporting of possible criminal offences

Only three files (1.9%) stated that the clinician had reported an alleged offence to legal authorities, and 11 (6.8%) suggested that there had been some discussion about the possibility of reporting a current or historical alleged offence. Considering the high overall prevalence rate (including 81 files recording CSA, 36 files noting ASA, and 61 files recording APA, all crimes in New Zealand), three reports to legal authorities seems problematic. These low and disappointing numbers are similar to previous findings (Agar et al., 2002; Eilenberg et al., 1996; Read & Fraser, 1998a). None of the files in Eilenberg's (1996) original study included any documentation of reporting to protective services or legal authorities. Findings were the same for the New Zealand inpatient study (Read & Fraser, 1998a) where no abuse was reported to appropriate authorities. In fact, sexual abuse has been suggested to be the most under-reported of all violent crimes (Fisher, Daigle, Cullen, & Turner, 2003, 2006).

Comparisons to the 1997 study

The proportion of reporting of alleged crimes has increased from 0% in 1997 to 1.9% in 2010, with a further 6.8% documenting a discussion about the possibility of reporting in 2010 compared to 0% in 1997. These numbers remain extremely low.

Demographics

Gender

Females were significantly more likely to have all forms of abuse and neglect, except childhood physical abuse, recorded in their files. These findings directly correspond with enquiry rates, as females were asked significantly more frequently than males. Overall abuse rates showed that 60% of females experienced multiple forms of childhood and/or adult abuse compared to 34.4% of men. Twenty women had more than six different forms of abuse recorded compared to two men. This gender difference was even more pronounced in regards to abuse and neglect occurrences during adulthood, when 56% of females were recorded as having experienced some form of abuse or neglect compared to 14.4% of males. Recorded abuse rates are frequently higher for females (Agar et al., 2002; Fergusson et al., 2008) possibly, as previous research has suggested clinicians are more reluctant to ask male clients about these experiences (Read & Fraser, 1998a). This may explain part of these significant gender differences, but it is unlikely to be the entire explanation, which probably includes complex socio-cultural values and norms about gender and sex. Interestingly, these gender

differences were not seen in AREs. It would be valuable to explore this further in future research.

As previously noted, females were significantly more likely to be asked about abuse and neglect before, during, and after the IA. For instance, 56.6% of females were asked about abuse or neglect during the IA compared to 34.4% of males. This is in line with other research suggesting that males are less likely to be asked about abuse than females (Lab et al., 2000; Mills, 1993; Read & Fraser, 1998a). This difference was also noted during the evaluation of the New Zealand training programme over eight years ago (Cavanagh et al., 2004), where prior to the training clinicians reported that they were less likely to ask male clients about abuse. These results would suggest that this discrepancy remains, over eight years later, even though the training programme encouraged staff to ask all clients, possibly suggesting that socio-cultural norms and gendered biased beliefs remain strong.

Ethnicity

There was also some significant differences dependant on ethnicity. For example, both Māori and Pacific Island clients had four or more forms of abuse recorded in their file more frequently than New Zealand European clients. Minority groups in New Zealand and in many other countries around the world are over-represented in many negative statistics, including mental health problems (Marie et al., 2008). These differences tend to be even more evident in societies where the differences between rich and poor are greater, such as the USA, the UK, and New Zealand (Wikinson & Pickett, 2009).

The only significant difference in enquiry rates dependent on ethnicity was that clients identified as Māori were asked about adverse events more frequently than clients identified as Pacific Islanders during and prior to the IA. Māori also had higher recorded rates of all forms of childhood abuse and/or neglect. As overall results indicate, identified abuse rates increase concurrently with enquiry rates.

Clients identified as Māori and Pacific Islander had ASA and APAN recorded in the formulation significantly more frequently than clients identified as New Zealand European. Interestingly, a larger proportion of New Zealand European clients had ASA information included in their treatment plans, but this was not so for APAN. Findings were less conclusive for childhood abuse and neglect. Clients identified as Māori had abuse information mentioned in their treatment plans and in referral information more frequently compared to New Zealand European clients but not in formulations. It is difficult to say what

may have contributed to these differences. Future qualitative research may be able to further inform these findings.

Age

The only demographic difference noted in regards to enquiry about family relationships and alcohol and drug use was age. Younger clients were asked both questions significantly more frequently. For example, the mean age for clients who were asked about alcohol and drug use was 34.6 years versus 44.1 for those not asked. However, family relationships continue to have implications on individuals even as they get older (e.g., Silverstein & Giarrusso, 2010), and substance misuse can remain common throughout life (e.g., Epstein, Fischer-Elber & Al-Otaiba, 2007). Thus, asking across the lifespan is important.

Diagnosis

As in previous New Zealand studies (Read & Fraser, 1998: Agar et al., 2002) clients diagnosed with a psychotic disorder were less likely to be asked about abuse. Only 23.4% of clients with a diagnosis of psychosis were asked, compared to 88.9% of those diagnosed with PTSD. Once again, these discrepancies remain despite being addressed during the mandated training (Read, 2007). This makes it likely that attitudes and beliefs, including belief in a medical paradigm in which childhood adversities are considered relatively unimportant, may be perpetuating these inequities.

Clinicians

Moreover, and at odds with previous findings (Agar et al., 2002), female clinicians were found to ask about abuse more frequently than male clinicians. Considering that some agencies gender match clinicians and clients (when possible) this problem could be magnified as these findings would suggest that when this occurs male clients seen by male clinicians may have significantly reduced chances of being asked about abuse, and may therefore be even less likely to be offered appropriate treatment.

Interestingly, one of the few significant differences in responding to disclosures dependant on demographics was that, while female clinicians ask about abuse and neglect more frequently, male clinicians include CPN and AEA in their formulations, treatment plans, and referrals more frequently than female clinicians. Findings were similar for APAN, although only noting a difference in the treatment planning and referral information. Female clinicians

included ASA in their formulations and CEA in their treatment plans significantly more frequently than male clinicians. These findings may seem counterintuitive and are unlike those noted in Agar and Read's study (2002), where females were found to be more likely to include abuse-related information in treatment plans and refer clients on for abuse-related treatment.

Comparisons to the 1997 study

There were a few significant demographic differences in the sample compared to 1997 that are worth noting. Firstly, this project included 60 (24%) files identified as Māori clients compared to 21 (10.5%) files in 1997. This difference may be explained by the change of inclusion criteria to all four CMHCs in ADHB, as the last audit only collected data from one CMHC located in one of the wealthiest suburbs in Auckland, which has a smaller portion of Māori residents. It is also possible that clinicians ask about and record ethnicity more frequently than in 1997. The larger proportion of Māori clients in the current research project is, however, a more representative sample of the ethnic distribution of clients seeking help for mental health problems (Ministry of Health, *Mental health: Service use in New Zealand* 2001/02 to 2006/07).

Another significant difference was that almost three quarters (74.8%) of clients in this audit were seen for their IA by a psychiatrist compared to 54.4% in 1997. This increase in psychiatrists conducting IAs was paralleled by a significant reduction of psychologists and social workers carrying out the IA in 2010. This is interesting as data has shown that there has been a significant overall increase in abuse enquiry rates since data collection in 1997 and one barrier to asking about childhood abuse often quoted is aetiological beliefs (Young et al., 2001), especially the biological causation model often held by medically trained professionals. Despite this, recording rates have improved, indicating that beliefs may have begun to change across professions to adopt a more psycho-social approach to enquiry. Alternatively, it may simply be that enquiring about abuse is now mandated, making it more difficult to ignore this question during IAs. Unfortunately, these improvements have not translated into an increase in referral rates for abuse-related therapy.

Moreover, significantly more clinicians in this audit utilised a standardised assessment form, 61.2% compared to 13% in 1997. It is likely that the overall computerisation of medical files has contributed to this increase as most clinicians would never read a hard-copy file anymore. One possible implication of this is that computerised core adult assessment forms are easier to access for clinicians without trolling through sometimes hundreds of pages of notes to find

previously recorded information, hopefully resulting in fewer failing to notice previously identified abuse and neglect.

Summary of comparison to the 1997 study

One of the main research aims for this project was to investigate if there had been any change in the rate of enquiry and how clinicians respond to disclosures at CMHCs since the time of the original data collection in 1997 (Agar et al., 2002). Overall there have been significant improvements, both in enquiry about and response to abuse disclosures. However, there are a few areas where these improvements are absent. Males and clients with a diagnosis of psychosis continue to be overlooked when enquiring about adverse events despite numerous recommendations to the contrary. Moreover, and of equally significant concern, is that referral rates for trauma-focused therapy have remained low and static over the past decade, making it likely that many clients seen by a CMHC in Auckland may be denied access to best possible treatment.

Attachment Related Experiences

Overall prevalence rates

It is important to remember that AREs recorded in this audit are supplementary to abuse and neglect variables. AREs have a considerable impact on the development of individual attachment styles (Sroufe et al., 2005) and have been shown to account for a significant amount of the variance contributing to mental health problems (Dallaire & Weinraub, 2007). There are many different AREs that can contribute to the development of mental health problems throughout life. Thus, asking clients about these experiences ought to be central to clinicians' enquiries as this information may have significant bearing on formulation and treatment planning. Moreover, given the dramatic impact AREs including death can have on an individual's wellbeing both in childhood and adulthood enquiring as to its occurrence may aid in assuring that best possible treatment is recommended.

Overall prevalence rates of other AREs, excluding abuse and neglect variables, have not been recorded in previous file audits, disallowing any direct comparisons. However, 80% of all 250 files had documented some form of ARE during childhood (childhood attachment related experiences (CAREs)). It seems likely that asking about AREs such as loss and adoption may be less challenging for many clinicians than asking about experiences such as sexual abuse,

perhaps resulting in higher recording rates than for abuse and neglect. No attempt was made to investigate if AREs were included in formulations and/or treatment plans. Both of these aspects would warrant further investigation, and will be discussed in greater details later in this chapter.

Overall, 80% of files had recorded at least one CARE and 58.4% had identified multiple CAREs, revealing that possible disruptions in attachment are relatively common within a clinical sample. Moreover, individuals who had CAREs noted in their files also reported experiencing more adult ARE. It is possible that individuals become more at risk of future AREs due to experiences during their childhood. However, it is also possible that this finding reflects the intergenerational nature of mental health problems (Davey & Eggebeen, 1998; Turney, 2011). This was further supported by results indicating that clients being seen by community mental health services experienced events negatively correlated to secure attachment more frequently than a non-clinical population. For example, 17.2% of this sample had been placed in foster-care or permanently adopted compared to less than 0.2% of the general population (Pollock, 2011). It also seems likely that many children removed from their primary caregiver(s) also experience some form of abuse and/or neglect prior to and, for some, following, the adoption, possibly contributing to cumulating effects.

Enquiry rates

Almost three quarters (72.4%) were asked about their relationship with their parents/caregiver. This was significantly more than those who had been asked about their abuse history. One reason for this high rate of enquiry may be that clinicians ask about family relationships to establish if clients are able to live with their family or receive additional support. The majority of clients (58.8%) described their relationship with family as conflictual or estranged. Only 13.6% described their relationship as close or good. Information from a file audit is not enough to evaluate attachment or attachment style. It does, however, seem possible that these results reflect low attachment security, as it is established that a variety of AREs, including abuse and neglect, result in insecure attachment and are associated with many mental health problems (Grossmann, et al., 2005). Moreover, these findings appear different from general population studies, global distribution of attachment style suggesting that 62% are securely attached to their caregiver (van Ijzendoor & Sagi-Schwartz, 2008). Overall these results seem to support the probability that Attachment Theory holds some of the answers into how abuse and other adverse events contribute to poor mental health throughout life.

Implications

For clinical practice

It is important that these results are disseminated to clinicians working within CMHCs in Auckland and the wider community. Significant improvements would not have been possible if clinicians were unwilling to adapt their behaviours and take on recommendations suggested by training programmes. Thus, providing positive feedback is important as reinforcement of good clinical practice. A full copy of this thesis will be given to the clinical directors of ADHB as well as all four CMHCs audited in this project. Furthermore, verbal presentations will be offered for staff at all four CMHCs and findings will be submitted to international journals and presented at conferences, hopefully encouraging constructive debate.

Despite these encouraging findings there are some important implications for future clinical practice. One of the more concerning findings was the lack of trauma-related treatment recommendations. There could be several reasons for this finding. One may be that access to therapeutically trained professionals in CMHCs is limited. Since completing the data collection for this project, I have been employed as an intern psychologist at one of these CMHCs for twelve months. I frequently noticed during team meetings and complex case reviews that many clinicians reported that they were disinclined to refer their clients for psychological therapy as the wait list was too long. This may be true; however it does not negate the importance of actually recommending best possible treatment for clients and documenting the need for therapy. Moreover, ADHB policy suggests that all clients with an identified abuse history are offered treatment or referred to specialised services including ACC. This is clearly in conflict with findings from this study and would be in need of further attention at management level.

These findings also support the need for more therapy time e.g., more therapeutically trained professionals employed at CMHCs (psychologists and psychotherapists, ideally with specific abuse-focused training) and signals the need for further funding or redistribution of existing budgets. This is clearly an ongoing and complex challenge, and even more so in the current economic climate. However, results like these may go some way towards influencing both public opinion and policy-makers' decisions about allocating funding.

As previously mentioned, this is the first study that included childhood neglect as a variable, and results indicated that awareness and/or beliefs about the impact of neglect need further attention. It is possible that increased attention to sexual and physical abuse may have contributed to an oversight of other forms of adversities including neglect. However, as emotional and physical, neglect can have a significant impact on the developing individual and can contribute to insecure attachment and mental health problems throughout life, it remains important to increase clinicians' awareness of these connections to ensure accurate formulations and best possible treatment recommendations.

Interestingly, clinicians frequently asked about and recorded variables associated with the attachment literature. Unfortunately, information was not gathered as to the prevalence of these variables in formulations and treatment planning. Even though these findings are preliminary, and need to be replicated, they can hopefully contribute to an increased awareness of attachment and the possible impact of insecure attachment on individuals' mental health. Moreover, they might also contribute to a further shift in the direction of a more psycho-social understanding of psychological distress.

Finally, there are legal obligations to report current childhood abuse in New Zealand (Child, Young Person's and their Families Act, 1989). As recently as 2012 legal changes were made in New Zealand, making it a criminal offence to not report suspected current child abuse. However, these laws do not include historical abuse or assaults against adults. Collectively, findings from this study and many previous findings suggest that it may be time to consider similar legal amendments for historical abuse. This may support both clinicians and victims to address these difficult events. In addition, one could argue that clinicians may have ethical obligations to at least discuss the option of reporting alleged crimes with their clients, and if so, recording this information for future clinicians' benefit. However, result were once again disappointing and in need of further attention.

Many of the other clinical implications may best be served by amendments to training programmes. This will be discussed in the following section.

For future training/trainers

This project has identified some areas of interest for current and future training providers both in New Zealand and internationally. Initially, there appears to be a persistent reluctance to ask male clients about abuse, despite, current training programmes covering this bias specifically. It is difficult to know how we can change this, but additional time allocated

during training, specifically discussing this disinclination, and further attention at management level may make some progress. This problem appears to have existed for decades now and it seems likely that male clients may be receiving a less than satisfactory service from community mental health services, warranting some specific attention.

Another continually overlooked group are individuals who have been diagnosed with a psychotic condition. As with male clients, this group is asked about abuse less frequently and subsequently is less likely to access trauma-focused therapy. This is of further concern as research repeatedly has shown that there is a strong connection between abuse and development of psychosis (e.g., Janssen et al., 2004; Read et al., 2005). Thus asking about abuse-related experiences and recommending trauma-related counselling where appropriate seems essential. Training providers may need to reflect on how they deliver this message and what else could possibly be done to improve these rates.

It would also be an improvement if future training programmes incorporated a discussion on an extended range of adverse events, including neglect, poverty, and attachment variables such as loss, adoption, and separation. This would contribute to a constructive debate on the aetiology of mental health problems and what forms of treatment may support people in their recovery. A future aim for training providers and health boards ought to be that enquiring about adverse events become as normative as asking about alcohol and drug use across gender and diagnostic categories.

District health boards are often restricted by funding and government policy, thus supportive initiatives needs to be made by the policy makers. Some suggestions are discussed on page 117.

For future research

Research into clinical enquiry behaviour is limited. As with many quantitative research projects, understanding of these results would be enhanced by future qualitative projects, including exploring differences between clinicians identified as ‘good’ history takers and those identified as recording less satisfactory psycho-social histories in their clients’ files. This may provide some insight into beliefs, assumptions or systemic problems that may contribute towards a continuing reluctance to ask about adverse events, including them in formulations and recommending trauma-focused therapy. Moreover, conducting semi-structured interviews with clinicians and clients may shed some further light on gender differences in enquiry behaviours identified by this study.

In addition, this project only noted whether or not adverse events were included in summary formulations, treatment planning, and referrals. Future research would benefit from investigating whether the qualities of these have improved and how many clients actually received therapy within the service or from external services. This seems especially important as there appear to have been no improvements in referral rates for trauma-focused therapy since the last data collection in 1997.

Another possibility for future research is further investigation into attachment variables. As suggested in previous chapters, Attachment Theory may provide a link between adverse events in childhood and mental health problems. Findings from this study suggest that attachment-related experiences, frequently linked with insecure attachment, are common within a community sample and clinicians seem to ask about relationships with caregivers. However, no attempt was made to explore if clinicians had included these variable in formulations and treatment recommendations, possibly overlooking an important link in need of future exploration.

Moreover, results from this study seem to suggest that the training programme mandated by ADHB has had positive implications on clinicians' enquiry behaviour. However, this can only remain a hypothesis until an official evaluation of this training programme has been undertaken, ideally recording differences in enquiry behaviour between clinicians who have undertaken the training and those who have not.

Finally, and of some urgency there is no research to-date exploring enquiry behaviours of clinicians working in child and adolescent services. As a large proportion of adverse events and attachment-related experiences recorded in this study occurred during childhood, this makes them very relevant to child and adolescent services. This seems like a significant gap in the literature in need of urgent attention.

For social policy and primary prevention

Results from this study seem to suggest that clinicians have become more aware of a link between childhood adversities and mental health problems, or at the very least, more aware that it is important to ask clients about these experiences. This is indeed encouraging. However, how to increase policy makers' awareness of this likely link continues to be a challenge. If we accept that childhood adversities and attachment security play a significant role in the aetiology of mental health problems, primary prevention policy becomes essential. Recent government initiatives such as consultation (e.g., the green paper for vulnerable

children) with families and professionals are welcomed (MoSD, 2011). However, evidence is mounting as to this connection and warrants further action.

It seems like some politically difficult decisions needs to be made, including allocating funding for early detection of abusive or neglectful homes, providing free quality parenting support, and more specialist staff working with families to reduce these negative trends (e.g., Mardani, 2010).

Another important finding from this study is that although more clinicians ask and document abuse histories for many of their clients, only a small portion get referred for trauma-focused therapy. One reason for this concerning finding may be the lack of availability of affordable therapy. Thus committing more funds for therapeutically trained professionals working in community settings seems essential. There is currently a trend in New Zealand allocating more funding for child and adolescent mental health. While this is positive, it is problematic if this comes at a cost to adult mental health services, as adults are the parents of our next generation.

Another improvement would be publicly funded trauma treatment centres, where both clients and clinicians can gain support. Proving trauma therapy is highly emotionally demanding work for both clients and therapists, and working in supportive teams may help reduce therapist burnout and provide a supportive environment for clients while they work through their recovery process.

Concluding Remarks

As previously noted, research into clinicians' enquiry behaviour is limited. The majority of studies have focused on if and in what detail clinicians ask about abuse. Significantly less research has been conducted into how clinicians respond to the information gathered. This study explored both of these areas. It was also important for this project that data was collected on a wide range of variables, including emotional abuse and neglect, to ensure that awareness of the impact adverse events on individuals' mental health continue to extend beyond sexual and physical abuse. This is the first New Zealand study, and only the second internationally, to compare enquiring and response rates over time. It is the first, anywhere, to include neglect and attachment related variables.

Furthermore, effort was made to differentiate enquiry behaviour from recorded prevalence rates, further informing our findings. Collectively these variables have played a part in strengthening this study and contributing to filling a significant gap in the research literature.

Findings from this study are overall encouraging as there have been significant improvements in both enquiry and response behaviour since the last audit in 1997 (Agar et al., 2002). However, additional training or a somewhat modified training programme may yield even further improvements. One of the most concerning findings was that the majority of individuals who disclosed abuse and/or neglect were not referred for trauma-focused therapy. While efforts ought to be continued to educate clinicians to ask everyone about abuse and neglect, focus may also need to be on ensuring that individuals can access best possible treatment.

Further implications in light of these findings include improving enquiry rates for specific subgroups of clients seen in CMHCs, including men and clients experiencing psychosis. Moreover, it is hoped that this project contributes to an increased awareness and understanding of how a wide range of psycho-social experiences can impact wellbeing. Furthermore, if we accept that there is a link between adverse events throughout life and the influence of attachment and experiencing mental health problems, extra resources would need to be allocated not only to primary prevention but also to increasing accessibility to psycho-social interventions and supporting further research into clinicians' enquiry behaviour, especially in child and adolescent services.

Finally these findings are far from unique and we ought to consider how many more studies would need to be published before management and policy makers begin taking responsibility and implement some costly but essential policy for long-term social benefits.

“If you don’t know what is wrong with a person, ask him: he may tell you”

(Kelly, 1963, pp. 322)

Appendix A

Data collection form for proposed study at Cornwall House

This information is **strictly confidential**: If found <u>please</u> contact Dr John Read on or Maria Sampson on

<table>
<tr><td>File Nr</td><td>Nr

CMHC</td><td>Age at assessment

Marital status

Employment status</td><td>Ethnicity

Gender M F

Level of education</td></tr>
<tr><td colspan="2">Assessment Date 3 F2F
Yes No</td><td>Diagnosis at assessment
1.
2.</td><td>3.
4.
5.</td></tr>
<tr><td colspan="2">Medication at or subsequent to assessment?

Yes No</td><td>1.
2.
3.</td><td>4.
5.
6.</td></tr>
<tr><td colspan="2">Suicide

Previous attempts
Yes No

Multiple attempter
Yes No</td><td>Risk to self (from risk form)

Low

Medium

High</td><td>Risk to others (from risk form)

Low

Medium

High</td></tr>
<tr><td colspan="2">Gender of profession at admission

M F</td><td colspan="2">Profession</td></tr>
<tr><td colspan="2">Asked about alcohol or drug abuse

Yes No</td><td>At assessment Yes No

Prior to Assessment Yes No

Post assessment Yes No</td><td>Current/or recent problematic use

Yes No

Specify:</td></tr>
<tr><td colspan="2">DSM at assessment

Axis 1:</td><td>Axis 2:

Axis 3:</td><td>Axis 4:

Axis 5: GAF=</td></tr>
</table>

<table>
<tr><td>Were they asked about abuse during the assessment

Yes No

Prior to the assessment

Yes No

After the assessment

Yes No</td><td>Referral
Yes No

Formulation
Yes No</td><td>Treatment Plan

Yes No

Specify:</td></tr>
<tr><td>Has the client ever told anyone else about the abuse?
Yes No ?</td><td colspan="2">Specify:</td></tr>
<tr><td>What was the response from the disclosure?</td><td colspan="2">Specify:</td></tr>
<tr><td>Has the client had any treatment related to the disclosure?
Yes No ?</td><td colspan="2">Specify:</td></tr>
<tr><td>Were the client asked if he/she though that there were any connection between what happened and where they are now?

At assessment Yes No

Prior to the assessment

Yes No

After the assessment

Yes No</td><td colspan="2">Specify:</td></tr>
</table>

<table>
<tr><td>If abuse or neglect of any kind was noted but not referred for further treatment or mentioned in the formulation, was an explanation offered

Yes No</td><td colspan="2">If Yes Specify :</td></tr>
<tr><td>Was anything reported?

Yes No</td><td colspan="2">If Yes Specify:</td></tr>
<tr><td>Was reporting discussed?

Yes No</td><td colspan="2">If Yes Specify:</td></tr>
<tr><td>Was an Core Adult Assessment form filled out (or similar)
Yes No</td><td colspan="2">Specify form and date</td></tr>
<tr><td>Was the abuse section filled in on the Core Adult Assessment

Yes No</td><td colspan="2">Was abuse specified in other documents and, if so, where.</td></tr>
<tr><td>If yes, was CSA noted

At assessment
Yes No

Prior to assessment
Yes No
After the assessment
Yes No
Specify:

Perpetrator:

Duration:

Age abuse commenced:</td><td>Referral
Yes No

Formulation
Yes No</td><td>Treatment Plan

Yes No

Specify:</td></tr>
</table>

<table>
<tr>
<td>If yes, was CPA noted?
At assessment
Yes No

Prior to assessment
Yes No
After the assessment
Yes No
Specify:

Perpetrator

Duration:

Age abuse commenced:</td>
<td>Referral
Yes No

Formulation
Yes No</td>
<td>Treatment Plan

Yes No

Specify:</td>
</tr>
<tr>
<td>If yes, was CEA noted?

At assessment
Yes No

Prior to assessment
Yes No
After the assessment
Yes No
Specify :
Perpetrator:

Duration:

Age abuse commenced:</td>
<td>Referral
Yes No

Formulation
Yes No</td>
<td>Treatment Plan

Yes No

Specify:</td>
</tr>
<tr>
<td>If yes, was CEN noted?
At assessment
Yes No

Prior to assessment
Yes No
After the assessment
Yes No

Specify :

Perpetrator:

Duration:

Age abuse commenced:</td>
<td>Referral
Yes No

Formulation
Yes No</td>
<td>Treatment Plan

Yes No

Specify:</td>
</tr>
</table>

<table>
<tr>
<td>If yes, was CPN noted?
At assessment
Yes No

Prior to assessment
Yes No
After the assessment
Yes No

Specify :

Perpetrator:

Duration:

Age abuse commenced:</td>
<td>Referral
Yes No

Formulation
Yes No</td>
<td>Treatment Plan

Yes No

Specify:</td>
</tr>
<tr>
<td>If yes, was ASA noted?
At assessment
Yes No
Prior to assessment
Yes No
After the assessment
Yes No
Specify :

Perpetrator:

Duration:

Age abuse commenced:</td>
<td>Referral
Yes No

Formulation
Yes No</td>
<td>Treatment Plan

Yes No

Specify:</td>
</tr>
<tr>
<td>If yes, was APA or neglect noted?
At assessment
Yes No
Prior to assessment
Yes No
After the assessment
Yes No
Specify :

Perpetrator:

Duration:

Age abuse commenced:</td>
<td>Referral
Yes No

Formulation
Yes No</td>
<td>Treatment Plan

Yes No

Specify:</td>
</tr>
</table>

If yes, was AEA or neglect noted? At assessment **Yes No** Prior to assessment **Yes No** After the assessment **Yes No** Specify : Perpetrator: Duration: Age abuse commenced:	Referral **Yes No** Formulation **Yes No**	Treatment Plan **Yes No** Specify:

Attachment information found at any point in records (except 1st 2nd Q).

Asked about parental/caregiver relationships prior to 18 at assessment? **Yes No** After 18 **Yes No**	Specify:
Asked about any attachment related events at assessment? **Yes No** Prior to assessment **Yes No** After the assessment **Yes No**	Specify:
Death of parent/caregiver prior to 18? **Yes No** After 18 **Yes No**	Specify:
Adoption or foster care? **Yes No**	Specify:

Separation or divorce before 18? **Yes** **No** After 18 **Yes** **No**	Specify:
Significant attachment figure history of mental illness prior to 18? **Yes** **No** After 18 **Yes** **No**	Specify:
Significant attachment figure history of alcohol and/or drug abuse prior to 18? **Yes** **No** After 18 **Yes** **No**	Specify:
Witness "domestic violence" prior to 18? **Yes** **No** After 18 **Yes** **No**	Specify:
Bullying prior to 18? **Yes** **No** After 18 **Yes** **No**	If Yes Specify:
Other adverse events or experiences prior to18? **Yes** **No**	Specify:
Other adverse events or experiences after 18? **Yes** **No**	Specify:
Poverty prior to 18? **Yes** **No**	Specify:
Poverty after 18? **Yes** **No**	Specify:

<table>
<tr><td>Hallucinations

Aud

Vis

Tact

Olf</td><td colspan="2">Content</td></tr>
<tr><td>Delusions

Par

Grand</td><td colspan="2">Content</td></tr>
<tr><td>Thought Disorder</td><td colspan="2"></td></tr>
<tr><td>Cat/Disorg</td><td colspan="2"></td></tr>
<tr><td>Negative Symptoms</td><td colspan="2">Type/details</td></tr>
<tr><td>Dissociation</td><td colspan="2"></td></tr>
<tr><td>Age at 1st treatment</td><td>Nr of Inpatient Admissions</td><td>Age 1st inpt.</td></tr>
</table>

Notes:

References:

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