Author/s:
Sellick, Kathryn

Title:
Responding to sexual abuse survivors who hear voices: a challenge for mental health services

Date:
2017

Persistent Link:
https://hdl.handle.net/11343/192630

RESPONDING TO SEXUAL ABUSE SURVIVORS WHO HEAR VOICES: A CHALLENGE FOR MENTAL HEALTH SERVICES

Kathryn Sellick

ORCID: 0000-0003-4691-3676

Submitted in total fulfilment of the requirements of the degree

Doctor of Philosophy

June 2017

Department of Social Work

Melbourne School of Health Sciences

Faculty of Medicine, Dentistry and Health Sciences

University of Melbourne

ABSTRACT

A growing body of research indicates that a substantial proportion of individuals who hear voices (otherwise known as auditory hallucinations) have also had experiences of sexual abuse. In addition to this, research indicates that experiences of sexual abuse lead to an increased severity and complexity of presenting psychiatric distress. Consequently, need exists for mental health services to effectively respond to consumers who hear voices and have experienced sexual abuse. This is consistent with a growing interest in trauma-informed approaches to care. There is limited research, particularly in Australia, examining how the service system responds to sexual abuse survivors who hear voices. This research project aimed to address this gap by investigating how the Australian mental health system responds to individuals who experience voice hearing and have past experiences of sexual abuse.

This project implemented a multi-strand, mixed method design. Consumers who hear voices and had experienced sexual abuse (n=7) were interviewed about their use of mental health services. Mental health professionals (n=213) were surveyed about their work practices when working with voice hearers who have experienced sexual abuse.

The results of this study indicate that while a proportion of mental health professionals surveyed were routinely screening voice hearers for sexual abuse, almost half were not. Several factors were found to influence screening behaviour including the presentation of consumers, beliefs about the causes of voice hearing, concerns about upsetting consumers, the gender of the professional, and organisational requirements for screening. The consumers who were interviewed detailed rarely being screened for sexual abuse when using mental health services and identified numerous barriers to voluntary disclosure. Further, they identified various negative impacts of not being screened. This highlights the need for mental health professionals to effectively screen

for sexual abuse.

Mental health professionals surveyed largely included disclosures of sexual abuse in professional formulations and treatment plans, but found that a lack of appropriate, accessible trauma counselling services impacted on their ability to respond effectively to voice hearers who had experienced sexual abuse. The consumers interviewed reflected this finding and described struggling to find effective support in a divided service system.

Several themes were evident in the interviews and surveys that reflect supportive practice for voice hearers who have experienced sexual abuse. The value of helping consumers develop an understanding of their distress was highlighted. In addition, the need to avoid re-traumatisation was noted along with the importance of quality, power-sensitive relationships between consumers and professionals.

The results from this study indicate that there are several approaches that practitioners and organisations can take to meet the needs of voice hearers who have experienced sexual abuse. There are, however, a number of systemic barriers that can be seen to inhibit effective service responses. This reveals limitations in the current positioning of trauma-informed care in Australian mental health services and the highlights the need for integrated approaches to care for voice hearers who have experienced sexual abuse.

DECLARATION

This is to certify that:

I. this thesis only compromises of my own original work towards the Doctor of Philosophy,

II. due acknowledgement has been made to all other materials used,

III. the thesis is fewer than 100,000 words in length, exclusive of tables, bibliography, and appendices.

Signed:

Kathryn Grace Sellick

ACKNOWLEDGEMENTS

This research would not have been possible without the generous support and contribution of many individuals and organisations.

Thank you to the interview participants who shared their, often very difficult, stories of using mental health services. Your courage in sharing your experience is very much valued. I hope that this research is, in some way, successful in shaping a better mental health system.

Thank you to the many mental health professionals who took part in the survey. Your honest perspective on the work that you do has been invaluable in this research.

Thank you to the team at Prahran Mission and Voices Vic who encouraged me to begin this journey. A very special thanks to Indigo Daya – she highlighted the need for this research and has provided incredible support throughout all stages of this project. Our ongoing discussions have greatly influenced this research and have kept me committed to the task of improving mental health services for people who hear voices.

I am very grateful for all of the support from the Department of Social Work at the University of Melbourne. My primary supervisor, Dr David Rose, has provided countless hours of guidance, support, and encouragement. His ever-present optimism and belief in my capacity is very much appreciated. My secondary supervisor, Professor Louise Harms, has been an incredible source of wisdom and guidance. Her belief in me, combined with her outstanding feedback, has helped me to produce my very best work.

Thank you to Professor Cathy Humphreys, the chair of my candidature committee, for her advice and guidance. Her outstanding research and advocacy has been a huge inspiration for this work.

Thank you to Dr Sandy Clarke from the University of Melbourne Statistical Consulting Centre for invaluable statistical analysis advice.

I've very lucky to have shared my PhD journey with a group of wonderful women who have constantly inspired and supported me. Thank you Lauren Kosta, Gemma McKibben, Lyndal Hickey, Jen Donovan, Connie Kellett, and Katie Lamb.

A very heartfelt thank you to Dr Grady Hancock, Dr Melanie Thompson, and Dr Sabin Fernbacher for sharing their wisdom in surviving a PhD. Their ongoing encouragement, support and guidance has been very much appreciated.

During this research project, I was very lucky to be employed at Cohealth and the University of Melbourne and am grateful for their flexibility and encouragement throughout this process.

Thank you to my wonderful friends and family. The joint passion for social justice and learning shared by my parents is what drew me to this path. Throughout this research project I have been surrounded by the most incredible friends one could hope for, thank you for all the love and care over the years, and thank you for reminding me to never take life too seriously.

Finally, I am forever grateful for the love and support from my partner, Steph Spartels. It is not easy being with someone who is completing a PhD but she stood by me with such incredible strength and grace, even in the most challenging of times. Without her positivity, humour, wisdom, and unwavering belief in me, this would have been a much more difficult process. She also provided excellent support with her eagle-eyed proof reading and assistance with the design of the graphs and diagrams contained in this thesis.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

PART ONE

INTRODUCTION AND BACKGROUND TO THE RESEARCH

Chapter 1 – INTRODUCTION

> *Every time I tell my story about trauma and mental health and recovery, invariably I have someone come up to me, and it's not always consumers, sometimes it's workers as well, and thank me for sharing and telling me that they've been through something similar in their lives, and they've never been able to talk to anyone about it, or they thought they were the only one like that in the world. And I'm like, no, there are hundreds of thousands of us everywhere (Louise – interview participant).*

The genesis of this research project emerged while I was working as a social worker at a community mental health service and engaged with countless women and men who had experienced sexual abuse as children or sexual assault in their adult years. The sheer quantity of sexual abuse survivors that I worked with was alarming, but what was more concerning was how few had received any counselling or support around their experiences of abuse. Many of them had used mental health services for over a decade – frequenting psychiatric inpatient wards, being case managed by hospital outpatient services, residing in group homes, attending mental health day programs, and being treated primarily with a variety of medications. What was lacking in all of this service provision was an interest in trauma – an awareness of abuse or trauma histories did not seem to fall into the focus of mental health service delivery. As a social worker firmly grounded in a systemic view of the human experience, I struggled to understand the exclusion of this information when assessing and supporting individuals grappling with mental and emotional distress.

During this time, I worked alongside Voices Vic, a peer-run program that supported voice hearing groups throughout the Australian state of Victoria. Voice hearers who were championing the Hearing Voices Movement visited from the UK and Europe, delivering training in a new approach to voice hearing that viewed the phenomenon as essentially meaningful and connected to life events, culture, and relationships. The

trainers frequently spoke of surviving childhood abuse and neglect only to find themselves deep within the psychiatric system. They talked about how learning to work with their voices helped them understand and deal with the impacts of early abuse. From this perspective, voice hearing was not a sign of mental illness, but rather a common human experience that often arose out of stress and trauma.

Unlike the mental health services frequented by my clients, the Hearing Voices Approach located traumatic experiences at the heart of understanding mental and emotional distress. This dissonance prompted me to consider why mainstream mental health services seemed so reticent to address issues of trauma and abuse. I consulted with the Voices Vic team about valuable avenues for research. They too had an awareness of trauma and abuse being a peripheral issue in mainstream mental health service delivery and found that many of the voice-hearers they worked with had their experiences of sexual abuse ignored or marginalised by mental health providers. The Voices Vic team identified that this was a crucial area for service improvement and encouraged me to conduct research that would help service providers to better understand the needs of voice hearers who had experienced trauma.

This firsthand experience working with survivors of sexual abuse who had mental health issues and the encouragement of Voice Vic formulated the basis of this research project.

1.1 Trauma and mental Illness

> The mental health system is filled with survivors of prolonged, repeated childhood trauma. . . . While only a small minority of survivors, usually those with the most severe abuse histories, eventually become psychiatric patients, many or even most psychiatric patients are survivors of childhood abuse. . . . Thus abuse in childhood appears to be one of the main factors that lead a person to seek psychiatric treatment as an adult (Herman, 1992b, p. 122).

Judith Herman's (1992b) *Trauma and Recovery* marked a historic moment in understanding the impacts of interpersonal trauma, such as sexual abuse. It signalled a move towards the recognition that many individuals who suffer from mental illness do so because of traumatic life experiences. She outlined the profound ruptures caused by early interpersonal trauma that often lay the groundwork for an adulthood characterised by mental and emotional pain, interpersonal difficulties, and a fractured sense of self – experiences frequently perceived as symptoms of mental illness.

Research now indicates that the impacts of sexual abuse are far-reaching and complex in nature. Experiences of sexual abuse are known to raise the risk of developing mental illness across a range of diagnoses (Bradley, Jenei, & Westen, 2005; Chen et al., 2010). Recent research has found that sexual abuse is associated with psychosis and symptoms associated with psychosis, such as voice hearing (McCarthy-Jones, 2011; Varese, Smeets, et al., 2012). In addition to this, research points to sexual abuse increasing the severity and complexity of mental illnesses (Bebbington et al., 2009; Briere, Kaltman, & Green, 2008; Read, Agar, Barker-Collo, Davies, & Moskowitz, 2001) and increasing the risk of a range of other biopsychosocial and health issues (Anda et al., 2005; Dube et al., 2005; Felitti et al., 1998).

Given this, mental health providers need to respond effectively to sexual abuse survivors who present with complex mental health issues, such as voice hearing. This research project was part of a growing push for change in mental health service delivery to locate trauma at the core of many individual's experiences of emotional and mental distress. It sought to examine how Australian mental health services are responding to survivors of abuse who hear voices and to gain a better understanding of the avenues for change within the mental health system.

1.2 A focus on voice hearing and sexual abuse

This research project focused specifically on voice hearing as a symptom, rather than psychotic diagnoses such as schizophrenia, due to increasing evidence indicating that the experience of voice hearing is trans-diagnostic and is not necessarily indicative of a psychotic illness. Van Os et al. (2000) argue that since voice hearing is found across psychiatric populations, and within the general community, it is consequently best understood as a symptom that exists along a continuum, rather than a marker of specific pathology. While voice hearing within psychiatric populations is predominantly associated with psychotic diagnoses such as schizophrenia (Mueser, Bellack, & Brady, 1990), it is also commonly experienced by people diagnosed with borderline personality disorder (Kingdon et al., 2010), post-traumatic stress disorder (Alsawy, Wood, Taylor, & Morrison, 2015), bipolar affective disorder, and major depressive disorder (Toh, Thomas, & Rossell, 2015).

Research investigating the association between psychosis and trauma has increasingly focused on the role of traumatic experiences in the development of specific symptoms commonly associated with psychosis such as voice hearing. In a meta-analysis of such research, Bentall et al. (2012) found that childhood sexual abuse was particularly associated with voice hearing. Voice hearing is also associated with an increased prevalence of experiences of sexual abuse in individuals diagnosed with bipolar disorder (Upthegrove et al., 2015), depression (Hammersley et al., 2006), borderline personality disorder (Kingdon et al., 2010) and individuals within non-psychiatric populations (McCarthy-Jones, 2011). Consequently, this project focuses on how services respond to individuals who hear voices, rather than those with a specific diagnosis.

This project focused specifically on sexual abuse as the site of trauma for two reasons. First, for clarity, this project focused on a specific type of trauma due to the concept of trauma often being ambiguously defined (Joseph & Murphy, 2014; McNally, 2004; Weathers & Keane, 2007). Second, as described above, voice hearing has specific associations with sexual abuse, more so than other forms of trauma.

1.3 Service system responses

The research noted above indicates that the impacts of sexual abuse are complex and multifaceted. This points to the need for mental health professionals to have a broader awareness of the impacts of trauma and to consider the role of trauma and abuse in their assessments, formulations, treatment plans, and service delivery.

Previous research indicates that mental health professionals are intermittently screening for abuse and trauma, and infrequently including details of trauma in professional formulations and treatment plans. Studies examining case records of mental health consumers found that there was evidence of screening in between 14% to 56% of case records (Agar & Read, 2002; Mellinan, 1996; Posner et al., 2008; Read et al., 2016; Rossiter et al., 2015; Wurr & Partridge, 1996; Xiao et al., 2016). Lab et al. (2000) and Pruitt & Kappius (1992) surveyed mental health professionals about their screening practices and found that the majority of professionals intermittently screened consumers for abuse. When screening did occur, the inclusion of trauma in professional formulation and treatment plans was infrequent (Agar & Read, 2002; Mellinan, 1996; Posner et al., 2008; Read et al., 2016). Professionals were also rarely referring to trauma-specific counselling (Agar & Read, 2002; Read et al., 2016).

Research indicates that screening for abuse, inclusion of trauma in formulations and treatment plans, and referrals to trauma counselling are particularly low when consumers present with a psychotic illness (Agar & Read, 2002; Lab et al., 2000; Read & Fraser, 1998; Read et al., 2016; M. Young, Read, Barker-Collo, & Harrison, 2001). This may mean that many abuse survivors with presenting with symptoms commonly associated with psychosis, such as voice hearing, are not having their abuse histories recognised and responded to when accessing services.

Within the Australian context, there is a growing interest in trauma-informed care on a policy and practice level as a means of better meeting the needs of trauma survivors (Department of Health, 2011b; Kezelman & Stavropoulos, 2012). Trauma-informed service delivery aims to deliver health and social services in a way that is cognisant of, and responsive to, the high prevalence of abuse and trauma amongst consumers (Harris & Fallot, 2001b; SAMHSA, 2014a). This involves effective screening for trauma and abuse, understanding presenting issues within the context of trauma, delivering services in a power-sensitive way, recognising and responding to staff members who have experienced trauma either through exposure or vicariously while supporting survivors, and avoiding practices that may re-traumatise survivors of trauma (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005; Harris & Fallot, 2001b; SAMHSA, 2014a). Within the Australian context, this approach is in its infancy, and there is presently negligible research into its effectiveness when applied in Australian mental health settings.

The research into how mental health services are responding to trauma is limited, particularly in Australia, and has focused on how mental health services are responding to trauma across presentations and diagnoses. Given the known reluctance of professionals to address issues of trauma with consumers presenting with symptoms associated with psychosis, such as voice hearing, an examination of how mental health services respond to this group is needed.

1.4 The research study – Aims and questions

The overarching aim of this project was to gain a better understanding of how mental health services can be responsive to the needs of sexual abuse survivors who hear voices. To achieve this, the project addressed the following research questions:

1. What are the work practices of mental health professionals when working with voice hearers who have experienced sexual abuse?
2. What factors shape how mental health professionals respond to voice hearers who have experienced sexual abuse?

3. What do voice hearers who have survived sexual abuse identify as helpful or unhelpful when using mental health services?

The project examined how professionals are responding to voice hearers within the Australian mental health system. The Australian mental health service system sits within a blended policy environment with state jurisdictions largely in control of mental health service delivery and federal government involved in some select programs (Gerrand et al., 2013). Consequently, the nature of mental health service delivery varies from state to state. As this project largely recruited participants from the state of Victoria, discussion about the nature of the service system and mental health policy focuses on the Victorian experience.

The Australian mental health service system is staffed by a variety of professional groups, including social work, psychiatric nursing, occupational therapy, psychology, psychiatry, along with a peer workforce. For this reason, this project had a multidisciplinary focus rather than being aimed at a specific occupational group.

1.5 Research design – A focus on system change

This research aimed to contribute to change in the mental health system. Consequently, a critical realist approach to social research informed the research design. As detailed in Chapter 4, critical realism aims to not only understand *what* is happening in a social phenomenon but seeks to understand *why* it is happening by attempting to explain what underlying mechanisms and structures give rise to the phenomenon (Bhaskar, 1979). Through seeking to understand the mechanisms that cause social problems, a critical realist approach to social research aims to reveal potentially oppressive forces that give rise to these problems. This explanatory critique creates scope for changing the structures and mechanisms that have been identified as oppressive (Mingers, 2014).

Due to the lack of research in this area, this project was interested in *what* was happening when Australian mental health services worked with sexual abuse survivors

who hear voices. However, given the aim of the project was to understand how services can better respond to sexual abuse survivors who hear voices, it was also interested in *why* particular service responses were occurring. Understanding *why* these service response trends were occurring can reveal what structures or mechanisms are shaping how mental health services are responding to sexual abuse survivors. This can inform a better understanding of the potential for change in the service system to meet the needs of this group.

In attempting to explain social phenomenon, critical realists support the use of both qualitative and quantitative methods. However, both approaches are capable of only understanding part of a social phenomenon. Given that the social world is complex and multidimensional, critical realism promotes the use of mixed method designs to capture a holistic understanding of the phenomenon being studied (McEvoy & Richards, 2006). For this reason, this project adopted a multi-strand mixed method design aimed at understanding the consumer-service provider relationship from both perspectives. Strand one of this project involved in-depth interviews with voice hearers who had experienced sexual abuse. The aim of the interviews was to understand the impact of service system responses from a lived experience perspective and to gain an understanding of what voice hearers identified as helpful or unhelpful when using mental health services. Strand two involved a survey of mental health professionals about their work practices, attitudes and beliefs when working with voice hearers who had experienced sexual abuse. An online survey was distributed to a range of mental health services in Australia to promote amongst their staff. These services included public clinical services, community health services, non-government providers and professional peak bodies. The two strands were initially analysed separately, but results from both strands were used to illuminate and give context to results found in each strand. The findings were then viewed holistically, with reference to key theoretical and policy issues that surround mental health service delivery in Australia with the aim of developing tentative explanations for the trends evident in the results.

1.6 Terminology

This thesis uses several key terms that are complex and, at times, contentious. The way in which these terms are defined and used in this thesis is detailed below.

VOICE HEARING AND VOICE HEARERS

Voice hearing, also known as auditory hallucinations, is a phenomenon whereby individuals hear speech in the absence of stimuli (Longden, Madill, & Waterman, 2012). Population studies have found that the phenomenon occurs in the general population between 2.3% (Tien, 1991) and 8% (van Os et al., 2000). While many people who hear voices report being untroubled by this experience (van Os et al., 2000), a proportion find hearing voices highly distressing.

The term *hearing voices* or *voice hearing* has its roots in the Hearing Voices movement that argues for a broad, holistic and consumer-driven approach to these experiences. Within this approach the term *hearing voices* is positioned as the focus rather than the term *auditory hallucinations* as these experiences "should be thought of not as a pathological phenomenon in need of eradication but as a meaningful, interpretable experience, intimately linked to a hearer's life story" (Intervoice, 2013).

Woods (2013) argues that the term *voice hearer* is a political term that serves to inverse the traditional psychiatrist/patient relationship, so that voice hearers become *experts by experience* challenging the dominant discourse and practices of the psychiatric *experts by profession*. She also contends that the term *voice hearer* creates a critical alternative identity to that of the deeply stigmatised and contested label of *the schizophrenic.* She argues "while "schizophrenic" is a label given to someone *by* psychiatry, "voice hearer" is an identity more commonly articulated and authorised *outside* and *in opposition to* psychiatry"(Woods, 2013, p. 265).

The terms *voice hearing* and *auditory hallucinations* are both used in the literature describing this phenomenon. For this reason, while the term voice hearing will be

predominantly used in this thesis, auditory hallucinations will be used when discussing literature that uses this term.

Trauma and sexual abuse

The aim of this project was to gain an understanding of how the Australian mental health service system responds to survivors of sexual abuse who hear voices. The project was located within a service context that is increasingly considering how services can respond to trauma survivors more broadly. For this reason, the terms *trauma* and *sexual abuse* will be used throughout. The term *sexual abuse* will be used when discussing how services respond specifically to sexual abuse or specific discussions about sexual abuse. The term *trauma* will be used when discussing the wider implications of how the service system responds to trauma survivors.

Trauma is defined within psychiatric texts as experiencing or witnessing an event that causes or threatens death, serious injury, or sexual violence (APA, 2013). Within this thesis, the definition will expand to include interpersonal events occurring in childhood that are a threat to healthy development such as sexual abuse, physical violence, the witnessing of domestic violence, neglect, and the loss of a primary caregiver (Courtois & Ford, 2012).

Sexual abuse is defined as any sexual activity involving touching, fondling, penetration, exhibitionism, the involvement of minors in pornography, or the luring of minors online (Collin-Vézina, Daigneault, & Hébert, 2013).

Consumers/Survivors

There is continuous debate around the appropriate terminology to use when referring to individuals who use mental health services. The terms service user, client, patient, participant and consumer are used throughout the literature. Each of these terms has its merits and drawbacks. However, the term *consumer* is most frequently used within

the Australian context (Epstein, Olsen, & Grey, 2012).

Within trauma literature, the word *survivor* is used to describe individuals who have experienced traumatic events (Herman, 1992b). As this project was interested in individuals who are both consumers of mental health services and survivors of sexual abuse, the two terms will be used interchangeably.

Trauma screening

This project investigated how mental health professionals screened for sexual abuse. Screening for sexual abuse is typically conducted as part of a broad approach to trauma screening that asks questions about specific forms of trauma (Fallot & Harris, 2001; SAMHSA, 2014b). When this thesis discusses screening for sexual abuse, it is referring to asking questions about sexual abuse within a broad approach to trauma screening.

Research participants

There were two types of research participants in this project, consumers who were interviewed and professionals who were surveyed. The former will be referred to as interviewees, and the latter will be referred to as respondents.

1.7 Outline of thesis

This thesis is divided into four parts. The first outlines the context of this study, the second details the research methodology and design, the third details the results of the project, and the fourth discusses the implications of the results.

Part 1

Chapter 2 outlines the current research investigating how mental health services respond to survivors of trauma. It then discusses trauma-informed care as an approach

to service delivery positioned to support services to respond to trauma survivors effectively. This approach is discussed within the Australian mental health practice and policy context, with a consideration of the features of the Australian service system that may impact on how services can respond to voice hearers who have survived abuse.

Chapter 3 outlines the different theoretical conceptualisations of the impacts of sexual abuse and how this relates to voice hearing. The implications of these conceptualisations on mental health service delivery are also discussed.

PART 2

Chapter 4 outlines the design of the research project. It discusses critical realism as the paradigm that guided the multi-strand mixed method design. Details about both strands of the design are described with attention to sampling, recruitment, implementation, analysis, and ethical considerations.

PART 3

Chapter 5 describes the demographics of the survey respondents. It also outlines the basic profile of the interviewees.

Chapter 6 details the results of the study that indicate how survey respondents reported screening voice hearers for sexual abuse and the factors that were found to influence screening practices. In addition, it details the interviewee perspective on screening and disclosure.

Chapter 7 outlines how survey respondents included details of disclosed abuse in treatment plans and formulations, along with issues relating to referrals to trauma-specific services. It details how survey respondents liaised with family members and carers when working with voice hearers. Finally, it outlines the results around training, support from management, and workload.

Chapter 8 further examines the consumer perspective on service provision and outlines the themes present in the interviews that indicate what voice hearers found helpful or unhelpful when they used mental health services.

PART 4

Chapter 9 discusses the results in relation to the research questions, with a consideration of the practice, policy, and theoretical issues outlined in Chapter 2 and 3. It then outlines practices that can be adopted at a practitioner and organisation level to meet the needs of voice hearers who have experienced sexual abuse along with a systemic model of service provision. The chapter concludes by outlining the strengths and limitations of this research project.

Chapter 10 reviews the aims of this project and discusses the implications of the results. It then outlines potential avenues for further research.

1.8 Summary

This chapter has outlined my professional experience working with mental health consumers who had experienced sexual abuse, along with a summary of literature investigating how mental health services respond to trauma survivors. This background highlighted two primary drivers of this research; the need to explore how the service system is responding to voice hearers who have survived abuse, and an interest in creating service system change. These dual drivers have informed the research questions, methodology, and research design described in this chapter.

Chapter 2 – RESPONDING TO SEXUAL ABUSE IN MENTAL HEALTH SETTINGS

Over the past three decades, a growing body of research has demonstrated strong links between traumatic experiences, such as sexual abuse, and a range of mental health and psychosocial issues. This points to the need for mental health services to effectively respond to trauma survivors. This chapter details current research investigating how mental health services are responding to trauma and abuse through processes of trauma screening and the inclusion of abuse in formulations and treatment plans. Trauma-informed care has emerged as an approach aimed at shifting service delivery to better meet the needs of trauma survivors. The principles of this approach are outlined, along with some of the key debates within trauma-informed literature. The positioning of abuse and trauma within the Australian mental health system is then considered along with several features of the system that may impact on its ability to meet the needs of sexual abuse survivors.

2.1 The broad impacts of sexual abuse

Research is increasingly demonstrating strong links between traumatic experiences, such as sexual abuse, and a range of mental health diagnoses. Chen et al. (2010) systematically assessed the evidence for the association between sexual abuse and psychiatric diagnoses and found that the experience of sexual abuse was significantly associated with anxiety disorders, depression, eating disorders, post-traumatic stress disorder, sleep disorders and suicide attempts. Sexual abuse is very strongly associated with borderline personality disorder (BPD) For example, in a study of 600 individuals diagnosed with BPD, Battle et al. (2004) found a very high rate of experiences of child maltreatment. In particular, they found that 44.1% of the sample experienced sexual abuse. Other studies have found higher rates of sexual abuse amongst this population ranging from 61.5% (Zanarini et al., 1997) to 77% (Bryer, Nelson, Miller, & Krol, 1987). When examining the etiological factors that contribute to BPD, Bradley et al. (2005) found that experiences of sexual abuse predicted BPD above all other potential

etiological factors.

Research investigating the associations between trauma and mental illness has expanded to include diagnoses that had previously been conceptualised as largely biological, such as schizophrenia. A significant quantity of research has investigated the associations between childhood adversity and psychosis (Bebbington et al., 2004; Cutajar et al., 2010; Janssen et al., 2004; Spauwen, Krabbendam, Lieb, Wittchen, & Van Os, 2006). A meta-analysis of studies investigating the association between childhood adversity and psychosis by Varese et al. (2012) concluded that childhood adversity is strongly associated with an increased risk for developing psychosis. Experiences of sexual abuse, in particular, have been found to have strong associations with psychosis (Bebbington et al., 2004; Cutajar et al., 2010).

There has also been substantial research looking specifically at the association with sexual abuse and voice hearing. McCarthy-Jones (2011) conducted a critical review of seven papers that investigated the association between childhood sexual abuse and auditory hallucinations. He found that 36% of psychiatric patients who heard voices and 22% of non-patients who heard voices had experienced sexual abuse. In addition to this, 56% of psychiatric patients who had experienced child sexual abuse reported that they heard voices, along with 21% of the non-psychiatric population who had experienced childhood sexual abuse. While the study acknowledged that there is not sufficient evidence in this research to draw conclusions about the potential role of child sexual abuse in the causation of auditory hallucinations, it did state that there is a clear association between the two experiences.

Beyond the development of psychiatric illnesses, sexual abuse is known to increase the severity and complexity of mental health presentations. For example, Bebbington et al. (2009) drew data from the 2000 British National Survey of Psychiatric Morbidity and found experiences of sexual abuse were strongly associated with a history of suicidality. Sexual abuse is also known to increase rates of hospitalisation (Maguire, McCusker,

Meenagh, Mulholland, & Shannon, 2008; Read, 1998). In addition to this, research indicates that sexual abuse is associated with a range of other health and psychosocial issues such as alcohol and drug abuse, marital problems, domestic violence, sleep disturbance, severe obesity, suicide attempts, as well as an increased risk of sexually transmitted diseases, lung disease, cancer, and heart disease (Anda et al., 2005; Dube et al., 2005; Felitti et al., 1998).

Given the strong associations between experiences of trauma and experiences of mental illness, it is not surprising that a significant proportion of consumers of mental health services have experienced abuse and trauma. In a survey of 1382 female users of psychiatric services, Bengtsson-Tops, Markström, and Lewin (2005) found that half had reported some form of childhood abuse, with 27% reporting that they had experienced sexual abuse. Other studies have consistently found that users of psychiatric services report high incidences of traumatic experiences and between a quarter to a third of service users report sexual abuse (Coverdale & Turbott, 2000; Rossiter et al., 2015; Wurr & Partridge, 1996). This high prevalence of sexual abuse survivors using mental health services points to the need for mental health services to be responsive to this group.

2.2 Service system responses

Given the wide and varied impacts of sexual abuse, there is a need for mental health professionals to have a broader awareness of the impacts of trauma and to consider the role of trauma and abuse in their assessments, formulations, treatment plans and service delivery. A small number of studies have investigated how mental health services screen for trauma and abuse, and how disclosures of abuse influence formulations, treatment plans, referrals to trauma counselling, and referrals to legal support.

The majority of this research has investigated how mental health professionals screen for trauma and abuse. Studies examining case records of mental health consumers

found that there was evidence of screening in between 14% to 56% of case records (Agar & Read, 2002; Mansfield, Meehan, Forward, & Richardson-Clarke, 2017; Mellinan, 1996; Posner et al., 2008; Read et al., 2016; Rossiter et al., 2015; Wurr & Partridge, 1996; Xiao et al., 2016). There appears to be a substantial gap between the rates in which trauma is detailed in case records and the rates of trauma reported by consumers. For example, Rossiter et al. (2015) surveyed 129 adults attending a general adult mental health service for traumatic events and assessed their case records for documentation of trauma and abuse. They found that 77% of the individuals surveyed had experienced childhood trauma, however, only 38% had details of trauma recorded in their case records. Given this low rate of screening, combined with the known high rate of sexual abuse amongst mental health consumers, there is a high likelihood that many survivors of sexual abuse who enter mental health services are not being screened adequately for abuse.

Several studies have surveyed mental health professionals about their work practices, attitudes and beliefs around trauma and abuse. These studies found that mental health professionals report intermittently screening consumers for sexual abuse and reveal several barriers that prevent professionals from screening (Day, Thurlow, & Woolliscroft, 2003; Lab et al., 2000; McLindon & Harms, 2011; Pruitt & Kappius, 1992).

A fear of upsetting consumers or increasing distress was frequently cited as a barrier to screening for abuse (McLindon & Harms, 2011; Pruitt & Kappius, 1992; A. Young, 1997). This may be related to a perceived lack of time to adequately deal with distress that may emerge upon disclosure. McLindon and Harms (2011) surveyed 15 crisis and assessment workers about their work practices regarding sexual abuse or assault. Fourteen strongly disagreed with mandatory screening, with concerns about distressing consumers being noted as a significant barrier to screening. Given the short-term nature of this service, respondents were concerned that they had a lack of time to adequately deal with any distress that emerged as a result of disclosure.

Some research suggests that concerns about upsetting consumers by asking about sexual abuse or trauma may not be entirely founded. Cusack et al. (2006) used a Trauma Assessment for Adults (TAA) to screen for traumatic events amongst 142 consumers with a serious mental illness and found that none of the participants became distressed as a result of screening. Similarly, Bont et al. (2015) tested a Trauma Screening Questionnaire (TSQ) that assessed for experiences of traumatic events and corresponding trauma symptoms amongst 2608 patients with a psychotic diagnosis. They found that none of the caregivers of the participants reported any adverse reactions to the screening. It is worth noting, however, that this study excluded patients who were in locked psychiatric wards which may mean that patients suffering from acute mental health symptoms were excluded from the study. Both studies found that participants were grateful that they were being asked about their trauma histories as this had been largely neglected in their past experiences of mental health treatment.

The gender of professionals and consumers appears to a play a role in how professionals screen for abuse. Studies of case records by Agar and Read (2002) and Read and Fraser (1998) found that men were less likely to be screened for abuse than women. Lab et al. (2000) surveyed professionals specifically about their work practices regarding sexual abuse amongst male consumers and found that most respondents reported rarely screening men for sexual abuse. Further, they found that the majority of respondents believed that male consumers should only sometimes be asked about sexual abuse. They partly attributed this trend to the pervasive myth that men rarely experience sexual abuse or assault, and found that many professionals underestimated the rate of sexual abuse experienced by men. Gender of the professional was also found to influence screening behaviour with women screening more frequently than men (Agar & Read, 2002; Little & Hamby, 1996; McLindon & Harms, 2011). Little and Hamby (1996) hypothesised that the higher rate of women screening for abuse might be related to female clinicians themselves being more likely to have experienced sexual abuse and are consequently more aware of the high prevalence.

The most commonly cited factor found to inhibit professionals screening for trauma was working with a consumer with a psychotic diagnosis (Agar & Read, 2002; Lab et al., 2000; Read & Fraser, 1998; Read et al., 2016; M. Young et al., 2001). In the study by Bont et al. (2015) detailed above, 78.2% of the 2608 patients screened with the TSQ had experienced a traumatic event, and 16% met the criteria for PTSD. However, only 0.5% of the individuals who met the criteria for PTSD had such a diagnosis noted on their case files. They argued that one reason for the underreporting of PTSD in patients with psychosis may be a "hierarchical system of diagnosis. . . . once a psychotic disorder (such as schizophrenia) has been diagnosed, other diagnoses are often not considered" (de Bont et al., 2015, p. 413). Lab et al. (2000) found a large number of survey respondents commented that it was inappropriate to ask men with psychotic disorders about sexual abuse as they deemed the presenting problem to be irrelevant to abuse. In their survey of mental health professionals, Young et al. (2001) found that professionals were reluctant to screen consumers with a psychotic diagnosis for abuse due to concerns that their disclosures would be delusional, or their beliefs that psychosis had biological aetiology and therefore was unrelated to trauma.

Studies that investigated trauma screening from the consumer perspective have also found that mental health professionals were not routinely screening for sexual abuse. For example, Lothian and Read (2002) surveyed 74 mental health consumers in New Zealand about their experience regarding their first assessment from a mental health service and found that only 20% had been asked about trauma or abuse. A similar study by Read, McGregor, Coggan, and Thomas (2006) surveyed 191 women who had received counselling for sexual assault and found that that the average time it took for the women to disclose their experience of abuse or assault was 16 years. Furthermore, they found that only 22% of women who had accessed mental health services had been asked about sexual abuse. They concluded that due to the lengthy time women took to disclose experiences of abuse and the low rate of screening by mental health services, there was a strong need for mental health staff to be trained in assessing for sexual abuse and sexual assault histories amongst patients.

When abuse or trauma has been disclosed to mental health professionals, studies have found that professionals include information about trauma in formulations and treatment plans at a relatively low rate (Agar & Read, 2002; Mellinan, 1996; Posner et al., 2008). For example, Posner et al. (2008) examined consumer case records and found that when abuse was disclosed it was rare for details of trauma to inform diagnosis and formulations, and very few records included trauma-related interventions in their treatment plans. Studies also indicate that professionals are rarely referring to trauma counselling services (Agar & Read, 2002; McLindon & Harms, 2011). Agar and Read (2002) found similar trends and noted that these were more extreme in the case of consumers with a psychotic diagnosis.

A number of studies recommended better training for professionals to increase their ability to adequately screen and respond to trauma and abuse (Agar & Read, 2002; Day et al., 2003; Read & Fraser, 1998; Read et al., 2006; Rossiter et al., 2015; Xiao et al., 2016). Along with this, the inclusion of abuse screening questions on assessment forms is also recommended (Briere & Zaidi, 1989; Mellinan, 1996; Posner et al., 2008; Read & Fraser, 1998; Xiao et al., 2016). In response to a study by Agar and Read (2002) indicating that professionals were infrequently screening for trauma and failing to include details of trauma in formulations and treatment plans, the Auckland District Health Board implemented best practice guidelines around responding to trauma and abuse. This included mandated training for all staff. To evaluate this intervention Read et al. (2016) conducted another file review of community mental health services in this region to see if staff behaviour had changed from the 2002 study. They found significant improvement in how often abuse was noted in case records, how often abuse was included in formulations and how often abuse was included in treatment plans. They found no improvement in the rate of referrals to treatment and no improvement in rates of referrals to legal authorities. They also found that consumers diagnosed with a psychotic disorder were still less likely to be screened for abuse and received less

adequate responses upon disclosure. The authors concluded that while it seems that the guidelines and training improved some levels of staff behaviour, there were still avenues for improvement.

The studies described above indicate that mental health services are struggling to meet the needs of sexual abuse survivors. This appears to be particularly the case for consumers who present with a psychotic diagnosis or psychotic symptoms. For this reason, more research is needed to investigate why professionals are particularly reluctant to screen for sexual abuse amongst consumers presenting with symptoms commonly associated with psychosis such as voice hearing

2.3 Trauma-informed care – a new paradigm for service delivery

The research outlined above indicates that there is scope for mental health services to better meet the needs of trauma survivors. Trauma-informed care has emerged as an approach to practice that aims to deliver services in a way that is responsive to the needs of trauma survivors. Trauma-informed care developed in response to trauma research indicating the far-reaching impacts of trauma along with the trauma-survivor movement that articulated pathways to recovery from a lived experience perspective (SAMHSA, 2014a). The concepts of trauma-informed care were initially developed by Harris and Fallot (2001b, p. 4) who proposed two key purposes of trauma-informed practice:

> First, being trauma-informed means to know the history of past and current abuse in the life of the consumer with whom one is working. Such information allows for more holistic and integrated treatment planning. . . . Second, to be trauma-informed means to understand the role that violence and victimisation play in the lives of most consumers of mental health and substance abuse services and to use that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allow services to be delivered in a way that will facilitate consumer participation in treatment.

Trauma-informed care has had the most traction in the United States of America with

the Substance Abuse and Mental Health Services Administration (SAMHSA) funding the Women's Co-occurring Disorders and Violence Study (WCDVS). This has led to an emerging knowledge base around how best to work with women who are survivors of violence and have co-occurring mental health or drug and alcohol issues. SAMHSA (2014a, p. 9) defines a trauma-informed service as:

> A program, organization, or system that is trauma-informed *realizes* the widespread impact of trauma and understands potential pathways to recovery; *recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and *responds* by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively *resist re-traumatization*.

Further, SAMSHA (2014a) recognises that staff of health and welfare services may also be survivors of trauma or may struggle with secondary trauma resulting from supporting survivors. Consequently, the SAMSHA (2014a, p. 11) guidelines stipulate the need for trauma-informed parallel practice "as staff need to feel safe, as much as people receiving services". They specify that trauma-informed services must recognise and respond adequately to trauma experiences amongst their staff members by providing supportive supervision and debriefing, fostering an emotionally and physically safe work place, and empowering staff to have control over their work.

Complex trauma as the theoretical basis for trauma-informed practice

Central to trauma-informed approaches is an awareness of the complex nature of post-traumatic responses. Harris & Fallot (2001b) compare a trauma-informed conceptualisation of trauma with traditional approaches to understanding the impacts of trauma. The traditional model of post-traumatic responses, most clearly seen in the diagnostic criteria for PTSD (APA, 2013), views post-traumatic responses as largely linear and contained to observable reactions to the traumatic event, such as avoiding reminders of the trauma, experiencing intrusive memories of the trauma, or experiencing hyperarousal. In contrast, the trauma-informed model of trauma borrows from the work of Herman (1992b) and van der Kolk et al. (2005) in framing post-

traumatic responses from ongoing and early traumas as far more multifaceted and complex. Harris and Fallot (2001b, p. 12) argue that such trauma profoundly shapes an individual's development and worldview:

> The impact of trauma is thus felt throughout the individual's life in areas of functioning that may seem quite far removed from the abuse, as well in areas more obviously connected with trauma.

Kezelman & Stavropoulos (2012) describe this further, arguing that survivors of abuse often adopt protective strategies that were initially protective and resourceful, but which frequently become problematic as they become entrenched in adult functioning. This results in individuals presenting at health and welfare services with issues that seem unrelated to trauma, which may mean that experiences of trauma go unrecognised and untreated. Furthermore, they argue that trauma survivors often do not connect their present issues with the trauma that occurred in childhood.

IMPLICATIONS OF A COMPLEX TRAUMA ON PRACTICE

This conceptualisation of the complex impacts of trauma informs many of the key principles of trauma-informed practice. Trauma-informed approaches to practice aim to position trauma as central in how professionals and organisations view those who are presenting at services and the issues that they present with (Elliott et al., 2005). Behavioural, emotional and cognitive issues are not seen simply as symptoms of illness or deviance, but are viewed as issues that potentially developed in response to traumatic experiences (Harris & Fallot, 2001b; Kezelman & Stavropoulos, 2012). Consequently, trauma-informed models of care reframe such symptoms as adaptions for survival. Symptoms such as dissociation, emotional dysregulation, self-harm, and impulsive behaviour are no longer seen as random and pathological; they are framed as adaptive resonses to traumatic life expereinces.

Bloom and Farragher (2011) argue that trauma-informed approaches to care aim to shift society's tendency to view people in distress as either sick or bad. Survivors of abuse who present with complex symptoms are typically diagnosed with an illness, usually a psychiatric diagnosis, or if their behaviour is problematic enough they are

labelled as bad and incarcerated. They argue that a trauma-informed approach to understanding distress or difficult behaviour is constructed as an injury rather than a sign of illness or deviance. Injury implies that the distress is connected to the environment, which therefore has been caused by something. This shifts the focus to a consideration of "What has happened to you?"rather than "What is wrong with you?" (Bloom & Farragher, 2011, p. 136) . It is also suggestive of healing and repair, being injured is not a fixed state.

Screening and disclosure

The premise of complex traumatic responses also guides trauma-informed approaches to screening and disclosure. As detailed above, research indicates that there is an underreporting of experiences of abuse in mental health services (Briere & Zaidi, 1989; Rossiter et al., 2015; Wurr & Partridge, 1996). This underreporting can be attributed to the narrow focus of post-traumatic stress responses. As discussed above, a trauma-informed perspective views post-traumatic stress responses as complex and multifaceted, resulting in consumers frequently presenting at services with a range of issues that may seem unrelated to any traumatic experience. Harris and Fallot (2001b) argue that services that operate from a traditional model of trauma may fail to identify trauma survivors who present with symptoms that fall outside of the PTSD diagnosis.

In addition to this, research has found that many survivors of sexual abuse are reluctant to disclose their experiences of abuse to others. Tener and Murphy (2015) conducted a literature review of 28 studies undertaken between 1980 and 2013 investigating how adults disclose experiences of child sexual abuse and found several factors prohibited disclosure. On an intrapersonal level, they found that survivors grappled with a number of barriers to disclosure. Survivors frequently found disclosure difficult as a result of struggling to remember details of abuse. Further, they found disclosure difficult due to feelings of shame, guilt, or embarrassment regarding their abuse experiences. In addition to this, many survivors actively sought to repress memories of abuse which served as a further barrier to disclosure. Several barriers were found to exist on an

interpersonal level including a fear of being disbelieved by others, fear that they will be judged, and fear that it will damage their relationships with others. Finally, Tener and Murphy (2015) identified that cultural stereotypes about sexual abuse survivors, such as the belief that survivors often become perpetrators, were seen to further inhibit disclosure.

Based on this underreporting of abuse, routine trauma screening of all consumers features as central to trauma-informed practice. Fallot and Harris (2001, p. 24) argue that routine screening serves two key purposes:

> The primary purpose is to determine appropriate follow-up and referral, including urgent responses to imminent danger. In addition to identifying people whose histories call for trauma-specific services, such screening communicates to all consumers that the program believes that abuse and violence are significant events and that staff are willing to discuss trauma with survivors. Even if a trauma survivor decides not to talk about such experiences with staff at this early stage, staff have increased the possibility of later disclosure by communicating their recognition of and openness to hearing about painful events.

Along with a group of consumer/survivors, they developed an approach to trauma screening that attempts to emphasise consumer choice and control. Here professionals are clear about the context and purpose of screening, ensure that consumers are aware that they can refuse to answer questions or can cease the interview, and are attuned and responsive to the consumer's needs in terms of self-soothing and self-protection. This process is aimed at obtaining information about whether the consumer has experienced trauma or abuse. Fallot and Harris (2001) are clear to distinguish this process from a full trauma assessment that is designed to obtain more details about traumatic experiences and trauma-related symptoms.

Guides to screening for trauma frequently stress the importance of using unambiguous, straightforward language that asks specifically about sexual or physical abuse rather

than traumatic events more generally (Fallot & Harris, 2001; Guarino, Soares, Konnath, Clervil, & Bassuk, 2009; Read, Hammersley, & Rudegeair, 2007; SAMHSA, 2014b). Fallot and Harris (2001) argue that asking questions about specific forms of trauma, such as sexual abuse, is important to avoid ambiguity around what is meant by the term trauma.

Universal screening for all consumers as part of initial assessments is frequently cited as best practice as a means of accurately assessing consumers as well as creating an environment where consumers can feel safe talking about experiences of abuse and trauma (Clark, Classen, Fourt, & Shetty, 2014; Fallot & Harris, 2001; SAMHSA, 2014b). However, some trauma-informed guidelines advocate for a more selective approach to screening. For example, in the Blue Knot Foundation's Practice Guidelines for Trauma-informed Care and Service Delivery, Kezelman and Stavropoulos (2012) stress that screening must consider the service context and whether or not safety can be ensured when asking questions about abuse. Spielvogel and Floyd (1997) also stress the importance of trauma screening for mental health consumers but argue that self-injurious behaviour, serious thought disorders, serious affective disturbance, or serious cognitive impairment should be stabilised before a consumer is screened for trauma. This lack of clarity around how to effectively screen mental health consumers for trauma indicates the need for further consideration of the complexities involved with trauma screening.

Empowerment

Alongside drawing from models of complex trauma, trauma-informed care also borrows heavily from anti-oppressive practice with a focus on empowerment and consumer inclusion (Elliott et al., 2005; Harris & Fallot, 2001b; SAMHSA, 2014b). Experiences of powerlessness and helplessness are often key features of interpersonal trauma. These experiences may be replicated when survivors use health and welfare services. Consequently, trauma-informed approaches to practice emphasise the importance of delivering services in a way that is conscious of power and aims to help survivors

develop the ability to have agency over their lives (Harris & Fallot, 2001b). Elliot et al. (2005) argue that trauma-informed services must employ an empowerment model to service delivery. This involves a focus on developing equal partnerships between service users and providers, a mutual collaboration on service goals, and encouraging mutual support between service users. Within these relationships is a valuing of the different knowledge that the service provider and consumer possess. The service provider is equipped with professional training and expertise, and the consumer is equipped with their authority over their experiences (Markoff, Reed, Fallot, Elliott, & Bjelajac, 2005). From an empowerment model, both knowledge bases are essential in effective service relationships.

An important element of this approach is to maximise consumer's choice and control over the treatment and service they receive. Harris and Fallot (2001b) argue that traditional mental health services are characterised by a hierarchal approach to decision making, with service providers having control over resources and largely controlling decision making in relation to diagnosis, treatment, and referral. Further, they argue that mental health and addiction services tend to be highly risk-averse, and are likely to restrict treatment or service options that emphasise consumer autonomy. This approach to practice inhibits the ability of services to support consumers in their development of agency. They point to this power imbalance as being reflective of the power imbalances experienced in abusive relationships:

> The traditional service relationship replicates some of the most damaging dynamics of childhood trauma. The trauma survivor who was unable to stand up for herself as a child may be unable to have autonomous opinions and desires even if the provider assures her that her wishes will be respected (Harris & Fallot, 2001b, p. 19).

They argue instead for an approach that highlights consumer control over treatment and service decisions and suggest that this control can serve to help reduce consumer anxiety and consequently reduce the likelihood of difficult behaviours that may require forcible treatment. Markoff et al. (2005) contend that consumers should be given

choice and control over as many aspects of service delivery as possible, including where and when to meet, the frequency of appointments, preferences about the gender of staff, and how to decide on goals and treatment objectives. They argue that access to a variety of information about trauma, treatment options, and diagnoses is essential to increasing consumer control as it further enables them to make informed decisions. There are potential barriers to implementing these features of trauma-informed care within statutory health and welfare services due to the power imbalance inherent within these settings. This will be explored further when considering the implementation of trauma-informed care into Australian mental health services.

Inclusion and consumer involvement

The active involvement of survivors/consumers in the running of the organisations is another feature of trauma-informed approaches to care. Elliot et al. (2005) argue that inclusion of survivor/consumers in designing, implementing and evaluating services not only ensures that services are run with the lived experience in mind but also creates empowering opportunities for survivors/consumers. While some trauma-informed literature advocates for the involvement of survivors/consumers on all levels of service development and delivery (Kezelman & Stavropoulos, 2012), other literature focuses more on their role in a peer support capacity (SAMHSA, 2014a).

Trauma-informed care – questions regarding implementation

Trauma-informed care offers an approach to delivering services to effectively meet the needs of trauma survivors. However, there are a number of questions about its implementation within mental health services. For example, questions arise as to whether trauma-informed mental health services should be delivering trauma-specific treatment. In addition to this, there are questions about the ability of mental health services to employ empowerment principles when holding the mandate to involuntarily treat consumers. These questions become more apparent when considering how services respond to sexual abuse survivors within the Australian mental health system.

2.4 Responding to abuse within the Australian mental health sector

This project was specifically interested in how Australian mental health services respond to sexual abuse survivors. There has been minimal research investigating how Australian mental health services are responding to abuse and trauma survivors. One study by Xiao et al. (2016) examined the case records of 100 female psychiatric inpatients in an Australian hospital and found similar trends to those described earlier in this chapter. The records indicate that professionals were not routinely screening for trauma, and when a history of trauma was present, there was rarely information detailing the relationship between trauma and trauma-related symptoms.

Another study by Mansfield et al. (2017) examined case records across inpatient and community services before, and after, an assessment that included sexual abuse screening was implemented. They found that before the assessment was implemented 37.5% of case records had evidence of sexual abuse screening, this increased to 67.3% after the assessment was implemented. They also surveyed mental health professionals and asked to what degree they agreed with the statement" I routinely ask patients about childhood trauma including sexual abuse" and found the mean response was 3.50 on a scale between 1 and 7, indicating a degree of inconsistency regarding routine sexual abuse screening. Further, they found that details of sexual abuse were not included in a large proportion of treatment plans.

An examination of how abuse and trauma are positioned within Australian mental health policy further reveals how services may be responding to abuse and trauma. Fernbacher (2008) conducted a review of federal and Victorian mental health policy and found that there was a lack of policy guidance for mental health services to effectively respond to survivors of sexual abuse or family violence. This is evident in the most recent National Mental Health Plan (Department of Health and Aging, 2009) where sexual abuse is mentioned within a population health framework as a risk factor for mental illness but does not give any guidance about how mental health services can

best meet the needs of abuse survivors.

One notable exception to this policy trend is the development of the Service Guideline for Gender Sensitivity and Safety (Department of Health, 2011b) in the state of Victoria. This guideline specifies that the experience of sexual abuse is linked with the development of mental illness and consequently promotes a trauma-informed approach to mental health service delivery. At a practitioner level, the guidelines promote a person-centred, power-sensitive approach to practice that is conscious of recognising the impacts of past trauma and aims to avoid practices that may re-traumatise survivors of abuse. On an organisational level, the guidelines stress the importance of a service culture that recognises the impact of trauma on consumers and highlights the imperative to design services in a way that is responsive to the needs of trauma survivors. The development of processes to help staff routinely screen consumers for experiences of abuse is encouraged. The guidelines are designed to inform service delivery across the state, however, to date, there is minimal information regarding how the guidelines are being implemented. There is also limited research that outlines how services are currently responding to abuse and trauma and what barriers may be present when implementing trauma-informed care.

There are several features of the Australian mental health system that may impact how effectively organisations can respond to sexual abuse survivors as well as the implement a trauma-informed approach to care. These include the outcomes of deinstitutionalisation, the move towards a recovery framework, the use of involuntary treatment, the experience of transgenerational trauma amongst Aborignal Australians, and the role of mental health services in delivering trauma-specific services.

2.5 Deinstitutionalisation in Victoria

Like much of the Western world, the Australian state of Victoria went through a process of deinstitutionalisation in the 1990s whereby large psychiatric hospitals were closed and mental health care largely directed to the community (Gerrand, 2005). The move to

provide mental health care in the community has been a fraught process. While the first four years of deinstitutionalisation in Victoria were characterised by careful attention to ensure adequate services were available in the community before institutions were closed down, this progress slowed in the mid-90s with the neo-liberal government shifting funding away from mental health reform. This left many services under resourced while facing a growing demand (Gerrand, 2005). An example of this is the gradual dismantling of assertive outreach and acute assessment and treatment teams in the community (Rosenberg, 2011). Increasingly, funding is directed towards acute inpatient care at the expense of effective treatment in the community and sub-acute residential services (Andrews, 2005; Rosen, Gurr, & Fanning, 2010). The result has been a vastly under resourced community sector, where consumers in crisis have little option other than to present at emergency departments. This has caused a cycle whereby mounting pressure on emergency and inpatient units has led to further funding being reallocated towards hospital settings at the expense of community based services (National Mental Health Commission, 2013).

The deinstitutionalised Victorian mental health system is also characterised by a fractured service system with funding directed at specific issues rather than an integrated approach to care. Rosenberg (2011) points to the fact that individuals who experience mental illness frequently require support for a range of other psychosocial issues such as housing, health, alcohol and other drug abuse, education, employment, and social security. He argues that due to service system silos around these issues, and a lack of cross-sector coordination, many people fall through the cracks of the service system. A key example of this is the lack of coordinated care for individuals with co-occurring mental illness and substance abuse issues. The 2013 National Report Card on Mental Health (National Mental Health Commission, 2013) found that while the majority of individuals seeking help for mental illness also struggled with substance abuse issues, only 7% had received concurrent treatment for both issues.

The resulting picture is a service system that has ineffectively transitioned from

institutional mental health care to providing care in the community. This is found across Australian states and territories which all went through a similar process of deinstitutionalisation. Numerous investigations into the current state of the mental health system in Australia have found that the system has largely failed to deliver quality services, that there is a very high level of unmet need, and that the service system was poorly organised and largely fractured (Australian Institute of Health and Welfare, 2016a; Groom, Hickie, & Davenport, 2003; Mental Health Council of Australia, 2005; National Mental Health Commission, 2013, 2014).

The Australian mental health system could be characterised as a system that is struggling to deliver effective services due to ongoing systemic pressures. Bloom and Farragher (2011) describe how systemic pressures impact on service delivery organisations in a way that inhibits their ability to respond effectively to trauma survivors. They theorise that health and welfare services often unintentionally harm survivors of abuse due to a parallel process that occurs within mental health systems. When faced by systemic pressures, organisations react in a similar fashion to individuals who experience persistent stress. They argue that the constriction of health and welfare budgets, the move towards managed care, increased productivity demands, and the dominance of the biomedical paradigm, have placed the mental health service system in a state of constant stress, resulting in health and welfare organisations becoming trauma-organised. As a result the system responds defensively – organisations tighten up on hierarchies, leadership tends to be more autocratic, organisations tend towards risk aversion, and there is a lack of capacity to learn and effectively plan for the future. This creates services that are not able to respond effectively to consumers. For example, Bloom and Farragher (2011) argue that organisations that lack resources tend to deliver services in a more punitive fashion as it is costlier to invest in processes to respond to crises without force.

While Bloom and Farragher's (2011) writing about trauma-organised health systems focused on the American social and health service system, there are similar features

evident in the Australian mental health system. The fractured move to community care, the fragmented service system, and poorly funded services that focus heavily on short-term acute care are strikingly similar to the dysfunctional system described by Bloom and Farragher. From this perspective, this high level of stress may prevent the mental health service system from responding adequately to abuse survivors as organisations in this system are chronically stressed. This can be seen to cause a range of dysfunctional organisational issues such as the adopting of punitive measures in relationships with consumers and staff, poorly managing crises, inadequately communicating internally and with external stakeholders, and high staff burnout and turnover.

Bloom and Farragher (2011) also argue that chronically stressed organisations are impaired in their ability to engage in continuous improvement and organisational development. The chronic stress that is evident within the Australian mental health system may not only inhibit the ability of organisations to effectively respond to abuse survivors; it may also serve to impede the implementation of trauma-informed models of care. This is evident in previous policy change initiatives. For example, in response to the very high co-occurrence of drug and alcohol abuse with mental illness, the state of Victoria launched a No Wrong Door policy that aimed at better serving consumers with co-occurring needs. Despite significant investment, the impact of this policy is questionable. While there is evidence that professionals were more aware of dual diagnosis issues and there was an increase in professionals screening for co-occurring issues as a result of this policy, the delivery of integrated dual diagnosis services was found to be minimal (Australian Healthcare Associates, 2011). Roberts and Maybery (2014) attributed some of the difficulties in implementing this framework to the underfunded and fractured nature of the service system. Given the continuing chronic stress faced by the Australian mental health system, attempts to implement trauma-informed care may confront similar problems.

2.6 Involuntary treatment

The role of involuntary treatment within the Victorian health system is another factor that may impact on the ability of services to respond effectively to sexual abuse survivors. The Victorian Mental Health Act (Department of Health & Human Services, 2014) specifies that while mental health services should aim to use the least restrictive treatment options available, it enables certified mental health professionals to involuntarily treat individuals who are deemed to be at risk of harming themselves or others. As part of the process of deinstitutionalisation, community treatment orders (CTOs) were developed that served to mandate psychiatric treatment for individuals living in the community. Victoria is known to have amongst the highest rates of CTO usage in the world (J. Campbell, Brophy, Healy, & O'Brien, 2006).

The implementation of trauma-informed principles in mental health services is complicated by the role of involuntary treatment. The focus on having consumers in control of their care and encouraging power-sensitive relationships is difficult to implement if consumers are being treated involuntarily (Bloom & Farragher, 2011). Patel (2008, p. 341) argues that the implementation of CTOs places workers in a dual role as both a "supervisor of involuntary treatment and collaborator in care" and concludes that this impairs their ability to deliver holistic, collaborative care. The implementation of trauma-informed practices in psychiatric inpatient units can be seen as particularly difficult due to the role of involuntary treatment and the use of restrictive practices such as seclusion and restraint. The Victorian Mental Health Act (2014) grants power to mental health professionals to physically restrain or seclude patients if they are deemed to be at serious risk of harm to self or others and all other less restrictive options have failed. Between 2015-2016, 5% of episodes of care in Australian psychiatric inpatient services involved seclusion. Emerging data indicates similar rates of physical restraint occur in Australian psychiatric services (Australian Institute of Health and Welfare, 2017).

Restraint and seclusion practices within inpatient settings can prove to be particularly

traumatising for sexual abuse survivors. In a review of literature investigating consumer experiences of restraint in psychiatric services, Strout (2010) found that consumers frequently reported negative psychological impacts including feeling frightened, dehumanised, humiliated, powerless and degraded. She also found that consumers who were survivors of abuse found the experience of restraint re-traumatising as it often mirrored their experiences of abuse. Markoff et al. (2005) argue that services can work to reduce these practices by developing safety plans with consumers that outline potential triggers for distress, specific strategies to be implemented should distress escalate, and key steps that will be taken before restraint or seclusion is used. They also stress the importance of transparency around what kind of behaviours will lead to restraint and seclusion.

Given the clear paradox that exists when implementing trauma-informed practices in psychiatric inpatient settings, it is not surprising that the majority of literature around the implementation of trauma-informed approaches in mental health settings focuses on how to reduce seclusion and restraint. Muskett (2014) conducted a literature review of studies that investigated the implementation of trauma-informed practices in psychiatric inpatient settings. Most of the literature focused on reducing seclusion and restraint as a key aspect of trauma-informed practice. She found that many of the studies emphasised the role of effective leadership in guiding teams to implement trauma-informed principles. Effective leadership was characterised by having a clear leader committed to the change, executive support from across the organisation, and the inclusion of all levels of management as active participants of the change process. In addition to this, data collection mechanisms and self-evaluation tools designed to monitor outcomes of the implementation were also seen as valuable in implementation. There is also emerging research into sensory modulation as a means of responding to aggressive consumers in inpatient settings in a less restrictive way. This involves supporting consumers to use a designated space that is equipped with various calming sensory items such as weighted blankets, aromatic oils and diffusers, music, and ambient lighting. A preliminary study in New Zealand found that such spaces

helped consumers facilitate a calm state when distressed (Sutton, Wilson, Van Kessel, & Vanderpyl, 2013). Whilst this research is in its infancy, it indicates that sensory modulation interventions may be effective in supporting trauma-informed inpatient units.

The role of involuntary treatment in the Victorian mental health system poses some clear challenges for the implementation of trauma-informed care, and the way in which the system can respond to abuse survivors more generally. Given the experiences of powerlessness felt by sexual abuse survivors, this is an area of trauma-informed mental health service delivery that requires more consideration.

2.7 Recovery as a framework for practice

Mental health policy in Victoria, as well as on a national level, is increasingly informed by the recovery model of mental illness. The similarities between this model and trauma-informed care, along with the difficulties truly implementing this model within Australian mental health services, raises questions about the promise of trauma-informed models of care.

The recovery model emerged from the mental health consumer movement in the 1990s that critiqued the deficit-focused model of mental illness that framed disorders such as schizophrenia as chronic and deteriorating. The recovery model challenged this framing, pointing to substantial long term recovery rates amongst people diagnosed with schizophrenia and strived to develop models of practice aimed at facilitating recovery (Kruger, 2000). Instead of a focusing on curing the symptoms of mental illness, the recovery model is aimed at helping individuals to live a meaningful, satisfying life, potentially alongside experiences of mental illness. Anthony (1993, p. 527) defines recovery as:

> A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the

> development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.

Leamy, Bird, Le Boutillier, Williams, and Slade (2011) conducted a systematic review of literature investigating models of personal recovery and identified five key processes that support recovery; connectedness, hope and optimism about the future, rebuilding/redefining identity, meaning in life, and empowerment. They also identified a range of practices that mental health services can adopt to support consumers in their recovery. This includes the adoption of a focus on the strengths of consumers, implementing a holistic approach to assessment and treatment, delivering services in a way that maximizes consumer choice and autonomy, assisting in the development of goals that enhance connectedness and meaningful activities, inspiring hope that recovery is possible, and encouraging consumer care involvement in the development and implementation of programs (Le Boutillier et al., 2011; O'Connell, Tondora, Croog, Evans, & Davidson, 2005; Slade et al., 2014).

The concept of recovery has been embedded into mental health policy at a national and state level within the National Mental Health Plan (Department of Health and Aging, 2009), the National Framework for Recovery-Oriented Mental Health Services (Australian Health Ministers' Advisory Council, 2013) and Victoria's Framework for Recovery-Oriented Practice (Department of Health, 2011a). These frameworks draw from recovery literature and explicitly outline the practices, capabilities and leadership that should underpin all mental health service delivery.

While the rhetoric around recovery signifies a notable shift in mental health policy, there are concerns that the key principles of recovery are not translating into service delivery (Bateman & Smith, 2011; Courtney & Moulding, 2014). One key barrier to the implementation of the recovery model into mental health service delivery is the statutory role of many mental health professionals in Victoria. Along similar lines to the paradox of implementing trauma-informed principles in statutory settings described

earlier, the role of mental health professionals in administering and monitoring treatment orders can be seen to undermine recovery principles. This is due to the reduction in consumer autonomy and choice, as well as the enhanced power imbalance between professionals and consumers (Courtney & Moulding, 2014).

In addition to this, the adoption of the recovery model requires some fundamental shifts in how mental health services are delivered. Schrank and Slade (2007) argue that for psychiatric services to truly practice in a recovery orientated manner they must shift away from clinical notions of recovery, which have a focus on symptom reduction, to a personal model of recovery that values the subjective goals of the service user. This requires a shift in expertise whereby consumers become experts by experience and service delivery is driven by their goals and desires, rather than objectives defined by professionals as outside experts. They also argue that practice from a recovery perspective necessitates a degree of holism where the focus of care is on the whole person within their environment. A study by Cleary et al. (2013) indicates that Australian inpatient units are struggling to shift practices to truly reflect this personal model of recovery. They interviewed psychiatric nurses working in an Australian inpatient setting and found that they were vague in their understanding of what recovery meant and tended to focus on symptom reduction as a marker of recovery. They reported that nurses understood recovery largely as rhetoric, rather than a framework influencing practice. Bateman and Smith (2011, p. 70) contend that the nature of clinical mental health service delivery is fundamentally at odds with recovery principles and are sceptical of the intentions of public mental health services adopting recovery frameworks:

> Public mental health services attempt to adopt recovery principles into their practice but ultimately only tinker at the edges, co-opting the language of recovery without substantially changing service design, treatments, environments, or the relationship with consumers, carers and communities.

The difficulties involved with implementing a recovery framework in the current Victorian mental health system is indicative of a paradigmatic clash. The recovery

model's focus on self-determination, autonomy and holism sits uneasily with the statutory and expert nature of clinical mental health delivery.

The principles of trauma-informed care outlined in the Service Guideline for Gender Sensitivity and Safety (Department of Health, 2011b), as described earlier in this chapter, are remarkably consonant with the recovery principles. The focus on strengths, empowerment, agency and control, and consumer involvement found within trauma-informed care mirror the principles articulated within the recovery model. At its core, trauma-informed care can be seen as the recovery model with the addition of a trauma lens that contextualises the experience of mental illness. In theory, trauma-informed care should be easily implemented within a mental health system that is guided by recovery principles. However, the paradigmatic clash described above, and the concerns about the piecemeal adoption of recovery principles raises questions about the possible barriers to the implementation of trauma-informed care in the Australian mental health setting. There are examples of trauma-informed care being implemented in a piecemeal way in Australian mental health services. For example, Isobel and Edwards (2017) outlined a trauma-informed model of practice that was developed and implemented for psychiatric nurses working in an Australian psychiatric inpatient unit. This model was based on principles of safety, empowerment, choice, collaboration and trustworthiness. Attached to each of these principles was a range of strategies, very few of which specifically related to trauma. Rather, they were strategies that could be seen as effective, empowering, accountable practices that would benefit all mental health consumers. The article also specifies that the model was not intended for nurses to identify or treat trauma. Furthermore, they sidestep the contradictions inherent within applying trauma-informed care within involuntary settings. They argue that in the application of trauma-informed care to involuntary treatment settings, there may not be a way of resolving the potentially re-traumatising nature of enforced care. The trauma-informed approach described in this study amounts to a substantial watering down of trauma-informed principles, much the same as the reducing of recovery principles to rhetoric that Cleary et al. (2013) found when studying the implementation

of the recovery model by psychiatric nurses. The paradigmatic differences between trauma-informed models of care and the clinical model that currently guides much mental health service delivery in Australia may have an impact in how effectively Australian services can use trauma-informed models of care to meet the needs of sexual abuse survivors.

2.8 Aboriginal Australians and transgenerational trauma

The experience of transgenerational trauma experienced by Aboriginal Australians is a further feature of the Australian context that has implications for how the Australian mental health system responds to trauma and abuse. Ralph, Hamaguchi and Cox (2006) detail the waves of trauma that have impacted subsequent generations of Aboriginal Australians. They identify the first wave of trauma being the violence, massacres and segregation associated with the white settlement in Australia. The second wave is related to the systematic removal of Aboriginal children from families where it is estimated that up to 1 in 3 Aboriginal children were removed between 1910 and 1970 (Human Rights and Equal Opportunity Commission, 1997). Ralph, et al. (2006) argue that the impact of these traumas is felt across successive generations of Aboriginal Australians and profoundly effects the health and wellbeing of Aboriginal individuals, families and communities living today. Milroy (2005, p. xxi) argues that:

> Given that the traumas of separation, social control and exclusion have been sustained over several generations and that almost the entire Aboriginal population was affected, the ability of individuals to psychologically integrate and for families and communities to collectively resolve these experiences in the face of ongoing denial of history is extraordinarily difficult.

The experience of transgenerational trauma results in children being brought up facing the direct impact of the trauma and loss that has occurred before them. Instances of present trauma, such as sexual abuse, is experienced against the backdrop of families and communities that are scarred by past trauma and loss (Ralph et al., 2006).

Given the layers of trauma and loss through forced removal from land, massacre,

segregation, and forced removal of children, it is not surprising that Aboriginal Australians report higher levels of mental illness than non-Aboriginal Australians. One third of Aboriginal Australians over the age of 18 report having high/very high levels of psychological distress, a rate that is almost a three times greater than non-Aboriginal Australians (ABS, 2013).The rate of suicide amongst Aboriginal Australians is double that of non-Aboriginal Australians. This rate is higher amongst Aboriginal Australians under 30 with the rate of suicide for Aboriginal young people up to five times higher than non-Aboriginal young people (Department of Health, 2013). In their study into transgenerational trauma, sexual abuse, and suicide amongst young Aboriginal women, Ralph et al. (2006, pp. 122–123) found that experiences of trauma and abuse had an association with suicidality and argue that this link is particularly strong in Aboriginal communities given the layers of historical trauma. They concluded that:

> Aboriginal youth in the Kimberley region may experience several layers of trauma, through their own direct and secondary exposure as set against a backdrop of historical unresolved trauma and grief. These layers of trauma are thought to be cumulative in the manner in which they inform the adolescents' experience, and continue to adversely reinforce the basic assumptions that are violated by chronic trauma exposure; that the world is meaningful and safe, that the self is worthy, and that others can be trusted.

The historical and contemporary experiences of trauma that are unique to Aboriginal Australians has implications for the implementation of trauma-informed care in Australian mental health settings. While trauma-informed literature emphasises the importance of respecting diversity and different cultural responses to trauma (Elliott et al., 2005; Kezelman & Stavropoulos, 2012) there is scant consideration for the role of transgenerational and historical trauma in the experiences of consumers. Further, much of the theoretical basis for trauma-informed care is drawn from Western psychology. This raises questions about the effectiveness of this approach in non-Western cultures, particularly those who have been subjected to Western colonisation. Dudgeon and Walker (2015, p. 276) are deeply critical of the imposition of Western psychology on to

Aboriginal Australians and argue that:

> Psychology colonises both directly through the imposition of universalising, individualistic constructions of human behaviour and indirectly through the negation of Aboriginal knowledges and practices.

From this perspective, there is a need for a much deeper consideration of the impacts of transgenerational trauma and the role of indigenous knowledge within trauma-informed approaches to mental health service delivery.

Dudgeon and Walker (2015) point to the Social and Emotional Wellbeing (SEWB) model of health as an alternative framework for understanding, and responding to, Aboriginal health and mental health, one that is drawn from Aboriginal knowledge, culture and spiritualty. In contrast to the individualistic focus of Western psychology, SEWB is "predicated on a collectivist perspective that views the self as inseparable from, and embedded within, a range of interconnected domains" (Dudgeon & Walker, 2015, p. 278). These domains include mind and emotions, body, family and kinship, community, land or country, and spirit, spirituality and ancestors. Gee et al. (2014) argue that these dimensions must be understood within a social, political, cultural, and historical context that takes into account the role of issues such as past trauma, dispossession from land, racism, poverty, and cultural displacement. Viewed holistically, these contexts interact with the interconnected dimensions of social and emotional wellbeing. For example, they highlight how the historical context of communities impact on present social and emotional wellbeing:

> These critical factors—such as a community's local history of colonisation and the extent to which a cultural group was able to resist assimilation, maintain cultural continuity, and retain the right of self-determination and sovereignty—will all significantly influence a community's capacity to retain their cultural values, principals, practices, and traditions. This, in turn, will differentially empower or impinge upon individual and family SEWB (Gee et al., 2014, p. 62)

By viewing social and emotional wellbeing against the social, political, cultural and

historical context, a SEWB model of health has scope to incorporate the impact of transgenerational trauma on mental health and current experiences of trauma. Consequently, this perspective may be useful when considering how mental health services can best respond to trauma related issues in the Australian context.

2.8 The role of mental health services in delivering trauma-specific programs

The way in which mental health services respond to sexual abuse survivors is further influenced by their role in delivering trauma-specific programs. Currently, the majority of mental health services in Australia do not deliver programs that specifically treat the impacts of trauma. This is also reflected in the Service Guideline for Gender Sensitivity and Safety (Department of Health, 2011b) that positions Victorian mental health services as potentially trauma-informed, but does not guide them to deliver trauma-specific services. Instead, they stress the importance of strong relationships with sexual assault and domestic violence services.

Within the trauma-informed literature, it is unclear what role mental health services play in a trauma-informed service system. In the literature, there is consistently a distinction between trauma-informed care and trauma-specific services. Trauma-specific services are defined as having a focus on directly *treating* consumers with issues relating to traumatic experiences (Jennings, 2004). Within these settings recovery from trauma is the primary goal of the service. Trauma-specific services aim to support recovery from trauma using a range of treatment modalities including cognitive behavioural therapy, integrative family systems therapy, and emotional and experiential therapies (Courtois & Ford, 2009). In comparison, trauma-informed approaches refer to a system-wide approach to service delivery with a focus on how organisations can change to be more responsive to the needs of trauma survivors. Here, there is an assumption that trauma survivors make up the majority of consumers who access health and welfare services. Consequently, trauma-informed approaches are designed for all services where trauma survivors are likely to come into contact, rather than

specifically for services that directly treat the impacts of trauma. While trauma-specific services can be governed by trauma-informed practices, trauma-informed services are not necessarily focused on treating trauma or associated symptoms (Kezelman & Stavropoulos, 2012). The focus of trauma-informed care is not so much on treatment per se, but rather how systems work, how a survivor is perceived, and how their experience of distress is understood in the context of traumatic experience.

In the trauma-informed literature, it is unclear where mental health services ideally sit within this distinction. Do mental health services adopt a trauma-informed approach to care but refer to specialist trauma services when needed? Alternatively, do mental health services have a role to play in providing trauma-specific treatment?

In their discussion on the implementation of trauma-informed approaches to mental health and substance abuse services, Markoff et al., (2005, p. 528) argue that trauma-informed mental health services must aim to incorporate trauma-specific treatment when working with survivors of abuse:

> Because trauma is so pervasive among women in both kinds of settings and because trauma is such an important experience linked to both mental health and AOD difficulties, our major message is that services for mental health, AOD, and trauma need to be integrated, not provided separately.

From this perspective, mental health services must work with consumers to understand how experiences of trauma are intertwined with mental health issues and seek to treat both issues in unison.

Similarly, Harris and Fallot (2001a) argue for a fully integrated approach to trauma, substance abuse and mental health. They contend that services traditionally operate in a parallel approach where different providers target specific issues. This approach is inherently problematic, as different services may have different requirements for treatment that are incompatible. In addition to this, a parallel treatment approach perpetuates the notion that the self can be compartmentalised with different parts of

the self being treated separately. They suggest that this mirrors the compartmentalisation that many trauma survivors adopt as a means of coping with experiences of trauma and may be a harmful approach when working with survivors.

Other trauma-informed literature positions mental health services as separate from trauma-specific services. For example, in their discussion on implementing trauma-informed care as a model of practice for nurses in a psychiatric inpatient unit, Isobel and Edwards (2017) specified that the adoption of trauma-informed care was aimed at increasing nurses ability to understand and recognise the impacts of trauma, not to identify and treat the sequelae of trauma. Isobel (2016, p. 590) argues that it is essential that trauma-informed care be implemented within psychiatry but goes on to suggest that:

> Understanding the impact of trauma on individuals does not discount their current or future diagnosis, nor alter the course of their care, but rather contextualises them, their diagnosis, their behaviours and their experiences, while informing practice in a way that aids effective treatment and recovery.

From this perspective, trauma-informed care is not as much a paradigm shift as described by Harris and Fallot (2001b) and Bloom (1997), but rather it represents adding a trauma focus to an existing psychiatric model. Here, mental health services do not necessarily have a role to play in providing trauma-specific services but can attempt to shift their organisational and practice culture to be more aware of the impacts of trauma. The Guidelines for Gender Sensitive Practice and Safety (2011b) positions Victorian mental health services within this school of thought.

When mental health services are positioned as being trauma-informed but not trauma-specific, there is an inherent assumption that there are other services available to treat complex trauma. Much of the trauma-informed literature specifies that trauma-informed services must be integrated with other services that meet the needs of abuse survivors, including trauma-specific services. Huntington, Moses and Veysey (2005) include service integration as one of the four key principles for best practice in treating

women with trauma history and co-occurring disorders. Integration here is defined loosely where "two or more agencies, service providers or community groups establish linkages to share information, resources, funding and policy development"(Huntington et al., 2005, p. 401). When they evaluated how organisations implemented service integration in WCDVS, they found that service integration typically involved organisations coordinating on a policy and management level. This generally involved women receiving specific services for a range of psychosocial issues rather than a unified response. This level of integration is remarkably different from Harris and Fallot's (2001a) model where trauma, mental illness and substance abuse are addressed within a single system with a single model of care. This is difficult to achieve if separate services are targeting specific psychosocial and health issues.

The challenges involved with integrating services appears to be the most commonly cited issue with implementing trauma-informed care. The philosophical and paradigmatic differences between mental health, drug and alcohol, trauma, and other services were seen to be a significant impediment to integration in the WCDVS (Elliott et al., 2005; Huntington et al., 2005). The different funding sources of services was also seen to impede integration (Markoff et al., 2005). Due to these differences, it was noted that effective integration required a lengthy period of time and strong leadership oversight (Heckman, Hutchins, Thom, & Russel, 2005; Hopper, Bassuk, & Olivet, 2009).

Australian mental health policy, including recent policy initiatives aimed at delivering effective services to abuse survivors, positions mental health organisations as delivering services in a parallel fashion to services targeting the impacts of trauma and other psychosocial issues. Given the challenges involved with integration described above, this may inhibit mental health services from responding effectively to sexual abuse survivors.

2.9 Implementation of trauma-informed care

When considering trauma-informed care as an alternative model of service delivery to best meet the needs of abuse survivors, it is useful to consider the evidence base for the effectiveness of the approach. The bulk of the research into the implementation of trauma-informed models of care in mental health services stems from the WCDVS conducted in the United States. Nine sites took part in the study and were required to implement an approach to service delivery that provided a comprehensive range of services that were integrated, trauma-informed, and had consumer involvement on all levels of service delivery (Huntington et al., 2005). Cocozza et al. (2005) evaluated the program level effects across the nine sites and found that there was an association with the delivery of these services and improved post-traumatic symptoms and lowered drug and alcohol use. As the guidelines were general, each site maintained autonomy over what and how services were delivered. Not surprisingly there were variations in effect sizes between sites. The sites that offered integrated counselling that addressed mental health issues, trauma and substance abuse concurrently were associated with the highest rates of symptom reduction. Other sites that offered trauma, mental health and substance abuse services separately had lower rates of symptom reduction. This preliminary research indicates that mental health services may more effectively respond to trauma survivors if they integrate mental health and trauma interventions.

There is less research into the effectiveness of trauma-informed care as a broad approach to organisational change. Many of the studies that have been conducted have looked at the effectiveness of training packages on increasing staff awareness about the prevalence and impacts of trauma, but have not investigated the impacts of trauma-informed care on a consumer level. For example, Giller et al. (2006) evaluated a mental health training curriculum that was delivered to professionals working in the United States aimed at increasing staff ability to respond to the complex needs of trauma survivors through a relational, self-reflective framework. Their evaluation found that staff felt they could understand complex trauma responses, develop capacities to respond to complex trauma, and could recognise and address signs of re-

traumatisation. This study did not evaluate whether this training translated into changes in work practices or client outcomes.

Berliner and Kolko (2016) found similar trends in the US child and family sector where trauma-informed initiatives have been widely supported at federal and local levels. They evaluated several studies of trauma-informed care implementation that focused on staff training and found that while training increased staff awareness of the prevalence and impacts of trauma, there were questions regarding how much this awareness was changing practice. They argued that trauma-informed models may be too conceptually broad and tend to lack clear direction on how to operationalise principles. They also commented that many trauma-informed principles such as a focus on strengths, empowerment, and quality relationships mirror features of good practice for all children and families. While these principles ensure that traumatised children are treated in a caring environment, what is most important is the effective screening of children for abuse and ensuring that they are directed to effective care. While this critique focuses on the implementation of trauma-informed care in the child and family sectors, similar issues may be present in the implementation in mental health settings.

2.10 Summary

This chapter has reviewed the current research into how mental health services are responding to trauma survivors, which indicates that mental health services are struggling to respond effectively. Trauma-informed care has emerged as a way of shifting services to better respond to trauma survivors. This approach has gained some recent traction in Australian mental health policy, which has historically neglected to address issues related to trauma and abuse. While trauma-informed care may be useful in increasing the awareness of the impacts of trauma and the links with mental illness, there are a number of questions regarding the effectiveness of the approach and complexities involved with the implementation within the Australian mental health system. The fractured and underfunded nature of the mental health system, the role of

involuntary treatment, and the resistance to change evident within mental health service systems calls into question the ability for the service system to respond effectively to sexual abuse survivors. The positioning of Australian mental health services as trauma-informed rather than trauma-specific, particularly in such a fractured service environment, may further inhibit effective system responses. In addition to this, the broad, value-based nature of trauma-informed approaches to care in the absence of operational principles raise questions about the effectiveness of the approach to adequately meet the needs of survivors. While trauma-informed care is a valuable step towards a system that adequately responds to abuse survivors, more consideration is needed regarding how the mental health system can best meet the needs of sexual abuse survivors. This need for a greater awareness of how mental health services can best respond to abuse survivors has informed the research design of this project, as detailed in Chapter 4.

Chapter 3 – THEORETICAL DEBATES: SEXUAL ABUSE AND VOICE HEARING

The way in which mental health services respond to sexual abuse survivors who hear voices is shaped by the practice and policy issues discussed in Chapter 2. Considering voice hearing following sexual abuse, there are conceptual challenges that may further impact how services respond to survivors of sexual abuse who hear voices. This chapter outlines the different discourses that seek to explain the phenomenon of voice hearing and how it is, or isn't, connected with the experience of sexual abuse. First, it considers the biomedical model of mental illness, with a particular focus on diagnostic approaches that demarcate and label different manifestations of distress. Systems theory is then presented as an alternative way of understanding mental illness that frames experiences of distress as emergent from the interaction between the individual and their environment. Finally, the Hearing Voices Approach is outlined as a perspective that seeks to understand voice hearing from a lived experience perspective. Here, the phenomenon of voice hearing is framed as closely tied to the voice hearer's context and biography, with experiences of trauma seen as highly relevant to the development and experience of voice hearing.

3.1 The biomedical model of voice hearing after sexual abuse

Contemporary mental health service delivery is largely based on a biomedical psychiatric conceptualisation of emotional and mental distress (Deacon, 2013). This section will detail the positivist basis of biomedical psychiatry and will consider how the impacts of sexual abuse, and its relationship with voice hearing, are conceptualised within this framework.

POSITIVISM AND PSYCHIATRY

Much of modern day psychiatric understandings of distress stem from biomedical perspectives that emerged in post-enlightenment Europe (Scull, 1989). Pre-

enlightenment thinking around mental illness tended to attribute the origins of mental and emotional disturbance to religious or spiritual explanations. For example, voice hearers were often perceived as possessed and subjected to moral or religious treatments (Watkins, 2008). Along with the Enlightenment's focus on science and rationality came the reconceptualising of mental disturbance as an illness to be treated within the medical profession (Scull, 1989). Doerner (1977, p. 292) noted that this rejecting of pre-enlightenment thought about distress became the basis for psychiatric thought by 1900:

> Psychiatry looked on itself with uncritical matter-of-factness as natural-scientific enlightenment, as a fight against demonologic and other superstitions and for the rights of the mentally ill.

This shift in thinking is seen in the positivist basis for the biomedical model of mental disorder that arose in the post-enlightenment era. The positivist approach to understanding the human condition originated from Auguste Comte (1876) who stressed that sociology, or the study of humanity, must be understood using the same principles of observation, experimentation, and rational logic that characterised physics, mathematics and chemistry. Key to Comte's thinking was the notion that scientific knowledge was the only form of knowledge with other forms of knowing deemed invalid. Cheung Chong & Nolan (1994, p. 227) point to the key basis of positivist epistemology:

> As a system of thought, it is based on the premise that natural science is the supreme form of knowledge, and that facts are the only possible objects of knowledge. Those who espouse a positivistic stance reject the existence of any forces or substances that cannot be verified by science. Thus all that can be known is what we can observe, and it is through this observation that we ascertain the laws governing human behaviour.

Positivism demands objectivity as a means of guaranteeing a rational, logical understanding of the phenomena being studied. When applying this approach to the study of humanity, first person accounts of phenomena are disregarded due to the

subjectivity laden in the personal recounting of experience. Subjectivity is thought to be not of the physical world, so it is disregarded (Baker, 1992).

This positivist focus on empiricism as a means of understanding psychological and emotional distress can be seen to influence a downward reduction approach to psychiatry that is based on the premise that the best approach to understanding a phenomena is to understand its most basic constituents (Rudnick, 2002). This focus on a downward reduction approach to understanding distress influences psychiatry to focus on biological markers of mental illness. For example, Guze (1992, p. 16) argues that trying to understand the content and quality of a patient's distress is a fruitless activity as this does not enhance the ability to diagnose and treat the underlying brain condition:

> Thus, if one considers the possibility that many, if not most, psychiatric disorders result from some variation in brain function, the possibility clearly arises that that the patients "disclosures" may not be specific to the disorder under study.

The focus on understanding psychological phenomenon with the principles of observation, experimentation, and objectivity necessitated a nosological framework to classify and categorise mental disorders. This is the driver behind the development of the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Bracken, 2002), which is the most commonly used diagnostic framework in Australia and much of the Western world. At the core of this framework is the premise that mental illnesses exist as discrete categories that can be diagnosed through observable symptoms. In this framework the impacts of sexual abuse are largely understood within the diagnostic category of PTSD.

The development of Post-Traumatic Stress Disorder

The development and inclusion of PTSD is notable as it points to the social and political forces at play in the creation of diagnostic categories. Throughout the nineteenth, and for most of the twentieth century, there has been a degree of silencing around the

psychological impacts of trauma (Herman, 1992b; McFarlane, 2000; Scott, 1990). This is notably seen in Freud's retraction of his trauma theory of hysteria due to the social conservatism of nineteenth century Europe (Herman, 1992b). This silencing and denial of the prevalence and impact of trauma is mirrored throughout the twentieth century. Reports of the psychological impact of warfare that emerged from the first and second world wars were largely minimised. Soldiers experiencing distress after combat were frequently labelled morally corrupt, malingering or cowardly (Scott, 1990). The acknowledgement of the real impact of warfare was seen as too dangerous to the war efforts (McFarlane, 2000). The culture of denial began to shift during the Vietnam War. Vietnam veterans, grappling with the devastating impacts of combat, joined with psychiatrists who had an interest in combat related disorders to push for the inclusion of Post-Traumatic Stress Disorder (PTSD) in the Diagnostic and Statistical Manual of Mental Disorders III (Scott, 1990).

Second wave feminism further shone a light on the psychological impacts of trauma with a growing focus on the high frequency of violence experienced by women. Feminist researchers such as Ann Burgess and Linda Holmstrom (1974) as well as Diana Russell (1984) not only revealed the high frequency of gendered violence but also began to understand the psychological impact of this violence. From a liberal feminist perspective, the recognition of trauma from the psychiatric establishment marked a significant win in the struggle for women's equality. Berg (2002) argues that liberal feminists applauded the introduction of PTSD, as it in part served to redress the previous sexist imbalance that had existed in psychiatry. Rather than pathologising women's behaviour that falls outside of the norms of a sexist society, the concept of PTSD served to link women's emotional distress with contextual factors such as surviving violence and abuse. Tseris (2013, p. 155) argues that this recognition of the social contexts of women's emotional distress meant that "women's over-representation within the psychiatric system was able to be radically reconceptualised". Women's psychological distress was no longer seen just within the frame of women's apparent biological vulnerability, but rather as a possible reaction to an adverse

environment.

The Diagnostic and Statistical Manual 5 (APA, 2013) categorises PTSD as a collection of symptom clusters in response to experiencing or witnessing an event that involved death or threatened death, actual or threatened serious injury, or actual or threatened sexual violence. Prolonged exposure to such events within professional duties is also included as a potential precursor to PTSD. The symptom clusters are based around experiencing intrusive memories linked to the traumatic experience, avoidance of reminders of trauma-related stimuli, negative alteration in cognition and mood, and trauma related alterations in arousal. These symptoms must have been experienced for more than one month and must impact on the individual's functioning (APA, 2013).

Voice hearing does not feature within the diagnostic criteria for PTSD, however, pseudo-auditory hallucinations are mentioned as a potential additional feature of the diagnosis (APA, 2013). Within psychiatric literature, there is ongoing speculation about there being a difference between the hallucinations experienced by individuals diagnosed with schizophrenia and individuals with other diagnoses. For example, Brewin & Patel (2010) hypothesised that voices heard by PTSD sufferers were pseudo-hallucinations rather than the real hallucinations experienced by people diagnosed with schizophrenia. These claims have been disputed by a number of studies. McCarthy and Longden (2015) conducted a review of studies investigating the phenomenology of voice hearing amongst individuals diagnosed with PTSD and those diagnosed with schizophrenia and concluded that there are minimal differences between the two groups.

VOICE HEARING AND TRAUMA WITHIN DIAGNOSTIC SYSTEMS

Within psychiatric diagnostic frameworks, the phenomenon of voice hearing is largely considered as separate from trauma and stress diagnoses. Within the DSM 5, voice hearing is strongly associated with psychotic diagnoses. For example, auditory hallucinations are one of the five symptoms required for a diagnosis of schizophrenia.

Auditory hallucinations are also listed as a symptom that indicates psychotic forms of depressive and bipolar disorder and as an associated feature of a number of personality and dissociative disorders (APA, 2013).

Despite the body of research indicating an association between experiences of trauma and the development of psychosis (Varese, Smeets, et al., 2012) the DSM does not list trauma and abuse as potential risk factors for the development of psychotic disorders such as schizophrenia (APA, 2013). The biomedical model is largely interested in investigating the biological markers of voice hearing. Biomedical research into the aetiology of voice hearing continues to focus on biological factors such as DNA variations (Sanjuan et al., 2004), neural mechanisms (Frith, 2005) and sensory prediction deficits (Shergill, Samson, Bays, Frith, & Wolpert, 2005).

The DSM does list early trauma and abuse as associated with personality disorder diagnoses such as borderline personality disorder (BPD) as well as dissociative disorders such as dissociative identity disorder (DID) (APA, 2013). This is reflective of the research indicating that a very high proportion of individuals diagnosed with BPD and DID have experienced early abuse or trauma (Bradley et al., 2005; Foote, Smolin, Kaplan, Legatt, & Lipschitz, 2006; Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004).

Given the DSM includes auditory hallucinations as associated features of BPD, DID, and PTSD, though not as diagnostic criteria, there is some scope for this diagnostic model to link auditory hallucinations with experiences of sexual abuse. However, given that auditory hallucinations are so central to psychotic diagnoses, and the lack of consideration for the role of trauma in these diagnoses, this scope may be relatively weak.

3.2 Diagnosing beyond PTSD – complex trauma and voice hearing

Since the inclusion of PTSD in the DSM, PTSD has become one of the most researched psychiatric diagnoses and has become the focal point for psychiatric and psychological discourse around the impact of trauma (Joseph & Murphy, 2014). Despite the success of the development of PTSD in shining a light on the psychological impacts of trauma,

there are several limitations involved with this conceptualisation of post-traumatic responses. One of the key limitations is the narrow scope of the PTSD diagnosis to capture the far-reaching impacts of trauma. As detailed in Chapter 2, there is an increasing body of research indicating strong associations between traumatic experiences and a range of mental health diagnoses and psychosocial issues, including the experience of voice hearing (Anda et al., 2005; Battle et al., 2004; Bebbington et al., 2004; Chen et al., 2010; Dube et al., 2005; Felitti et al., 1998; Varese, Smeets, et al., 2012). While there is an acknowledgement within the DSM that there is an association between early trauma and BPD and DID, these diagnoses remain excluded from trauma and stressor-related disorders and do not include experiences of trauma as part of their diagnostic criteria (APA, 2013). The awareness of the far reaching impacts of sexual abuse has led to debates about how best to conceptualise the broad impacts of trauma.

COMPLEX TRAUMA

Research into the extensive impacts of sexual abuse has led to a critique of the limitations of PTSD as a diagnostic category. Herman (1992b) points out that the PTSD diagnosis was developed from research looking at the responses from single event traumas in adulthood rather than early, prolonged traumas such as child sexual abuse. She argues that traumatic responses from such prolonged traumas expand well beyond the hypervigilance, avoidance and intrusive symptoms defined by PTSD. Instead, she contends that complex post-traumatic responses include a range of symptoms including dissociation, chronic self-harm, alterations in consciousness, profound relationship difficulties, and a sense of hopelessness and despair.

Van de Kolk et al. (2005, p. 396) investigated the symptomology of a large group (n=400) of treatment seeking, traumatised individuals, and 128 community residents. They found that those who had experienced prolonged interpersonal trauma had a high incidence of symptoms that fell outside of traditional PTSD symptoms. This included symptoms relating to affect regulation and impulse control, issues with self-perception, issues with interpersonal relations, and dissociation. They also noted that there is very

high co-occurrence of a range of psychiatric diagnoses with PTSD and concluded that:

> It seems of paramount importance to address critically the fact that psychiatric disorders, categorically defined, frequently occur together, and that many disorders, in particular PTSD, seem to occur rarely in pure form, without comorbidities. It is clear that traumatized individuals develop a range of shifting maladaptive patterns, depending on their stage of development, social support, and relationship to the origin of the trauma.

These findings add weight to Herman's (1992b) earlier conceptualisation of complex post-traumatic stress.

Complex Post-Traumatic Stress Disorder

It is now evident that the impacts of trauma frequently fall outside the symptom clusters described within the PTSD diagnosis. The narrow diagnosis has consequences for how survivors of trauma and abuse are treated by the mental health system. Brown (1992, p. 213) argues that the limited definition of PTSD means that "syndromes that might constitute a normative, if not frankly normal responses to abnormal events in the social and interpersonal environment, continue to be construed as forms of psychopathology". On a pragmatic level, this limited approach has serious implications for diagnosis and treatment. As Herman (1992b, pp. 118–119) argues:

> The lack of an accurate and comprehensive diagnostic concept has serious consequences for treatment, because the connection between the patient's present symptoms and the traumatic experience is frequently lost. Attempts to fit the patient into the mold of existing diagnostic constructs generally result, at best, in a partial understanding of the problem and a fragmented approach to treatment.

In an attempt to address the limitations of the PTSD diagnosis, a new diagnostic category has been developed in the form of Complex Post-traumatic Stress Disorder (CPTSD) (Cloitre et al., 2009; Herman, 1992a). The proposed CPTSD symptoms include emotional dysregulation, difficulties with interpersonal relationships, dissociation, somatization, and adversely affected meaning systems. Despite over two decades of research and advocacy for the inclusion of CPTSD into the DSM 5, the diagnostic

category was not included In an evaluation of the evidence for the inclusion of CPTSD, Resick et al. (2012) argued that the symptoms described as part of CPTSD overlap significantly with PTSD, Borderline Personality Disorder (BPD), and Major Depressive Disorder (MDD) and consequently should not be considered as a discrete disorder. They also raised questions about a lack of evidence to prove that interpersonal trauma directly leads to the symptoms described within CPTSD as well a lack of tools that could effectively diagnose CPTSD[1].

The overlap of symptoms between PTSD, BPD, MDD and CPTSD may point to a key limitation in the attempt to try and fit complex trauma responses into a diagnostic framework such as the DSM. The psychological impacts of complex trauma are so varied that attempts to categorise them into a single diagnosis will invariably exclude some potentially post-traumatic symptoms. This is clearly evident in how voice hearing is positioned within the CPTSD diagnosis. Bransford and Blizard (2016) argue that voice hearing is an example of a symptom that may have trauma-genic aetiology but does not fit within current models of post-traumatic stress. This results in survivors of abuse who present with symptoms, such as voice hearing, frequently being diagnosed and treated without a consideration of the possible impacts of trauma on their emotional and psychological distress.

[1]While Resick et al., (2012) describe the process of evaluating the concept of CPTSD as largely guided by research into the validity and robustness of the proposed diagnosis, the influence of stakeholders associated with the American Psychiatric Association are also known to have directly influenced the development of the DSM V (Cooper, 2014; Greenberg, 2013). For example, Greenberg (2013) notes the high proportion of biological psychiatrists, neuroscientists and geneticists on the research committees for the DSM V and speculates that this biological focus had a strong influence in decision making around diagnostic categories. In addition to this, pharmaceutical companies have close relationships with the American Psychiatric Association, and due to substantially benefiting from decisions made about diagnostic categories within the DSM V, they are known to influence decision makers through gifting and funding research programs (Cooper, 2014).

IMPLICATIONS FOR PRACTICE

These features of the biomedical model can be seen to shape practice within mental health services in several ways. A focus on diagnosis informs how assessments are conducted within mental health services. From a biomedical approach, assessment is focused on gathering symptomology to find a diagnosis which consequently leads to decision making around treatment. For example, in the Australian setting, Meadows et al. (2012) outline an approach to assessment which involves the description of the patient's psychiatric history, presenting symptoms, safety and risk issues, issues with daily living, previous responses to treatment, and diagnosis. This approach to assessment often pays limited attention to the biography of the consumer, or the consumer's subjective understanding of their distress.

Diagnosis also informs approaches to treatment. For example, the Royal Australian and New Zealand College of Psychiatry (RANZCP) clinical practice guidelines for schizophrenia (Galletly et al., 2016) specify that antipsychotic medication is the first line of treatment for schizophrenia with other psychological therapies such as CBT for psychosis being ancillary to medication. In contrast, clinical guidelines for the treatment of PTSD or BPD prioritise psychological therapies over the use of medication (Forbes et al., 2007; National Health and Medical Research Council, 2012). Therefore, whether a consumer presenting with voice hearing is diagnosed with BPD, PTSD or schizophrenia will have a profound impact on the treatment they receive.

A FOCUS ON THE INDIVIDUAL

The biomedical model has been widely critiqued for focusing on the individual and obscuring relational, social, structural and cultural factors that play a role in the impacts of trauma and the experience of distress (Berg, 2002; Bracken, 2002; Bracken & Thomas, 2001; Burstow, 2003, 2005; Crowe, 2006; Humphreys & Joseph, 2004; Humphreys & Thiara, 2003; Tseris, 2013). Moncrieff (2010, p. 381) argues that by constructing psychiatric diagnoses as value free scientific categories the psychological

problems associated with social problems are essentially medicalised:

> By purporting to indicate the presence of an objectively identifiable bodily disease, psychiatric diagnosis is able to re-designate social problems as medical ones, and the social response to those problems as medical treatment.

Boyle (2011, pp. 38–39) furthers this idea and points to the psychiatric and psychological professions as notably resistant to the evidence for an individual's context playing a role in the development and experience of distress. She argues that the framing of distress within the individual serves both professions by upholding their legitimacy through colluding with dominant powers in society. She argues that conceptualising the context of distress is fundamentally political as it exposes power relationships in society:

> Just how un-neutral context is, can be gauged by listing those aspects more consistently relating to distress and problem behaviour – child abuse and neglect, school and workplace bullying, domestic and sexual violence, discrimination, poverty, and unemployment. It is not difficult to work out that these events involve relatively powerful groups – government corporations, men, white people, adults – damaging less powerful groups. In the case of emotional distress, then, context seems to include or even equate to the operation of power.

From this perspective, diagnosis becomes a political act as it serves to focus the understanding of distress as individual pathology at the expense of understanding the social or political forces that may be contributing to this distress.

The conceptualisation of the impacts of trauma within diagnostic categories highlights the focus on the individual at the expense of broader social, political and cultural issues. Berg (2002, p. 60) argues that the framing of the impacts of trauma within psychiatric diagnoses may do more harm than good as "focusing on the "dysfunction" of the female abuse victim serves to depoliticise the movement against the sexual and physical abuse of women". By focusing on diagnosing and treating traumatic symptoms in women, energies are shifted away from social and political attempts to prevent

gendered violence. The individual focus of the medical model is seen as effectively focusing on the women's problematic responses to life circumstances rather than looking at the collective issues that affect all women.

3.3 Systems Theory – an alternative model

As described above, the biomedical model of mental illness attempts to create clear boundaries around experiences of distress that consequently inform approaches to treatment. The impacts of trauma are tightly defined by the PTSD diagnosis, which does not match well to the broad and complex impacts of sexual abuse. A further limitation of the diagnostic framework is that it can be seen to depoliticise experiences of distress, locating distress within the individual without considering the social, political, and cultural context. Systems theories offer an alternative approach by conceptualising how factors that lay within an individual's relational, social, structural and cultural worlds interplay to create unique, subjective experiences of distress.

Systems Theory

Systemic perspectives on the human condition originate from the theories of biologist Ludwig von Bertalanffy (1968) who challenged reductionism as a means of understanding natural phenomenon. He argued that all organisms are open systems that are constantly interacting with their environment. He challenged the downward reduction approach to understanding phenomenon and argued that to understand the organism, one must not only understand the parts that make it up, but also understand how the parts interact with each other and how these systems interact with systems in their environment. Central to this perspective is the concept of emergence. Emergence describes a new phenomenon, processes, structures, and patterns that arise due to the interaction of lower level components of a system. These emergent phenomenon cannot be fully understood through solely understanding individual components, therefore, the whole is greater than the sum (Goldstein, 1999). For example, consciousness could be seen as an emergent phenomenon, it is indeed partly a result of

neurobiological processes, but the understanding of these parts alone does not explain the nature of consciousness (Chalmers, 2006).

For von Bertalanffy (1968), humans are open systems, made up of complex interacting parts, that are in constant interaction with larger systems (relational, political, cultural, social, spatial) within which they exist. He theorised that psychological pathology resulted from a dysfunctional interaction between the human system and its environment. He also contended that there is an inherent equafinality within open systems, where the same end point can be reached via multiple trajectories. Therefore, there are many different pathways that lead to the development of similar features of the human condition. This conceptualisation of aetiology is notably antithetical to linear notions of causality that often characterise biomedical models of causation.

Uri Bronfenbrenner (1992) expanded on von Bertalanffy's general systems theory and attempted to apply eco-systemic principles to the understanding of the human condition and brought into greater focus the role of culture, socio-political structures and time in shaping the human experience. Howe (2009, p. 118) succinctly describes Bronfenbrenner's view of the multiple systems involved with human experience:

> Our genetic make-up affects our temperament, personality, intelligence and many of our behaviour traits. Genes interact with their environment. Family and friends clearly have an impact on experience and development. But the climate in which we live our lives, indeed the very way we think, is also affected by the neighbourhoods in which we live, the schools we attend, the health service we enjoy, the language we speak, the culture in which we grow, the political context in which we relate to one another. Change in any of the levels – or ecosystems – affects what goes on in all other levels.

From this perspective, given all that shapes human experience, a broad focus on the individual within their context is essential when attempting to understand human phenomena.

Systems theories had a profound influence on psychiatric thought in the mid-twentieth century. Swiss psychiatrist Adolf Meyer (1952), like von Bertalanffy, was wary of the mechanistic nature of biological psychiatry and instead stressed the importance of understanding an individual's problems in the context of their biography. An individual may have inherited or acquired a biological susceptibility to mental illness, but understanding the illness on a biological level alone is insufficient, the emergence of mental illness must also be understood through understanding the individual's reactions to their environment. Pilgrim (2007, p. 538) argues that Meyers downplayed the relevance of diagnosis, but rather sought to understand the nature of the patient's experience:

> His main question of interest was not 'what is this patient's diagnosis?' but 'why is this particular patient presenting with these particular symptoms at this time in his or her life?'

Meyer's ideas were furthered by Engel (1980) who developed the biopsychosocial model of psychiatry. Borrowing from von Bertalanffy, Engel argued that humans were intrinsically connected with their environment. He writes:

> Nothing exists in isolation. Whether a cell or a person, every system is influenced by the configuration of the systems of which each is a part, that is, by its environment. More precisely, neither the cell nor the person can be fully categorised as a dynamic system without characterising the larger system(s) (environment) of which it is a part (Engel, 1980, p. 537).

From this perspective, understanding mental disorder, or the impacts of trauma, by only understanding the neural processes that are occurring within the brain is a vastly incomplete understanding. A more complete understanding sees emotional and psychological distress as arising in a person who is part of a whole system, with different layers of this system (neurology, psychology, relationships, culture) interacting to give rise to psychological and emotional distress. For example, a man experiencing depression may have a parent who has suffered from depression and may share a genetic vulnerability for depressive symptoms. He may have also have grown up in a

family environment that was hostile on account of his parent's depression, in a geographical location with low education and employment prospects, within a culture that tightly defines masculinity as stoic and unemotional. From a biopsychosocial perspective, his depression emerges through a complex interaction between all of these factors.

Pilgrim (2002) details how systems theorists had a profound impact on American psychiatry in the mid-twentieth century and served to bridge the gap between psychoanalytic and biological focused psychiatrists. The biopsychosocial model incorporated both perspectives into a coherent whole when attempting to understand mental illness. However, due to internal debates within psychiatry and the development of the DSM-III along biomedical lines, the biopsychosocial model of psychiatry became increasingly marginalised. Bland et al. (2012) argue that while a biopsychosocial perspective is increasingly being used in psychiatric assessments in the Australian system, there are doubts about how reflective these are of a true systemic assessment. While psychiatry has largely moved away from systems theories as a means of understanding the human condition, other professions that work in the mental health space, such as social workers, continue to use systems theories as the basis for understanding the people that they work with (Healy, 2005).

BIOPSYCHOSOCIAL MODELS OF VOICE HEARING

Based on increasing evidence to suggest that there are environmental correlations with psychosis, there has been a renewed interest in biopsychosocial explanations of psychosis and symptoms related to psychosis, such as voice hearing (Barker, Gumley, Schwannauer, & Lawrie, 2015; Bentall et al., 2014; Bentall & Fernyhough, 2008; Read, Fink, Felitti, & Whitfield, 2008). Read et al. (2008) point to the disproportionate amount of research into psychosis attempting to uncover biological aetiology, as compared with research into environmental factors. They suggest that this overwhelming focus on biology obscures investigation into how biological and environmental factors may interrelate to create aetiological pathways to psychotic symptoms. Further, they argue

that while there are biological processes that occur within individuals who are experiencing psychosis, there are biological processes that occur with all human functioning. To focus on just biological processes as the cause of psychosis fails to consider how the brain and the environment are in constant interaction. Read et al. (2008, p. 246) argue that:

> Brain researchers studying schizophrenia often operate as if the brain exists in a social vacuum, ignoring the fact that a primary function of the brain is to interact with the environment.

Instead, they argue for a return of an integrated biopsychosocial model of psychosis that conceptualises psychosis as emerging through a complex interplay between biological, psychological and social factors.

Bentall et al. (2014) reviewed the research into social environmental risk factors of psychotic symptoms and found that different environmental risk factors were associated with different symptoms associated with psychosis. They found that experiences of sexual abuse were more commonly associated with auditory hallucinations than other psychotic symptoms such as delusions or thought disorders. They also reviewed the research attempting to model the aetiological pathways between childhood adverse experiences and auditory hallucinations and concluded that there were two likely biopsychosocial explanations for the emergence of voice hearing amongst individuals who had experienced trauma. The first relates to the theory that auditory hallucinations are caused by deficits in source monitoring whereby individuals who hear voices experience difficulty discerning between occurrences that are generated from within the mind and occurrences that are generated outside of the mind (Ditman & Kuperberg, 2005). Bentall et al. (2014) argue that it is possible that the intrusive thoughts that occur as a result of experiencing trauma may intersect with this source monitoring difficulty to produce the experience of hallucinations.

The second explanation involves the role of dissociative states in creating hallucinatory experiences. Dissociation is a common response to early childhood trauma and can be

seen as an adaptive response to traumatic experience where children cannot fight or fly (Perry, Pollard, Blakley, Baker, & Vigilante, 1995). Whilst protective in childhood, dissociative tendencies that persist into adulthood are associated with a range of psychopathology including borderline personality disorder and post-traumatic stress disorder (van der Hart, Nijenhuis, & Steele, 2005). There is increasing research indicating associations between childhood trauma, dissociation and voice hearing. For example, Sar et al. (2010) investigated rates of childhood trauma amongst 70 individuals diagnosed with schizophrenia and assessed for co-occurring dissociative symptoms. They found that those who had experienced childhood trauma also rated highly with both dissociative symptoms and psychotic symptoms such as voice hearing.

Moskowitz and Corstens (2008) theorise that voice hearing co-occurs with dissociation and should not be solely considered a psychotic symptom. Varese et al. (2012) tested this theory by administering questionnaires testing for hallucination proneness, symptoms of dissociation, and childhood adversity to 45 individuals diagnosed with schizophrenia spectrum disorders and 20 healthy controls. They found that dissociation positively mediated the relationship between childhood adversity and voice hearing, particularly with regards to childhood sexual abuse. Longden et al. (2012) argue that the correlations between dissociation, voice hearing and trauma, along with the high prevalence of voice hearing amongst individuals with trauma-genic diagnoses such PTSD and borderline personality disorder (BPD) point to voice hearing being potentially a post-traumatic symptom. They argue that voice hearing is best "understood as dissociated or disowned components of the self (or self-other relationships) that result from trauma, loss or other interpersonal stressors"(Longden et al., 2012, p. 1).

Emerging research into the similarity between neurobiological markers of psychosis and early trauma further support the notion that trauma may play a role in the emergence of psychosis. Read, Perry, Moskowitz and Connolly (2001) developed a trauma-genic neurodevelopmental model of psychosis based on these similarities. Expanding on Walker and Diforio's (1997) diathesis stress model of schizophrenia, they argue that

many of the neurobiological differences found in people diagnosed with psychosis are also found generally in children who have been abused. For example, both individuals who have a diagnosis of schizophrenia, and children who have been subject to serious abuse have been found to have increased over activity in the hypothalamic-pituitary-adrenal (HPA) axis. Therefore, they propose a trauma-genic neurodevelopmental model whereby exposure to early childhood trauma results in changes in neurobiological development that can lead to an increased vulnerability to psychotic symptoms. Read, Fosse and Perry (2014) conducted a literature review of research that supported this model. They found that research indicated a number of processes that related psychosis and sexual abuse, such as overactivity of the HPA axis, changes in the prefrontal cortex, and changes in the hippocampus. Further, they found emerging evidence to suggest that there may epigenetic processes that mediate the relationship between trauma and the biological features associated with psychosis. They theorise that further research into the neurobiological associations between abuse and psychosis could help identify specific neural functions that relate to different symptoms of psychosis such as voice hearing.

These models attempt to integrate biological, psychological and environmental factors to explain the emergence of voice hearing. Beyond this is a consideration for how culture mediates the experience of voice hearing. This is most clearly seen when considering how different cultural and religious groups understand the phenomenon of hearing voices. One study by Luhrmann, Padmavati, Tharoor & Osei (2014) interviewed voice hearers from the USA, Ghana and India. They found that voice hearing experiences were notably different between the countries in relation to content and how the voices were perceived. For example, almost all of the voice-hearers from Ghana reported that their voice hearing experiences were positive and described rich relationships with their voices. This is compared with voice hearers from the USA who largely viewed their voices as very negative. The authors supposed that this variability was indicative of cultural differences, particularly how the self and mind are culturally understood. Luhrmann et al. (2014, p. 3) write:

> We believe that these social expectations about minds and persons may shape the voice hearing experience of those with serious psychotic disorders. Our participants in San Mateo were more likely to experience their voices as an assault. The voices were felt to be intrusions into their private world, and the sense that they could not be controlled upset them deeply. Our participants in Chennai and Accra were not as troubled by the presence of voices they could not control; they interpreted them, in effect, as people who cannot be controlled. The voices seem to make more sense to them, and they were more likely to say they liked them.

From a systems perspective, the brain activity taking place as these individuals heard their voices may be similar but their experience of the voices was different depending on the cultural context.

Al-issa (1995) conducted a literature review of sociocultural factors that influence the experience of hallucinations and concluded that cultural differences, particularly cultural concepts of reality, have an impact on the development and experience of hallucinations. He points to strong views on rationality held within Western cultures and the impacts this has on how individuals and communities make sense of voice hearing. This rationality conceives reality as something that is concrete and observable, there is little space for fantasy or the imaginary. Hallucinations such as voices are therefore strictly conceived as outside of reality and, therefore, are a cause for alarm by individuals who hear voices and those around them. He argues that the anxiety and fear provoked by this reaction can interfere with an individual's cognitive processes, which may exacerbate and intensify these voices. He compared this with some non-Western cultures that are less concerned with rationality, where the distinction between reality and the imaginary is blurred, and found that in these cultures voices are met with less alarm and were frequently normalised by cultural and spiritual frameworks. Here, from a systems perspective, there is an interplay between the cultural, biological, psychological and spiritual systems of the individual who hears voices. The interactions between these systems can account for the marked differences in experiences of voice

hearing in different cultural groups.

Systems theories can therefore be useful in broadening the scope of understanding around the experience of voice hearing. Positioning voice hearing within an environmental and cultural context creates a broader perspective than the reductionist frame of the biomedical model. This perspective can be flexible to the subjective experience of voice hearers within their social and cultural worlds and provides scope for understanding the interplay between biology and environment in the emergence of voice hearing. This translates into a more flexible, holistic approach to practice when working with voice hearers. Systems theories offers a broader scope for intervention, as it is interested in the whole person and their interaction with their environment, opening up multiple avenues for intervention

SYSTEMIC PERSPECTIVES ON SEXUAL ABUSE

Systems theories can be a useful way of conceptualising the varied individual impacts of sexual abuse. One key question that emerges from research into the impacts of trauma is the varied individual responses to traumatic events (Yehuda & McFarlane, 1995). For example, one individual who experienced sexual abuse as a child may develop into a well-adjusted adult with minimal experiences of psychological distress, while another suffering the same level of abuse will struggle in adulthood with severe mental illness alongside a range of other psychosocial problems. The variability in human responses to trauma is unexplainable by linear models of causality. From a systemic perspective, the multiple systems that both make up the individual and surround the individual involve countless variables that may alter how the individual experiences life. Consequently, each individual will respond to experiences of sexual abuse in a unique way, dependent on the make-up of their internal and external systems.

Campbell, Dworkin and Cabral (2009) draw on Bronfenbrenner's (1992) ecological theory of human development to conceptualise the impacts of sexual assault on women's mental health. When reviewing the literature investigating factors that influence the impact of sexual assault, they concluded that the impacts are mediated by

factors across Bronfenbrenner's systems. They argue that while personal factors, such as personality and biological predisposition to heightened cortisol production play a role in post-traumatic responses, so do relational factors such as positive or negative responses to trauma disclosures, or the degree of social support around the victim. These factors are also shaped by structural level forces that determine whether survivors have access to adequate physical and psychological health care post assault, as well as access to safe legal support. For example, they point out that the nature of the legal system accessible to rape victims can play a crucial role in a women's recovery from rape. They found that legal processes that had low rates of conviction and involved the questioning of survivor's responsibility for rape had a detrimental impact on post-traumatic symptoms. They concluded that in some complex rape cases women fared better when they did not access legal support than women who did access support. Cultural factors further shape post-traumatic responses. Cultural understandings of sexual assault shape how individuals understand their traumatic experience and how their social world responds to potential disclosures. For example, Neville and Heppner (1999) note that there is a substantial body of research that suggests that feelings of self-blame are associated with the negative psychological consequences of rape, however, there is little research investigating what precipitates differing levels of self-blame. They argue that understanding the cultural assumptions around female and male sexuality, consent, and sexual assault powerfully influence survivor's beliefs about sexual assault and consequently how they perceive their responsibility for the assault. When women hear messages about sexual violence that suggest that survivors are in some ways (through clothing choices or alcohol consumption) deserving of sexual assault, they are likely to internalise these messages. If they experience rape these beliefs may have the impact of increasing self-blame, thus increasing their risk of psychological distress.

Lasser & Bathory (1997, p. 162) use systems theory to understand the impacts of sexual abuse and map out the exponential possibilities of the interaction between the neurobiological changes that occur as a result of abuse, and the developmental stage

that the child is at. They argue:

> Trauma appears to cause global changes in a child's life; although it may initially affect a minute neurochemical level, its influence expands infinitely. It is as if one misses a stitch in a tapestry; eventually, the whole work unravels. One small change in a traumatized child can begin an alteration in every aspect of his or her life: neurochemical, neurobiological, psychological, and social. A tapestry lends only a partial metaphor, because it unravels in an organized fashion, or pattern. In a traumatized child the changes do not necessarily follow any order.

The multiple variables impacted by abuse go on to continue interacting with variables throughout the individual's life. This model can serve to explain the far reaching impacts of sexual abuse (Dube et al., 2005). It also explains why survivors of sexual abuse present with such different issues – each has responded to the abuse with their own unique variables across their subsystems.

IMPLICATIONS FOR PRACTICE

Systems theories offer an alternative to biomedical conceptualisations of trauma and voice hearing. Rather than focusing on what is occurring within the individual, systems theory widens the scope of analysis, taking into account contextual factors that may influence the experience and impacts of sexual abuse, or the development of voice hearing. It also challenges the linear modes of causality that are inherent within the PTSD construct. This enables a more nuanced understanding of the complex and far reaching impacts of sexual abuse and how sexual abuse may be related to the experience of voice hearing.

Systems theories offer scope for a holistic approach to assessment and intervention. This is most clearly seen in social work assessments and interventions that aim to understand a client's experience by understanding the nature of their relationship with their environment and intervening at the points where systems are causing harm (Germain & Gitterman, 1996). The focus on holism within systems perspectives is also helpful in understanding how the varied impacts of sexual abuse affect each other.

When outlining the complex picture of post-traumatic stress responses Van der Kolk (2008, p. 402) argues that holism is essential:

> Approaching each of these problems as piecemeal, rather than as expressions of a vast system of disorganisation runs the risk of losing site of the forest in favor of one tree.

The value of a systems approach lies not only in the ability to understand the complex layers involved with experiences of distress or experiences of trauma, it also offers multiple pathways for intervention. For example, when supporting sexual abuse survivors using a systemic approach there are multiple avenues for intervention. While there can be work done on a psychological level to help survivors learn new coping mechanisms, there is also value in providing education that unpacks myths and stereotypes about sexual abuse. This perspective also re-orientates practice towards addressing the social and cultural issues that perpetuate violence against women and children.

3.4 The lived experience perspective

The experience of voice hearing, and its relationship with sexual abuse, can also be understood from a lived experience perspective. Within the biomedical model the impacts of trauma are framed within the language of psychiatry and psychology rather than the language of the survivor (Humphreys & Joseph, 2004). This discursively shapes how the impacts of trauma are understood. The experiences of mental and emotional distress are similarly framed by psychiatry and psychology without consideration for the perspective of the individuals experiencing distress.

Gilfus (1999) argues that the medicalising of trauma marginalises alternative perspectives on the impacts of trauma, as well as knowledge derived from the lived experience of trauma survivors. She argues that while early trauma theory was a significant step forward in legitimising the distress caused by trauma and abuse,

locating it within the psychiatric paradigm served to individualise the focus on trauma at the expense of the political and social context. This focus on individual symptoms within pathological terms serves to tightly define the impacts of trauma:

> The individual model of trauma, then, selectively defines who can lay claim to certain legitimated sources of injury and constructs the person subjected to victimisation not as a survivor but as a victim, viewed through the narrow lens of psychological dysfunction, stripped of her social and cultural context (Gilfus, 1999, p. 1243).

The defining of traumatic responses from the medical establishment serves to objectify survivors of abuse. Gilfus argues instead, that individual responses to trauma are inherently subjective. Consequently, the impacts of trauma must be understood from survivors' perspectives. By viewing the impacts of trauma through the lived experience perspective it is likely that the social and political context of trauma would be more adequately captured. Through understanding the lived experience perspective, a survivor-centred epistemology can be developed:

> Rather than pathologizing the world view that emerges from trauma and oppression, I suggest that we explore an epistemology that flows from these worldviews as an important way to think about notions such as safety, home, justice, trust, and mental health (Gilfus, 1999, p. 1252).

This survivor epistemology offers a different vantage point from traditional trauma theory and views the survivor as a whole person, capable of expert knowledge, located within a social, cultural and political context. Through viewing the experience and impacts from trauma from these standpoints, Gilfus (1999) believes we can reach a much more nuanced understanding of the experience and impacts of trauma.

Within the mental health context, there are similar concerns about how the experiences of mental and emotional distress are framed by expert outsiders, rather than those with a lived experience. The psychiatric survivor movement that emerged in the 1970s as a collection of individuals who defined themselves as surviving the abuses of the psychiatric system, are deeply critical of the way in which the psychiatric system

tightly defines mental and emotional distress (Adame & Knudson, 2007). Having their experiences of distress defined by outsiders is not only oppressive, but results in a partial understanding of what it means to experience distress. Bassman (1997, p. 239), a psychologist who was diagnosed with schizophrenia in his early 20s, writes of the crucial importance of the lived experience perspective of psychiatric survivors:

> As people whose feelings, thoughts, and experiences have been described, judged, and interpreted by others, survivors insist on speaking for themselves and defining their own experience. For the survivor activist, there are no outside experts who can understand better what has helped and what has hurt than the people who have been there.

Adame and Knudson (2007, p. 170) argue that the psychiatric survivor movement creates a space where the dominant discourse of mental illness and distress can be challenged:

> The survivor movement itself clears a dialogical space where people may begin to construct or participate in counter narratives. In such a space, they gain the freedom to define exactly what it is that they feel like they are recovering from, whether it is child abuse, poverty, political oppression, or the mental health system.

Beyond challenging the oppression inherent in having experiences of distress defined and labelled, the sharing of lived experience also creates a knowledge base that can help others struggling with similar issues. Noorani (2013) describes individuals who have a lived experience of distress as *experts-by-experience* as they hold an understanding of distress unachievable by those who do not have a lived experience. Peer support groups utilise the concept of *expert-by-experience* through developing a range of approaches derived from the positive experiences of the group. Noorani (2013, p. 65) argues that the *expert-by-experience* position is also useful in educating those who have not experienced such distress. In the process of sharing lived experiences, peers become “explorers with knowledges beyond our mere speculations”.

THE HEARING VOICES APPROACH

A notable example of a model derived from a lived experience perspective is the Hearing Voices Approach. This approach seeks to broaden the understanding of voice hearing and views voice hearing as inherently meaningful, with the content and themes of voices potentially relating to the voice hearer's biography, meaning systems, and culture. The catalyst for this approach occurred in 1987 as a result of the therapeutic relationship between Dutch social psychiatrist Marius Romme and his patient Patsy Hague. Patsy, influenced by the work of Julian Jaynes' (1976) *The origins of consciousness in the breakdown of the bicameral mind,* and frustrated by the psychiatric treatment she was receiving, persisted in encouraging Marius to explore the meaning and history of her voices. Spurred by his experience with Patsy Hague, Marius Romme and his wife Sandra Esher (1989) interviewed 300 voice hearers aiming to better understand the phenomenology of voice hearing. They concluded that the reductionist, symptom focused biomedical approach to voice hearing was not always helpful. Instead, they argued that helping voice hearers engage and understand their voices may be a beneficial approach. This initial research sparked the Hearing Voices movement that aimed to investigate alternative ways of understanding voice hearing in order to support voice hearers in learning to live with, and make sense of their voices. The movement is broad and encompasses a wide variety of understandings of the voice hearing experience. Here, subjectivity is valued, as the experience of voice hearing is seen to be shaped by personal biography, relationships, belief systems and culture (Corstens, Longden, McCarthy-Jones, Waddingham, & Thomas, 2014).

Within the Hearing Voices Approach, trauma and other adverse experiences are often the focus in understanding the voice hearing experience. Corstens et al. (2014) argue that most experiences of voice hearing can be tied to life events, particularly events that were overwhelming, traumatic or disempowering. Consequently, it is important to understand voices within the context of these events. Romme (2012) advocates for a formulation approach where voice hearers develop a profile of their voices and explore this profile in relation to life experiences. Romme and Esher (2010) developed the

Maastricht Interview which asks voice hearers about the qualitative nature of their voices, when they first emerged, how the voice hearer makes sense of their voices, how they cope with them, and key events in their biography that may be linked to their voices. Using this profile, the interviewer and voice hearers collaborate in developing a psychosocial dynamic formulation (Romme, 2012) that captures who and what the voices represent. Voices can represent actual people, such as abusers, or themes of emotional conflict. Johnstone (2012) argues that formulations can help restore personal meanings and can be valuable in shaping the focus of therapeutic work. For example, a formulation may point to difficult emotions such as guilt and shame that have arisen as result of experiencing sexual abuse. This then informs a therapeutic response that would aim to help the voice hearers deal with misplaced feelings of guilt and shame.

Corstens and Longden (2013) used this approach to explore the themes of voices, and the relationships between voices and past experiences with 100 voice hearers. They found that in 94% of cases, themes of emotional conflict from life experiences featured in the formulation. They also found that 78% of voice hearers heard at least one voice that took the form of someone significant in their lives. They argue that working with voice hearers to understand the origin and context of their voices can be a crucial point in the recovery process. It is important to note that this study took a broad approach when identifying adverse life events and corresponding thematic content of voices. Hardy et al. (2005) investigated the descriptions of hallucinations and experiences of trauma amongst 75 individuals diagnosed with non-affective psychosis. They found that of the 40 individuals who had experiences of trauma, 12.5% were found to have voices with content directly related to trauma, 57.5% had thematic but indirect content related to trauma, and 42.5% experienced voices with content not related to trauma.

Voices can also be explored using a voice dialoguing technique, which borrows from the work of Stone and Stone (2011) who theorised that individuals are made up of different selves or sub-personalities that play different roles in an individual's life. These different

selves can be primary or disowned and can have positive or negative influences on an individual's life. Voice dialoguing in this context involves an interviewer attempting to speak directly to the different selves to uncover their motivations in the individual's life. This approach has been applied to the experience of voice hearing where an individual's voices are interviewed. Here "voices are interpreted as selves that relate to overwhelming emotional difficulties in the hearer's life"(Corstens, Longden, & May, 2012, p. 97). The aim is not to get rid of the voices, but to explore the relationship between the voice hearer and their voices, with the aim of enabling the voice hearer to gain more control and ownership over them.

Peer support groups are a key element of the Hearing Voices Approach as they create a space where voice hearers can support each other to "develop their own framework of reference" (Blackman, 2007, p. 11) when learning to understand and cope with their voice hearing experiences. In a preliminary investigation into the efficacy of hearing voices groups, Meddings et al. (2004) found that participants in hearing voice groups experienced decreased rates of hospitalisations, an increased ability to use coping skills to manage their voices, increased sense of self-esteem, and developed more of a sense of control over their voices.

The focus of the Hearing Voices Approach is not on the removal of symptoms, but aims to help voice hearers to find ways to live a full, rich life with the presence of voices. Corstens et al. (2014) argue that learning to accept the presence of voices is more helpful than seeking to eliminate them. There is research that indicates that meta-cognitive beliefs about voice hearing play a role in the distress experienced by voice hearers and suggests that the acceptance of voices can result in lower experiences of distress (Gaweda, Holas, & Kokoszka, 2012; Hill, Varese, Jackson, & Linden, 2012; Lobban, Haddock, Kinderman, & Wells, 2002). Through accepting and understanding the voice hearing experience, voice hearers are able to focus their attention on building a fulfilling life rather than excessively trying to eliminate their voices (Corstens et al., 2012).

The Hearing Voices Approach provides a key example of how the lived experience perspective can radically change how a phenomenon is understood. Through listening to voice hearer's perspectives on their experiences and building a therapeutic approach based on these perspectives, the Hearing Voices Approach has created a powerful counter narrative to the biomedical model that views voices solely as symptoms indicative of pathology. Rather than the biomedical model's interest in the biomarkers of voice hearing, the Hearing Voices Approach is fundamentally interested in the meaning of voices. Through incorporating the lived experience, a much broader perspective on voice hearing is developed, one that is responsive to subjectivity, positions voice hearing within an individual's context, and subsequently places value on the meaning constructed around voice hearing experiences. The positioning of voice hearing in relation to an individual's context and biography means that this approach closely links experiences of sexual abuse to the experience of voice hearing. Voices are seen to potentially emerge from traumatic experiences and the content and quality of voices is seen to be influenced by these experiences. From this perspective, having an awareness of past experiences of sexual abuse, along with the subjective meaning systems about the abuse held by the voice hearer, is essential when supporting voice hearers who have experienced abuse.

3.5 Summary

This chapter, along with Chapter 2, has outlined key theoretical and policy issues that influence how Australian mental health services respond to voice hearers who have survived sexual abuse. Using a critical realist approach to social research (Bhaskar, 1979), described in the next chapter, these issues provide the backdrop to the results of this study. This chapter has detailed the various ways that voice hearing, and its relationship to experiences of sexual abuse, are conceptualised by different discourses that inform mental health service delivery. Across these discourses voice hearing is either positioned as a symptom largely separate from the impacts of sexual abuse, a

symptom that is potentially emergent from the interaction between the individual and experiences in their environment such as sexual abuse, or an experience that emerges from stressful life events and is deeply connected to an individual's context.

This study is interested in how these different discourses shape how mental health services respond to sexual abuse survivors who hear voices. The results from this study were analysed with a consideration for how these different discourses influenced the trends and themes found in the interviews with voice hearers and the survey of mental health professionals.

PART TWO

METHODOLOGY AND RESEARCH DESIGN

Chapter 4 – RESEARCH DESIGN

This chapter outlines the research design implemented in this project, with a consideration of the key principles of critical realism as the philosophical paradigm that influenced this design. It then details the multi-strand mixed method approach that was implemented along with a description of the sampling, recruitment strategy, research tools and analysis of each strand. Finally, it outlines how both strands of this project were analysed holistically with reference to the policy and theoretical context of the Australian mental health system discussed in Chapters 2 and 3.

4.1 Critical realism and social research

Critical realism emerged as a philosophical approach in the last half of the 20th century through the work of Roy Bhaskar (1979, 1998, 2009), who aimed to establish an alternative to the positivist/constructivist paradigm binary. For critical realists, there are clear ontological and epistemological limitations of both positivism and constructivism. Critical realism questions the positivist focus on reality being known only through observable events and the lack of consideration for how the observer shapes the understanding of observed events. In addition to this critical realism critiques how positivism fails to consider contextual factors that may be at play when examining social processes (McEvoy & Richards, 2006). Just as positivist research within hard sciences is based on experimentation and observation within closed, controlled systems, the positivist approach to social research presumes that social phenomenon occurs within closed systems, which enables the search for linear links between variables. Critical realists point to the limitations of this assumption. The social world is made up of multiple open systems that are in constant interaction, which increases the multitude of variables at play both around the phenomenon being studied and within the worldview of the observer (Mingers, 2014). This nature of the social world complicates the application of positivist approaches to research, particularly the focus on linear relationships. From a critical realist perspective, the context of both the phenomenon being observed and the context of the observer play a crucial role in how phenomenon

is understood.

Critical realism also highlights the limitations of the constructivist alternative to positivism (Houston, 2001). The move to argue that all reality is socially constructed due to the inherent subjectivity of the observer renders all truth relative and disables the ability for social research to influence social change. Houston (2001) argues that constructivism serves to inhibit efforts to move towards social change as the relativism that is the inevitable outcome of this paradigm problematizes any attempt at developing models of human agency, oppression, and change.

At the heart of critical realist concerns with both positivism and constructivism is the focus on epistemology over ontology, as highlighted by Fletcher (2017, p. 182):

> Despite the seeming opposition between the constructivist and positivist perspectives, each reduces reality to human knowledge, whether that knowledge acts as lens or container for reality.

Critical realism brings ontology back into focus. For critical realists, there is such a thing as an independent, external world that exists regardless of whether it is being observed or not. We can seek knowledge about the world, however, this knowledge is always fallible and contextual due to the inherent subjectivity involved with acquiring knowledge (Mingers, 2014). Knowledge, therefore, has layers of depth that can be understood but never in its entirety (Bhaskar, 2009). When considering how mental health services respond to sexual abuse survivors, there are interactions that occur between service providers and consumers, however these are understood subjectively through the perspectives of the consumers, the perspectives of service providers, and in this project, the perspective of the researcher. Therefore, the nature of the interactions between service providers and sexual abuse survivors is best understood with a consideration of all of these perspectives.

Bhaskar (1979) bridged the gap between positivist and constructivist notions of ontology by arguing that there is a reality in the world that exists outside of human

observation but can only be known through the subjective, language laden perspective of the observer. He distinguished between three ontological domains. The first level is the *empirical* level where events occur that can be observed, measured and understood empirically, though always mediated by subjectivity. The second level is the *actual*, here events occur/do not occur with no filter of human observation. This is the crucial difference between a critical realist perspective and a constructivist perspective – there is a reality that exists outside of human construction. Finally there is the *real*, which is made up of structures or mechanisms that generate the phenomenon observed at the empirical level. The goal of a critical realist approach to research is to not only understand *what* is happening on the empirical level but to seek out *why* it is happening by attempting to explain what mechanisms or structures give rise to what we observe.

This focus on attempting to explain the mechanisms that lead to social phenomenon enables critical realist research to be used for emancipatory goals. Through understanding the mechanisms and structures that cause social problems there is scope to reveal oppressive mechanisms that lie at the root of such problems (Houston, 2001). Beyond this, critical realists believe that by understanding the mechanisms behind social problems there is an imperative to change these mechanisms. Mingers (2014, p. 47) contends that:

> No social theory can be purely descriptive: it must be evaluative, and thus there can be no split between facts and values. Following from this is the view that social theory is inevitably transformative, providing an explanatory critique that logically entails action.

The critical realist focus on understanding not just *what* is happening in relation to a social problem, but also what mechanisms and structures cause the problem to occur is consistent with the aims of this research project. Due to the lack of research investigating how the Australian mental health system is responding to sexual abuse survivors, this research is interested in *what* is happening when mental health services work with voice hearers who have experienced sexual abuse. However, it is ultimately

aimed at contributing to the knowledge base to help mental health services respond effectively to sexual abuse survivors. For this reason, it is also interested in *why* particular trends are occurring. Drawing on the emancipatory aims of critical realism, understanding *why* these trends are occurring can reveal what structures or mechanisms are shaping how mental health services are responding to abuse survivors.

In seeking to understand *why* particular trends are happening, critical realism has an interest in causality. However, critical realists are deeply concerned with the positivist focus on hypothesising generalisable laws that explain occurrences, particularly in the social world. Critical realists point out that the social world is comprised of multiple, heterogeneous systems that contain different levels of mechanisms that cause change. Given the multiplicity of interacting systems, efforts to exactly predict occurrences fall short (Bhaskar, 1975). Instead, critical realism aims to understand the tendencies of systems that move and shift dependent on the context of the system. For this reason Houston (2001, p. 851) argues that the:

> Firm prediction in the social sciences has to be jettisoned in favour of an approach centred on the identification, analysis and explanation of psychological and societal mechanisms and their causal tendencies.

The focal point of critical realist social research is therefore not the prediction, but explanation of social phenomenon. Due to the complex, fluid and heterogeneous nature of socials systems and the inherent subjectivity involved in social research, the tendencies theorised by critical realists are always framed as fallible and open to revision (McEvoy & Richards, 2006).

In seeking to explain social occurrences, critical realism adopts a retroductive logic to research. Bhaskar (1979, p. 32) argues for a model of inference that moves:

> The manifest phenomena of social life, as conceptualised in the experience of the social agents concerned, to the essential relations that necessitated them.

Retroduction involves observing what is occurring on the *empirical* level of reality and seeks to explain why this is occurring at the *real* level by generating hypothetical

theories that explain the occurrences. Given that there may be several explanations for what has occurred, the task is then to evaluate and eliminate explanations with the attempt to reach the best fit (Mingers, 2014).

4.2 Critical realist approach to mixed research methods

The ontological and epistemological assumptions of critical realism shed light on the strengths and weaknesses of qualitative and quantitative research methods. McEvoy & Richards (2006) argue that from a critical realist perspective there is no preference for specific research methods, but methods should be chosen that best suit the aim of explanation inherent within critical realism. They argue that quantitative methods are useful in that they can be used to develop reliable descriptions of the phenomenon being studied and can reveal trends that may point to causal mechanisms. However, quantitative methods that are aimed at providing prediction are at odds with critical realist understandings of epistemology. Mingers (2014) argues that while many statistical methods can articulate the association between two variables, they are limited in how they can explain why the two variables may related. From a quantitative perspective, if the mechanism cannot be statistically proven, there is no way of understanding it.

Qualitative methods can be useful from a critical realist perspective as they are inherently open ended, which allows for information about the phenomenon that could not have been anticipated before the research commenced. Qualitative methods can also be used to illuminate the relationships between variables in ways that are obscured by quantitative methods (McEvoy & Richards, 2006). Further, qualitative methods are able to understand the meaningfulness of social processes, as well as capture the perspective of the lived experience of participants in these processes (Mingers, 2014). Therefore, from a critical realist perspective, qualitative methods are particularly useful when seeking to explain what quantitative methods cannot. Mingers (2014) warns that qualitative methods become problematic when those who use them claim that that there is nothing beyond the individual meanings or claim that different viewpoints are

all equally valid.

Based on the strengths and limitations of qualitative and quantitative research methods, critical realists tend to favour mixed method research designs. Mingers (2014) argues that given the limitations inherent in all research methods, using just one method will always obscure a dimension of the phenomenon being studied. Therefore, the implementation of multiple methods provides scope to obtain a richer understanding of the phenomenon. Mixed method designs are also best equipped to understand the complex, multidimensional nature of the social world. Given that all knowledge is subjective, and therefore partial, there is a need to consider multiple perspectives of a phenomenon. The aim here is not to triangulate forms of data to enhance to validity, but to capture different perspectives on a social phenomenon. For example, this study is interested in how mental health services are responding to sexual abuse survivors. To understand this, it is important to seek the perspective of key players within this interaction: service providers and consumers. Different methods are needed to understand these different perspectives. Given the breadth and variability of mental health services in Australia a survey, largely using quantitative methods is useful to gain a broad picture and description of what is occurring in the system. To understand the perspective of consumers, interviews are most suitable as they allow a flexibility in understanding this dynamic. Further, interviews are particularly effective in revealing the lived experience of service provision as they allow for "spontaneous, rich descriptions where the participants themselves provide what they experience as the main aspects of the phenomenon investigated" (Kvale, 2008, p. 60).

4.3 Research design

The previous chapters indicate that there is scope for mental health services to better respond to the needs of sexual abuse survivors, particularly those experiencing symptoms associated with psychosis, such voice hearing. This project aimed to gain an understanding of how mental health services can meet these needs. To do this, it

addressed three questions:

1. What are the work practices of mental health professionals when working with voice hearers who have experienced sexual abuse?
2. What factors shape how mental health professionals respond to voice hearers who have experienced sexual abuse?
3. What do voice hearers who have survived sexual abuse identify as helpful or unhelpful when using mental health services?

To answer these questions this project adopted a mixed method approach to research design that was informed by the principles of critical realism. Teddlie and Tashakkori (2009, p. 156) describe a number of mixed method design typologies to conceptualise mixed method projects. Their description of a multi-strand mixed method design best describes the design of this project:

> QUAL data is collected at one level of analysis (e.g., child) and QUAN data are collected at another (e.g., family) in a parallel or sequential manner. Both types of data are analysed accordingly, and the results are used to make multiple types of inferences, which there are integrated into meta-inferences.

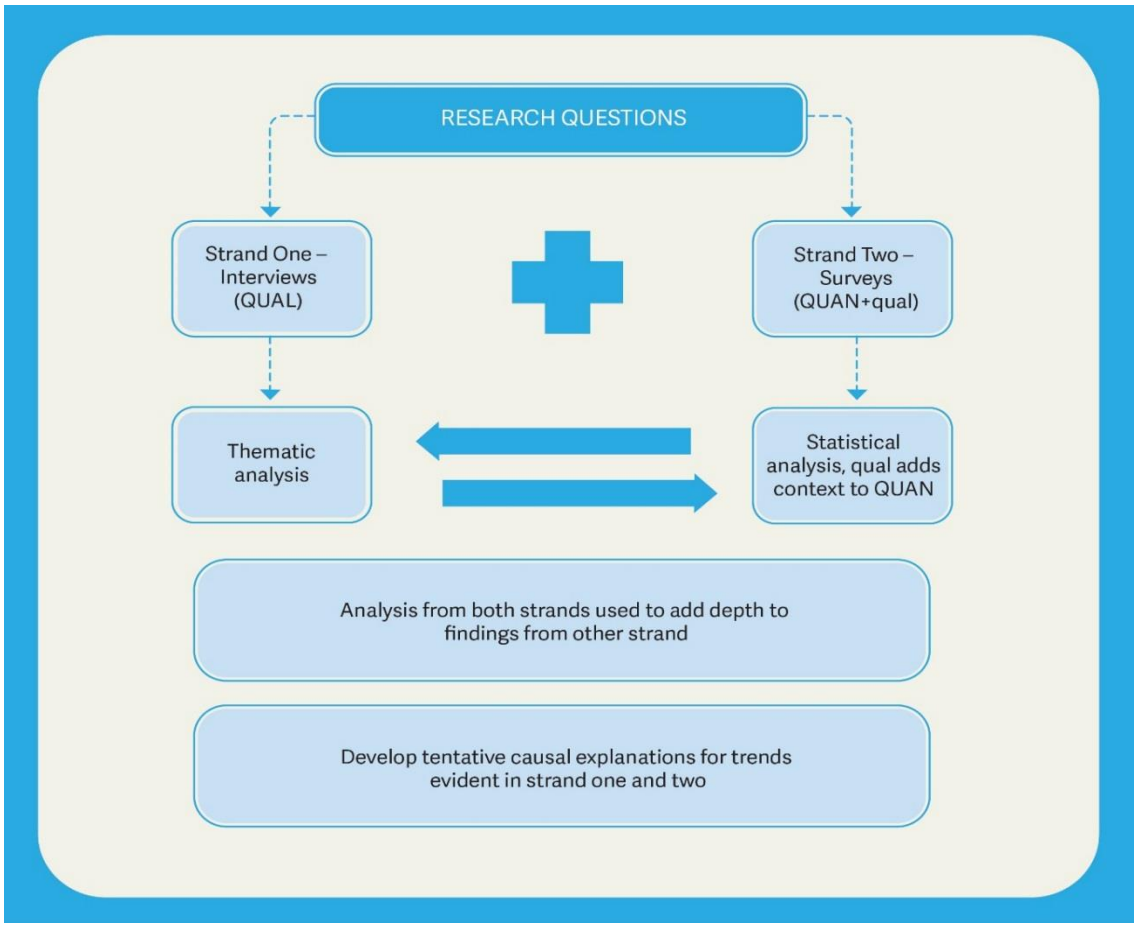
As indicated in Figure 4.1, this project involved two strands of enquiry and subsequently two methods of data collection and analysis. The first strand focused on voice hearer's perspectives of using mental health services and collected data from semi-structured interviews that were then thematically analysed. The second strand focused on mental health professionals' perspectives when working with voice hearers who have experienced sexual abuse. A survey was used as the method to collect data, which was primarily analysed using statistical methods. However, some qualitative data was collected and analysed thematically. Data collection and analysis for both strands were conducted concurrently.

Following the analysis of both strands, findings from each strand were used to gain a deeper understanding of trends found in the other strand. For example, themes that

were present in the interviews regarding screening and disclosure provided an understanding of the lived experience of the practices regarding screening and disclosure evident in the survey results.

The final stage of analysis involved generating some tentative causal explanations for the trends found in both strands. These explanations considered the depth of information from the combined strands as well as the paradigmatic and policy context of the Australian mental health system, as described in Chapters 2 and 3.

Figure 4.1 – Research model



4.4 Strand one – Interviews

METHOD OVERVIEW

Strand one of this project involved interviewing individuals who report that they hear

voices and have had an experience of sexual abuse. The interview focused on their experiences using mental health and other social services. Aiming to get a rich description of voice hearer's lived experience, a semi-structured interview was chosen for "the purpose of obtaining descriptions of the life world of the interviewee with respect to determining the meaning of the described phenomena" (Kvale, 2007, pp. 7-8). This approach was chosen over a highly structured interview in order to allow flexibility in exploring voice hearers experiences accessing these services and allowing for participants to offer "spontaneous, rich descriptions where the participants themselves provide what they experience as the main aspects of the phenomenon investigated" (Kvale, 2007, p. 60).

An interview schedule (Appendix 3) was developed with questions focused around the following areas:

- What services the interviewee had used
- Whether staff had asked about sexual abuse or trauma
- Whether the participant disclosed their abuse histories to staff voluntarily
- How staff responded to disclosures of abuse in terms of support offered, referrals made to other services, assurances of safety, and discussions of links between abuse and presenting mental health issues
- What interviewees found helpful or unhelpful in their interactions with services around these issues
- How trauma counselling services responded to disclosures of voice hearing and other mental health issues
- What participants identified as the most helpful experiences they have had in dealing with their experiences of abuse.

This schedule was used as a guide to cover key areas across the interviews, however,

many participants discussed a range of other issues relating to the subject matter and the researcher supported this process.

Employing some principles of participatory action research, the researcher consulted with several voice hearers and service providers who had volunteered to provide feedback on the interview schedule. The aim of the consultation process was to develop an interview schedule that served to "produce knowledge and action directly useful to a group of people" (Reason, 1994). This process took two months and significant changes were made to the interview schedule. This included asking questions about the impact of not being asked about sexual abuse, developing a question investigating what would make the participant feel safe in disclosing, expanding the range of services discussed to include peer support groups and private psychologists, and asking questions about whether participants felt that staff believed their disclosure. The University of Melbourne ethics committee subsequently approved the amended interview schedule.

Interviews were conducted at Prahran Mission [2] or at the University of Melbourne with the interviews taking between 45 minutes and an hour and half. The researcher recorded each interview electronically and took brief notes of the participant's responses and details evident in the process of interviewing that may have been missed in the recording. The interview was then transcribed verbatim. The researcher sent participants a copy of the transcript and invited them to meet again if they wished to verify the transcription, to consult on key themes from the previous interview, or provide any further details about the issues discussed. No participants took this invitation up.

ETHICAL CONSIDERATIONS

The University of Melbourne Human Research Ethics Committee approved this strand

[2] A non-government run mental health service

of the research on the 20th of December 2013 (Ethics Application Number 1340208). After consulting with voice hearers about the interview schedule, a revised schedule was submitted and was approved on the 2nd of May 2014.

Given this strand of the research project involved interviewing vulnerable populations about sensitive topics, several strategies were implemented to mitigate any risk of interviewees suffering unwanted distress because of participating in the project. These included:

- Focusing the interview on experiences of service delivery rather than details of sexual abuse or psychiatric symptoms
- Discussing self-care at the start of each interview and checking in with participants around their emotional state as needed throughout the interview
- Obtaining a contact person for each participant that the researcher could contact if there were any concerns about their wellbeing (see Appendix 5)[3]
- Debriefing participants at the end of each interview and providing them with a debrief sheet (see Appendix 4) that outlined self-care strategies and telephone support lines
- The researcher also provided her contact details if the participant required further debriefing.

The interviewees responded to these strategies well, and while some were visibly upset at points during the interviews, none escalated to a point where the researcher was concerned about their wellbeing. No participants contacted the researcher for support after the interview.

[3] This was not an entry requirement for the study. If participants declined to provide a contact they were not excluded from the study.

As the recruitment was occurring through the researcher's former work place, Prahran Mission, a further ethical issue involved the potential confusion of the researcher's role if former clients participated in interviews. The Plain Language Statement (see Appendix 2) specified that the interviews were for research only and were not intended for any therapeutic benefit. The researcher reiterated this at the start of the interviews.

One unexpected ethical issue emerged in the recruitment phase. A local consumer organisation promoted the interview via their mailing list. Following this, the researcher received a voicemail message from a woman who expressed that she was distressed upon receiving this email at work due to finding the content triggering. She did not leave a number for the researcher to call her back. The researcher contacted the consumer organisation about this complaint and found that they had also received communication from this person. The researcher and staff at the organisation decided to include a trigger warning on any further communication about the study to a broad population. The researcher received no further complaints of this nature.

Recruitment

Voice hearers who were over the age of 18, resided in Victoria and identified as having past experiences of sexual abuse were able to participate in the interviews. As the interviews were regarding sensitive topics, the recruitment strategy aimed to ensure that participants were voluntarily participating with informed consent. Elam and Fenton (2003) argue that effective, ethical recruitment of research participants for projects involving sensitive topics often involves working closely with the community being studied. For this reason, the researcher consulted with Voices Vic [4] about effective avenues for recruitment. With their support recruitment occurred via the following channels:

[4] Voices Vic was a program run by Prahran Mission that supported hearing voices groups throughout the state of Victoria and offered training around voice hearing to mental health professionals.

- A flyer advertising the project distributed through Voices Vic (see Appendix 1)
- Direct recruitment of voice hearers by Voices Vic staff
- Information about the project distributed through consumer organisations
- A paper presented at the 2015 TheMHS conference promoting the study.

The researcher was also interviewed for a news article about voice hearing and two participants contacted the researcher as a result of reading the article.

The researcher provided interested potential participants with more information about the project and a Plain Language Statement (Appendix 2) that outlined the aim of the project, what participants were to expect when participating, and what risks were involved with participating. If participants decided to continue they were invited for an interview. At the start of the interview participants were asked to read and sign a consent form that outlined how data would be collected in the interview and how it would be used and stored. It also asked participants to include details of a contact person should they become distressed (see Appendix 5).

Analysis

The interview transcriptions were analysed using Braun and Clarke's (2006) approach to thematic analysis. The researcher used NVivo qualitative analysis software and utilised Bazeley and Jackson 's (2013) guide to Nvivo to assist in this process. After transcription the researcher read over the full set of transcripts, noting potential codes that could be used and writing various memos about initial interpretations and reflections on the interviews. Memo writing continued throughout all stages of analysis.

Transcriptions were then coded using an open coding approach described by Ezzy (2013) where each line of the transcript was coded in a way that reflected either the content, spoken word of the interviewee, reference to particular issues, emotion or process. The initial two transcriptions generated a large number of codes. The majority

of the coding for the following transcripts fitted in with codes established from the initial coding. When new codes were developed in later transcripts, the researcher reviewed pre-coded transcripts with consideration for this new code. For example, one participant made reference to many personal qualities that helped in her recovery process. The role of personal qualities had not been noted in previous transcripts so they were reviewed to code for this theme. Some content of the transcripts were not relevant to the research question and were excluded from coding. While the coding was not reviewed by an independent rater, the initial coding was reviewed by the researcher's supervisor to ensure that the coding accurately reflected the content of the transcripts.

The researcher grouped together initial coding where there were common concepts. Parent codes were established for these groupings. For example, in all interviews there was content about the nature of relationships, both positive and negative. The researcher established a parent code named *Relationship* followed by two codes for *Positive Relationship* and *Negative Relationship*. Various codes relating to different aspects of relationship such as *Professional distance* and *Being treated as human* were included under the parent codes.

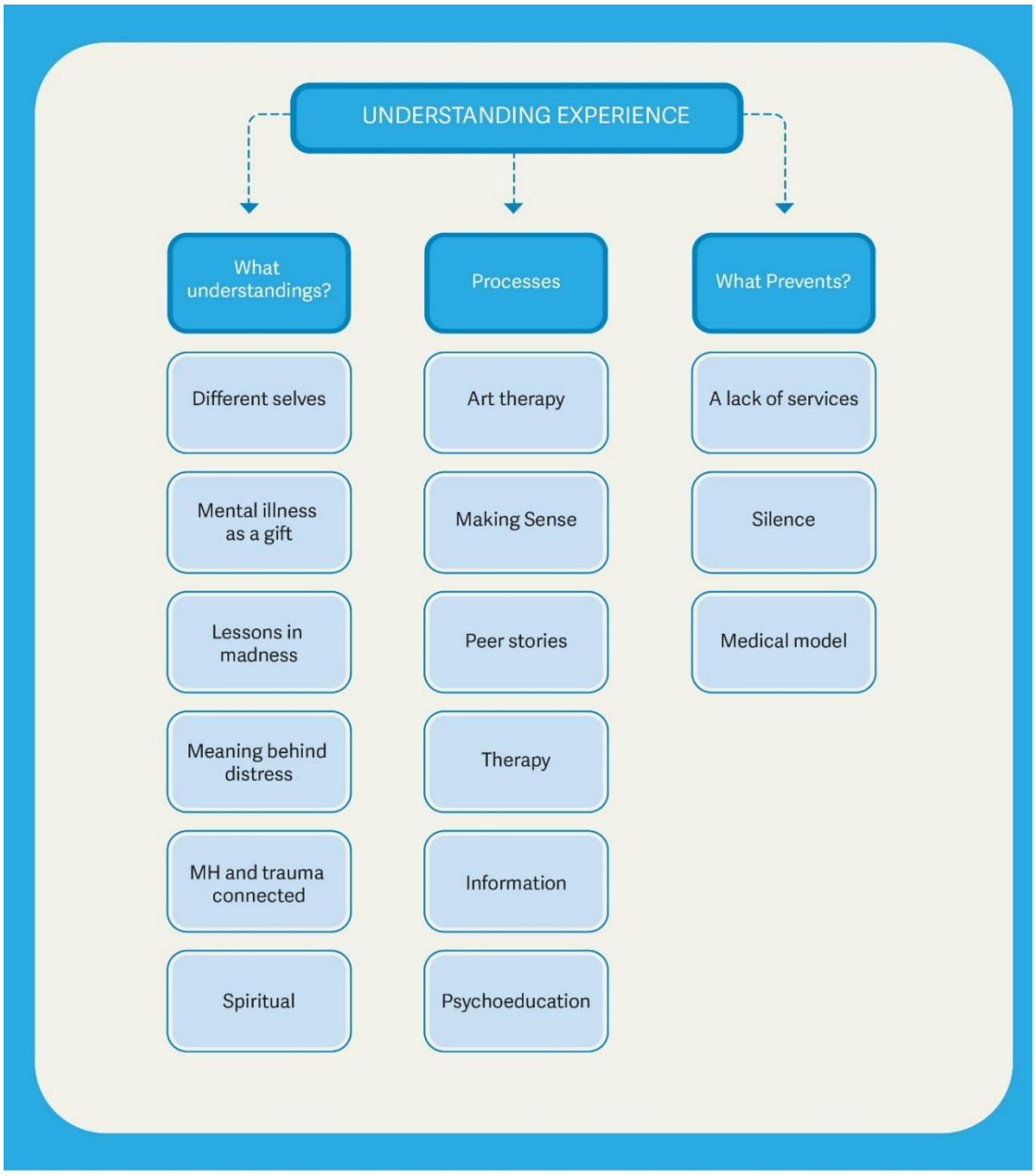
To guide further analysis, the researcher returned to the research questions after the initial coding and thematic grouping. In particular, the researcher reviewed the coding with a consideration of what voice hearers identified as helpful or unhelpful in their interactions with service providers. Viewing the coding with the research questions in mind revealed several thematic groups that appeared to refer to processes which could be considered helpful or unhelpful. These were then grouped together with processes that seemed to be related.

From here, three key processes were identified and codes were organised in relation to these processes. For each process the researcher tried to identify in the data *what* the process was, *why* it was important, *what* enabled this process to occur, and *what*

prevented it. Mind-mapping tools were used as a way of grouping themes together. For example, there were numerous codes referring to *meaning behind distress, making sense*, *understanding selves* and *lessons in madness*. The researcher felt that these all seemed related to the process of understanding experience. From here, *understanding experience* became a parent code. Underneath this the researcher grouped coding that related to *what are the understandings*, *what supports understanding* and *what prevents understanding*. The transcripts were then reviewed to ensure that any relevant content was coded under these groups. The researcher then used these categories to form a holistic picture of the *Understanding Experience* theme. The mind map for this theme is represented in Figure 4.2.

Following the analysis of the survey results, the researcher returned to the transcripts to code for themes that illustrated the lived experience of trends found in the survey. For example, interviewees spoke about the personal impacts of professionals not screening for abuse. Themes from the interview were also analysed to gain a broader understanding of trends found in the survey. For example, a trend emerged that indicated that male staff were significantly less likely to screen voice hearers for abuse than female staff. Examining the themes relating to the gender of staff in the interviews revealed that some interviewees felt uncomfortable disclosing sexual abuse to men.

Figure 4.2 – Thematic analysis mind map



4.5 Strand two – Surveys

OVERVIEW OF METHOD

As noted earlier, a critical realist perspective sees the social world as multi-layered and inherently subjective. Therefore, there is a need to understand a social phenomenon from multiple perspectives to gain a depth of knowledge about it (Mingers, 2014). For

this reason, it was important capture the perspective of service providers, alongside the perspective of consumers. This enabled a holistic understanding of how mental health services are responding to sexual abuse survivors who hear voices.

The Australian mental health system is made up of a variety of different services and is staffed by a range of professionals. To adequately capture how the system is responding to sexual abuse survivors who hear voices it was necessary to gain the perspective of a broad range of service providers. For this reason, a short survey deliverable remotely (online) was chosen to reach many professionals across multiple services (Hooley, Marriot, & Wellens, 2012).

The survey largely collected numeric data to obtain descriptive statistics about how mental health professionals are responding to voice hearers who have experienced sexual abuse. Alongside many of the multiple choice questions, open-ended questions were included to collect information that lay outside the closed responses and to provide scope for respondents to give context for their answers. The survey also included several broad, open-ended questions, which allowed for respondents to comment on issues not raised in the survey.

Development of survey

The researcher developed the survey by reviewing the research into how mental health services respond to trauma. The aim was to build on the evidence developed in other studies, to identify whether similar themes were occurring in Australia, and to expand on hypotheses developed in other research projects.

As described in Chapter 2, research investigating how mental health services were responding to trauma survivors found that professionals were intermittently screening for trauma and abuse. In addition to this, professionals were infrequently including trauma and abuse in formulation and treatment plans, and rarely referring consumers who disclosed to legal authorities (Agar & Read, 2002; Day et al., 2003; Lab et al., 2000;

Mellinan, 1996; Posner et al., 2008; Read & Fraser, 1998; Read et al., 2006; M. Young et al., 2001). These studies found that professionals were less likely to screen consumers who were male and consumers who presented with psychosis. They also found several factors that seemed to prevent professionals from adequately screening and responding to trauma. This included a concern about upsetting consumers, a lack of adequate training, concerns about asking disturbed consumers, low feelings of competence around the subject matter, staff being over stretched and lacking time, concerns about eliciting false memories and conceptions of schizophrenia as a biological condition. The studies found that including screening questions on assessment forms, training staff to screen for trauma, and adopting an organisation wide approach to increasing adequate responses to trauma, served to marginally increase rates of screening and inclusion of trauma in formulation and treatment plans.

These findings informed the questions developed for the survey in several ways. The researcher developed questions to further investigate the influence of a consumer's presentation, age, and gender on how professionals screen for sexual abuse. In addition to this, questions were developed to investigate what beliefs or concerns influenced respondents work practices. Questions were also included to ascertain the role of management, workload, training and organisational leadership in how services responded to voice hearers. The full survey is included in Appendix 8.

Ethical considerations

The University of Melbourne's Human Research Ethics Committee approved the survey on July 13, 2015 (Ethics Application number 1340208). While the survey had a low risk of triggering respondents, the researcher still took care to provide support and resources to respondents. The plain language statement (Appendix 7) was clear about the subject matter that would be included in the survey and the potential for emotional distress when completing it. The survey directed respondents to a page outlining several self-care strategies should they feel distressed.

Survey operation

The researcher developed an online survey which was designed and hosted using Survey Monkey. A print version was also created for manual distribution. Answers to print surveys were subsequently entered into Survey Monkey. A link to the online survey was included on all recruitment material and a website that was created for this project.

Piloting

The researcher piloted the survey with five individuals, four of whom worked in the mental health field and one who was a post-graduate research student. They were asked to time how long it took them to complete the survey, to comment on the clarity of the questions, to note if there was any point where they would have considered dropping out, and to note any concerns they had about the survey. The survey took between 20 to 45 minutes to complete with respondents' commenting that this time may be too long for professionals. Other feedback was minimal and largely focused on the wording of some questions.

The researcher edited the survey in response to this feedback. Several open-ended questions were removed to shorten the response time and the questions asking for responses on a Likert scale were condensed into a matrix. This reduced the number of questions considerably. Three more mental health professionals were asked to pilot the survey and the complete times reduced to approximately 15 minutes.

Project website and link to survey

The survey was available from a web link hosted by Survey Monkey. This was embedded in email communication and flyers advertising the survey. A WordPress website was also created to promote the project; https://ksellickresearch.wordpress.com/. The

website contained:

- An updated blog detailing stages of the project
- Information about the project for both interviews and surveys
- Contact details for the researcher and supervisors
- A link to the plain language statements for the interviews and the surveys
- A link to the survey
- Debriefing information for participants.

Structure of survey

The survey asked several questions about demographics, work practices and beliefs about voice hearers. Questions were mostly multiple choice or scaled, however each section had room for open-ended responses. There were three purely open-ended questions at the end of the survey that sought to obtain more in depth information than the closed questions could gather. Respondents were directed through the whole survey, however, respondents were directed to skip several questions if they had not directly had a voice hearer disclose experiences of sexual abuse to them. For the full survey see Appendix 8.

Scope and recruitment

The survey was open to Australian mental health professionals who worked with consumers who heard voices. The researcher recruited for the survey through a variety of channels. Managers from a range of mental health services including Cohealth, Inner

South Community Health[5], Prahran Mission, Austin Health[6], and Orygen Youth Health[7] agreed to promote the survey amongst their teams. The survey was also advertised in newsletters published by VICSERV [8] and the Australian Association of Social Workers. The researcher presented a paper at the 2015 TheMHS[9] conference to promote the project and passed out flyers advertising the survey. Learning about the paper, a journalist interviewed the researcher about voice hearing and trauma and published an article about the topic on news.com.au which generated substantial interest. Respondents were also offered the opportunity to enter a prize draw for a $100 Coles Myer Gift Card.

In the early stages of recruitment, the largest number of responders came from non-government run services. The focus of recruitment then shifted to clinical services in order to increase the balance of clinical and non-clinical respondents. The researcher monitored the survey during recruitment and deleted surveys that were significantly incomplete. There was a total of 23 surveys deleted due to being significantly incomplete. Once the survey number reached over 200 completed, the decision was made to cease data collection after 5 months of collecting surveys.

ANALYSIS

The quantitative data was analysed using SPSS Statistics 22. Analysis was largely descriptive with tests establishing the frequencies, mean, and range of responses. Variables were cross-tabulated and analysed for association using a Chi-square test for independence. Cramers V was used to measure the effect size of cross-tabulations. In order to effectively cross-tabulate answers a number of variables were compressed. For

[5] Cohealth and Inner South Community Health Service are community run health services in inner Melbourne
[6] Austin Health is a large public health provider with a psychiatric inpatient service, sub-acute residential services, secure residential services, and outpatient psychiatric services
[7] Orygen Youth Health is a specialist youth psychiatric service with an inpatient facility and outpatient services.
[8] The peak body for non-government mental health providers in Victoria
[9] The Mental Health Service Conference

example, to cross-tabulate the general screening question with demographic factors, attitudes and beliefs, answers were compressed in to three categories. “Never” and “Rarely” were compressed into one variable “Rarely”. “Sometimes” remained “Sometimes” and “Often” and “Always” were compressed to “Often”.

Answers to open-ended questions were analysed using Braun & Clarke’s (2006) approach to thematic analysis. The researcher reviewed the themes once the numerical data was analysed to consider if they illuminated anything further about the trends evident in the data. For example, the themes present in responses regarding referrals to legal authorities revealed that the vast majority of respondents commented that consumers had not wanted a referral. This helped explain why so few respondents answered that they referred to legal authorities.

The thematic analysis of the open-ended questions broadened the scope to understand why particular trends where occurring. For example, the survey asked respondents to rate how frequently they screened voice hearers for experiences of sexual abuse. This was accompanied by an open-ended question that asked what influenced them to screen this often. These open-ended questions were thematically analysed and compared to see if different themes emerged amongst respondents dependent on how frequently they screened for abuse. The survey also allowed space for responses that fell outside the fixed answers. Notable responses were coded and quantified allowing the data to be analysed with original numeric data.

4.6 Integrated analysis of strand one and two

Following Teddlie and Tashakkori’s (2009) conceptualisation of a multi-levelled mixed design, once both strands of this study were analysed the findings were viewed together to inform inferences about how the mental health system is responding to voice hearers who have experienced sexual abuse. Results from both strands relating to similar themes were viewed together in order to understand the theme from both

perspectives.

It was important to consider the role of time at this stage of analysis. The surveys of mental health professionals provided a picture of what is presently happening in Australian mental health services with respect to voice hearers who have experienced sexual abuse. The interviews with voice hearers largely deal with service use that had occurred in the past. For this reason, the data in the survey was used to understand what is presently happening in the mental health system and what beliefs and attitudes shape these trends. The stories detailed in the interviews were used to understand the lived experience of the work practices detailed in the survey and to illuminate trends found in the survey from a consumer perspective. The interviews formed the basis for understanding what was helpful or unhelpful when working with sexual abuse survivors who heard voices.

Critical realism stresses the need to understand the structures and mechanisms behind trends that are found within research. To do this, research findings are understood retroductively by considering the results in light of the contextual, structural, and theoretical backdrop of the phenomenon being studied (Mingers, 2014). From here tentative explanations can be developed that use these contextual factors to explain what is evident in the research. In this project the findings were considered against the backdrop of the policy and practice issues described in Chapter 2 and the theoretical issues that inform how the impacts of sexual abuse are understood, as described in Chapter 3. From here, several explanations were developed to attempt to explain the trends that were evident in the results. These explanations are outlined in Chapter 9.

4.7 Summary

This research project employed a multi-strand mixed method design, informed by the principles of critical realism, which sought to understand how the Australian mental health system is responding to voice hearers who have survived sexual abuse. In-depth interviews with voice hearers who have survived sexual abuse were used to gain a lived

experience perspective of this question. An online survey of mental health professionals was used to explore how professionals are working with voice hearers who have experienced sexual abuse and what shapes these responses. Each strand was initially analysed separately, but was then viewed holistically with a consideration for what the results from each strand illuminated about trends evident in the other. These results were then considered against the paradigmatic and policy context of the Australian mental health system with the aim of developing tentative explanations for the themes and trends found in the results.

PART THREE

DEMOGRAPHICS AND RESULTS

Chapter 5 – SURVEY DEMOGRAPHICS AND INTERVIEWEE PROFILES

This chapter details the demographics of the respondents who completed the online survey. It then details the profiles of the voice hearers who participated in interviews about their experiences accessing mental health services.

5.1 Demographics of survey respondents

Basic demographics were collected for all respondents who completed the online survey (N=213). As it was not mandatory for all questions to be completed, the total number of responses to specific questions varied throughout the survey. Throughout this chapter the number of respondents will only be detailed if it is less than 213.

AGE

A third of respondents were aged between 26-35, with 31% of respondents falling into this category. A further 23% of respondents were aged between 36-45, and 23% were aged between 46-55. The percentage of respondents aged between 66-75 was 1.4%, reflecting the common retirement age of Australian workers.

GENDER

Nearly four fifths (79.8%) of respondents were female. This is reflective of the general makeup of the Australian health work force, with 88% of registered nurses, 83% of social workers, 92% of occupational therapists, 78% of psychologists, and 67% of welfare support workers being female. Psychiatrists are the one profession in the sector more likely to be male with 61% being male (Department of Employment, 2016). Psychiatric nurses are slightly more likely to be male than the general nursing workforce, with an estimated 31% of psychiatric nurses being male (Australian Institute of Health and Welfare, 2016b).

Type of service

Respondents were employed across a range of mental health and community services. As detailed in Table 5.1, the majority of respondents worked in public mental health services with 31.5% of respondents working in public outpatient services and 18.3% working in public inpatient services. Non-government mental health services were also represented highly with 22.5% of respondents working in Community Managed Mental Health (CMMH) services, 7% employed in Personal Helpers and Mentors (PHaMs) programs, and 3.8% working for peer support programs. A smaller proportion of respondents worked privately with 7.5% of respondents working for private mental health services or in private practice. This reflects the trend of high levels of service provision in public mental health settings as compared with non-government run services such as CMMH and PHaMs (National Mental Health Commission, 2014).

Table 5.1 – Type of Organisation

Type of Organisation	**Frequency**	**Percent**
Public Outpatient	67	31.5
CMMH	48	22.5
Public Inpatient	39	18.3
Private Mental Health	16	7.5
PHAMS	15	7.0
Other community service	9	4.2
Peer support	8	3.8
Other hospital	7	3.3
Training and Consultancy	4	1.9
Total	213	100.0

Occupation

Respondents worked in a variety of occupations. Out of 212 respondents, most were social workers who made up 31.6% of all respondents. This was followed by community

support workers (18.9%) and psychiatric nurses (18.4%). A smaller number of peer workers (8%), occupational therapists (7.5%), and psychologists (7.1%) participated in the survey. Only 0.9% of respondents were psychiatrists. While there is limited data that captures the professional make-up of the whole Australian mental health sector, there is some indication that there is a higher proportion of psychiatric nurses, psychologists and psychiatrists than is represented in this study (Australian Institute of Health and Welfare, 2016b). The proportion of social workers responding to this study is higher than the general mental health workforce. This may be a result of social workers having a greater interest in issues relating to trauma or because this was a project implemented and promoted by a social worker.

Geographical region

A significant majority (81.5%) of respondents worked in metropolitan areas (urban population exceeding 100,000 people). A smaller proportion of 15.2% worked in rural areas (urban population exceeding 10,000) and 3.3 % noted that they worked in remote locations (urban populations lower than 10,000). The proportion of respondents working in metropolitan areas was slightly higher than the national average, which estimates that around three quarters of the mental health workforce work in major cities (Australian Institute of Health and Welfare, 2016a).

Nature of work

The majority of respondents worked in a full time capacity with 65.6% of 212 respondents working full time, 31.1 % working part time, and 3.3% working on a casual basis.

Most respondents either worked directly with individual consumers or with consumers in a group environment, with 63% of respondents working with a specific case load of consumers, 17.1% working with consumers as needed in an inpatient or residential service, and 5.7% working with consumers in a group setting. Management level

workers also responded with 17.6% providing supervision to staff and 6.2% providing secondary consultation. As detailed in Table 5.2, just over half (53.1%) of respondents worked with a caseload of fifteen consumers or less. Around one fifth (22%) of respondents did not work with a specific caseload.

Table 5.2 – Average case load

Average case load	Frequency	Percentage
0-5	20	9.6
6-10	45	21.5
11-15	46	22.0
16-20	20	9.6
21-25	15	7.2
26-30	10	4.8
Over 30	7	3.3
No specific case load	46	22.0
Total	209	100

As detailed in Table 5.3 almost all (97.6%) respondents worked with a proportion of voice hearers with most respondents stating that their work with voice hearers made up between 1-25% of their time.

Table 5.3 – Percentage of work with voice hearers

% of work with voice hearers	Frequency	Percent
0%	5	2.4
1-25%	88	41.7
26%-50%	53	25.1
51%-75%	43	20.4
76%-100%	22	10.4
Total	211	100.0

EDUCATION

The majority of respondents were university educated, with 45.5% of respondents holding a highest level qualification at a Bachelors level, followed by 30% of respondents with a Masters level qualification, and 5.6% of respondents educated up to doctorate level. A number of respondents were educated up to a vocational level with 4.2% reporting a Certificate IV as their highest qualification, 10.8% with a diploma as their highest qualification, and 2.3% educated up to an advanced diploma level. A small percentage (1.4%) had been educated up to a high school level. This is reflective of the Australian mental health workforce with tertiary educated professionals making up the bulk of clinical mental health services and the NGO sector attracting some staff with vocational education (Australian Institute of Health and Welfare, 2016b).

LENGTH OF TIME WORKING IN MENTAL HEALTH SECTOR

The majority of the respondents to this survey had considerable experience working in the mental health sector. As detailed in table 5.4, over half of the respondents had worked in the mental health sector for over 5 years, with a third working in the sector for over 10 years.

Table 5.4 – Length of time working in mental health sector

Length of time in field	**Frequency**	**Percentage**
Less than 12 months	25	11.9
Between 1-2 years	25	11.9
Between 3-5 years	47	22.4
Between 6-10 years	42	20.0
Over 10 years	71	33.8
Total	210	100.0

5.2 Profile of interview participants

Seven interviews were conducted with individuals who heard voices and had past experiences of sexual abuse. Basic demographic information was collected from interviewees with the focus on obtaining details about the different services they had previously accessed.

Interviewee Louise

Louise was a middle aged woman in her forties. She described using mental health services for approximately fifteen years. She detailed around ten admissions to public psychiatric inpatient units and utilised public outpatient services through a dialectical behavioural therapy program. In addition to this, she accessed community managed mental health services, sexual assault counselling services, private psychologists, and a private psychiatrist. Louise worked in a service where she accessed Hearing Voices training from peers with a lived experience of voice hearers. She also had informal support from these peers.

Interviewee Pat

Pat was a middle aged man. He described accessing mental health services for a number of years. He used public mental health inpatient services and was case managed for a short period of time by public outpatient services. He used a community managed mental health service for a short period of time and also accessed sexual assault counselling services. Pat detailed using private psychologists and counsellors. He also discussed informal support from peers.

Interviewee Daisy

Daisy was a middle-aged woman who described using mental health service since her early adulthood. She accessed a number of public inpatient facilities, as well as a private inpatient hospital. She spent some time being case managed by public outpatient

services in addition to using private outpatient services. She used a number of community managed mental health programs and has accessed sexual assault counselling services for a short period of time.

Interviewee Geraldine

Geraldine was a middle aged woman who described using number of mental health services. She had not accessed public inpatient or outpatient services but had seen a number of private psychiatrists. She had accessed sexual assault counselling as well as other counselling services. She had engaged in an art therapy course for survivors of sexual abuse.

Interviewee Pauline

Pauline was a middle-aged woman who described accessing mental health services since her early adulthood. She had accessed a number of different public inpatient services and had received case management from public outpatient services. She had used a number of community managed mental health services along with peer support services.

Interviewee Jess

Jess was middle aged woman who described first accessing mental health services in the United Kingdom where she used psychiatric inpatient services and psychiatric support in the community. In Australia she had accessed peer support, community managed mental health services and private counsellors. She also accessed respite programs from a sexual abuse support organisation.

INTERVIEWEE LINDA

Linda was a middle aged woman who described receiving support largely from private psychiatrists. She has also accessed art therapy groups, peer support groups and counselling services.

5.3 Summary

This chapter has outlined the demographics of the survey respondent which largely reflect the nature of the Australian mental health workforce in terms of gender, geography, and education. However, the representation of professional groups is biased towards social workers and does not accurately capture the proportion of psychiatrists working in the field. Interviewees were mostly middle aged and had a range of experiences accessing a variety of mental health and community services with most interviewees using services over many years. The bulk of their interactions with service providers had occurred a number of years before the interviews took place. Consequently, the content of the interviews largely reflected the nature of service provision in the past rather than was is currently occurring.

Chapter 6 –TRAUMA AND ABUSE SCREENING

This chapter is the first of three chapters that outline the key findings of this project.. The results in this chapter and Chapter Seven address the first two research questions:

1. What are the work practices of mental health professionals when working with voice hearers who have experienced sexual abuse?
2. What factors shape how mental health professionals respond to voice hearers who have experienced sexual abuse?

This chapter details the results of both strands relating to screening for sexual abuse . The interviewee perspective on screening and disclosure is initially described, with a consideration of the barriers to voluntary disclosure and the impacts of not being screened for sexual abuse. The rates of screening evident in the survey of service providers is outlined along with the factors that were found to shape respondent's screening practices.

6.1 Interviewee perspective on screening and disclosure – A conspiracy of silence

> *So without him asking, without anyone asking, I wasn't going to bring it up. I was doing my best to push it down and not think about it. And hide from it, I didn't even have the words for it, so I needed to be asked. And I wanted to be asked, even though I was scared of it, I was waiting for it but eventually I stopped thinking about it (Louise).* [10]

The interviews with voice hearers revealed several themes related to how mental health professionals screened for sexual abuse. Interviewees frequently spoke of not being asked about abuse or trauma and also described several barriers that inhibited them from disclosing voluntarily. Various impacts of not being able to discuss their experiences of trauma were present throughout the interviews.

[10] Quotations from the interviews and surveys have been reported verbatim.

A lack of screening

All seven interviewees described not being asked by mental health professionals about experiences of abuse or trauma. Most interviewees experienced this across multiple services. For example, Louise detailed how she was not screened for trauma over ten years of intensive service use, including when she accessed a dialectical behavioural therapy program through a public mental health service:

> *Kath: When you were doing the DBT group, did that come up at all?*
>
> *Louise: No, trauma didn't come up in the group. And it's really interesting that treatment, as you know, is targeted at borderline personality disorder which has the highest rate of trauma, particularly sexual abuse.*
>
> *Kath: It was never discussed?*
>
> *Louise: Never discussed, never mentioned.*

Louise spoke about the lack of screening and support for disclosure when she used mental health services, along with a lack of information available in mental health services about trauma and trauma based services. She described the silence surrounding issues relating to sexual abuse:

> *Louise: It's like, Pat Deegan talks about a conspiracy of hope to help with recovery but around trauma it's like there is a conspiracy of silence, and consumers don't talk about it, families don't talk about it, workers don't talk about it, clinical or consumer. No one talks about it.*

This conspiracy of silence was present in all of the interviewee's experiences using mental health services.

Barriers to disclosure

The importance of screening consumers for abuse and trauma is evident in the numerous barriers to disclosure that were named by interviewees. Six of the interviewees described in detail their reluctance to disclose experiences of sexual abuse to mental health professionals. Through these descriptions, several barriers to the disclosure of sexual abuse were identified.

Shame

The shame associated with sexual abuse is a key factor that prevented interviewees from disclosing their experiences of sexual abuse. Pat spoke about the shame of sexual abuse having a silencing effect and the need for mental health professionals to be aware of this:

> *Kath: Did you ever talk about it to anyone?*
>
> *Pat: Ahhh, I sort of tried to. As a survivor of sexual abuse, one of the things you learn is not to talk about it. So they need to be able to understand the trauma model, that it is really frightening to be able to disclose things and they need to be sensitive to that.*

Louise described how the silence around sexual abuse that she found when using mental health services reflected the silence around sexual abuse that she witnessed in the general public. She argued that mental health professionals need be aware of this silencing and do as much as possible to help consumers disclose their experiences of abuse:

> *Louise: Particularly with sexual abuse, there is so much shame and there is so much pressure to keep silent and to never tell anyone that it needs a huge counterbalance to be able to talk about it. A huge amount of shining the light on it and telling people that it's ok to talk about it. Being the opposite of hushing it up.*

Difficulty expressing experiences

At times the very difficult nature of sexual abuse experiences prevented interviewees from disclosing. Louise, who had not disclosed her experiences of abduction and rape as a teenager to anybody, recalled initially waiting for her first psychologist to ask her about her experiences as she could not find a way to describe them:

> *Louise: I can remember my early appointments with a psychologist, I first entered the mental health system seeing a private psychologist and when he was taking my history I remember thinking he's going to ask me soon about that*

thing that happened when I was a kid, that's what I used to call it, but he didn't. I kept waiting for him to ask and I remember sitting in the chair thinking, he's going to ask about that sooner or later and I'll have to talk about it. But it wasn't something that I felt I could bring up on my own, I mean, how do you introduce into a conversation, oh incidentally I was abducted and raped when I was 13, do you think that might have something to do with what is happening and do you think we could talk about it?

Louise later found that this pattern of not being asked about previous experiences of abuse continued as she accessed a range of different mental health services. She described her first positive relationship with a mental health professional and how she still felt that she could not voluntarily disclose her abuse:

Louise: Having said that, when I first met the psychologist at the Alfred clinic she asked me a quite wonderful question, it was quite revolutionary at the time, it was - "How do you want me to work with you?" Which was the first time anybody had offered me choice in the service. So theoretically that was the point that I could have said "I'd like you to work with me about past trauma" but the system had pushed it right out of my head, I didn't have the language, I didn't even know that was a possibility so there was no way I would have brought it up.

Repression or Avoidance

Others spoke about repressing or avoiding memories of sexual abuse and this being a reason for not disclosing experiences of abuse to staff members. Pauline commented that she would often play the role of a clown when in hospital and consistently tried to bring light and humour to the other patients. She reflected that this might have been a way of avoiding looking at these experiences herself:

Kath: While you were in hospital settings did you ever talk about any experiences of abuse or assault to staff?

Pauline: (pauses) Possibly not. You know I was pretty flamboyant. I was always pretty flamboyant, and I suppose that I never seriously would have spoken about things that really sort of bothered me. Because it's possible that I didn't even

look at it myself. Do you know what I mean?

Like Pauline, Geraldine commented that she would try and avoid thinking about her experiences of sexual abuse. She described her reluctance to talk about her experiences of abuse with her psychiatrist as she was attempting to compartmentalise her memories of the abuse:

Kath: What do you think stopped you telling him? Did he ever ask you about abuse?

Geraldine: I don't think I ever told him, I think I was keeping it to myself. I think I thought of him as focusing on one part of me and this was a separate part of me.

Fear of losing control

Daisy and Geraldine both spoke about a fear of losing control as a factor prohibiting them from disclosing experiences of abuse. Daisy talked about struggling with her voices and other symptoms when discussing experiences of sexual abuse in the past and this leading her to feel reluctant to disclose to other professionals:

Kath: And you mentioned that you couldn't feel comfortable talking about it in much detail. What was holding you back?

Daisy: I was scared of losing control.

Kath: And is that a common experience for you in terms of broaching those kinds of topics?

Daisy: Yes.

Kath: Being scared that you will lose control?

Daisy: Yeh.

Kath: Has that happened to you Daisy, when you've talked about those experiences of abuse, have you lost control?

Daisy: Yes, the voices get worse and yes I do, I lose control. I get psychotic.

Kath: Ok. So you are resisting talking about it because of that fear?

Daisy: Yes.

Geraldine spoke about having a good relationship with her current psychiatrist spanning

many years. At the time of the interview, she had recently disclosed her experiences of sexual abuse and her wish to talk about it. When asked why she had not disclosed earlier in the relationship she said:

> *Geraldine: I think with me, it was all about my head not functioning well and having the voices tormenting me and not being able to go there, or it would have got worse. It was just a matter of what I could manage.*

She spoke further about how she was now in a stable place in terms of her mental health, accommodation, employment and social network. She felt that this stable base enabled her to discuss her experiences without fear of losing control.

Biological models of mental illness

The use of biological models of mental illness can also be seen to inhibit disclosure. Louise spoke of how the consistent silence she experienced in the mental health system around the issue of sexual abuse contributed to her believing that her experiences of sexual abuse were unrelated to her experience of mental ill health. Louise spoke about this being one of the reasons she did not disclose her experiences of abuse voluntarily:

> *Louise: And I think I believed for a long time, oh that's got nothing to do with this, I've got an illness, this is all about my brain and sooner or later we're going to find the right pill, which never happened. I had lots and lots of wrong pills though (laughs).*

Daisy and Linda both spoke about having an awareness that medication was the focus of their interactions with mental health professionals and subsequently did not disclose their experiences of sexual abuse. Daisy commented that she did not disclose her experiences of sexual abuse in a public inpatient service as she believed that medication was their only focus:

> *Kath: Did you ever disclose voluntarily?*
>
> *Daisy: No… All they cared about was popping pills.*

Linda also reflected on a similar dynamic present with a private psychiatrist. She commented on feeling reluctant to disclose her experiences of abuse with her

psychiatrist as the focus of their appointments was on medication management:

> *Kath: Is that because he didn't ask or because you didn't feel like talking about it?*
>
> *Linda: No he didn't ask, he told. He told, because he knew what the problem was and he just told you what to do and there is this drug that you are supposed to take. And the Saturday morning, because it was bulk billed, Saturday morning 15 minute things, were to see are the meds working, if not, what do we need to increase, decrease or change.*

Fear of involuntary treatment

Other interviewees cited concerns about involuntary treatment as a barrier to disclosing experiences of sexual abuse to mental health professionals. Pat reflected on his reluctance to talk about anything personal while he was in a public inpatient service as he was scared of being involuntarily treated with ECT:

> *Kath: Did you discuss your experiences of trauma with them?*
>
> *Pat: Um, to be honest, um no. I didn't feel like I could to be honest.*
>
> *Kath: So what was it that prevented you from talking?*
>
> *Pat: I think fear, I think that when I did actually talk about things, there was times I was told that I would have ECT, be given ECT because it was used a leverage to keep me sort of, on the path of recovery, or at least appear to be. So yeah, I feel that there was a real abuse of power there and I was scared to talk about anything personal in a system that was very much medical. So just getting through it.*

Jess also spoke about her reluctance in discussing her experiences of abuse with an outpatient service:

> *Kath: Did you feel safe discussing your experiences of abuse with her?*
>
> *Jess: I probably didn't disclose perhaps as much because I knew that she still had the influence to send me back in services. So yeah.*

Here, the focus is less on the actual practices of staff members but more the awareness of the power that the staff member had under the Mental Health Act.

Pauline spoke about being conscious of withholding information from psychiatrists as she feared that talking about her experiences of abuse would result in an increase in her medication:

> *Pauline: And it's very hard to talk to people about, certainly I learned not to say things to certain people like psychiatrists and people of that profession. And I mean this hearing voices group, that I've never been, it sounds really, really inclusive and marvellous but the time I was around you wouldn't want to be talking about that stuff because straight away your medication would be put up. I had to deal with it in my own mind (teary) and it was really, really hard.*

Here, again, the awareness of the power of mental health professionals to determine treatment acted as a barrier to disclosure.

Factors supporting disclosure

While interviewees identified several barriers to disclosure, they also discussed some factors that helped them talk to mental health professionals about their experiences of sexual abuse.

Asking about abuse or trauma

While most interactions with service providers described in the interviews involved professionals not screening for abuse, there were five instances where interviewees described being asked about experiences of abuse. Most of the descriptions are broad and don't discuss the interaction in detail.

Jess, however, described a positive experience with a worker whom she was doing training with who asked about past abuse when she noticed that she had begun feeling distressed during training:

> *Kath: And so tell me a bit more about that experience. Did she talk to you about the abuse and trauma? Did she ask you directly or did you disclose?*
>
> *Jess: I'll tell you how it happened shall I? Well we were attending a workshop*

with Pete Bullimore and he was talking about sexual trauma and paranoia and his experience. And he was also mentioning, because at that time I was having really, what I thought were bizarre flashbacks, and bits and pieces and my voices were very odd. And they can still be very persecutory. So I just got quite triggered at the workshop and Sandi said –"Let's go for a coffee", and she was talking about "What was it that triggered you?" And I said that when Peter was talking about a client, and it was some sort of ritualistic experience. So she said, "What was your experience, what triggered you?" I said "Well I think that's what I experienced, and I'm not 100% sure and I don't know if anybody really who knows anything about it". Nobody talks about ritualistic abuse or intentional trauma. So she said, "I believe you, and I'd be willing to work with you".

This experience fell outside of standard assessment processes, however, this interaction began a positive therapeutic relationship with Jess being able to discuss her experiences of abuse with this worker.

Information and Peer stories

Interviewees commonly spoke about hearing other peer stories or obtaining information about trauma and voices as a catalyst for disclosing their experiences of abuse. Louise talked about her work alongside voice hearing advocates from the UK and being inspired by their stories:

Louise: And people sharing their stories of recovery. Because what got me, I don't know if you're going to ask this later, but what helped me to disclose down the track was to hear other people with lived experience share their stories, that was what gave me the courage.

She reflected on hearing peers talk, not only about their recovery stories but also openly about their experiences of trauma and how they related to their voice hearing. She describes this as the opposite of the conspiracy of silence:

Louise: And it just blew me away, to hear people talking so openly about this stuff that we just don't talk about. And really, really understanding and getting how, is the word indelibly, linked it was with what has been called mental illness.

Geraldine reflected on how learning more about trauma in the context of her work encouraged her to speak to her psychiatrist about her experiences of sexual abuse:

> *Kath: What has prompted you to do that?*
>
> *Geraldine: With my job, I did some trauma training the other day down at Medicare Local at Werribee, it was funded by the Royal Commission, and there was a couple of spare spots and I managed to get one. And I did that, and that inspired me, it talked about how trauma effects the development of your mind, your brain and your emotions and it just touched on some of those things. I sort of felt that maybe I am well enough now and got enough mental understanding and ability to investigate some of these things.*

Interviewees commented that access to information about trauma and abuse would have helped them disclose to professionals. Louise spoke about seeing posters around health services that encouraged the LGBTI community to feel comfortable disclosing their sexual or gender identity to professionals and suggested that similar posters could be designed around trauma:

> *Louise: Even something as simple as that, you don't have to tell us if you've experienced trauma, but you can. Or things that say, did you know that more than 70% of people in the public mental health system have experienced trauma, and trauma can be many different things. Talk to your worker to find out more.*

Pat also mentioned the lack of posters or information about trauma available in mental health services and suggested that this information would have been helpful. He also suggested that trauma based workers, such as sexual assault counsellors, should be accessible in mental health services:

> *Pat: I think one of the things that would have helped in the inpatient unit would have been the capacity to talk to someone who was a professional within CASA*[11] *that actually understands mental health and consumer perspectives.*

Providing information and access to peer stories may be an avenue for services to

[11] Centre Against Sexual Assault

create an environment that helps consumers feel more comfortable with disclosing experiences of sexual abuse.

Impacts of not disclosing

The impacts of not disclosing past experiences of sexual abuse are evident in the interviews. Several interviewees felt that they were ill for a longer period of time as a result of not being able to discuss their experiences of abuse with professionals.

Jess spoke about the impact of not having access to appropriate services due to a lack of screening:

> *Jess: I was just debilitated for such a long time. I could have, I don't know. I mean everyone's process and journey is individualistic, but I just feel that, you know, maybe not to have struggled for so long.*

Louise echoed this sentiment when she spoke about the impact of the silence she experienced in the mental health system:

> *Kath: So what was the impact of not being asked in your earlier inpatient admissions?*
>
> *Louise: I think it's huge, I think I lost years and years and years of my life to being a consumer of the mental health system that I didn't need to lose at all.*

These prolonged experiences of illness are also associated with a loss of opportunities. Linda expressed significant grief at the losses she experienced due to being unwell for a significant period of time:

> *Linda: So, unfortunately, it didn't provide as much assistance as I really, really desperately needed at the time. And unfortunately that had actual consequences. It was another twenty years before I got sorted out. And in that time (cries) that's the time that you have kids.*

Linda also spoke about her illness changing her career trajectory as she repeatedly had to take leave from work.

Jess, Louise, Linda, Pat and Daisy reflected on how having adequate support to talk

about their experiences of sexual abuse and associated distress was a fundamental part of their recovery journey, albeit a process that should have occurred earlier in their lives.

The role of mental health professionals to help disclosure

As described above, there may be many barriers that inhibit consumers from disclosing sexual abuse voluntarily to mental health practitioners. The difficulty disclosing experiences of sexual abuse described by the interviewees points to the need for mental health professionals to ask about trauma and abuse as part of their ongoing work with consumers. Louise explicitly stated her belief that mental health professionals must routinely screen for trauma and abuse:

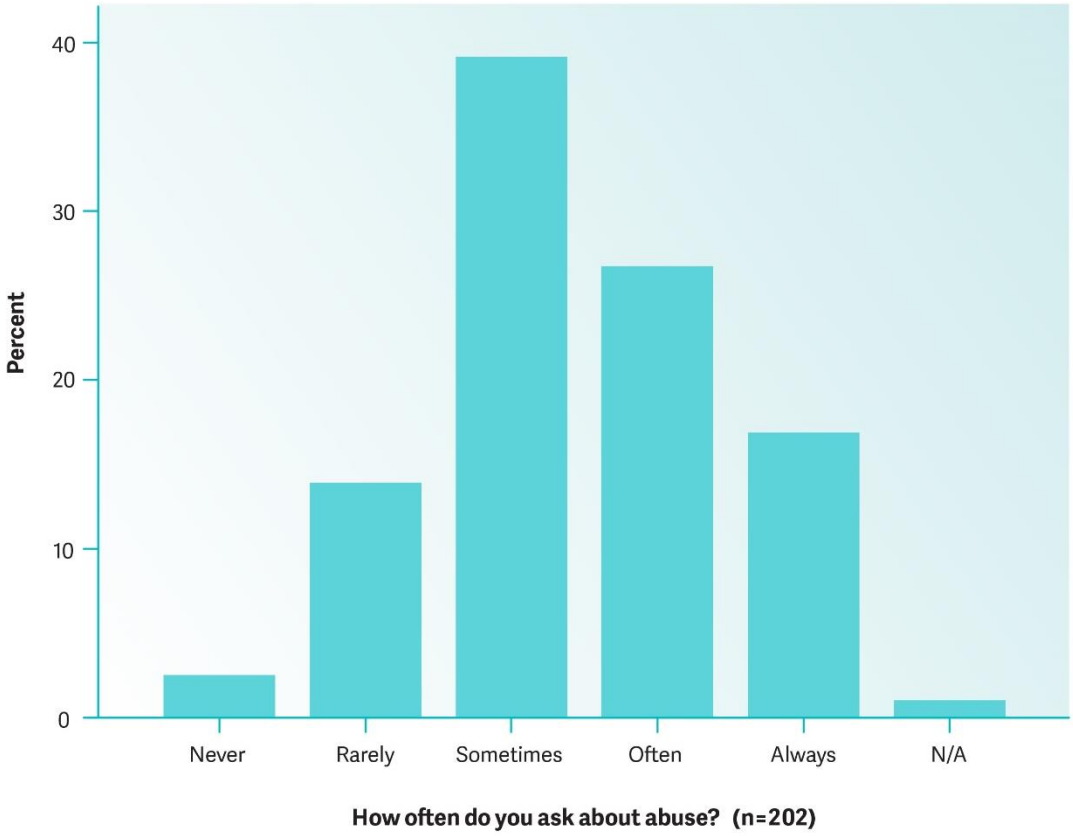
> *Louise: Ask, ask, ask, ask, ask and back that up with the skills so that workers know what to do. Because I don't think hardly anyone in the mental health sector knows how to talk about trauma. And I think workers are more scared of talking about trauma than those of us who've been through it are. They are scared we'll get sicker. I've heard so many workers say – Oh what if we open the can of worms? It's like dudes – we are floridly psychotic! What do you think this is? There are worms everywhere! Just ask the fucking question.*

6.2 Current rates of screening

While the professional practices regarding screening described in the interviews reflected past service use experiences, the survey results reflected how the service system is currently responding. The results indicate that a significant proportion of respondents were reporting that they screened voice hearers for past experiences of sexual abuse. However, as shown in Figure 6.1 (overleaf), most respondents seem to be screening intermittently, with the 39.1% of respondents answering that they *Sometimes* ask voice hearers about sexual abuse. This was followed by 26.7% answering *Often* and 16.8% stating that they always ask about abuse. A smaller group (13.9%) said they rarely asked and 2.5% said that they never asked. Two (2) respondents were coded as not applicable as they did not work directly with voice hearers. For this question, the

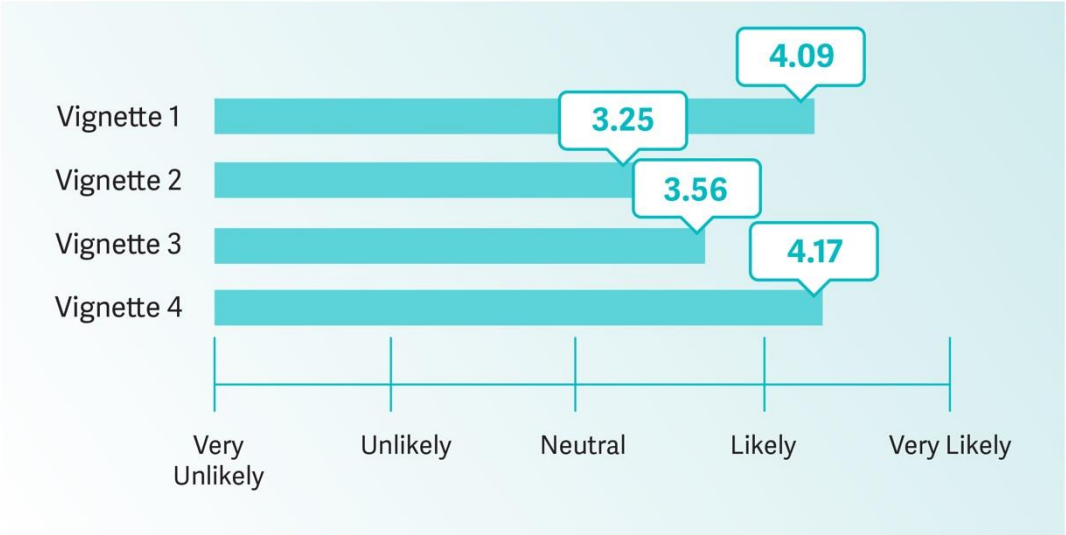
mean score was 3.42 on a 5 point Likert scale where 1=Never ask and 5=always ask.

Figure 6.1 – Frequency of screening



Respondents were also asked to rate how likely they were to screen consumers described in four vignettes who varied in terms of age, gender, presentation, and content of voices. As indicated in Figure 6.2, the mean response varied across the vignettes, pointing to a tendency to vary screening for abuse on a case by case basis. A mean score of 1 indicates that that respondents were very unlikely to ask the consumer described in the vignette about sexual abuse, and a mean score of 5 indicates that respondents were very likely to ask about sexual abuse. The higher the mean score, the more likely respondents were to ask the described consumer about their experiences of sexual abuse.

Figure 6.2 – Mean responses to vignettes



Vignette 1

Vignette one described a young woman whose voices seem to be related to sexual content. She can speak clearly with staff and is not suicidal. The mean response equates to 4.09 with 43.2 % reporting that they would be likely to ask about abuse, followed by 37.6% who said that they would be very likely to ask.

Table 6.1 – Vignette 1

How likely are you to screen for sexual abuse? (n=213)	**Percent**
Very unlikely to ask	.5
Unlikely to ask	9.9
Neutral	8.9
Likely to ask	43.2
Very likely to ask	37.6
Total	100.0

Vignette 2

Responses were notably different in vignette two which described a middle-aged man whose voices did not clearly seem related to sexual content. Instead, he hears the

voice of God telling him he is a sinner. His behaviour and communication are erratic. The mean response is 3.25, which is the lowest of the four vignettes. The majority of respondents reported that they were unlikely to ask (26.8 %) followed by neutral (25.4 %).

Table 6.2 – Vignette 2

How likely are you to screen for sexual abuse? (n=213)	**Percentage**
Very unlikely to ask	5.2
Unlikely to ask	26.8
Neutral	25.4
Likely to ask	23.0
Very Likely to ask	19.7
Total	100.0

Vignette 3

Vignette three described an older woman whose voices do not seem directly related to sexual content but are focused on unusual or improbable beliefs. She presented as suspicious of staff, particularly men. The mean response here is 3.56. Here the majority are likely to ask (37.1 %) followed by neutral (23.0%).

Table 6.3 – Vignette 3

How likely are you to screen for sexual abuse? (n=213)	**Percentage**
Very unlikely to ask	5.2
Unlikely to ask	12.7
Neutral	23.9
Likely to ask	37.1
Very likely to ask	21.1
Total	100.0

Vignette 4

Vignette four described a young man whose voices are not clearly related to sexual content. However, the described onset is following his first sexual experiences. He also presented with symptoms of anxiety and dissociation. This vignette had the highest mean response of 4.17 with most respondents reporting that they were either likely (41%) or very likely (41%) to ask about abuse.

Table 6.4 – Vignette 4

How likely are you to screen for sexual abuse? (n=213)	**Percentage**
Very unlikely to ask	.9
Unlikely to ask	4.2
Neutral	12.7
Likely to ask	41.0
Very likely to ask	41.0
Total	100.0

The variability in responses to the vignettes suggests that respondents were more likely to screen for sexual abuse if there is some indication of sexual themes in voices, or sexual experiences relating to the timing of the onset of voices. Conversely, respondents were less likely to ask consumers who present with voices seemingly unrelated to sexual experiences but instead contained paranoid themes. They were also least likely to screen the consumer who presented with erratic behaviour and communication. These trends continue to be evident in a further examination of the factors that impact on screening as described below.

6.3 Factors that impact on screening

The results from the survey point to several factors that were associated with different rates of screening amongst respondents.

INDICATORS OF ABUSE

Indicators of abuse in a consumer's presentation seem to play a role in how respondents screened for sexual abuse. As noted above, respondents were more likely to screen in the vignettes where symptoms related to sexual themes. This suggests that the content of voices may be a factor that influences whether professionals screen for abuse and trauma.

The open-ended responses to the screening questions support this idea. The most cited theme in the answers regarding what influenced how respondents screened the different vignettes was *content of voices*. Here, respondents noted that the vignettes referring to sexual content of voices made them more likely to ask about abuse or trauma compared with voices that did not seem connected. For example, one respondent wrote:

> *For me, it was whether the voices frame of reference was towards a certain gender, behaviour type eg. Promiscuous, or with a focus on the body*[12]*.*

While most of the respondents simply stated that the content of consumer voices would prompt them to ask about abuse, some respondents explained with more detail why the content of voices would prompt them to ask. Frequently, there was the assumption that the content of voices often carries meaning that is related to past experiences in the consumer's biography. For example:

> *My perspective and understanding that voices and other psychotic experiences are likely linked with life experiences.*

Others suggested that the content of the voices would give them an opening to discuss experiences of trauma and abuse:

> *I think if people mention that sex or sexuality are linked to their voice hearing experience that indicates an opening to ask directly about sexual assault.*

Here, the content of voices could be seen as indicators of abuse that act as a prompt for workers to ask for more details about possible experiences of abuse and trauma. This

[12] Survey responses have been reported verbatim and have only been edited for spelling errors.

theme was the most cited theme in relation to the vignettes. Of the 174 open-ended responses, 47 were coded as relating to the content of voices or symptoms.

Respondents commonly cited indicators of abuse when asked to describe what influenced their rates of screening voice hearers for sexual abuse. This incorporated more than just the content of voices and included delusional content, high anxiety, or other forms of trauma related distress. For example, one respondent stated that they would ask about sexual abuse if there were:

> *indicators of abuse such as sexualised behaviour or sexual content of AH/delusions, personality structure, level of vulnerability.*

Of the 183 open-ended responses to this question, twenty responses were coded for this theme. It was the most common theme amongst respondents who said that they "Sometimes" asked about abuse.

There was also a frequent reference to asking about abuse or trauma if there was indication of trauma in the consumer's known history. For example, one respondent who answered that they would sometimes ask about abuse stated:

> *If they have a history of sexual abuse, I am more inclined to ask.*

Answers relating to this theme were most commonly found in respondents who answered that they sometimes screen voice hearers for abuse.

Indicators of abuse, whether viewed in the presenting symptoms of the consumer, or evident in their known history, appear to be a factor that influenced whether respondents screened for abuse. Indicators of abuse were the most common response in relation to how respondents rated the vignettes. It was also the most common response linked with respondents who answered that they sometimes ask voice hearers about experiences of sexual abuse. Of 76 open-ended answers from respondents who said that they sometimes screened for abuse, 28 responses were coded as relating to indicators of abuse in presentation or history.

This is compared with respondents who answered that they often or always ask voice hearers about sexual abuse. Here, the most common response was that screening for trauma was part of their standard approach to assessment. For example, one respondent stated that:

> *I believe that developmental and trauma history are integral to an assessment on all who come to me.*

Of the 78 open-ended answers from respondents who stated that they often or always screened for abuse, 23 were coded as relating to a standard approach to practice. Only four responses were coded as relating to indicators of abuse.

Paranoid or erratic presentation

While indicators of abuse were a factor that encouraged respondents to screen for trauma, consumers presenting with disturbing or unusual symptoms seemed to be a factor that discouraged respondents from screening for abuse. As described earlier, the second vignette described a middle-aged man who presents with paranoid voices and erratic behaviour. Respondents were less likely to screen this consumer for experiences of abuse compared with the other vignettes.

This is reflected in how respondents felt about screening voice hearers presenting with disturbing symptoms, with 36.9% of 176 respondents stating that they felt neutral, agreed, or strongly agreed with the statement "I am reluctant to ask a consumer about experiences of abuse who I feel is presenting with disturbing symptoms". This was the second strongest held belief in the survey.

As detailed in Table 6.5, the rate at which respondents agreed with this belief had an association with how frequently they screened voice hearers for sexual abuse. A Chi-squared test for independence indicated a moderate and statistically significant association with the rate at which a respondent agreed with this belief, and how frequently they claimed to screen voice hearers for abuse, χ^2 (4, n= 174) = 14.57, p= 0.006, V= 0.205.

Table 6.5 – Disturbing symptoms and screening rates

		How often do you ask voice hearers about past experiences of sexual abuse?		
		Never/Rarely	Sometimes	Often/Always
Reluctance to ask a consumer presenting with disturbing symptoms	Disagree (n=110)	10.9%	33.6%	55.5%
	Neutral (n=36)	27.8%	47.2%	25.0%
	Agree (n=28)	28.6%	35.7%	35.7%
	Total (n=174)	17.2%	36.8%	46.0%

The open-ended responses to the vignettes and screening questions shed some light on why respondents may have been reluctant to screen consumers with paranoid, disturbing or erratic presentations. Respondents commented on concerns that asking a consumer when they are presenting with disturbing symptoms may increase distress. For example, one respondent stated:

> *The awareness of the individual to their condition. In vignettes where the individual appears to be disoriented I am unlikely to ask at that time as it may be more distressing/elevating than useful.*

Some respondents indicated that such presentations were indicative of psychosis and they deemed it inappropriate to ask consumers experiencing psychosis about experiences of abuse. For example:

> *High commonality between mental illness and history of child sexual assault. Would not be likely to ask if someone presents with a mental state consistent with a psychotic illness.*

WAITING FOR CONSUMERS TO DISCLOSE

In the open-ended responses to the screening questions, there was a total of twenty-nine responses that related to respondents expecting consumers to disclose abuse. Respondents detailed their tendency to wait for consumers to disclose before discussing trauma and abuse in any depth, rather than asking questions directly. Of these responses, some were based on the presumption that such disclosures would emerge because of an effective therapeutic relationship. For example:

> *I do not always ask specifically about sexual abuse - this can depend on how safe it feels to ask directly. I would hope that I co-create an environment in which it would feel safe enough for these issues to be voiced if and when it is right for the patient (or indeed other family members) to do so*.

Other respondents placed the responsibility for disclosure on the consumer. For example, one respondent stated:

> *We leave this up to the participant to talk to us about.*

Here screening for trauma is not part of standard practice but rather an issue that is left for the consumers to discuss. Another respondent stated that they would only discuss abuse and trauma *"If they have initiated the conversation".*

Respondents also referred to asking about abuse or trauma if consumers had given them some reason to believe that there was a history of sexual abuse. Here, the onus was still on the consumer to lead the way with these discussions. For example:

> *It's not a question I ask all clients. I would need to have a reason for asking ie., the client would need to indicate or lead me to believe that they have been the victim of sexual abuse or assault.*

Not surprisingly, these responses were all connected to respondents who answered that they would rarely or sometimes ask about abuse or trauma. Of the 29 open-ended answers from respondents who said that they never or rarely screened voice hearers for sexual abuse, 11 were coded as relating to waiting for consumers to disclose. It was

the most coded response amongst these respondents. It was also the second most coded response from respondents who said that they sometimes screened voice hearers for sexual abuse. There were no responses coded in this way that connected with respondents who answered that they would often or always screen for sexual abuse. This belief that consumers will voluntarily disclose experiences of abuse seems to influence how frequently a professional will screen for abuse and trauma.

CONCERN ABOUT UPSETTING CONSUMERS

The strongest belief held by respondents when working with voice hearers who had experienced sexual abuse related to feeling concerned about upsetting consumers. Here, 56% of 176 respondents said that they either felt neutral, agreed or strongly agreed with the statement "I am concerned about upsetting consumers by asking about their experiences of sexual abuse or assault". The strength to which respondents believed in this statement was associated with rates of screening for abuse. As detailed in Table 6.6 (overleaf), 28.3% of respondents who agreed or strongly agreed with the statement never or rarely screened for voice hearers for abuse. This is compared with 9.1 % of the respondents who disagreed or strongly disagreed with the statement. A Chi-squared test for independence indicated that there was a small but statistically significant association between the degree to which respondents felt concerned about upsetting consumers with questions of abuse and how often they screened voice hearers for abuse, χ^2 (4, n= 174) = 11.77, p = 0.019, V = 0.184.

Upsetting or re-traumatising consumers frequently featured in the open-ended answers about the challenging issues involved when working with voice hearers who had experienced sexual abuse. Respondents commented that they were concerned that talking about abuse and trauma would destabilise consumers, increase their symptoms, or retrigger traumatic responses. For example, one respondent commented that their biggest challenge involved "*Containing distress. Management of symptoms in a way that is not re-traumatising".* There seems to be a concern about discussions of trauma making consumers unwell, a concern that may serve to inhibit professionals from

screening for abuse and trauma.

Table 6.6 – Upsetting consumers and screening rates

		How often do you ask voice hearers about past experiences of sexual abuse?		
		Never/Rarely	Sometimes	Often/Always
Concern about upsetting consumers	Disagree (n=77)	9.1%	36.4%	54.5%
	Neutral (n=37)	16.2%	32.4%	51.4%
	Agree (n=60)	28.3%	40.0%	31.7%
	Total (n=174)	17.2%	36.8%	46.0%

GENDER

Gender also seemed to play a role in terms of professionals asking voice hearers about sexual abuse. As indicated in Table 6.7, male respondents were less likely to ask voice hearers about sexual abuse, with 28.9% of men stating that they would never or rarely ask, as compared to 13.1% of women. A Chi-square test for independence indicated there is a small association between gender and rates of screening, χ^2 (2, n= 198) = 6.5, p= 0.039, V= 0.181.

Table 6.7 – Gender and screening rates

		How often do you ask voice hearers about past experiences of sexual abuse?		
		Never/Rarely	Sometimes	Often/Always
What is your Gender?	Male (n=38)	28.9%	39.5%	31.6%
	Female (n=160)	13.1%	39.4%	47.5%
	Total (n=198)	16.2%	39.4%	44.4%

Female respondents were also more likely to screen the consumer described in Vignette 3. Table 6.8 indicates the differences between male and female respondents when answering this question. A Chi-squared test for independence indicated a small but statistically significant association between gender and the likelihood of screening the described consumer for sexual abuse, χ^2 (2, n= 211)= 6.17, p= 0.046, V= 0.171. There was no significant association with gender and the screening rates for the other vignettes. Older age, being female and presenting with symptoms that are seemingly unrelated to sexual abuse are the defining features of this vignette, indicating that these features may play a role in inhibiting male respondents from asking consumers about trauma and abuse.

Table 6.8 – Gender and screening rates for Vignette 3

		Vignette 3 (compressed)		
		Unlikely	Neutral	Likely
What is your gender?	Male (n=41)	26.8%	31.7%	41.5%
	Female (n=170)	15.3%	22.4%	62.4%
	Total (n=211)	17.5%	24.2%	58.3%

A number of respondents rated that they felt uncomfortable asking opposite gendered consumers about sexual abuse, with 26.7% of 174 respondents rating that they felt neutral, agreed, or strongly agreed with the statement "I am reluctant to ask a consumer of the opposite gender about their experiences of sexual abuse and assault". There was no significant difference between how men and women answered this question. The rate in which respondents agreed with this statement had a medium association with how often they screened voice hearers for sexual abuse. As indicated in Table 6.9, 57.4% of respondents who disagreed or strongly disagreed with the statement answered that they often or always screened voice hearers for abuse. This is compared with 16.6% of respondents who agreed or strongly agreed with the statement. A Chi-squared test for independence indicated a medium and statistically significant association between these variables, χ^2(4, n= 174)= 31.59, p= 0.00, V= 0.30.

Table 6.9 – Asking opposite gendered consumers and screening rates

		How often do you ask voice hearers about past experiences of sexual abuse?		
		Never/Rarely	Sometimes	Often/Always
Concern about asking opposite gendered consumers	Disagree (n=129)	10.1%	32.6%	57.4%
	Neutral (n=32)	37.5%	46.9%	15.6%
	Agree (n=13)	38.5%	53.8%	7.7%
	Total (n=174)	17.2%	36.8%	46.0%

Fewer respondents felt reluctant to ask consumers of the same gender with 11.4% of 176 respondents answering that they felt neutral, agreed or strongly agreed with the statement "I am reluctant to ask a consumer of the same gender about their experiences of abuse and assault". There was no association with agreeing with this statement and screening for sexual abuse.

Interestingly, gender did not feature heavily in the open-ended responses to the screening questions. In response to the question asking respondents what influenced the way they rated the vignettes, 10 respondents specified that the gender of the consumer influenced their responses. Only one respondent mentioned gender when asked what influenced their rate of screening. Whilst most respondents simply mentioned gender as an influencing factor, rather than specifying how gender played out in their work practices, a few respondents referred to the gender of the consumer or their own gender as influencing factors. For example, one respondent said that they were more likely to ask the women in the vignettes as *"Females are more likely to have experienced sexual assaults than men".* Others acknowledged their own gender as a factor:

Age and gender were the two factors I would consider before asking the 65 year

old woman (being male and under 40 myself), however I would be very likely to ask instead if the woman would feel safer talking with another female.

The results from this study indicate that staff screening behaviour may be gendered, with male respondents less likely to report routinely screening voice hearers for past experiences of sexual abuse. There also appears to be a relationship between concerns about asking opposite gendered consumers and rates of screening. The results from the interviews sheds more light on this trend.

The role of gender in relation to screening and disclosure featured in two of the consumer interviews. Here, both Geraldine and Daisy spoke about the male gender of their workers as inhibiting them from disclosing their experiences of sexual abuse. Geraldine spoke about how her experiences of abuse at the hands of male perpetrators made her feel uncomfortable with men in general and therefore was reluctant to disclose her experiences of abuse to male professionals:

Kath: What would have made you feel comfortable telling him?
Geraldine: Ahh, look, probably with these guys, I wouldn't talk to them about it (laughs). A woman I might consider opening up more but because they were men I possibly wouldn't have. Because I used to be afraid, really afraid of men for a long time. I've had to deal with that, and I've sort of overcome it. I used to be quite afraid.

Daisy spoke about having a solid relationship with an outreach worker that she had maintained for a number of years. Despite their close relationship, she said that she would not feel comfortable disclosing her experiences of sexual abuse to him based on his gender:

Daisy: John is a gentle giant, he is nice. But I don't talk about it because he is a male. . . . He is good on practical things, mental illness and that but I wouldn't talk to him about sexual assault.

Whilst Daisy and Geraldine specified gender as a factor inhibiting disclosure three other

interviewees spoke about openly discussing their experiences of abuse with opposite gendered workers.

It seems as if sensitivity to gender is important here as some consumers will feel uncomfortable discussing experience of sexual abuse with opposite gendered workers. Male professionals may be aware of this need for sensitivity and this could account for why male respondents reported screening less than female respondents.

BELIEFS ABOUT CAUSE OF VOICE HEARING

The majority of respondents believed that voice hearing was linked with environmental causes, with only 1.7% of 174 respondents agreeing or strongly agreeing with the statement "I do not ask consumers who hear voices about their experiences of sexual abuse as I believe that trauma is not related to voice hearing" and 2.9% of 174 respondents agreeing or strongly agreeing with the statement "I believe that voice hearing is related to biological causes and so do not feel the need to enquire about sexual abuse or assault". However, rates of screening did vary dependent on the strength to which a respondent rated this question. Due to the very small numbers of respondents who agreed or strongly agreed, these answers were excluded from cross tabulation.

Of the 24 respondents who answered *Neutral* to the statement "I do not ask consumers who hear voices about their experiences of sexual abuse as I believe that trauma is not related to voice hearing" 50% answered that they never or rarely screen voice hearers for sexual abuse. This was compared with 13% of the 92 respondents who stated that they strongly disagreed. A Chi-squared test for independence indicated that there was a strong association between the degree to which respondents believed that trauma and voice hearing were related and how often they screened for abuse, χ^2 (4, n= 174)= 34.41, p= 0.000, V= 0.314.

Rates of screening were also impacted by the extent to which respondents agreed with the statement "I believe that voice hearing is related to biological causes and so do not feel the need to enquire about sexual abuse or assault". Of the 21 who felt Neutral about the statement, 38.1% answered that they never or rarely screened voice hearers for experiences for abuse. This is compared with 15% of the 100 respondents who answered that they strongly disagreed with the statement. A Chi-squared test for independence indicated a small but statistically significant association between the degree to which respondents agreed with this statement and how frequently they screened, $\chi^2(4, n=174)= 12.66, p=0.013, V=191$.

In the open-ended answers to the screening questions a total of 23 respondents commented that a belief that trauma and mental illness influenced how they screened voice hearers for sexual abuse. Respondents associated this with either learning from experience working in the sector or from an understanding gained from current research. For example, one respondent stated:

> *The majority of people with mental health problems have experienced some form of trauma (sexual and non-sexual) in the past, and this may be contributing to their current mental health difficulties, or may be a perpetuating factor.*

This theme was the second most coded response amongst respondents who answered that they often or always screened voice hearers for sexual abuse.

Organisation and screening requirements

The survey results indicate that screening rates vary dependent on the type of organisation the respondent worked for. For the purposes of this analysis organisation types were compressed into three categories; public clinical mental health services, non-clinical mental health services, and other services. As indicated in Table 6.10 (overleaf), respondents who worked for public clinical services were more likely to screen than respondents from non-clinical and other services, with 50% of the respondents from public clinical services answering that they would often or always ask voice hearers about sexual abuse. This was compared with 36.4% of the respondents

from non-clinical mental health services and 38.5% of the respondents from other services. Respondents from non-clinical mental health services were more likely to report that they never or rarely screened as compared with clinical and other services.

Table 6.10 – Organisation type and screening rates

		How often do you ask voice hearers about past experiences of sexual abuse?		
		Never/Rarely	Sometimes	Often/Always
Organisation Type	Public clinical MH services (n=108)	13.9%	36.1%	50.0%
	Non clinical MH services (n=66)	21.2%	42.4%	36.4%
	Other services (n=26)	15.4%	46.2%	38.5%
	Total (n=200)	16.5%	39.5%	44.0%

One reason for screening rates varying between organisation types may be related to organisations requiring staff to screen for trauma and abuse. Out of 200 respondents, 44.5% worked for organisations that required them to screen for trauma. Of this group, 41.9 % said that there were trauma screening questions on assessment forms, 20.3% said that requirements for screening were embedded in organisational policy and procedure, 30.4% said that they were encouraged to screen by management, and 7.4% said that their organisation encouraged a broad approach to assessment which includes trauma screening.

The results from this survey indicate that organisational requirements for screening had an association with rates of screening. As seen in the Table 6.11 (overleaf), respondents whose organisation required them to screen for abuse or trauma were significantly more likely to ask voice hearers about sexual abuse than respondents whose

organisations did not require them to ask. A Chi-square test for independence indicated a medium association between organisational requirements for screening and rates of screening, $\chi^2(2, n= 180)= 24.4$, $p= 0.00$, $V= 0.368$. There was no association between type of organisational requirement and screening rates.

Table 6.11 – Organisational requirements and screening rates

		How often do you ask voice hearers about past experiences of sexual abuse?		
		Never/Rarely	Sometimes	Often/Always
Does your organisation require you to screen?	Yes (n=89)	3.4%	40.4%	56.2%
	No (n=91)	28.6%	40.7%	30.8%
	Total (n=180)	16.1%	40.6%	43.3%

Notably, different types of organisations varied as to their likelihood of requiring staff to screen for trauma and abuse. Clinical mental health programs were more likely to require staff to screen for trauma and abuse with 53.2% of the 109 respondents who worked for clinical services answering that their organisation required staff to screen for trauma and abuse. This is compared with 33.8% of the 65 respondents from non-clinical mental health services and 34.6 % of the 26 respondents from other services. Given the strong association between organisations requiring staff to screen for trauma and rates of screening, this may account for the differences in screening rates between public clinical mental health services and other services.

TRAINING

As indicated in Table 6.13 (overleaf), respondents who had received trauma-informed training screened more frequently than those who did not, with 48.3% of the respondents who had received training answering that they often or always screened voice hearers for sexual abuse. This is compared with 39.5% who had not received

training. A Chi-squared test for independence indicated that there is a small association but it is not statistically significant, χ^2 (2, n= 171)= 3.25, p= 0.197, V= 0.138.

Table 6.12 – Training and screening rates

		How often do you ask voice hearers about past experiences of sexual abuse?		
		Never/Rarely	Sometimes	Often/Always
I have received training around trauma-informed care	Yes (n=118)	13.6%	38.1%	48.3%
	No (n=53)	24.5%	35.8%	39.6%
	Total (n=171)	17.0%	37.4%	45.6%

Issues relating to training featured in the qualitative responses to the vignettes and screening question. Twenty of the respondents referred to training they had received and how this influenced their approach to screening. This was either training on a general level, trauma-informed care training, or training around voice hearing. For example, one respondent stated that his medical training informed his understanding of the prevalence of sexual abuse and subsequent approach to screening:

> *Taught in med school that previous sexual abuse is of very high prevalence in patient with mental health conditions.*

LENGTH OF TIME WORKING IN THE FIELD

The length of time working in the mental health field also appeared to influence how frequently respondents screened voice hearers for abuse or trauma. As detailed in Table 6.14 (overleaf), the longer respondents worked in the field, the more likely they were to screen voice hearers for abuse. Of the respondents who had worked for up to two years, 19.6% answered that they often or always screened for abuse, compared with 56.5% of the respondents who had worked in the sector for over six years. A Chi-square test for independence indicated that there was a medium and statistically

significant association between length of time working and rates of screening, χ^2 (4, n= 198)= 23.4, p= 0.000, V= 0.243.

Table 6.13 – Length of time in sector and screening rates

		How often do you ask voice hearers about past experiences of sexual abuse?		
		Never/Rarely	Sometimes	Often/Always
Length of time working in the sector	0-2 years (n=46)	32.6%	47.8%	19.6%
	3-5 years (n=44)	13.6%	50.0%	36.4%
	Over 6 years (n=108)	11.1%	32.4%	56.5%
	Total (n=198)	16.7%	39.9%	43.4%

Interestingly, the length of time working in the field was also associated with a number of other factors that impacted rates of screening. The longer a respondent worked in the field, the less likely they were to feel concerned about upsetting consumers by asking about sexual abuse. Of the 38 respondents who had worked up to two years, 50% answered that they agreed or strongly agreed with the statement "I am concerned about upsetting consumers by asking about their experiences of sexual abuse or assault". This is compared to 29.4% of the 102 respondents who had worked for over six years. Here, a Chi-squared test for independence indicated a small but statistically significant association between these two factors, χ^2 (4,n= 175)= 12.43, p= 0.014, V= 0.188. As noted above, the extent to which respondents were concerned about upsetting consumers by screening for abuse had an association with rates of screening.

In addition to this, the longer respondents worked in the sector, the less likely they were to believe that trauma was not related to voice hearing. Of the 38 respondents who worked for under two years, 26.3% answered that they felt neutral, agreed or

strongly agreed with the statement "I do not ask consumers who hear voices about their experiences of sexual abuse as I believe that trauma is not connected to voice hearing". This was compared with 9.8 % of the 102 respondents who had worked for over six years. Here, a Chi-squared test for independence indicated a small but statistically significant association between these two factors, χ^2 (4, n= 175) = 11.79, p= 0.019, V= 0.184. It may be that the longer a professional works in the field, the more first-hand experiences they have with voice hearers, which consequently changes their beliefs about the aetiology of voice hearing. As described above, the extent to which respondents believed in trauma being related to voice hearing also had a relationship with how often they screened.

Not surprisingly, the length of time respondents had worked in the field was associated with whether or not they had received trauma related training. Of the 38 respondents who had worked for under 2 years in the sector, 19.2% had received trauma related training as compared to 65.8% of the 100 respondents who had worked over six years. This may be another factor that contributes to why length of time working in the field is associated with higher levels of screening.

Practice wisdom

The results described above point to practice wisdom being an important factor that influences whether or not staff screen for abuse. The longer someone has worked in the field, the more practice wisdom they will accumulate; this may result in feeling less concerned with upsetting consumers. Their belief in the role of trauma in the experience of voice hearing also seems to increase. This role of practice wisdom is supported by the open-ended responses to the screening questions.

Content coded as practice wisdom was counted thirty times in the qualitative question relating to the vignettes. This is the second most coded theme for this question. Here, practice wisdom related to knowledge and understanding that was attributed to work experience rather than formal training. For example, one respondent stated:

> *Regardless of presentation most people I have worked with, with MH issues, have experienced some form of trauma regardless of whether they hear voices. This is also backed by research. My experience tells me that those who do hear voices are even more likely to have experienced trauma and that their voices often have a direct relationship to this trauma.*

Respondents commonly stated that they had worked over the years with a large number of voice hearers who had experienced abuse and this had consequently informed their knowledge and practice in relation to screening.

This theme was also evident in the open-ended answers to the general screening question. It was mentioned thirteen times and featured most prevalently amongst respondents who answered that they always or often screened voice hearers for sexual abuse.

6.4 Summary

This chapter has outlined the results from this study that indicate how mental health professionals surveyed screened voice hearers for sexual abuse. The results from the survey indicate that respondents intermittently screened voice hearers for sexual abuse. Several factors were evident that influenced screening rates including organisational policy, gender, content of consumer presentation, beliefs of staff, and practice wisdom. The results from the interviews illustrated the lived experience of not being asked about sexual abuse. Interviewees described consistently not being asked about trauma or abuse when using mental health services and detailed several barriers to voluntary disclosure. The interviewees reflected on the impacts of not being asked about abuse, namely that the lack of screening prevented them from receiving adequate support, which consequently delayed their recovery.

Chapter 7 – RESPONDING TO VOICE HEARERS WHO HAVE EXPERIENCED SEXUAL ABUSE

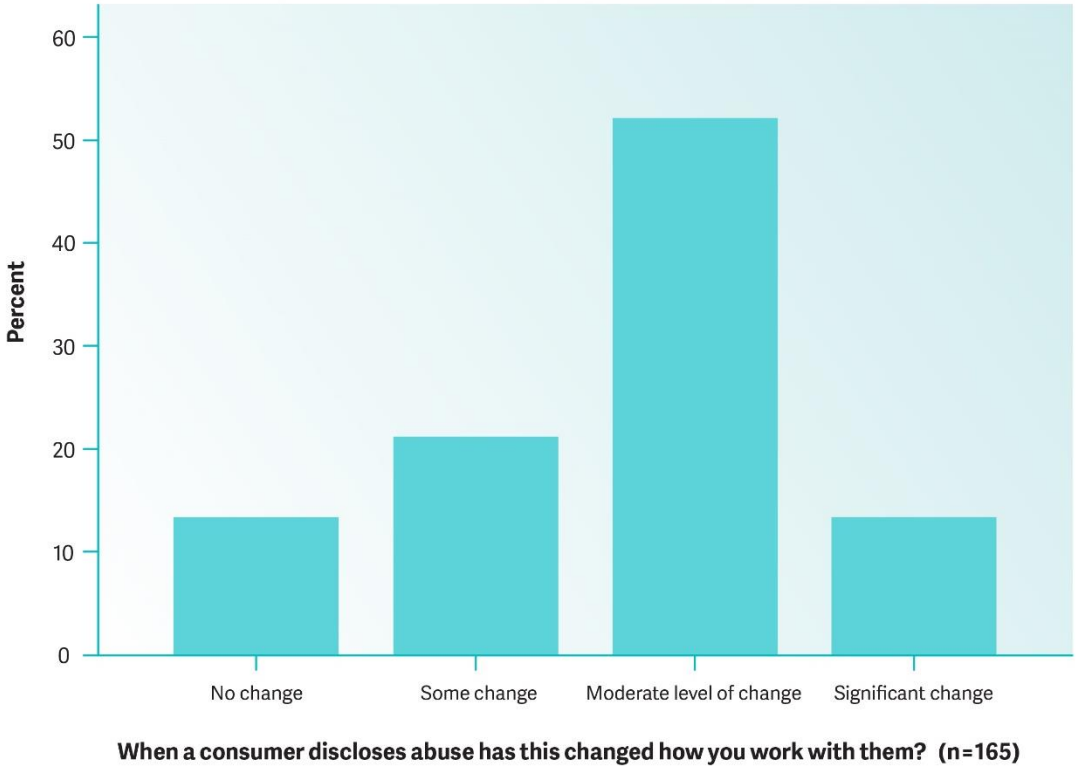
The previous chapter outlined the results of this project that capture how surveyed professionals screened voice hearers for sexual abuse, along with the lived experience perspective on screening and disclosure within mental health services. This chapter further outlines the findings of this project that relate to how surveyed professionals and their organisations responded to voice hearers who have survived sexual abuse. It details how respondents incorporated disclosures of abuse into their formulations and treatment plans, issues relating to referrals to trauma based services, and how professionals related to legal authorities. Themes relating to supportive practice are then outlined along with issues relating to liaising with families and carers. Finally, the role that training and support from management play is considered alongside systemic pressures that impact on service provider's ability to respond effectively to voice hearers who have experienced sexual abuse.

7.1 Responses to disclosure

The majority of respondents had worked with voice hearers who had experienced sexual abuse, with 89% of 200 respondents noting that a voice hearer had disclosed past experiences of sexual abuse to them.

As indicated in Figure 7.1, just over half (52.1%) of respondents said that they would instigate a moderate level of change in their work with voice hearers following a disclosure of past experiences of sexual abuse. A further 21.2% said disclosures would instigate some change in work practice, 13.3% said their practice would change significantly and 13.3% said that there would be no change to their practice.

Figure 7.1 – Change in work practice following disclosure



Several themes emerged in the open-ended responses to this question. Respondents indicated that the main way their work would change would be to consider referring to trauma counselling services. In general, respondents said that they would be careful not to refer unless the client is interested in accessing this support. For example:

> *This depends on the individual, current supports and if they wish to discuss their choices further. Some are satisfied to have told someone for the time, others welcome referrals to sexual trauma specific services. I am more aware of their vulnerabilities and sensitivities, therefore able to offer more informed support.*

Several respondents noted that they would change their work practice to be more sensitive to issues relating to abuse or assault. This included being conscious of how abuse related topics are discussed, and being sensitive to any work practices that may re-traumatise consumers. For example, one respondent pointed to the importance of being particularly sensitive to the needs of abuse survivors:

While you have to be sensitive in regards to everyone's life experience, when someone has been sexually abused you need to make sure that you do not re-traumatise them. You also have to check if the abuse is historic and/or current. If it is the latter, there is a whole different approach to take.

Sensitivity to issues of safety also featured in the comments, with respondents mentioning safety in general or practical terms. Here, there was a focus on ensuring a consumer's current personal safety.

The majority of respondents said that they would include details of abuse in professional formulations with 79.4% of 164 respondents stating that they would always include details of abuse history in a consumer's professional formulation. This was followed by 15.8% who responded that they sometimes included details in their professional formulations. The majority of responses in the open-ended component of this question related to the perceived importance of including these details in order to have a full understanding of a consumer's life. For example, one respondent stated:

This is vital information and will impact on the care plan significantly.

Some referred to the fact that the inclusion of experiences of abuse should be standard practice, while others made the point that including these details gave context to the presenting symptoms. For example, one respondent stated:

This forms part of the whole if the persons experience and needs to be part of the understanding of what has happened to them.

Respondents also reported frequently including trauma based responses in their treatment plans, with 62% of 166 respondents answering that would always include trauma based responses, 24.1% stating that they often included these responses and 8.4% stating that they sometimes included trauma based responses. Only 1.8% answered that they never or rarely included trauma based responses in treatment plans.

Respondents were asked to specify what kinds of trauma related responses they included in their treatment plans. The most common responses were to provide information about trauma related services (87.3%), to provide referrals to trauma counselling services (82.3%), provide psycho-education (78.7%), and provide trauma counselling directly (42.7%).

Referrals and a lack of appropriate services

Respondents frequently referred consumers to trauma counselling services when they disclosed past experiences of sexual abuse. While this is a sound response to a disclosure of sexual abuse, respondents raised concerns about the efficacy of these referrals and the availability of appropriate and accessible services. This lack of appropriate services is also reflected in the interviews with voice hearers. The majority of respondents referred voice hearers who had disclosed abuse to trauma counselling services, with 59.7% of 164 of respondents reporting that they often or always refer. A further 31.7% reported sometimes referring, and only 6.7% said that they never or rarely referred. As detailed in Table 7.1, most respondents said that they referred to specific sexual assault counselling services. A further 63.9% of respondents referred to private psychologists, 38.7% referred to external counsellors, and 30.3% referred to private psychiatrists.

Table 7.1 – Referrals to trauma based services

Service Type	**N**	**Percentage of cases (n=154)**
Sexual Assault Service	126	81.3%
Private psychologist	99	63.9%
Counsellor outside of service	60	38.7%
Private psychiatrist	47	30.3%
Private counsellor	37	23.9%
Counsellor in service	19	12.3%
Private social worker	18	11.6%

While most respondents were regularly referring consumers to trauma-based counselling, there appeared to be a level of ambivalence regarding the effectiveness of these referrals. Only a 27.7% of 159 respondents reported that they felt the referrals were effective or very effective and 43.3% of respondents reported that they found the referrals somewhat effective. A further 12% reported that they were either slightly effective or not effective. In addition to this, 17% answered this question with an open-ended response, with most of these respondents stating that they did not know how effective the referrals were.

This ambivalence around the effectiveness of referrals seemed to be related to a concern about a lack of appropriate services available for voice hearers who have survived sexual abuse. Almost of half (46.6%) of 174 respondents answered that they felt neutral, agreed, or strongly agreed with the statement "I don't feel that there are any appropriate services to support voice hearers who have experienced sexual abuse or assault".

The opened-ended questions regarding referrals reflected these concerns. A strong theme emerged in these questions relating to a lack of appropriate services available for voice hearers who had experienced sexual abuse. Respondents felt that services such as Centres Against Sexual Assault (CASA) were ill-equipped to work effectively with voice hearers. For example, one respondent was critical of a CASA worker whom they believed did not have the relevant knowledge to work with voice hearers:

> *CASA was terrible. Persuaded client to stop taking meds, which caused significant deterioration. Prefer to refer within mental health as clinicians tend to react better to hallucinations (ie: don't over react by denying services or recommending withdrawal of medications).*

In addition to this, respondents mentioned barriers to services relating to geography or cost. Respondents from rural or remote areas commented on the lack of services available. For example, one respondent commented on the lack of available services in

their area:

> *The biggest difficulty working in rural remote areas, is not being able to access trauma services directly for voice hearers.*

Respondents identified that cost was a significant barrier to accessing quality services. Respondents noted that often the only services available were delivered privately and the limited Medicare rebates resulted in these services being too costly for consumers. For example, one respondent stated that while there were good services available, the cost was prohibitive:

> *There are services, but these need to be more widely promoted. Particularly private practitioners with trauma knowledge/sensitive practice and of course finding affordable services for our client group can be challenging.*

The concern about the lack of appropriate, accessible services was the most commonly cited theme in the open-ended responses to questions regarding referrals.

Another theme present in the open-ended questions around referrals related to a concern that services existed in "silos" of specialisation. One respondent articulated these concerns succinctly:

> *Our systems are set up so that some services with expertise exclude other presentations. A trauma service will feel uncomfortable with a person diagnosed with schizophrenia, and an early psychosis service will argue that trauma work is not a service priority. This may be a consequence of specialisation and risk management that devalues good generalist skills and of the significant service pressures that public systems are under.*

Respondents were critical of both mental health services, and trauma counselling services regarding specialising their approach. One respondent criticised mental health services as focused solely on symptoms:

> *Public mental health need to understand CASA's role, rather than dismissing sexual assault and focusing entirely on hearing voices.*

Other respondents were critical of sexual assault counselling services as they found that they refused to work with clients with complex mental health issues. One respondent

raised concerns about a CASA service not taking referrals from consumers with active symptoms:

> *Many specialist trauma services (such as CASA) will not accept consumers from community mental health services when they have active symptoms and refer them back to community mental health services. The only problem is, some consumers always have active symptoms.*

Issues relating to concerns about a lack of appropriate services and the siloing of services are of particular concern given that referrals to other services make up the bulk of treatment responses by mental health professionals.

Consumer's experience of a lack of services

The interviews with voice hearers revealed a similar theme with regards to a lack of appropriate services. Interviewees experienced this in several ways; being denied services due to mental health issues, not feeling comfortable disclosing mental health issues to trauma counsellors, or barriers regarding cost.

Jess, Linda and Pat all reported being declined trauma counselling or having services ceased because of their mental health concerns. Linda detailed numerous experiences seeking help from professionals who either provided a diagnosis but no therapy or declined to offer a service due to her presenting mental health issues. She described accessing a psychologist at her university, who after their second session said that the complexity of the issues she presented with meant that he could not work with her, referring her instead to a psychiatrist. Linda reflected that she did need some specialist care:

> *Linda: For me it's the equivalent of – you've got a cut on your finger, or you've got a mangled arm. You either go to a GP or you go to a specialist. I felt instinctively that my mess was a bigger mess than most peoples. And it made sense to me that I needed specialist care, not generalist care.*

Linda pursued several psychiatrists, most of whom she found focused on medication rather than any therapy. She reflected on her current psychiatrist, who provides therapy, and her concerns that such psychiatrists are difficult to find:

> *Linda: And people like me who need therapy. Hell, no drug was going to make me better. We are severely limited in terms of who can provide that.*

Linda experienced being shifted towards psychiatric services due to her complex presentation, only to face a struggle finding a psychiatrist who could provide therapeutic support. This seems to reflect the concerns about the lack of specialist care raised by the survey respondents.

This lack of appropriate services is also notable in how interviewees refrained from speaking about their mental health experiences with trauma counsellors. Daisy, Louise and Pat talked about refraining from speaking about their voices with sexual assault counsellors. Louise spoke very positively about her experience with her sexual assault counsellor but reflected that she refrained from speaking in depth about her voice hearing as she sensed that her worker was not comfortable discussing her voices:

> *Louise: You know you talk about trauma here and not madness, and in the hospital you talk about madness but not trauma. That is what it felt like (laughs).*

Here, Louise reflected the specialisation or siloing of services that was raised as a concern amongst survey respondents.

Interviewees also spoke about their reluctance to disclose their voice hearing experiences to trauma counsellors due to concerns about the stigma attached to voice hearing. Pat talked about feeling conscious of the stigma attached to voice hearing and this contributing to his reluctance in discussing his mental health issues with his sexual assault counsellor. He feared that his counsellor would dismiss his experiences as delusional if he disclosed his voice hearing experience:

> *Pat: Basically because I felt like I was stigmatised because of my mental health. I think I did mention that I had a diagnosis. But I tend to be very selective about who I disclose to, especially about voice hearing because, you know, it's too easy*

for people to justify a dismissal of a person's experience due to that. It's too easy to say you know this person has not really experienced this because they hear voices.

Kath: So you were worried that you wouldn't be taken seriously?

Pat: Yeh, I wanted to deal with this shit and I didn't want to sort of be dismissed.

When Pat did become unwell, he found that his sexual assault counsellor was quick to cease counselling and send him to a psychiatrist:

Pat: When I did start to divulge that I was becoming unwell I was referred to a psychiatrist anyway so I don't know what it would have been like if I'd been more open with them about my mental health. I wouldn't have been able to access the service maybe? I don't know.

Kath: So when you were starting to struggle, it felt like they were quickly pushing you out the door to a psychiatrist?

Pat: Absolutely, and finished the counselling and referred me to a psychiatrist.

Again, this experience also reflects the concerns about siloing brought up by survey respondents.

Jess spoke about attempting to access sexual assault counselling services who told her they could not meet her needs due to the complexity of her presentation. She spoke about a lack of affordable counsellors that understood dissociative identity disorder and trauma:

Jess: And this person that I spoke to, she couldn't offer Medicare and she was quite expensive, she was $180. And said that she would get back to me with other people that I could see and didn't. And, so I didn't particularly feel like she really wanted to engage even. So I said I couldn't afford it.

Here, the cost of services further inhibits the accessibility of appropriate effective services. Again, this reflects concerns raised by survey respondents.

The lack of space in mental health services for voice hearers to speak about their experiences of abuse, combined with a lack of other appropriate services, culminates in

a notable gap in services that can adequately meet the needs of voice hearers who have experienced sexual abuse.

Trauma counselling

As described earlier, 42.8% of respondents reported providing trauma related counselling directly as part of their treatment responses. Respondents reported using a variety of therapeutic approaches when providing trauma counselling directly. As indicated in Table 7.2, the majority reported using a combination of approaches. Psycho-education, cognitive behavioural and narrative approaches also featured strongly in responses.

Table 7.2 – Approaches to trauma counselling

Therapeutic approaches	**N**	**Percentage of cases (n=131)**
Combination of approaches	101	77.1%
Psycho-education	76	58%
Cognitive Behavioural	60	45.8%
Narrative	55	42%
Behavioural	27	20.6%
Psychodynamic	21	16%
Feminist	18	13.7%

In the open-ended responses to this questions respondents commented that they used several other therapeutic approaches. These included specialised cognitive behavioural approaches such as Acceptance and Commitment Therapy and Trauma-Focused CBT. Respondents also commented that they used approaches based on lived experience/consumer perspectives such as intentional peer support and the Hearing Voices Approach.

PSYCHO-EDUCATION

As described earlier, providing psycho-education featured as key trauma based intervention in treatment plans. This is also an approach to counselling that is listed above. Respondents worked for organisations that had information about trauma or trauma-related services, with 44.3% of 201 respondents stating that their organisations had this information available for consumers. Psycho-education featured in the open-ended questions regarding responses to disclosure with respondents stating that they would provide psycho-education when voice hearers disclosed past experiences of sexual abuse. This also featured as a theme in the open-ended questions regarding practice wisdom. Here, psycho-education referred to either information about voice hearing, information about trauma, or information about links between the two. For example, one respondent said that providing information about trauma and voice hearing was most helpful when working with voice hearers who had survived sexual abuse:

> *Ability to provide clients with a different perspective or rationale for their symptoms that enable them to feel more empowered and informed.*

Referrals to legal authorities

Referrals to legal authorities are another possible response to consumers who have disclosed sexual abuse. Survey respondents were reluctant to pursue this path with voice hearers who disclosed experiences of sexual abuse with 49.1% of 165 respondents stating that they would never or rarely refer voice hearers who disclosed abuse to legal authorities. A further 21.2% said that they would sometimes refer, 15.2% would often refer, and 9.1% would always refer.

The open-ended responses to this question illuminated some of the reasons behind the relatively low interest in reporting to authorities. Out of the 129 open-ended responses, 52 said that the decision to report to legal authorities lay with the consumer. Within this group, 26 respondents referred to consumers actively declining offers to support them to report. For example:

Whether or not the consumer wants this to happen. Vast majority of consumers I have worked with personally have identified not wanting to report abuse/assaults for a number of reasons.

Twenty respondents stated that they always provided information about avenues for reporting and relevant support. However, this again was often met with consumers declining support. For example:

I offer clients the opportunity to report previous abuse or assault to legal authorities, however, I also acknowledge that many people do not feel comfortable doing this. In that case, I advise them that it is okay for them to change their mind at a later date and can seek supports such as CASA or other counselling or support services to assist them in making a report.

Another theme present in the responses was the acknowledgement of the lengthy, stressful nature of the legal process that respondents perceived as too difficult and potentially re-traumatising. For example, one respondent stated that this was the reason why consumers have declined referrals to legal authorities:

The person indicating that they didn't wish to report it (often they thought it would be too stressful to follow through with the process of reporting it, and that this would compound their trauma).

Respondents said that an awareness of legal requirements in their work place would be a reason to report disclosures of abuse to legal authorities. This was cited in 14 of the open-ended responses. Most of these related to working with minors and having to comply with mandated reporting requirements. For example:

I provide information about legal rights and options and consider mandatory reporting obligations if a young person is under 18 and continues to be at risk.

There was also an awareness of reporting when there are concerns for current safety. This featured in 11 responses. Here, if respondents believed that there was a present

risk, they would report to legal authorities. For example, one respondent specified that reporting to legal authorities would only occur to them if a consumer's current safety were at risk:

> *Truth be told, if the event was old and the person has moved on, it hasn't occurred to me to report it. When I say moved on, I mean they no longer have an active wish to focus on that period of their life. For a recent event, I have encouraged the person to follow up with police reports after the initial intervention.*

As seen in the above quote, the time since abuse is also a factor with seventeen respondents stating they would not report if the abuse happened in the distant past.

Consumer perspective on reporting to legal authorities

Only one consumer reported having a professional offer to support them to contact legal authorities. Louise spoke about her sexual assault counsellor asking if she wanted to report her abuse to the police and seek victims of crime compensation. Louise reflected on her conflicted feelings about reporting the abuse. She spoke of feeling guilty about not reporting but said that she was more concerned with the difficulty involved with the legal process:

> *Louise: Because I worry that, what if he is still out there and my actions, if I pursue some action then it would stop him from doing something bad. But I don't know, I worry that it is a cop out, but I also think that I have to put myself first at this point and I don't want to go through that legal process because I've seen too many people get, you know, raped all over again in the system. I do feel guilty about it though, it's a shit of a system, no matter which way you go, justice wise, either way you go you feel shit.*

Louise reflected the concerns raised by respondents in terms of the stressful nature of the legal process acting as a barrier to reporting abuse to legal authorities.

7.2 Supportive practice

Several themes were present in the open-ended questions regarding supportive practice when working with voice hearers who have experienced sexual abuse. They related to helping voice hearers better understand their experience of distress, being conscious of the pace and timing of work with voice hearers, quality therapeutic relationships, and the importance of believing and validating voice hearers who have disclosed abuse.

MAKING SENSE OF DISTRESS

Respondents consistently referred to helping voice hearers make sense of their experiences of distress and past abuse. A total of 68 out of 307 responses were coded for this theme and it was the second most coded theme around practice wisdom.

A key element of this theme related to respondents helping consumers make sense of their distress by connecting it with past experiences of abuse. For example, one respondent commented that helping consumers draw these connections was the most helpful part of their practice:

> *Helping the client make meaningful connections between their abuse experiences and their current distress, including the content/identity/emotional valence of their voices.*

Along similar lines, respondents also reflected on the value of understanding voice hearing within a consumer's context. For example:

> *In working with my clients who hear voices, I am always aware of context. Their voices do not occur in isolation and do not tell the whole story of who they are. I want to understand the voices in the context of the person's whole life.*

One element of connecting voice hearing with abuse is that it helped to normalise experiences of distress. Respondents commented that they would frame voices and other forms of distress as normal responses to experiences of trauma. For example, one respondent commented that "*normalising voices and talking about the protective role that they play"* was the most helpful practice they used when working with voice

hearers who had experienced sexual abuse.

Several respondents described processes where they would help consumers gain an understanding of their voices by developing voice profiles, talking directly with voices, or exploring the role of the voices in the consumer's life. For example, one respondent described their approach to working with voice hearers who had experienced abuse:

> *Normalise their individual impact acknowledge their response as their bodies way of managing. Allow the voices to be present and explore what they are saying and how they are informing the victim/survivor and their day to day world and begin to explore what they might know to be different, what is informing the voices*.

Another respondent commented on how they worked to develop an understanding of consumer's voices:

> *Depends on the client and the voice. I would try to find a safe voice or if a harmful voice was present, to see what its meaning was and if it can be talked to in a non-threatening way.*

Finally, respondents commented on the value of listening to consumers tell their story. Here, there was a reference to being open to listening to stories, the importance of being a witness to stories of abuse, and using narrative practices such as re-storying with consumers. For example, one respondent offered this advice to other professionals working with voice hearers who had experienced sexual abuse:

> *Don't under-estimate the healing power of being a good listener and witnessing the recovery story first hand.*

Timing and pace

Respondents frequently commented on the importance of being aware of the pace and timing of the work being done with voice hearers who had survived abuse. This theme was coded in 52 of the practice wisdom responses.

Respondents frequently spoke about the importance of going at the consumer's pace when engaging in therapeutic work. Going at the consumer's pace was often framed as enabling consumers to be in control of the therapeutic work:

> *Take it at a case by case situation. Not a one size fits all. Be led by the consumer. Keep checking if the conversation is going OK for them.*

This was often coupled with the importance of workers letting go of their own agendas when working with voice hearers who had experienced abuse. For example, one respondent stated:

> *Listen to their immediate concerns and don't rush into your own agenda for their treatment.*

Respondents also spoke about the nature of trauma work taking time and the need for staff to be patient with this. For example, one respondent offered this advice to others working with voice hearers who had experienced abuse: "*Be patient. Telling the whole story and events may take time"*. This involved being conscious of timing in order to manage the distress that may arise when discussing traumatic experiences. For example, one respondent advised: "*To ensure you leave adequate time to ground the client after they've been exploring their experience"*.

Respondents frequently commented on the importance of having enough time to work effectively with consumers. For example:

> *Having enough time to take things at the clients pace - I have had one client for 4 years and we still are continuing to explore her trauma as there have been 15 occurrences.*

Not surprisingly, not having enough time was listed as amongst the biggest challenges faced by respondents. This referred to not having sufficient time in the context of their program and having to negotiate competing work demands. For example, one respondent stated their biggest challenge was:

> *Having enough time, space and knowledge to deal with disclosure of sexual abuse in the context of my program.*

AVOIDING RE-TRAUMATISATION

Re-traumatisation featured as one of the biggest challenges respondents faced when working with voice hearers who had experienced sexual abuse. Respondents commented that this is especially difficult with consumers who presented with voice hearing and other complex symptoms. For example, one respondent commented that their biggest challenge was: "*Holding the space to keep it safe and grounded when the client is becoming more chaotic and fractured"*. Others commented on the difficulty they found in assessing whether or not consumers were emotionally ready to talk about abuse. For example, one respondent commented that their biggest challenge was "*Assessing the consumer's capacity to manage the thoughts, feelings and impulses that may arise from a direct conversation about sexual abuse or assault"*. While concerns with re-traumatisation amongst survey respondents tended to focus largely on emotional safety, a few respondents reflected on the use of force by mental health professionals when confronted with strong emotions in consumers. For example, one respondent commented that the biggest challenge working with this group was: "*Dealing with distress, anger, strong emotions in an inpatient setting- risk of colleagues wanting emotions shut down, use of restraint".*

Respondents also commented on a lack of appropriate services in the community to support consumers who are in crisis. Respondents noted that this was of particular concern when consumers were engaging in trauma work. For example, one respondent commented that the biggest challenge involved with supporting voice hearers who had survived abuse involved not having adequate resources to prevent a consumer relapsing due to discussing trauma:

> *Stopping the situation escalating, for example consumers who hear negative voices after hours who cannot access their support network which can result in police intervention or emergency department presentations.*

Respondents described several strategies to prevent re-traumatisation. Similar to the issues regarding pace described above, respondents commented on the importance of going slowly when discussing experiences of abuse to ensure that consumers were emotionally safe. For example, one respondent commented on the dangers of going too quickly when discussing traumatic experiences:

> *Tread carefully, be aware of what you are doing, and if you don't know, get help. I have seen well meaning clinicians engage clients in long discussions about their abuse when the consumer was unable to tolerate this, the consumer was very destabilised (and I think retraumatized).*

Respondents commented on the importance of continuously assessing a consumer's distress levels and helping consumers develop emotional regulation skills before talking in depth with consumers. For example, one respondent commented:

> *Respect verbal and nonverbal cues about discomfort with discussing particular aspects of the trauma and give the consumer time to become more comfortable. Thoroughly assess the consumers emotion regulation skills before commencing trauma work and always help with skills building if necessary before commencing.*

Other respondents commented on the value of using specific strategies to help manage presenting distress. For example, one respondent commented on the importance of "*Assisting with de-escalation and grounding techniques- making sure they can remain safe after discussions"*.

Quality relationships

Issues relating to the nature of the therapeutic relationship feature throughout the open-ended questions in the survey. Content relating to relationship was coded 151 times throughout the survey.

Respondents frequently cited engagement and rapport as being components of quality relationships. In the open-ended questions around screening, respondents often emphasised the importance of good engagement and rapport before asking consumers

about experiences of abuse. For example, in response to the vignettes, one respondent stated:

> *In my experience, a good degree of rapport is required to be established before embarking on that line of questioning. A certain degree of trust (on the client's behalf) is required.*

Respondents also stressed the value of rapport and engagement in the open-ended questions relating to practice wisdom. Respondents noted that establishing rapport was the most helpful skill when working with voice hearers who have experienced sexual abuse. For example, one respondent commented:

> *Engagement and forming a relationship with the consumer is the first priority.*

Respondents frequently mentioned engagement and rapport alongside building trust as an important aspect of quality relationships. Trust was seen as an important factor in building therapeutic relationships that can best support voice hearers who have survived abuse. For example:

> *Building relationships, trust with people; creating sense of safety with someone for disclosure of experiences, and ensuring privacy, follow up, etc is maintained.*

Respondents also highlighted the importance of good communication processes as crucial elements in building rapport. The value of listening featured heavily in the open-ended from service providers around practice wisdom. Listening was coded 39 times in the open-ended responses around practice wisdom. Various qualities of good listening were described such as a "*supportive listening",* "*strong listener*", "*deeply listening*", "*non-judgemental listening*" and "*listening carefully*".

Throughout the survey, respondents noted that quality relationships were marked by respect. For example, one respondent offered this advice for working with voice hearers who have survived abuse:

> *To use a gentle, calm and respectful approach and be clear you are not judging them in any way.*

Discussion around respect was commonly linked with phrases such as "*providing a non-*

judgemental space", "*being non-judgemental*" and "*taking a non-judgemental stance*". One respondent stressed the importance of being non-judgemental when working with survivors of abuse:

> *listen, support , NEVER judge (note they probably already are way too harshly and are experiencing high level of shame).*

Here a respectful, non-judgmental stance can be seen as valuable in building quality relationships with voice hearers.

Respondents also frequently commented on being present with voice hearers who had experienced sexual abuse. Phrases such as "*being with them*", "*remaining present*", "*present in the moment*" and "*being there*" were frequently used when describing what service providers found helpful when working with voice hearers who had experienced sexual abuse. Respondents also spoke about the importance of *"being human"*. For example, one respondent stated in their advice for other workers:

> *Leave all preconceptions/judgements behind and stop thinking about what you can do, listen with your heart, be human in the moment, not a 'worker'.*

Along similar lines, respondents commonly used phrases such as "*be open and warm*", "*be real*" and "*be honest and open*" as helpful approaches.

Interestingly, issues relating to relationships were the most coded theme in the open-ended question about the challenges of working with voice hearers who had experienced sexual abuse. Respondents commonly cited the complexity of presenting symptoms as a barrier to building rapport and trust. For example, one respondent commented that the paranoia that can often accompany voice hearing often prevented effective relationships:

> *Voice hearers sometimes display paranoid symptoms, therefore securing trust and rapport can be difficult when you are asking them about personal details such as sexual abuse or assault.*

Respondents identified counter-transference as another challenge when working with voice hearers who had experienced sexual abuse. Here, respondents reflected on the difficult nature of abuse stories and struggling to manage self when hearing these

stories. For example, one respondent stated:

> *Dealing with my assumptions, and ensuring I understand their own story, rather than one I've loaded with my bias or prior experiences.*

Believing and validating

Respondents frequently referred to the importance of believing and validating consumers' disclosures of abuse. This was coded in 43 of the open-ended responses regarding practice wisdom. There was an emphasis on believing consumers when they disclosed abuse and that disclosures not be discredited due a consumer's mental state. For example, one respondent advised:

> *Listen & believe. Be gentle and supportive. Don't disbelieve or discredit someone's disclosure of sexual assault because they are a voice hearer*.

Some respondents commented that it was important to express belief to consumers even if disclosure seemed improbable. For example:

> *I think this is especially true even if the story seems outlandish or unlikely - sometimes truth is harder to believe than fiction. It would be rare for me to be able to confirm the factuality of a consumer's story of abuse or assault and it's not my job to judge whether it's true or not. Irrespective of the facts from other peoples' perspectives, the experience of abuse or trauma is real to the consumer and it's important to accept that as valid.*

Respondents also spoke of validating experiences of distress. This involved acknowledging and affirming their experience distress, framing their experiences of distress as normal, and communicating an understanding of the consumer's experience and reality. For example, one respondent advised: "*Listening, compassion and acknowledgement of their experience"*. Another stated the importance of "*Validating the fear that they are experiencing"*.

Interestingly, concerns about believing disclosures from consumers who were delusional was one of the most commonly cited challenges respondents identified in

their work with voice hearers who have survived sexual abuse. Some respondents cited having direct experience with consumers who made claims about sexual abuse that were found later to be part of a delusion:

> *Occasionally I have had a client that the events reported have been delusional. I find this challenging and difficult to understand the nature.*

For a number of respondents, this seemed to inform a drive to find out the truth of disclosures of abuse. For example, one respondent stated that their biggest challenge was *"Remaining supportive and responsive whilst determining veracity of complaint*". Conversely, some respondents wrote about the importance of understanding the content of voices or delusions in a more metaphoric sense rather than focusing on what is real or not:

> *Managing psychotic/delusional expressions of sexual abuse aka abuse has occurred but individual expression of "fact" is altered.*

Respondents also made reference to their struggle working with other professionals who would dismiss disclosures of abuse as delusional. For example, one respondent said that their biggest challenge was *"getting consultant psychiatrists to not dismiss their thoughts as all delusional".*

7.3 Consent when working with families and carers

The results from the survey and interviews indicate that there are concerns regarding how professionals liaise with family members and carers when working with voice hearers who have survived abuse. A significant majority of respondents stated that they would ask for a consumer's consent before communicating with family or carers, with 74.6% of 181 respondents stating that they would always ask for consent and 17.1% answering that they would often ask for consent. Only 6.6% said that they would rarely or sometimes ask for consent. Interestingly, 51.7% of 180 respondents stated that there were times where they would not seek a consumer's consent when consulting with family members or carers. Respondents were asked to specify the reasons why they would not seek consent to consult with family members. The majority of responses related to concerns about the consumer's risk of harm, with 62.2% of 115 respondents stating that this would be the reason to consult with family without consent. A total of

37.8% of the respondents cited concerns around a consumer's lack of capacity due to poor mental state or being underage.

Public clinical mental health services were more likely bypass consent when consulting with family members, with 63.5% of the 96 respondents from public clinical services stating that there were times where they would not seek consent. This was compared to 39% of the 59 respondents from non-clinical mental health services and 36% of the 25 respondents from other services. A Chi-squared test for independence indicated a small but statistically significant relationship between the type of organisation and whether or not respondents would consult family members and carers without a consumer's consent, $\chi^2(2, n=180)= 11.68$, $p=0.003$, V 0.255. Interestingly, concerns about capacity were more likely to be cited by public clinical services, with 43.9 % of the 66 respondents from these organisations citing concerns about capacity, as compared with 27.3% of the 22 from non-clinical services and 20% of the 10 from other services. Breaking this down further, respondents working in public inpatient services were more likely to cite concerns about capacity than respondents from public outpatient services with 57.9% of the 29 inpatient respondents citing capacity as compared to 36.4% of 44 outpatient respondents. Given the acute nature of the consumer presentations in inpatient services, and the higher likelihood of consumers presenting with impaired capacity these figures are unsurprising. This does raise questions about how inpatient facilities maintain consumer confidentiality.

In the interviews, Pat described an incident that exemplifies the need for professionals to be careful when liaising with families and carers without consumer consent. While staying at an inpatient facility, he reported that a family member who was involved in his experience of abuse called the facility to enquire about him. Pat said that staff members informed the family member of his situation and allowed him to visit. Pat described this as a deeply upsetting experience:

> *Pat: That was really bad yeah. To know that I came back from leave and they said of this person was actually here and ah, I'd rather not specify the person.*

And you know, he was probably one of the triggers or the causative elements in the whole experience.

The role of family members or carers being involved in experiences of sexual abuse is, therefore, an important factor for professionals to consider when liaising with family members and carers.

7.4 Training

Most respondents had received training in trauma-informed care with 68.2% of 173 respondents stating that they had received some training. Respondents said that they received training from several different sources. Most respondents said that they had received training from a generalist training provider. Several respondents referred to learning about trauma as part of their university degree.

Respondents varied in how adequately trained they thought they were. Almost half of 174 respondents (46.6%) said that they agreed or strongly agreed with the statement "I feel that I am adequately trained to respond to voice hearers who have been sexually abused or assaulted". A further 26.4% responded that they felt neutral about the statement and 27% stated that they disagreed or strongly disagreed.

While most respondents said that they felt confident working with voice hearers who had experienced sexual abuse and assault, confidence levels varied significantly according to whether or not they had received training around trauma. Of the respondents who had received training, 22.8% said that they strongly agreed with the statement "I feel confident working with voice hearers who have experienced sexual abuse or assault" as compared with 7.3% of respondents who had not received training. A Chi-squared test for independence indicated a strong and statistically significant relationship between receiving training and feeling confident working with voice hearers who had experienced abuse, $\chi^2(2, n=173)=27.68$, $p= 0.00$, $V=0.4$.

7.5 Organisational management

Several issues relating to organisational management were evident in the survey. This included vicarious trauma and debriefing, time management, and workload.

Vicarious trauma and debriefing

Vicarious trauma was one of the most common challenges that respondents said that they faced when working with voice hearers who had experienced sexual abuse. For example, one respondent reflected on struggling with her negative emotions when hearing stories of abuse:

> *My own response i.e. the sadness I often feel for clients who not only have to deal with a serious illness but also manifestations of abuse.*

To support staff in handling potential vicarious trauma, it is valuable for organisations to provide supportive debriefing. Respondents varied when considering supportive debriefing from management. Here, 45.1% agreed or strongly agreed with the statement "I feel that my workplace provides adequate supportive debriefing after I discuss sexual abuse or assault with consumers". A further 26.9% said that they felt neutral about this statement and 28% said that they disagreed or strongly disagreed with the statement (n=171). This ambivalence around effective debriefing indicates that there may be a need for organisations to provide better support to staff to prevent vicarious trauma.

Time management and workload

A reasonable number of respondents felt that they did not have enough time to respond adequately to voice hearers who had experienced sexual abuse or assault. Out of 171 respondents, 33.9% agreed or strongly agreed with the statement "I feel like I don't have enough time to adequately support consumers who hear voices who have experienced sexual abuse or assault". A further 24.6% of respondents felt neutral about the statement, and 41.5% said that they disagreed or strongly disagreed. This seemed to vary dependent on the nature of the respondent's caseloads. As indicated in Table 7.3 (overleaf), the higher the respondent's caseload, the more likely they were to feel as

if they did not have enough time to effectively respond to voice hearers who had experienced abuse.

Table 7.3 – Average case load and time

		I don't feel that I have enough time to support voice hearers who have experienced sexual abuse		
		Disagree	Neutral	Agree
Average Caseload	0-10 (n=52)	53.8%	21.2%	25%
	11-20 (n=49)	38.8%	28.6%	32.7%
	Over 20 (n=27)	22.2%	22.2%	55.56%
	Total (n=128)	41.4%	24.2%	34.4%

A Chi-squared test for independence indicated a small but statistically significant relationship between case load and the degree to which respondents agreed with the above statement, $\chi^2(4,n= 128)= 9.95$, $p= 0.041$, $V= 0.197$. Respondents who worked in public mental health services were more likely to feel that they did not have enough time to adequately support voice hearers who have experienced sexual abuse. Here, 41.3% of the 92 respondents who worked in public clinical services agreed or strongly agreed with the above statement as compared with 25.5% of the 55 respondents working in non-clinical mental health settings and 25% of the 24 respondents from other services.

Along similar lines, a number of respondents also believed that the size of their workload prevented them from adequately responding to voice hearers who had experienced sexual abuse. Out of 169 respondents, 33.1% of respondents agreed or strongly agreed with the statement "The size of my workload prevents me from supporting consumers who hear voices who have experienced sexual abuse or assault". A further 23.7% felt neutral about the statement, and 43.2% disagreed or strongly

disagreed with the statement. Again, respondents from clinical public mental health services were more likely to agree with this statement, with 41.1% of the 90 respondents from public clinical services stating that they agreed or strongly agreed. This was compared with 23.6% of the 55 respondents from non-clinical mental health services and 25% of the 24 respondents from other services. Not surprisingly, respondents with high caseloads were more likely to feel that their caseloads prevented them from adequately responding to voice hearers who had experienced sexual abuse. A Chi-squared test for independence indicated that there was a medium and statistically significant relationship between caseloads and the degree to which respondents agreed with the above statement, $\chi^2(4,n= 127)= 11.65$, p= 0.20, V= 0.214.

Issues relating to time and workload also featured heavily amongst open-ended responses regarding the challenging aspects of working with voice hearers who have experienced sexual abuse. Respondents referred to short-term relationships, limited ability to provide long-term therapy and juggling competing demands as key issues in this area. One respondent commented on the competing nature of their different work tasks:

> *Increasing distress during psychotic episodes, having time to be supportive of clients narrative whilst also getting other clinically imperative work done like MSE, medication management etc.*

Systemic issues that affected time and workload seemed to have an impact on how adequately respondents felt they could respond to voice hearers who had experienced abuse. This issue appears to be of particular concern for respondents who worked in public clinical mental health services.

7.6 Summary

The results in this chapter capture an understanding of how surveyed mental health professionals respond to voice hearers who have experienced sexual abuse. Most respondents reported endeavouring to include details about disclosed abuse in treatment plans and formulations. The complexity of accessing legal support and negotiating with family and carers was also apparent in the results of the survey and the

lived experiences described in the interviews. Several themes around supportive practice were evident in the survey with respondents noting the value of helping voice hearers understand their experiences of distress, the importance of being conscious of pace and timing when discussing trauma, the need to avoid re-traumatisation, and the value of quality therapeutic relationships.

Systemic issues were highlighted with a focus on the lack of available and appropriate services for voice hearers who have experienced sexual abuse. The survey results highlighted service provider concerns about available services, while interviews reflected the struggle voice hearers experienced trying to find helpful responses in a divided service system. Workload and time pressures were additional systemic issues present in survey results, pointing to structural constraints on the provision of effective services for voice hearers who have experienced sexual abuse.

Chapter 8 – CONSUMER PERSPECTIVE ON SERVICE PROVISION

The previous two chapters have outlined how surveyed mental health professionals responded to voice hearers who have survived sexual abuse and revealed key areas for potential service improvement. This chapter further explores service provision from the consumer perspective and addresses the third research question:

> What do voice hearers who have survived sexual abuse identify as helpful or unhelpful when using mental health services?

Three themes that relate to what interviewees found helpful or unhelpful when using mental health services will be outlined. The first relates to the value of consumers understanding their experiences of mental distress. The second relates to the way in which service providers negotiate power in their work with consumers. The final theme considers the importance of effective therapeutic relationships based on a sense of shared humanity.

8.1 Understanding experience

> *Jess: I think the main thing would be to have had the understanding. For someone to explain to me what was happening to me.*

Throughout the interviews, participants spoke about the importance of developing an understanding of their experiences of voice hearing and mental distress. There seemed to be a need to make sense of experiences of distress, and interviewees described a variety ways of understanding these experiences. In addition to this, some factors were found to support, or inhibit, the process of understanding experiences of distress.

UNDERSTANDING THE MEANING BEHIND DISTRESS

Interviewees frequently spoke about the value in the search for the meaning behind their distress. Interviewees spoke about making sense of their distress by trying to

understand the meaning of their voices. Louise spoke of her experience listening to her voices and trying to understand what they represented. She said that she could see themes present in her voices that were representative of the internal conflicts she was grappling with in relation to her experience of sexual abuse:

> *Louise: In really listening to what the voice was saying that helped me to understand why I was going mad. That is wasn't so much the trauma, it was the way I had made sense of the trauma, it was twisted, it was about shame.*

In Louise's case, she came to a metaphoric understanding of her voices. Through learning what her voices represented she was better able identify and process damaging beliefs that were causing her distress.

Other voice hearers understood their voices in a more literal sense. Daisy spoke of understanding her voices and hallucinations more upon disclosing her experiences of sexual abuse, as she was able to draw links between her voices and the abuse that she experienced:

> *Daisy: My first voice was about 13 and I was assaulted between 8 and 12. So that makes sense, doesn't it?*
>
> *Kath: So, you feel the timing seems to be related. Is there anything else that you think may be related?*
>
> *Daisy: Well it's a male voice, it was Frank first, it was aggressive and that. And then there were two male voices come when I was 14 and then 21.*

Daisy reflected that these connections led her to believe that her early experiences of sexual abuse may have contributed to the distress she experienced in adulthood.

This linking between trauma and distress was another theme present when interviewees spoke about making sense of their experiences. By understanding these links, interviewees often found that they could better comprehend the environmental context of their distress. For example, Louise spoke about seeing a sexual assault counsellor who helped her locate her negative self-beliefs as linked to her experiences of being abducted and abused as a teenager:

> *Louise: Um, but that was part of the whole head fuck around it, what is wrong with me? How twisted am I that I could think that I could love someone who did that to me? And she told me all about Stockholm syndrome and gave me some material to read and it was like – Oh my God! It made something that I thought was absolutely deeply disturbed about me, in one session and one handout completely changed how I made sense of something that for twenty years had been driving me nuts. And it wasn't hard for her to do that.*

Frequently respondents found that establishing these links was helpful in their recovery. Jess spoke about drawing the links between her experiences of trauma and her experiences of voice hearing, and concluding that her voice hearing was a normal experience in the light of the trauma that she had experienced: *"And it's a normal human experience basically."* Throughout the interviews, there was a repeated emphasis on the value of normalising experiences of distress, especially by relating it to events in one's biography.

Interviewees spoke about how detrimental it was to not understand the context of their distress. Linda's experience of being diagnosed with borderline personality disorder exemplifies this theme. Linda's psychiatrist gave her a diagnosis of a personality disorder but did not provide any information about how her experiences of abuse and neglect may have played a role in her distress. She described how her psychiatrist individualised her distress and did not discuss the broader issues she had experienced in her life:

> *Linda: He said your problem is your personality, tell your mother she's just going to have to get used to it. . . . He had no hope to offer, so he couldn't engage in therapy so there was no engagement in any of the full on issues that were underlying.*

Linda described feeling increasingly suicidal and highly distressed after this meeting, due to feeling that her distress was completely internalised and had nothing to do with her difficult childhood. This compounded her very low feelings of self-worth:

Linda: And not being given a context for that. . . . Because clearly if you get told it is you, we're all told that we are in charge of ourselves and I am a self-determining individual, therefore it was me. I am the creator of my own problem. I am my own fault. All the pain, this pain I put myself through, all this pain I have put my family through is me. My god, my mother was right, and that is why she wouldn't bond with me, because I wasn't worth it, from birth.

Later in her life, Linda had a more positive experience when receiving another diagnosis of borderline personality disorder. An art therapist she worked with explained that this diagnosis was very common amongst people with traumatic backgrounds:

Linda: Anyway, she said – "the other word or name for it amongst us therapists is survivor of fucked up parenting" (laughs) I was like- "What, hey what?!" And she said, "It's not possible to have borderline and have good parenting, it doesn't happen". "What? You mean I didn't make myself borderline?" And she said "Of course not!" "Ok, hold on, tell me more". And she told me her perspective on borderline. Which was very different to the way I had come at it.

Upon learning of the role of trauma and neglect in her experiences of mental distress, Linda was better able to make sense of her experience and find the right help.

Signposts to recovery

The process of understanding experience can be seen to provide signposts that directed participants in their recovery journey. Participants used their understanding to investigate the issues revealed through the process of making sense of their experiences of distress. For example, Geraldine spoke of how learning about the impacts of early trauma on adult emotion prompted her to investigate her emotional life with more depth:

Geraldine: I sort of felt that maybe I am well enough now and got enough mental understanding and ability to investigate some of these things, particularly the emotions because I am interested in the emotions.

Louise was prompted to further investigate her feelings of shame after she located her

distress as a common response of sexual abuse survivors. She described spending time reviewing her beliefs about who was to blame for the abduction and rape that she experienced:

> *Louise: I would look at does that shame belong to me or does it belong to the guy who raped me? Or does it belong somewhere else? And I was able to start reassigning it which was really freeing. It was like innocent, tick, cool. It's not my shame so I'm going to stop carrying it. That's his, why I am carrying it? He put that onto me as part of that grooming, mindfuck process that they do. So that was good.*

Louise also spoke about how she learnt to be patient with the process of understanding her experiences and integrating these understandings into her life. She spoke of learning from Ron Coleman, a significant leader in the Hearing Voices movement, about the idea of intellectual versus emotional innocence. Louise found this immensely helpful, as she was intellectually understanding the sources of her distress but finding that she was still having emotional responses tied up with guilt and shame:

> *Louise: So even though I got it intellectually, I didn't feel it for a lot longer. But him telling me about that helped me not freak out about it. I don't think there was any quick fix for me to feel it, it was time and repetition of those learnings and going over them and not giving up that, it sort of settled into feeling right.*

Other interviewees spoke about how developing an understanding of their experiences prompted them to learn different ways to respond to their voices or symptoms of distress. After learning about the environmental causes of borderline personality disorder, Linda set about developing a range of different strategies to deal with her experiences of distress. One strategy that she developed involved externalising one of her negative voices that she named "Cockhead" and naming all the times that "Cockhead" was influencing her perceptions of herself and the world. She also shared what "Cockhead" would say with her family and colleagues. She described this process:

> *Linda: Like I said, it is still there but it is externalising it, opening it up, taking it out of the shadows in my brain, making other people look at it, um, making*

myself responsible for it, other than being its little victim. That really helped.

Linda found that this process not only resulted in developing skills to cope with this difficult voice but she also found that she heard the voice much less frequently.

Pat described a similar process that he went through when he engaged in theophostic prayer counselling during which he developed an understanding of how different parts of his personality had developed in response to his experiences of trauma. He spoke of going through a process of relating to the different parts of his personality with compassion:

> *Pat: And I think that this model isn't necessarily something that just has to be dealt with through prayer but identifying the different parts of the personality and addressing them. And thanking them actually for being such good assistants in survival.*

The signposts that emerged from developing an understanding of experience enabled participants to have more control over their recovery. Jess reflected on how being introduced to the concepts in the Hearing Voices Approach enabled her to feel in control of her recovery:

> *Jess: The fact that, I don't know, it normalised everything for me and there was psycho-education and there was a way to collaborate with the voices and have an understanding. . . . and that was the first time that I took on the concept of, that I could make it OK for me. . . . so, introducing those new concepts of you know, no, and that I could take control of my recovery.*

Lessons in the madness

Through developing an understanding of experiences of distress, interviewees identified that there were lessons in their experiences of madness whereby they developed a greater understanding of themselves and the world. Louise spoke in depth about becoming unwell after being stable for several years. She spoke of believing that this period of being unwell was necessary for her to learn some important lessons about

herself:

> *Louise: Because that stuff can, it can all come back up and what I often say is what I learnt to do is cope in socially acceptable ways. That really, what it was, was loads of layers and layers of bandages around my emotions and my mind to hold it together but all that shit was still there because I had never let it out, I had never dealt with it. But, having said that, I wouldn't change it, I wouldn't not go through that madness because it got me through to recovery as well. And there were lessons in the pain. There were lessons in the madness.*

During this time, Louise accessed support from peers and workers who helped her gain a deeper understanding of her experiences of distress and of herself. She reflected that the pain and distress she experienced was an essential part of gaining this understanding:

> *Louise: But I don't think it could have been done in a way that didn't involve any pain or any madness.*

Pauline reflected a similar theme when she discussed the growth that she experienced as a result of her distress and interaction with mental health services:

> *Pauline: Even though Professor Brown was scary, I'm glad of the situation. I am glad I was in Parkville twice, I am glad of all of the psychiatrists that I've seen, I'm glad of everything that has happened because it has made me who I am now.*

Pauline described her mental illness as a gift that taught her about herself and the world. She described how making sense of her experiences of distress was a key part of the value she held in her experience of illness;

> *Pauline: Mental health issues are a terrific thing to have if you know what you're doing with them.*

Jess also spoke of her voice hearing experience as a gift that helped her learn about herself and the world. She reflected on the value of listening to her voices and the messages they were giving her:

> *Jess: And how complex it can be, but there is always meaning. I love Rufus May*

when he talks about how they're messengers. And they are. And we need to stop and listen. That was the best advice that someone gave to me. Stop and listen. Don't keep running.

Despite years of grappling with voices that were often quite negative, Jess described feeling that she would not have survived without them: "*Yes. I do know that I wouldn't be here without them. So I do know that.*"

Here, the very experience of mental distress can be seen to push individuals to address underlying issues in their lives and to develop self-awareness in a way that may not have been possible without experiencing distress. In the process making a sense of these experiences a greater understanding of self and the world may also be an outcome.

Processes that support understanding

Interviewees described several processes that helped them better understand their experiences of distress. This included access to information and psycho-education, hearing peer stories of recovery, and utilising effective therapy.

Access to information and psycho-education can be seen as an important process that can support voice hearers in understanding their experiences. Interviewees spoke of learning about models of trauma and this being helpful in understanding their own experience. As discussed above, Linda gained a richer understanding of her experience of distress when she learnt about the environmental causes of borderline personality disorder. She spoke further about learning of a large American study that investigated the correlations between childhood adversity and a range of health and psychosocial issues in adulthood. The study used a scale to measure how many different types of childhood adversity individuals had experienced and investigated the correlations with this adversity and health and psychosocial outcomes (Felitti et al., 1998). She described how learning about this study helped her conceptualise the impacts of her childhood experiences:

Linda: Have a look at it and see what they say about people who score one out of ten, let alone what happens if you score two. And they stop counting at four. At four everything that is going to go wrong, goes wrong at four. Four or above, four or above, four or above, you are more likely to get raped as an adult if you're four or above, you're 100% chance of having a mental illness if you're four and above. Some huge percentage of chemical addiction if you're four and above. Try nine. (Laughs)

Through learning about this model of trauma, Linda was better able to contextualise her distress and shift blame away from herself.

Louise's sexual assault counsellor provided her with psycho-education around Stockholm syndrome and grooming, and this helped her better understand the context of her distress:

Lousie: She taught me about grooming, so I'd heard about grooming in other sessions but hadn't fully got it, or hadn't applied it to my own situation and that was really helpful as well. So there is a lot of stuff, there was a lot that she taught me, there was a lot of learning.

Accessing this information helped both Louise and Linda further understand the context of their experience of distress.

Hearing peer stories is another process that voice hearers named as helpful when trying to make sense of their experiences of distress. Interviewees spoke about the value of hearing from others who had been through similar experiences. Jess spoke about the value of peer stories when she attended hearing voices groups:

Jess: So I think definitely the hearing voices group was incredible. The fact that, I don't know, it normalised everything for me and there was psycho-education and there was a way to collaborate with the voices and have an understanding and you know there were people at different stages with their voice hearing experience and you know, there are obviously some really inspirational people as well.

Louise spoke about a significant turning point in her recovery journey where she attended workshops and training by some of the leaders in the Hearing Voices movement. She also spoke about how revolutionary it was to hear people speak openly about their experiences of trauma and abuse:

> *Louise: And suddenly all of these symptoms made sense and like of course, I didn't just randomly start hearing voices, listen to what the voices say, it makes absolute sense in the context of the trauma.*

Louise's experience of hearing peer stories was in stark contrast to the information she had previously received from mental health professionals, who led her to believe that her experiences of distress were biological and carried no meaning.

Interviewees also spoke about utilising effective therapy as another process that helped them make sense of their experience. One element of effective therapy involved providing information and psycho-education. In addition to this, effective therapists would create a space where distress could be unpacked, reframed, or reflected upon. Louise spoke of the therapeutic relationship with her sexual assault counsellor who helped her reframe how she understood her experiences of abuse:

> *Louise: But that was huge for me she listened and helped me unravel a lot stuff. . . . She worked creatively with me, she got me to do some drawings around how I felt.*

Linda spoke about her psychiatrist being an expert in borderline personality disorder and reflected that this helped her develop a better understanding of her distress:

> *Linda: That knowledge, that she was absolutely trained, she knew what she was dealing with. To the point where she could even make a joke about it and hit it.*

Linda reflected that her psychiatrist was able to use this expert knowledge in their therapeutic relationship to help her unpack and better cope with her distress.

What inhibits developing an understanding

The interviews revealed several factors that may inhibit the process of understanding distress. This included the lack of ability to discuss trauma with professionals, an emphasis on diagnosis, and a lack of appropriate services.

As discussed in Chapter 6, interviewees identified a significant level of silence in the mental health system with respect to sexual abuse. The lack of trauma screening by mental health professionals could be a barrier to voice hearers gaining an understanding of their experience. If a worker does not know about a consumer's history of abuse, it would be difficult to help them develop an understanding of their experiences of distress and abuse. Louise spoke about how due to her therapist not asking her about experiences of abuse, she was not able to explore it when working with her:

> *Louise: But it would have been great if she'd been able to have on that list, something that was like a huge number of people who come through services have experienced trauma, one of the things we could do is have a look at how it has impacted your life and look at recovery from that. But it was never on the list.*

Louise also reflected on this silence continuing even when she did disclose her experiences of abuse. When Louise eventually did start exploring her experiences of abuse with her therapist she became unwell and was hospitalised. When she disclosed how she was exploring her trauma, her psychiatrists advised her to discontinue this process:

> *Louise: So they said you've gotten back to work, you've done really well with your recovery, this is making you really sick again, you need to stop talking about it. This is in your past, forget about it, get back on medication, get back to work and don't go there.*

A focus on diagnosis without context can also be seen to inhibit interviewees in

developing an understanding of their experiences. As discussed earlier with Linda's experience of being diagnosed with borderline personality disorder, a focus on diagnosis without a context can have a detrimental impact on how distress is understood. Louise also reflected these sentiments when she described her early years of using psychiatric services. She said that she felt that there was an over emphasis on diagnosis without considering her life circumstances. Louise spoke at length about professionals not considering how or why she may be experiencing distress:

> *Louise: Yeh, and it had nothing to do with healing, it had everything to do with controlling what was seen to be dangerous or unreasonable behaviours and no attempt to understand but why, why is she saying and experiencing these things? What is going on behind it? No one ever wanted to know*

This led her to believe that there was no meaning in her experiences of distress:

> *Louise: And so I went down this path of this is a meaningless experience, take this pill, take that pill, take another pill, let's give you electric shock treatment and take some of your memories away which I will never get back*

Jess also spoke about her frustration with her experiences in an inpatient service where she felt that staff did not openly talk with her or listen to her story. When reflecting on what would have been a better approach she stated:

> *Jess: But also, ask me, what has happened to you? So why do you want to kill yourself?*

She also spoke of how frightening it was to be in an inpatient facility experiencing disturbing symptoms and not knowing what has happening to her:

> *Jess: It just astounds me that people don't take the time to say, to sit and try and explain to that person who is in that distress what is happening to them then and there and actually that they are safe and that what they experiencing is possibly due to x, y or z.*

The use of medication as the primary means of treating distress can also be seen to inhibit the process of making sense of experiences of distress. Pat spoke about spending

time in hospital and feeling that staff were more focused on medication than talking to him about the context of his distress:

> *Pat: And although at times I would, I was saying things that were not actually grounded in a common sense of reality but at the time, if you had of actually looked at what, if they had of actually listened to what I was saying, they would see some sense in it and be able to unpack it and talk about it, it would have been more beneficial than sort of dismissing and drugging me up.*

Pat reflected that while he was presenting with some confused ideas, there was meaning behind these experiences, however, he found that staff were not interested in helping him unpack these meanings.

Louise felt that medication itself inhibited her ability to make sense of her experiences of distress. She spoke about taking medication after she had begun working through her trauma and how she felt that while medication helped reduce some of her feelings of distress, it also blunted her emotions and impaired her ability to think, which consequently impaired her ability to process her experience:

> *Louise: But being medicated to the point where I can't even think, and particularly where I can't feel my emotions properly, I find that really unhelpful, because if I can't think clearly I feel really trapped. And if you can't think you can't get your way out of the problem, you can't deal with the issues and in terms of trauma you are just kind of stuck there again so you've got even less avenues to help yourself to heal.*

The lack of appropriate services described in Chapter 7 further served as a barrier to consumers understanding their experiences of distress. The interviewees frequently spoke about refraining from disclosing their voice hearing to trauma counsellors, which inhibited them from developing an understanding of how their voices could be related to their experiences of abuse. Linda described her struggle with finding specialist services and how this inhibited her ability to understand how her experiences of how childhood adversity impacted on her distress in adulthood:

Linda: And I'm not the first person to stand up and say they didn't understand me (laughs). Welcome to the world. The ball got dropped then. There was an opportunity there and it's just that they didn't know what they were dealing with. And they sure as hell didn't understand that it was a result of having a psychopathic father and an emotionally withdrawn mother

It was not until Linda was able to access a specialist psychiatrist that she was able to lay the groundwork to make sense of experiences of distress.

8.2 Power and control

Themes relating to power and control were present throughout the interviews with voice hearers. Interviewees described issues relating to coercive power, involuntary treatment, re-traumatisation, and disempowering practice as being amongst the negative aspects of service use. Conversely, interviewees described a range of empowering practices from service providers that were characterised by sharing control, going at the pace of the consumer, and believing in the capacity of the consumer.

INVOLUNTARY TREATMENT AND COERCIVE POWER

Interviewees spoke frequently about mental health professionals using coercive power. This is most evident when interviewees discussed experiences of involuntary treatment and how the threat of involuntary treatment was used as a method of control.

Pat, Louise, Jess, Daisy and Pauline all described instances where mental health services treated them involuntarily, either in an inpatient setting or on a community treatment order (CTO). In inpatient settings, interviewees described various instances of mental health professionals using direct physical force. Pauline described her memory of being forcibly restrained while in an inpatient facility:

Pauline: I do remember restriction, I know I was jumped on by four of them and

held. . . . And that's what they used to do when they'd throw you in. Three of them, four of them, one with each arm and virtually throw you in the room. I mean that was my memory of it.

Daisy spoke of mental health professionals restraining and injecting her with medication against her will during her stay in an inpatient service:

Kath: Ok. And when you were in high dependency were you ever restrained or anything like that?

Daisy: Yes, I've been held down and jabbed.

Kath: And how did you find those experiences?

Daisy: It was awful. I felt vulnerable, I felt like all my past had come back at me. And I'd been at Maroondah where there where cells that they would throw you in and take your clothes off and leave you there and lock you up.

Kath: And you mentioned that you felt that your past had come back up?

Daisy: Yeh it does. And then when you get out they say that if you play up again you'll go back in there. And you'd be thinking, I wasn't playing up before. I just didn't want to take medication or something.

Daisy reflected not only on how distressing she found the experience of being forcibly treated, but also on how this was used as a threat during her stay in hospital.

Interviewees also spoke about community treatment orders or the threat of treatment orders when using outpatient services. Pat described the stress he felt while being on a treatment order in the community:

Pat: And in terms of the CTO I was actually off it fairly quickly but you know it is a really difficult position to be in because it adds stress because you don't know if you have to, you're scared to breach it because then you'll be put back in a disempowering situation and there was no kind of ongoing counselling, there was no sort of access to group therapy or link in with consumer based groups. It was just you're on a CTO and this is what you have to do and that's it.

Interviewees consistently described an awareness of the power that professionals had

to involuntarily treat them. At times, mental health professionals explicitly named this power. Louise spoke about her time being treated by a community outpatient team and while she was never on a CTO, her case managers consistently told her that if she did not regularly attend her appointments she would be placed on one:

> *Louise: So years and years ago I was never put on a community treatment order but I was threatened with one. I was told that if you don't turn up to your GP every two weeks and get this injection of anti-psychotics, we'll put you on a treatment order and you'll have to do it. I'm not sure if that is even legal, I suspect it happens all the time and there is no way to measure it. What I didn't realise, was that in a way I'd actually done my way out of having rights, because if I'd been on a treatment order I would have rights to appeal and review but just doing it under threat I had none of those rights.*

Louise effectively had the experience of being involuntarily treated even without being under legal orders to do so as a result of the coercive power held by her treating team.

Daisy spoke of a similar dynamic that existed with her treating team. She talked about monitoring what she said to her psychiatrist, as she was aware of her capacity to certify her under the Mental Health Act:

> *Daisy: I'm just scared that they will certify me if I'm not careful.*
> *Kath: So what do you do to be careful with them?*
> *Daisy: Don't tell them everything.*
> *Kath: And how does that make you feel having to monitor yourself when you talk to your psychiatrist and GP?*
> *Daisy: It's hard. But I just want to come off a bit of clozapine and Belinda is saying, you'll be certified and you'll have to go back to the Alfred and then back to Albert Rd Clinic. It's just stupid.*

Again, Daisy's choices around her treatment were restricted by the power professionals had to involuntarily treat her.

The use of involuntary treatment and the associated coercive power can be seen to have several impacts. Interviewees described how the experience of being involuntarily

treated often mirrored their experiences of abuse. Louise spoke in depth about how practices such as restraint, forced medication and seclusion were similar to her experiences of abduction and rape:

> *Louise: So, as you already know, I was abducted when I was 13 and I was raped and I was held in this place for two weeks. And my experience going back to hospital, when it has been involuntary, is that strange men come to my house, they take me away by force, they take me to this really scary place, and I get forcibly given drugs that make me really sedated. All of those things are what happened to me during my trauma. So the place that is supposed to help me when I am most reliving that really awful stuff, kind of recreated it for me.*

Louise spoke about her most severe experiences of distress occurring when she was processing her trauma. At these times, she was only able to get intensive support in environments that were essentially re-traumatising. She acknowledged that her inpatient admissions kept her alive at a time when she was acutely suicidal, but pointed to the costs involved with the forceful nature of involuntary treatment:

> *Louise: I think, for some of those admissions I was really actively suicidal so in some ways, it's a very strong and violent and intrusive way to make you be safe from dying. And it has a cost because it made me unsafe in other ways. Honestly speaking, that would be a benefit as well, though there would be far better ways of making someone safe than doing it so violently and harshly. . . . I didn't need to be dragged off by the cops in the back of an ambulance and injected with drugs. But there was not another option, there are no alternatives.*

Pat also described how he felt re-traumatised when mental health services treated him involuntarily. Here, the focus was less on the physical interventions reminding him of his experiences of abuse, but rather on the impact of coercion and a lack of control over his treatment. He spoke specifically about how traumatic he found being threatened with ECT:

> *Kath: So is there anything else that you would like to say about your experiences in inpatient services at this point?*
>
> *Pat: Just that the threat of ECT was always there and I think that it is very wrong*

to impose ECT on a trauma survivor. More than anyone. So specifically that threat was something I found very present and very negative for my own recovery. . . . The threat of massive violation to someone who has already been massively violated. So it's very wrong.

Like Louise, Pat also reflected on the lack of services available when he was acutely unwell, resulting in him using inpatient services:

Pat: You know, what it is, is that there are two options at the time that I could have had, one was to continue down a path of psychosis and probably end up in a kind of conflictual situation with the wider community in some sense, or seen to be. Or bloody being locked up in this horrible place, you know. So it was detrimental to me in many ways but it was kind of the only option you know, and I hate to say it.

Interviewees also identified that the awareness of the capacity of mental health professionals to involuntarily treat them inhibited their ability to have open, honest therapeutic relationships. Pauline reflected on how she felt she needed to monitor what she revealed to her psychiatrist, due to their power to involuntarily treat her:

Pauline: And we were talking, those people, yes, I did open up but you know, but the psychiatrist was so called, he is a bit of an enemy. In a lot of ways he's your saviour but he's a bit of an enemy. Because if you, if I said you know I'm hearing this, I'm hearing that, Boom, well I think we should increase.

Jess also spoke about feeling inhibited in her openness with her case manager due to her awareness that she had the power to send her back to hospital:

Kath: Did you feel safe discussing your experiences of abuse with her?

Jess: I probably didn't disclose perhaps as much because I knew that she still had the influence to send me back in services. So yeah.

Kath: So in some ways you were just holding back? Because of that power?

Jess: Yes, very much so.

Interviewees frequently named the impact of the perceived power of mental health professionals as a key barrier to disclosing experiences of sexual abuse. Chapter 6 describes this in more detail.

Disempowering practices

Apart from using coercive power as described above, interviewees also named several other practices by service providers that they found disempowering. This included professionals assuming an expert role, professionals not consulting well with interviewees, being domineering, and dictating how sessions were run.

Interviewees spoke about their frustration with mental health professionals assuming an expert role in their interactions with consumers. Here, there was an undervaluing of consumers' wisdom and understanding of their own lives. Jess spoke in depth about her frustrations trying to find a therapist who would be flexible in their therapeutic approaches:

> *Jess: It's all about their therapeutic orientation and that this is the best way, you know, this is going to help you recover from your trauma.*

Jess had previously been seeing a counsellor who worked with her flexibly and together they built up a shared understanding of her experiences. Consequently, when she was looking for a new therapist she found that their fixed therapeutic approaches had the effect of devaluing her expertise in her own life.

Linda also spoke about her frustrations working with a psychiatrist who maintained the expert role in their relationship. She described how he determined the way their sessions would run:

> *Linda: No he didn't ask, he told. He told, because he knew what the problem was and he just told you what to do and there is this drug that you are supposed to take.*

Linda reflected that his lack of willingness to listen to her and share a degree of control around how they worked together resulted in her not receiving adequate support:

> *Linda: I have since come to the conclusion that he was probably a bit of a rort. Yeh. I don't know that I really got the kind of assistance I needed at that point.*

By assuming the role of expert, mental health professionals can devalue the knowledge base of consumers. This was evident in Pat's experience accessing a group program for gaining employment. He spoke of how he felt that staff devalued his knowledge and expertise:

> *Pat: I joined this really poxy, really crappy group because I was trying to integrate myself into the workforce which was really disempowering. . . . It was basically saying things like, don't stay up all night, don't do this, don't do that because these are the rules if you want to join the workforce again and you know, they were basically treating people with a hell of a lot more intelligence than the presenters of the course like imbeciles. And it was kind of like an imbecilic stamp that we get put on our heads at times because we've experienced some kind of trauma. So I don't know, that was one of the worse experiences I had, being preached at and talked down to by these people.*

Here, not only were professionals assuming the role of expert, they also did not consider what knowledge and skills consumers would be able to bring to this group.

This devaluing of consumer knowledge and wisdom was also evident in how interviewees described a lack of consultation about their treatment. Jess spoke about how staff working at an inpatient facility did not consult with her about her perceptions of her distress:

> *Jess: I suppose I was in the psych system from about 17 and I was hallucinating and it was, they just didn't listen. They will tell you what condition you've got, what diagnosis you have and it wasn't, nobody asked what was going on for me or what I had experienced previously or why I was so suicidal.*

Pat also had similar experiences regarding consultation. He reflected on mental health professionals ignoring his opinions about his medication regime while listening to his family instead:

> *Pat: They wouldn't actually listen to me, they actually listened to my relatives*

who were saying increase his medication which was really not a nice experience. So even though I was saying I'm on enough, I'm doing ok they were saying no, he needs more. So it was very disempowering.

Power imbalances were also evident in the way service providers controlled the nature of the professional relationship. Pauline described her psychiatrist restricting what they could talk about and limiting discussion to issues related to medication:

Pauline: When I was going to a private hospital up near the domain interchange, I went in to see the psychiatrist and I was talking. I have had family issues and I'm ready to talk to everyone about the family issues. And I'd been talking to him for ages about it and he just made a statement one day. He said you know I don't really want to hear all of this, I'm only here to tweak your medication, you can talk to your GP or other professionals about this. I'm only here to medicate you.

Pauline described her frustration at the control her psychiatrist exerted over their relationship, which resulted in her seeking out another psychiatrist.

Linda also spoke to a psychiatrist who did not respect her boundaries when she did not want to talk about certain issues. This dynamic reached a crisis point when he kept persisting with a line of discussion despite her asserting that she was not comfortable with this direction:

Linda: So we ended up having an argument in the session and I said "If you continue to push this line with me when I'm not ready. I will get up and leave" And he said "No no, we're doing it this way, this is what I expect of you and this is what you'll do". And I said "I am warning you again, this is my second warning. Find another way to deal with this issue, find another way to tell me. Give me something else to work on, but if you push this, I'm out of here. And this is the end". And he said "You don't get to determine what is being done in these sessions, I do". You know, he was very dominant. And I went "Ok, we're done, bye" and walked out.

Linda reflected that this dominant approach to the relationship was particularly triggering due to her experiences of growing up with an abusive father: "*A dominant male is not a safe environment by any stretch of the imagination for me".*

Daisy talked about her negative experience with a sexual assault counselling worker who controlled the nature of the therapeutic relationship in terms of pace. Daisy spoke about feeling rushed by her worker in terms of discussing her experiences of abuse. She describes the workers pace as manic and stressful:

> *Kath: And so can you tell me a bit about that experience, you mentioned before that the worker was manic?*
>
> *Daisy: She was full on. She was manic. I didn't connect with her. And she was kind of pushing me into areas I didn't want to go so quickly. It was too quick for me.*

While the power imbalance in this relationship is less explicit, the worker's lack of awareness of her client's needs could be seen as disempowering.

Empowering practices

In contrast with the disempowering practices described above, there were several helpful practices described by interviewees that were characterised by the sharing of power. This involved sharing control of how sessions were run, going at the interviewees' pace, valuing their capacity, valuing consumer wisdom, and having a sense of reciprocity in relationships.

Interviewees spoke favourably about therapeutic relationships where professionals worked with them flexibly and collaboratively. Jess spoke about a very positive relationship she had with a professional who was flexible in how she worked, shifting according to what Jess needed at the time:

> *Jess: So if I could not communicate we would, she would sometimes scribe for me or we would do some artwork, and at one stage we'd use some clay. Also, we didn't sit in the office all the time, I found it very useful to walk and talk, so we*

would walk and talk, or we'd go to the park and sit in the park. And if we were in the office there would be music sometimes that would be helpful for me, for us to play. Just, and things like, so Lucy always allowed me to lead the process.

Jess spoke about this ability to lead their work together as profoundly helpful in terms of feeling safe and in control.

Linda also spoke of how her psychiatrist would share control of their work together. She said that she would support Linda in the different directions she wanted to take in therapy such using creative tools and bringing in people to meet her. She described how important it was for her to have control over her self-exploration:

Linda: So, she had this acceptance of, or understanding that part of me and my therapy was I had to self-explore, obviously, borderline, you have to self-explore because there wasn't a self. And that meant some pretty silly stuff but that was OK. I felt safe.

Linda's experience of the power balance in this relationship was profoundly different from the domineering relationship described earlier in this chapter and resulted in Linda continuously working with this psychiatrist for over five years.

Along similar lines, interviewees spoke of the value of professionals going at their pace when working with them. Contrasted with her experience of workers pushing her too fast, Daisy spoke positively about workers going at her pace. She described this as one of the most helpful qualities she had experienced in her workers:

Daisy: Well the art of course. Just being listened to. Finding workers who I trusted that helped. Not being pressured, going at my own pace.

In contrast to the devaluing of consumer wisdom as described above, interviewees also spoke about the importance of having professionals who valued their knowledge and wisdom, particularly about themselves. Jess reflected on how her worker trusted that she knew what was best for herself. She found this particularly valuable when it came to her feeling suicidal. She described how her worker trusted her to keep herself safe

when she was expressing suicidal thoughts:

> *Jess: And the fact that I could talk about being exceptionally suicidal, I could talk about what my persecutory voices were saying and that there wasn't the "I'm going to call the CAT*[13] *team on you", you know she trusted me to keep me safe. And no one had ever done that before. Not ever.*

Jess spoke about how she found this trust fundamentally empowering; "*she honoured the fact that I was strong basically".*

Interviewees described the value of equal power relationships when working with peers or attending peer support groups. Jess spoke about the value of attending hearing voices groups:

> *Jess: And that was really, really powerful and again we were all equal and we all honoured each other's processes and where they were at with that process.*

This equality found in peer support groups was linked to the idea of reciprocity, where all parties were giving and receiving something from the interaction. Linda described how she valued the reciprocity she experienced when she attended peer support groups:

> *Linda: Contributing is obviously very important. So you feel that by just turning up you are contributing to someone else's improvement. Um. People need to be listened to. So whether I was doing the talking or I was doing the listening, either in talking I'm illustrating a common bond with someone who could hopefully make them feel better. Or, by listening they are being validated. So either role that you play there is positive.*

Interviewees consistently spoke favourably about these processes and often named them as an essential element in positive relationships with service providers. This is clearly highlighted by Jess when she said that the most helpful practice she experienced in her recovery journey was *"Me being in control of it".*

[13] Crisis and assessment team

8.3 Quality relationships – the importance of a shared humanity

> *What is helpful is trying to find what is actually inside a person and drawing it out you know, and strengthening that (Pat).*

The nature of the relationship between consumers and service providers featured consistently throughout the interviews. Positive relationships can be seen as the fundamental basis for the supportive practices described in this chapter, as well as in Chapter 6. Positive relationships can enable consumers to disclose experiences of abuse and can be a supportive factor in consumers developing an understanding of their distress. Issues around power and control can also be negotiated within the positive relationships through the sharing of power with consumers.

Interviewees consistently referred to a sense of a shared humanity as an important feature of these relationships. The emphasis interviewees placed on feeling viewed as human is in stark contrast to instances where interviewees felt their experiences and identities were reduced when engaging with services.

BEING TREATED AS HUMAN

When speaking favourably about relationships with service providers, interviewees consistently referred to being "*treated as human" (Pat)* or "*real peop*le"*(Jess)* or "*feeling human*"*(Louise).* The value of being treated as human is most clearly exemplified in Pat's descriptions of what he found helpful when using mental health services:

> *Pat: The only thing that ever assisted was the human, when people actually treated me myself as a human being and gave some hope and said you will get through this, you're a human being, they didn't say it like that but you know. It's just that human element is really crucial.*

This consistent emphasis on the importance and value of being treated as human suggests that interviewees had a sense of being viewed as less than human. This is apparent when interviewees described interacting with service providers whose approach had an emphasis on diagnosis. Jess spoke about her first experiences accessing a psychiatric inpatient facility and feeling as if their focus on diagnosis meant that they failed to take into consideration broader issues in her life:

> *Jess: They will tell you what condition you've got, what diagnosis you have and it wasn't, nobody asked what was going on for me or what I had experienced previously or why I was so suicidal.*

Louise also talked about how the focus on diagnosis limited how professionals could understand her whole experience. She described how her psychiatrist had a narrow scope for understanding her by being restricted to diagnostic categories:

> *Louise: And there was one point, which surprised me, it didn't feel that the psychiatrist was being un-compassionate, she said that I wish I could diagnose you with complex post-traumatic stress disorder and treat you accordingly but it's not a real diagnosis and so I can't. But that was just really frustrating, but why can't you if you think there is a better way to respond to me?*

Interviewees also described feeling as if their identities were reduced to the diagnosis they were given. Pat spoke frequently about feeling his identity was restricted by being given a diagnosis of schizophrenia:

> *Pat: Yeah, because how can you disempower someone who is already disempowered? And trying to find their power and their identity and you give them an identity of a schizophrenic.*

Linda reflected this sentiment when she talked about her initial diagnosis of borderline personality disorder. She described internalising the stigma attached to the diagnosis and feeling as if it defined her identity: *"Anything else in there that caused more distress? Well, being told your problem is you."*

Pauline spoke about her identity and her future being reduced when she was initially diagnosed with schizophrenia:

> *Pauline: And I sat across from him as a 21 year old not knowing anything, never heard about mental illness, not really, and he said to me that I would be on medication all of my life and don't have children.*

Pat described how the labelling involved with diagnosis made him feel like he was seen as less than a human:

> *Pat: If you know what I mean, there was, you must conform to what we perceive you to be and you must recover in the way that we tell you to. Which is really, really bad for people who experience it, it is very detrimental to our health. As human beings that are wider than, you know, that have more to us.*

Being treated as human on the other hand can be seen to have a focus on wholeness. When describing feeling treated as human, interviewees spoke about feeling as if workers saw all of them, not just a diagnosis. Louise spoke positively about a non-government program that she attended:

> *Louise: I felt like they saw me as a person, not at best a broken person needing to be fixed and at worse just an illness, just a diagnosis, not even quite a person. So I felt very human there, that I could be myself and I wouldn't be judged and nothing bad would happen and I also had a worker who absolutely believed in me, and I used to think she didn't have terribly good insight to believe in me (laughs).*

Jess also spoke of feeling seen as a whole person in her relationship with her support worker. She reflected that this enabled her to trust in the relationship enough to share her different selves:

> *Jess: But it was really profound. I think just being treated as a human being was really incredible.*

WORKERS BEING HUMAN

Interviewees frequently described the value in perceiving the humanness of their workers. They commented on service providers "*having a human element*"*(Pauline)* or "*being human*" *(Jess).* Here interviewees also spoke about valuing being able to see their worker as a whole person. Pauline describes the positive aspects of a relationship with her caseworker and points to a degree of reciprocity she experienced when he shared aspects of his own life:

> *Pauline: So, I found myself and he found himself so it was really, really, it was so equal. . . . There was no, we said we were able to open up, he opened up his life a lot. . . . But I'm assuming they say, keep your life private, but I believe that if you have a worker it has to be a relationship. It can't be – I'm helping you because honestly and truthfully it's a two way street. A relationship is to be helpful or, there is a circle, it goes around and around and around.*

Pauline valued the openness with which her worker shared his life experiences and spoke about feeling as if they were on a journey together. She named this openness and sense of reciprocity as a crucial element in her supportive relationship with this worker.

Along similar lines, Geraldine spoke about her positive relationship with her psychiatrist where she felt safe discussing her experiences of abuse. She spoke at length about how she could see that her psychiatrist was vulnerable and that this resembled her own experience of vulnerability:

> *Geraldine: So I know she's vulnerable and I had that experience but I mean, to me, I was going to see her last week or something and yeah, I used to smoke a lot and I've given up for 9 months I know she still smokes and she grabs her handbag and she's gone for five minutes so, she still has her vulnerabilities, her weak spots.*

This sharing of vulnerabilities and reciprocity seemed to increase a sense of semblance that serves to enhance the connection between consumers and workers.

In contrast to this, interviewees frequently spoke about professional distance inhibiting quality relationships. Linda spoke about working with a psychiatrist and struggling with his neutral affect:

> *Linda: Yep, he was very quietly spoken and unfortunately at the time, and even now to a certain extent, I am a very over the top person. So I don't understand shadow, I don't understand this need to be invisible, he uses his own invisibility cloak. And I just didn't get it, I don't understand why he isn't presenting. I just didn't get it, so I didn't trust it.*

This lack of openness inhibited a trusting, supportive relationship. Geraldine reflected this when she discussed working with a psychiatrist who seemed to not express emotion:

> *Geraldine: Morris, he didn't show emotion, how was I going to talk about emotion when he showed nothing.*

Jess also spoke about her struggle working with professionals who did not share themselves with her:

> *Jess: Honesty and integrity is really important as well. And that power imbalance that you get within a professional/client relationship makes it quite tricky. Or that they are so detached from them, it's all about this is the approach that we are working with, this is how it's going to work. And they don't bring any of themselves within that at all. And it's not therapeutic at all, well it wasn't therapeutic for me.*

Open communication skills – a way to connect

Open communication skills can also be seen as important in building a shared sense of humanness. Interviewees frequently used phrases such as '*Just being listened to*' (Daisy) and '*She just wanted to listen'* (Linda) when asked what they found helpful in their relationships with workers. They also spoke about being able to talk openly with workers. Phrases such as *'I can talk to her*' (Daisy), '*I was able to talk to her a lot*' (Pauline*), 'But I had some quite long chats with him*' (Louise) and *'We would talk a lot*' (Linda) featured throughout the interviews. Louise spoke of how extraordinary it felt to

have a nursing student actively listen to her whilst she was in an inpatient facility:

> *Louise: And there was also a student psych nurse who was quite extraordinary, that I talked with a lot because she just wanted to listen and she would say that I am here to learn from you guys and I will listen to anything.*

Feeling able to talk and be heard with service providers is seen in contrast to when interviewees described feeling as if they could not talk with workers. Interviewees described negative experiences where they were not listened to such as *'She wasn't listening to my side of the story*'(Daisy), '*they wouldn't actually listen to me*' (Pat) and *'they just didn't listen*' (Jess). Pat described feeling as if there was no space to talk about his experiences with staff on an inpatient ward:

> *Pat: And there was no space for such things to be discussed and as a consumer of the service I just sort of kept to myself.*

This lack of communication not only impacted on the quality of the relationship between service providers and interviewees but also on the service provider's ability to work with interviewees in developing a broader understanding of interviewee's experiences of distress. Linda described the poor communication with her psychiatrist resulting in him not fully understanding the issues she was grappling with:

> *Linda: It made me feel that he fundamentally did not understand what was going on in my head. And I felt that if you're a psychiatrist, it was sort of your job to have empathy and to understand the thought processes at least of your patients, so you could at least redirect those thought processes.*

8.4 Summary

This chapter has outlined three key themes present in the interviews that described supportive practice when working with voice hearers who have experienced sexual abuse. Developing a coherent understanding of experiences of distress featured as a helpful process throughout the interviews. This process enabled voice hearers to make sense of their experiences and provided signposts that further guided their recovery. Psycho-education, access to peer stories, and effective therapy were found to support

this process, while the silencing around abuse, a lack of effective services, the biomedical model, and a focus on medication served to inhibit this process.

Issues relating to power and control featured throughout the interviews when voice hearers considered their engagement with mental health services. Involuntary treatment, both in hospital and in the community, featured as one of the strongest themes relating to unhelpful service responses described by interviewees. Involuntary treatment served to mirror features of abuse experiences and had a negative impact on the relationships interviewees had with professionals. Interviewees also described a range of other disempowering practices that they found unhelpful, including professionals assuming the expert role, controlling how work was conducted, and not valuing the wisdom and knowledge of the interviewees. This contrasted with empowering practices whereby professionals shared control with interviewees, were careful to work at their pace, and respected their wisdom and knowledge.

Finally, quality relationships were identified as crucial to supportive work with voice hearers. Quality relationships are the basis of effective practice when working with any group of people and it is not surprising that themes relating to relationship were found throughout the interviews with voice hearers and surveys of service providers. Quality relationships in this setting, however, are notably characterised by a sense of shared humanity. Interviewees consistently stressed how valuable they found being treated as human and being able to see their workers as human. This human connection seems to be in striking contrast experiences where interviewees felt less than human.

PART FOUR

DISCUSSION AND CONCLUSION

Chapter 9 – DISCUSSION

The previous three chapters described the findings of this project, depicting how surveyed mental health professionals responded to sexual abuse survivors who hear voices, the impacts of these responses, and what voice hearers identify as helpful or unhelpful when using mental health services. Informed by a critical realist approach to social research, this chapter seeks to explain these findings by considering them in the context of the theoretical, practice, and policy issues described in Chapters 2 and 3. In doing this, it addresses the three research questions described in Chapter 1. It then outlines the implication of the results relating to processes that practitioners and organisations can adopt to meet the needs of voice hearers who have experience sexual abuse. Further, it proposes a systemic model of service provision as an approach to better meet the needs of voice hearers who have experienced sexual abuse. Finally, this chapter discusses the strengths and limitations of this project.

9.1 Working with voice hearers who have experienced sexual abuse

Question 1: What are the work practices of mental health professionals when working with voice hearers who have experienced sexual abuse?

The results of this project reveal several trends about how the surveyed mental health professionals respond to sexual abuse survivors who hear voices. This section discusses what the findings reveal about the work practices of mental health professionals. It will focus specifically on how survey respondents screened voice hearers for sexual abuse, how they included details of sexual abuse in formulations and treatment plans, and how they negotiated consent and confidentiality when liaising with families and carers.

SCREENING PRACTICES

This study found over half of survey respondents were not routinely screening voice hearers for sexual abuse. This is consistent with recent studies investigating trauma screening in Australian mental health services by Xiao et al. (2016) and Mansfield et al. (2017). Both of these studies found that around half of examined case records had evidence of trauma screening. Further, Mansfield et al. (2017) surveyed mental health professionals and similarly found that professionals report irregularity with respect to routine screening. These studies examined trauma screening for patients with all diagnoses rather than any specific diagnosis or symptom. Given the similar rates of screening found in this study this may indicate that the presence of voice hearing in a consumer's presentation does not drastically change how professionals screen for sexual abuse.

The results from this study do, however, indicate that some professionals vary their approach to screening for sexual abuse depending on additional features of a consumer's presentation. Respondents were most likely to screen consumers who presented with indicators of abuse in their presentation or history. Conversely, respondents were less likely to screen the consumers described in the vignettes whose voices were not related to sexual themes, but rather had a supernatural or paranoid quality. They were also least likely to screen the consumer who presented with erratic behaviour and communication. This seems to indicate that respondents were less likely to screen consumers who presented with symptoms that reflect additional features of a psychotic diagnosis such as delusions and disorganised behaviour (APA, 2013). In the open-ended responses to the screening question, several respondents explicitly said that they would not screen consumers who presented with psychosis. This is reflective of other studies that have found that mental health professionals are less likely to screen consumers who present with psychotic symptoms (Agar & Read, 2002; Lab et al., 2000; Read & Fraser, 1998; M. Young et al., 2001).

As detailed in Chapter 3, while many voice hearers who have experienced trauma have trauma related content in their voices, there is a proportion whose voices do not reflect memories or themes relating to traumatic experiences (Hardy et al., 2005). This indicates that while screening for abuse when voices seem related to sexual abuse may be an effective strategy for a proportion of voice hearers, it could exclude voice hearers who have survived abuse but whose voices do not have content or themes relating to sexual abuse. Consequently, the results from this study indicate that there may be a proportion of voice hearers who present with symptoms not clearly associated with traumatic content who are not being adequately screened for abuse.

The survey results indicate that female respondents were more likely to screen voice hearers for sexual abuse than male respondents. There was also an association between being concerned about asking differently gendered consumers about sexual abuse and lower rates of screening. From a consumer perspective, two female interviewees reflected on feeling reluctant to speak to male workers about their experiences of sexual abuse. Agar and Read (2002) also found that women were statistically more likely to ask about abuse than men. Little and Hamby (1996) hypothesised that female clinicians were more likely to screen based on women having a greater awareness of sexual abuse.

As sexual abuse is largely a gendered phenomenon, this finding is not surprising. Discussing issues relating to sexual abuse with a professional who is the same gender as the perpetrator of abuse may be distressing for survivors (SAMHSA, 2014b). Male workers may be sensitive to this and consequently feel reluctant to screen female consumers for sexual abuse. Young et al. (2001) also found that many mental health professionals assumed that consumers would prefer to be asked by a same gendered staff member. The findings from this study indicate that this may be valid assumption.

This points to a need for consumers to be able to choose the gender of their worker. Markoff et al. (2005) argue that due to the gendered nature of sexual violence it is important for consumers to have a choice regarding the gender of their worker.

Consideration for how assessments are conducted is also needed as assessments carried out by male workers may result in inaccurate responses to abuse questions amongst survivors of sexual abuse whose perpetrator was male (SAMHSA, 2014b).

The results from this project indicate that there is some degree of organisational leadership in promoting routine screening amongst mental health professionals. Almost half of the survey respondents worked for organisations that had requirements for screening. This is compared with a study by Young et al. (2001) that found that only 15% of professionals surveyed worked for organisations that had requirements for screening. Respondents who worked for organisations that had such requirements were significantly more likely to answer that they always or often screened voice hearers for sexual abuse, compared with respondents whose organisations did not have requirements. However, this result still found that 50% of respondents who worked for organisations that had requirements for screening were not routinely screening for abuse. This indicates that while requirements for screening improves screening practices for a group of professionals, it is not enough to improve the practices for all professionals. This is reflected in the research investigating the effectiveness of organisational requirements for screening. Mellinan (1996), Read and Fraser (1998) and Posner et al. (2008) found that including screening questions in assessment forms slightly to moderately improved screening rates. Read et al. (2016) found a more substantial increase in screening rates when a broad approach to organisational change was adopted including new policies and procedures around trauma screening and regular training for staff around responding to trauma. This research indicates that a wider organisational approach including policy changes and training packages may be more effective than simply changing assessment forms.

Responding to disclosures of abuse

The existing research into how mental health professionals respond to abuse survivors has focused on whether details of abuse or trauma are included in formulations and

treatment plans, and how often referrals are made to trauma counselling services or legal authorities. These studies have found services tend to perform poorly in this area, particularly when working with consumers who present with psychosis (Agar & Read, 2002; Mansfield et al., 2017; Mellinan, 1996; Posner et al., 2008; Read et al., 2016). The results of this study were more promising. Most respondents reported that they included information about disclosures of abuse in their formulations and treatment plans and regularly referred consumers to trauma counselling. It is worth noting that the studies listed above were all based on case record evaluations rather than surveys. Consequently, the high rate of respondents reporting that they include details of abuse in treatment plans and formulations may be a result of a social desirability bias. The survey results may be indicative of how respondents feel that should behave in relation to including details of abuse in formulations and treatment plans, this may not translate into how they practice.

Referrals to trauma-related services were the most common strategy that respondents included in their treatment plans when consumers disclosed that they had past experiences of sexual abuse. While this is a promising trend compared with other studies that have found that professionals are not regularly referring to trauma counselling services (Agar & Read, 2002; Read et al., 2016), respondents raised concerns about the effectiveness of these referrals. Interviewees also detailed struggling to find effective services. What emerges from these findings is a divided service system that struggles to meet the needs of sexual abuse survivors who hear voices. This represents a crucial issue that may impact how services respond to voice hearers who have experienced sexual abuse. While professionals may screen effectively and include abuse in treatment and formulation plans, this may fall short if there is a lack of effective, accessible services to support this group.

Another potential response to disclosures of sexual abuse is a referral to legal authorities. This study found that in general, respondents were reluctant to refer to legal authorities with almost half saying that they would never or rarely do so. This is reflected in the studies conducted by Agar and Read (2002) and Read et al. (2016) that

found minimal case records indicating that staff had reported abuse to legal authorities. Survey respondents in this study reported concerns that the nature of the legal process would be distressing for consumers and this made them reluctant to refer to authorities. In the interviews, a consumer also spoke about her concerns with the legal process and her reluctance to pursue this even when offered support from her sexual assault counsellor

The concerns about the distressing nature of the legal system are warranted. In their eco-systemic model of the impacts of sexual assault, Campbell et al. (2009) are clear to outline the detrimental impacts of an ineffective legal system and conclude that many survivors fair worse when they access an adversarial legal system that is characterised by low rates of conviction. The limitations of the legal system in responding to sexual abuse and assault is, therefore, crucial to understand when considering referring consumers to legal authorities upon disclosure. As Herman (1992b, p. 165) argues:

> In the matter or criminal reporting, as in all other matters, the choice must rest with the survivor. A decision to report ideally opens the door to legal restitution. In reality, however, this decision engages the survivor with a legal system that may be indifferent or hostile to her. . . . The survivor must make an informed choice with the full knowledge of the risks as well as the benefit; otherwise she will simply be re-traumatised.

From this perspective, the reluctance of respondents to refer voice hearers who have experienced abuse to legal authorities may not be an example of poor practice, but rather may be a response to the traumatic nature of the legal system.

Consent when liaising with families and carers

The results from this project raise some concerns about how confidentiality is maintained by service providers when working with sexual abuse survivors who hear voices. Respondents, particularly those working in inpatients settings, reported liaising with family members without consumer's consent due to concerns around duty of care

or if a consumer lacks capacity. Given the degree of acuity that inpatient services deal with, it is not surprising that there are more instances where concerns for duty of care was an issue. The practice of seeking information from family members when a consumer is deemed to lack capacity is problematic when considering sexual abuse survivors. Given the rate of sexual abuse occurring within the family, seeking information from family members runs the risk of unintentionally involving perpetrators in decisions about a survivor's care. In the interviews, Pat disclosed an experience of mental health professionals communicating with a relative, who was the perpetrator of his abuse, that Pat was using the service and available for visits. Not surprisingly Pat found this extremely distressing. Pat's experience exemplifies the need for professionals to take care when communicating with family members, particularly if trauma screening has not occurred.

The maintenance of consumer confidentiality is a core feature of the Victorian Mental Health Act (Department of Health & Human Services, 2014) and its importance is stressed throughout trauma-informed care literature (Kezelman & Stavropoulos, 2012; SAMHSA, 2014b). Interestingly, within trauma-informed care literature there is a scarcity of consideration for how mental health services should negotiate confidentiality when liaising with family members or carers (Harris & Fallot, 2001c; Isobel & Edwards, 2017; Kezelman & Stavropoulos, 2012; Muskett, 2014). This may be a result of the strong emphasis placed on the value of including families and carers in mental health treatment. Within Australian mental health services there has been strong advocacy from carers of mental health consumers for a greater carer involvement in mental health assessment, treatment and care planning. This is, in part, a response to historical notions of family blaming and a past resistance to carer participation in mental health services (Cleary, Freeman, & Walter, 2006; Lakeman, 2008). The increased emphasis on including family and carers in mental health care raises questions about confidentiality, particularly when a consumer either does not consent for information to be shared with a carer, or lacks the capacity to give consent for information to be shared (Slade et al., 2007). The issues of sharing information with family members and carers become more complex when considering the high rate of interpersonal trauma experienced by mental

health consumers. This raises as important tension when considering how mental health services work with sexual abuse survivors. While there is clear merit in including consumer's families and carers in treatment, given that families are often the site of trauma, there must be a degree of caution when mental health professionals liaise with families.

One potential strategy that could be implemented within Victorian mental health services is the use of Advance Statements that are enshrined in the Mental Health Act (Department of Health & Human Services, 2014) whereby consumers can include details of a nominated person to be contacted when they are receiving care. Details of family members who are not to be contacted could also be included. This strategy, however, would not be helpful for a consumer who is initially admitted to a service and has not had the opportunity to fill out an Advanced Statement. Markoff et al. (2005) recommends that services refrain from interviewing family members until domestic violence has been ruled out. This could be applied further to sexual abuse and other forms of interpersonal trauma. The complications of liaising with familes when a consumer's capacity is impaired again highlights the importance of effective screening for consumers. If abuse histories are known, measures can be implemented to ensure that perpetrators are not being provided information about the survivor's care.

KEY TRENDS RELATING TO PROFESSIONAL'S RESPONSES TO VOICE HEARERS WHO HAVE EXPERIENCED SEXUAL ABUSE

This study indicates that many surveyed mental health professionals were not routinely screening voice hearers for sexual abuse and seem more reluctant to screen voice hearers who present with additional psychotic symptoms. While many respondents worked for organisations that required them to screen for trauma, and this had a positive impact on screening rates, there remains a group of professionals who are reluctant to screen even with organisational requirements. This raises questions about why there appears to be a consistent resistance to screening as in indicated in this study, along with others investigating the screening practices of mental health

professionals (Agar & Read, 2002; Mansfield et al., 2017; Rossiter et al., 2015; Xiao et al., 2016). This study also indicates than when screening does occur, professionals endeavour to include details of sexual abuse in formulations and treatment plans but are hampered by a lack of appropriate services to refer consumers to. Finally, issues relating liaising with family members when voice hearers lack capacity raises questions about how service can ensure that perpetrators of abuse are not included in the provision of care.

9.2 Factors that shape professional responses

Research Question 2: What factors shape how mental health professionals respond to voice hearers who have experienced sexual abuse?

As described above, this study indicates a reluctance amongst some mental professionals to routinely screen voice hearers for sexual abuse. This reluctance is consistently found in other studies investigating how mental health services screen for abuse (Mansfield et al., 2017; Rossiter et al., 2015; Xiao et al., 2016). This section details what factors may contribute to this reluctance. It also examines what factors shape the lack of available services that impair mental health professionals' ability to respond effectively to sexual abuse survivors who hear voices.

CONCEPTUALISATIONS OF PTSD AND PSYCHOSIS

The selective screening of voice hearers dependent on their presentation may be reflective of how the impacts of sexual abuse, and how voice hearing, are conceptualised within mental health services. The construction of PTSD as the means for diagnosing the impacts of sexual abuse may have shaped how some respondents screened based on indicators of abuse. As described in Chapter 3, the PTSD diagnosis is the current focus of the psychological and psychiatric understanding of the impacts of trauma, and creates narrow scope to understand the psychological impacts of sexual abuse. The PTSD symptom clusters described in the DSM-V (APA, 2013) are directly relatable to the traumatic event and fail to capture the often complex impacts of sexual

abuse (Berg, 2002; Herman, 1992b). In the DSM-V pseudo hallucinations are described as a possible feature of PTSD, however, the manual instructs practitioners to carefully distinguish these symptoms from hallucinations associated with psychosis (APA, 2013). Only screening voice hearers who present with indicators of abuse reflects this scope as it frames post-traumatic symptoms as directly relatable to the incident of trauma. Consumers who present with voices or other symptoms seemingly unrelated to sexual abuse do not fall within this scope.

The reluctance of respondents to screen voice hearers who present with symptoms commonly associated with psychosis may be related to the framing of psychosis as biological condition. As discussed in Chapter 3, despite the known links between psychosis and trauma, the DSM frames the potential aetiology of psychotic disorders such as schizophrenia as biological (APA, 2013). This framing of psychosis as a biological illness may serve to prevent professionals from screening consumers presenting as psychotic for sexual abuse. Lab et al. (2000) found that professionals were not screening patients with psychosis due to a belief that information about trauma histories was irrelevant when treating psychosis. This may be associated with a belief that psychosis has a biological aetiology and therefore screening for abuse is irrelevant. Young et al. (2001) also found that practitioners who believed in biological causes of mental illness where less likely to screen for abuse. This study supports these findings as there was an association between the degree to which respondents believed that voice hearing was related to biology and how frequently they screened abuse.

The way in which presenting symptoms are conceptualised can therefore be seen to shape the screening practices of mental health professionals. If professionals are guided by diagnostic models such as the DSM V (APA, 2013) this may shape their approach to screening for sexual abuse – screening only those who present with symptoms that can be directly related to a traumatic experience. Further, as detailed by Bont et al. (2015) once a psychotic diagnosis is given to consumers, often professionals do not consider additional diagnoses such as PTSD. As many survivors of sexual abuse experience mental health symptoms that lie outside of the tight confines of the PTSD diagnosis,

such as those presenting with symptoms more commonly associated with psychosis, their abuse histories may be under recognised and not incorporated into treatment and service responses.

Concerns about upsetting consumers

The reluctance to routinely screen voice hearers may be related to a concern respondents had with upsetting consumers by asking about sexual abuse. There was an association between the degree to which respondents were concerned about upsetting consumers and lower rates of screening. Further, one of the most frequent challenges raised by respondents was a concern that talking about trauma would potentially re-traumatise consumers. Concerns about upsetting consumers by asking about sexual abuse is consistently found in the research investigating professionals perspectives on screening for trauma (Lab et al., 2000; McLindon & Harms, 2011; M. Young et al., 2001).

In the interviews, the fear of becoming unwell featured as a barrier to voluntarily disclosing sexual abuse to mental health professionals. Interviewees also spoke about instances when engaging in trauma work had exacerbated symptoms. However, all interviewees spoke of the value of openly talking about their traumatic experience. The concerns from survey respondents about upsetting consumers when talking about abuse, and the reflections of the interviewees on the potential for disclosure of abuse to exacerbate symptoms, is indicative of the tension between emotional safety and the stagnation of recovery discussed by Herman (1992b). She argued that discussing and working through trauma can indeed be destabilising and stresses the importance of establishing emotional safety before embarking on any in-depth work around trauma. However, she warned that continued avoidance of talking about abuse can stagnate the recovery process:

> Avoiding the traumatic memories leads to stagnation in the recovery process, while approaching them too precipitously leads to a fruitless and damaging reliving of the trauma (Herman, 1992b, p. 176).

This tension between emotional safety and the stagnation of recovery raises questions

about how professionals approach screening for sexual abuse. As outlined in Chapter 2, there is clear value in screening consumers for sexual abuse, however, there is a need to ensure that this is done while considering the emotional safety of consumers. While much of the trauma-informed literature simply argues for universal screening for all consumers (Elliott et al., 2005; Fallot & Harris, 2001; SAMHSA, 2014b) the results from this study indicate that there may be genuine concerns about the potential risk to consumers when screening for abuse. This points to the need for a more nuanced approach to screening that considers the possibility of screening for abuse exacerbating symptoms.

It is important to ensure that there is a distinction between trauma screening and a full trauma assessment. As detailed by Fallot and Harris (2001), trauma screening should involve questions to ascertain whether a consumer has experienced abuse or trauma and whether this abuse or trauma is a current issue that impacts on their safety. Any further discussion of the details of abuse should only occur when a consumer's emotional safety is ensured and that there is appropriate support available in the context of the program. If trauma screening is restricted to ascertaining whether abuse has occurred, the risk of emotional destabilisation may be less acute. This is supported by research by Bont et al. (2015) and Cusack et al. (2006) that found there were no reports of adverse responses to the screening questionnaires that that were used with individual's with psychotic diagnoses or other serious mental illnesses.

Further, there are sensitive approaches to screening that can be used to prevent distress. Fallot and Harris' (2001) approach to trauma screening described in Chapter 2 provides an example of this approach. Here, workers are attuned to a consumer's emotional state and consumers are given choice and control over the pace of the conversation. Given that experiencing distress may be an inevitable outcome of talking about abuse for some consumers, there is a need for professionals to be effectively trained in distress relieving techniques such as grounding and self-soothing exercises (Markoff et al., 2005). The provision of some support for staff in managing any potential distress as a result of trauma screening may lesson concerns about upsetting

consumers when screening for sexual abuse. Interestingly, the longer respondents had worked in the field, the less likely they were to be concerned about upsetting consumers when asking about abuse. One possible reason for this association could be that over time, professionals acquire skills to help them support distressed consumers.

While concerns about upsetting consumers when screening for abuse may not always be founded, there is very limited research into screening consumers who present with acute distress. For example, the study by Bont et al., (2015) did not include patients who were on closed psychiatric wards which may mean that their results are not applicable to patients who are in acute distress. Consequently, there may be times to consider issues of safety when screening consumers who are already highly distressed (Kezelman & Stavropoulos, 2012). As argued by Spielvogel and Floyd (1997), if a consumer is acutely suicidal, self-injurious and there is a lack of resources available to prevent immediate harm screening may need to be delayed until safety is re-established. Further, if a consumer is acutely thought disordered they may not be able to respond to screening questions. While there may be times when a consumer is too acutely unwell to participate in a full assessment, more clarity is needed when specifying what level of acuity justifies screening being postponed. For example, in the survey, several respondents said that they would not screen consumers who present as psychotic. Given the breadth of presentations categorised as psychotic (Johns & van Os, 2001) this term is simply too broad to be used as a mediator for screening.

The difficulty involved in assessing individuals who are acutely unwell poses a challenge for mental health services that aim to respond effectively to trauma survivors. While there may be times when it is inappropriate or not possible to screen for sexual abuse, there is the possibility that that screening will be deferred indefinitely. There is, therefore, a need to develop processes to ensure that screening does occur once acute symptoms have stabilised. Young et al. (2001) argue that if screening cannot occur during the assessment stage, case records must note that the assessment is incomplete and include plans to screen in the future.

Given that some consumers can remain in acutely unwell states for an extended period, a lack of screening can result in a long-term lack of awareness of abuse histories. This could have various consequences for the consumers such as re-traumatisation, misdiagnosis, and receiving treatment responses that do not consider trauma histories. This strengthens the case for a trauma-informed approach to service delivery that designs services with the assumption that many consumers of mental health services are survivors of abuse. Consequently, all aspects of service delivery, are designed with a consideration for how they may prevent the re-traumatisation of survivors of abuse (Elliott et al., 2005; Harris & Fallot, 2001b). This may support services to avoid re-traumatising consumers who present with acute distress and are unable to be screened for sexual abuse.

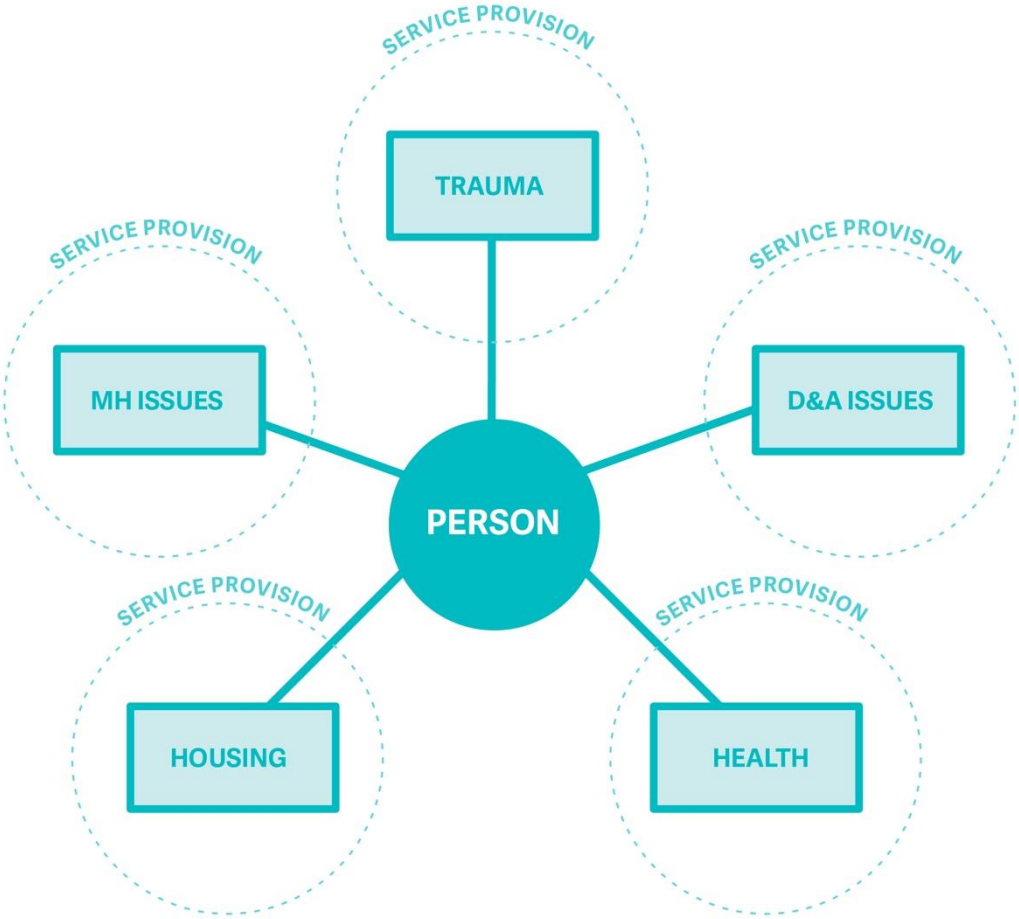
Systemic pressures

The under-funded, fragmented nature of the Australian mental health service system described in Chapter 2 is a key factor that can be seen to shape how mental health services are responding to voice hearers who have survived abuse (Groom, Hickie, & Davenport, 2003; Mental Health Council of Australia, 2005; National Mental Health Commission, 2013, 2014). This is particularly the case when considering the lack of available, appropriate services for voice hearers who have experienced sexual abuse. In a country where mental health services consistently struggle to meet the needs of mental health consumers, it is not surprising that voice hearers are struggling to find appropriate services. Survey respondents noted that appropriate services were particularly hard to find in rural or remote areas. Rosenberg (2011) points to the variability in services across geographical areas in Australia and the dearth of services in rural and remote areas.

The fragmentation of social services described by Rosenberg (2011) is notably evident in the results of this study. Interviewees described not being able to receive adequate support around their experiences of abuse from the mental health service system, and

found that sexual assault counselling services were reluctant to work with their mental health issues. The survey respondents reflected this concern, commenting that services exist within silos and fail to adequately support consumers with co-occurring needs. As indicated in Figure 9.1, the current service system delivers services to specific issues such as mental illness, trauma, and drug and alcohol abuse and there is minimal coordination between services. As described by Rosenberg (2011), issues such as mental illness rarely occur in isolation and experiences of mental illness frequently coincide with a range of other psychosocial issues such as homelessness, drug abuse, social isolation, unemployment and physical health issues. The fact that the Australian service system is primarily designed to focus on specific issues ignores this reality.

Figure 9.1 – Current model of service provision



The cost of services was another barrier identified by both respondents and interviewees. If there are no suitable trauma-specific services in the public system, then consumers are forced to turn to private psychologists or psychiatrists. The cost of using these services is prohibitive for many consumers. While government funded Medicare subsidises sessions with an approved mental health practitioner, there is frequently a significant gap in cost, and there is a limit to ten sessions per year (Rosenberg, 2011). Effective responses to complex trauma are known to take a significant amount of time (Kezelman & Stavropoulos, 2012). Here, there is a clear mismatch between the subsidised services available and the complex needs of sexual abuse survivors. The results of this study support this argument. With sexual assault and mental health services having limited capacity to meet the needs of sexual abuse survivors who hear voices, the lack of alternative affordable support leaves a notable gap in effective service provision for this group.

The lack of available appropriate services for voice hearers who have survived sexual abuse points to a key weakness in the current application of trauma-informed care within Australian mental health services. As discussed in chapter 2, there is a lack of clarity in the trauma-informed literature about whether mental health services should play a role in the delivery of trauma-specific treatment. This ranges from the belief that mental health services should treat trauma and mental illness in a truly integrated manner (Markoff et al., 2005) to the belief that mental health services can operate in a trauma-informed manner but not change how they diagnose and treat consumers (Isobel, 2016). The Guidelines for Gender Sensitive Practice (Department of Health, 2011b) position the Victorian mental health system along the lines of the latter approach. While these guidelines provide much needed guidance for mental health services to be more conscious about the impacts of trauma, they are premised on the notion that there are appropriate, accessible services available in the community. Without effective services, and without mental health services themselves delivering trauma-specific treatment, the implementation of trauma-informed care will fall short

of meeting the needs of sexual abuse survivors. While mental health professionals may screen more effectively and include details of trauma in formulation and treatment plans, and services may shift to deliver programs in a trauma-sensitive manner, without accessible, appropriate trauma-specific services this serves as a band-aid for a system chronically unable to support survivors of abuse with complex issues.

KEY FACTORS THAT SHAPE SERVICE SYSTEM RESPONSES

The reluctance of professionals to routinely screen voice hearers for sexual abuse can be seen to be shaped by the way in which the impacts of sexual abuse are conceptualised, the positioning of psychosis as a biological condition, and concerns about the upsetting nature of discussing sexual abuse. This points to a need for professionals to be aware of the broad impacts of sexual abuse that can include psychosis. It also points to the need for some further consideration for how professionals negotiate the tension between ensuring a consumer's emotional safety and the benefits of opening up space to discuss experiences of sexual abuse. The lack of appropriate services, the siloed nature of the service system, and the prohibitive costs of the private sector can be seen to severely impact on the service systems ability to respond effectively to voice hearers who have experienced sexual abuse. This points to the need for an examination of systemic issues when considering trauma-informed approaches to care, rather than solely a focus on the practices of organisations and practitioners.

9.3 Consumer perspective on service provision

Research Question 3: What do voice hearers who have survived sexual abuse identify as helpful or unhelpful when using mental health services?

The results from the interviews shed light on how voice hearers who have survived sexual abuse perceive service provision. This section considers the issue of trauma screening from the interviewee perspective along with the perceived impacts of not

being screened for sexual abuse. It then considers three themes identified as helpful practice – understanding experience, power and control, and quality relationships – in light of the literature discussed in Chapter 2 and 3.

SCREENING AND DISCLOSURE

Interviewees consistently spoke of not disclosing their experiences of sexual abuse to mental health professionals. Service providers did not ask about trauma and abuse in most interactions described by interviewees who also spoke about feeling inhibited from disclosing voluntarily. This resulted in interviewees experiencing a level of silence around the issue of sexual abuse when using mental health services. Two interviewees spoke explicitly about not telling anybody about their experience of abuse until their middle adulthood, despite many years of using mental health services.

The lack of screening by mental health professionals was further compounded by the numerous barriers to voluntary disclosure identified by the interviewees. On an intrapersonal level feelings of shame attached to abuse experiences, difficulty verbalising experiences of abuse, repression and avoidance, and a fear of losing control were all factors named by interviewees when considering what prevented them from disclosing abuse. These barriers are reflective of those found in Tener and Murphy's (2015) literature review of research into adult disclosures of sexual abuse detailed in Chapter 2.

Interviewees also identified several external barriers to disclosing sexual abuse that were related to the nature of the mental health system. These included service models with a biomedical focus and the fear of involuntary treatment. These are not explicitly named in the literature about child abuse disclosure but speak to unique barriers in the mental health sector.

The biomedical model's focus on diagnosis and pathology can be seen to obscure environmental and psychosocial factors that may be present in a consumer's life

(Bracken, 2002). Perceiving this narrow focus may act as a barrier to disclosing experiences of abuse to mental health professionals. For example, Louise's experiences with this model of practice found her internalising this narrow focus – she too believed that her experiences of distress were purely biological and consequently did not feel that her experiences of abuse were relevant. Rose et al. (2011) found similar trends when they investigated how consumers disclosed domestic violence in mental health settings. They found that consumers refrained from reporting experiences of domestic violence to mental health professionals as they felt their focus was on symptoms, diagnosis, and medication rather than understanding what was happening in the consumers' lives.

The power of clinical mental health services to involuntarily treat consumers is another barrier that is unique to the mental health setting. Quality therapeutic relationships can be a major factor in supporting disclosure (Deering & Mellor, 2011). The role of involuntary treatment may impact on mental health professionals' ability to develop quality relationships. Patel (2008) argues that the role of mental health professionals in enforcing treatment orders negatively impacts on their ability to form effective therapeutic relationships. Stanhope and Sullivan (2008) share this concern about involuntary treatment and argue that professionals' roles in monitoring and enforcing mandated treatment negatively impact on therapeutic alliance. This difficulty negotiating a supportive, therapeutic role with the monitoring and enforcing of treatment orders may pose a potential barrier to creating therapeutic relationships where consumers feel safe to voluntarily disclose their experiences of sexual abuse.

This silence around sexual abuse can be seen to have a number of impacts on the voice hearers interviewed in this study. Interviewees spoke about various impacts of not disclosing their experiences of sexual abuse, namely they felt that not disclosing prevented them from accessing appropriate services and prolonged their experience of mental illness. Elliot et al. (2005) discuss the re-traumatising impact of silence in these settings. Perpetrators often force survivors to remain silent about their abuse, and the lack of screening in mental health settings can be perceived by abuse survivors to

mirror this silence.

Conversely, interviewees spoke about how having space to talk about their experiences of abuse openly was fundamental in their recovery. The literature supports these findings. Ullman (2007) investigated the impacts of disclosure amongst child abuse survivors and found increased post-traumatic symptoms amongst those who delayed disclosure. When responded to positively, survivors note that disclosure is often an important turning point in their lives. Drauker and Martsolf (2008) found that sexual abuse survivors benefited from retelling the story of their abuse by gaining more insights into their experiences and shifting how they understood their abuse.

Understanding experience

Making sense of experiences of distress features as a key element that facilitated recovery for interview participants. Information, psycho-education, peer stories and effective therapeutic relationships were present as factors that enabled participants to develop understandings of their experiences. Several factors were identified by interviewees that can be seen to inhibit the development of this understanding. These included a lack of screening by staff, a focus on diagnosis and medication, and a lack of appropriate services for voice hearers who have experienced sexual abuse.

Both the experience of sexual abuse and the experience of voice hearing lie outside the realm of common human experience. To experience either is likely to rupture any previously held assumptions about the world. It is, therefore, not surprising that interviewees identified that developing an understanding of their experiences of distress and trauma was crucial in their recovery. Herman (1992b) describes the importance of reconstructing the story of trauma in therapeutic work. Here there is a focus on integrating experiences of trauma within a linear understanding of life events. There is also a focus on reframing previously held beliefs about the traumatic experience and the responses to trauma. Thomas and Longden (2015, p. 188) argue that there is a similar need for individuals to make sense of their experiences of

psychological and emotional distress. They state: “what is important is our struggle to impose some sort of order on our inchoate and emergent experiences”.

Interviewees spoke in detail about the importance of connecting their distress to their biography and culture. This is reflective of a systemic perspective that highlights the importance of context and history when understanding the human experience (Bronfenbrenner, 1992). From a systemic standpoint, the meaning of experiences of distress is fundamentally related to context. An individual’s biography, environment, culture, and place in history are all fundamental in how they make sense of their experiences of distress as well as their experiences of abuse.

Conversely, interviewees spoke about how they struggled to understand their distress when it was divorced from context, either by professionals framing their distress as biological, or not explaining the potential for their experiences of abuse to be connected with their distress. This reflects a limitation of the downward reduction focus of the biomedical model (Rudnick, 2002). For biomedical focused psychiatrists such as Guze (1992), the content of voices, or the meaning attributed to them by the voice hearer, are not relevant as they do not reveal anything about the variations in brain functioning that are causing the voices. Louise’s description of how she believed that her distress was meaningless exemplifies this focus. She described how she believed the biomedical discourse described to her by mental professionals and stated: *“I went down this path of this is a meaningless experience”.*

Several interviewees reported accessing Hearing Voices groups and attending training in the Hearing Voices Approach. Interviewees commented that accessing support relating to this approach helped them make sense of their distress. The connection between the voice hearing experience and context is fundamental to the Hearing Voices Approach. As described in Chapter 3, The Maastricht interview developed by Romme and Esher (2010) involves developing a profile of voices that seeks to understand the nature of an individual’s voice hearing experience and how it may connect with the voice hearer’s biography. Corstens and Longden (2013, p. 281) argue that this approach is a useful way

of helping voice hearers to incorporate their voices into a coherent narrative:

> By relating voices to overwhelming emotions, events and problems, voice hearers may acquire a fresh, personal knowledge in which painful feelings and beliefs can be addressed and reconciled with authentic problems in their past (and often in their present).

This approach provides a mechanism for voice hearers to develop a better understanding of their distress and to connect this up with their personal biography, opening up space for the development of a more coherent narrative of their experiences of distress. A key feature of the Hearing Voices Approach is that it is not prescriptive. It aims to help voices hearers develop their own formulations to make sense of their voice hearing experience (Corstens et al., 2014). These formulations guide approaches to treatment and learning new ways of coping with voices. The flexibility of this approach allows it to be tailored to the unique, individual world views of voice hearers.

Interviewees commented on the value of normalising and reframing experiences of distress as a common response to experiences of abuse. This reveals a strength of trauma-informed approaches to care that attempt to frame distress as potentially normative responses to traumatic events. For example, Harris and Fallot (2001b) argue that abuse survivors often feel as if their lives are chaotic and that there is a lack of coherence to their life. They argue that a trauma-informed approach links the distress experienced by survivors to their context and biography. Symptoms and behaviours that were once seen as pathological are reframed as emerging from traumatic experience. This can be seen to help survivors to develop a coherent understanding of their distress.

Interviewees named peer groups and the sharing of peer stories as helpful when developing an understanding of their distress. As described by Noorani (2013), the experience of serious forms of distress such as voice hearing is often difficult to fully comprehend unless you have lived through the experience. Peer groups, therefore, provide a space where consumers can share the wisdom gained through lived experience, which can assist other consumers in developing an understanding of their

distress. There is also value in having space to tell one's story. Drauker and Martsolf (2008, p. 1045) found that as survivors of abuse retold their stories to different people, there was a kind of revision where survivors incorporated different ways of understanding their experience of abuse:

> We argue that CSA survivors construe meaning and obtain an increasingly nuanced understanding of their CSA experience by communicating with others about their abuse; their interpretation of the essence of the abuse experience evolves through each telling interaction.

Therefore, having an opportunity to retell stories of abuse and distress can be seen as crucial in developing a coherent and helpful understanding of these experiences.

Power and control

Interviewees characterised supportive practice as being power-sensitive. Power-sensitive practice in the results of this study was characterised by interviewees having control over their treatment, professionals being flexible with approaches, and interviewees feeling as if their wisdom was valued. This was juxtaposed with a range of disempowering practices described which included involuntary treatment, workers taking an expert role in care, a lack of consultation with interviewees about treatment plans, workers taking a domineering approach within therapeutic relationships, and being inflexible in in their approach when working with consumers.

As described in Chapter 2, power-sensitive practice is seen to be central when working with sexual abuse survivors due to the powerlessness that is inherent within the experience of sexual abuse. Empowerment practices serve to create a space where the power imbalance created by sexual abuse is not recreated within a therapeutic environment. It also supports survivors to gain the skills to control their lives (Elliott et al., 2005; Harris & Fallot, 2001b; Herman, 1992b; Markoff et al., 2005).

The tension between these values and the role of involuntary treatment as described in Chapter 2 is evident in the results of this study. Interviewees frequently described being

treated involuntarily and detailed the re-traumatising and disempowering nature of these experiences. This is particularly evident when interviewees described being treated involuntarily in inpatient units. However, two interviewees spoke explicitly about how being admitted to hospital prevented them from causing harm to themselves.

This reveals an important dilemma faced by mental health services when working with sexual abuse survivors. While services can strive to work in ways that empower survivors and prevent re-traumatisation, there may be times where measures are needed to keep a consumer safe from harming self or others. Harris and Fallot (2001c) argue that where possible, hospitalisation of trauma survivors should be avoided. However, they concede that there may be times when a crisis is unable to managed in the community, resulting in the need for hospital admission. They stress the importance of collaboration and informed consent when admitting a consumer to hospital. Further, they emphasise the need for staff to use non-medical means of de-escalating emotional crises rather than resorting to forced medication. Only after all other options are exhausted should seclusion and restraint be used. To avoid hospitalisation Harris and Fallot (2001c) argue that services should work with consumers to develop relapse prevention or crisis plans that map out triggers and early warning signs with associated strategies to prevent hospitalisation. They suggest that trauma-informed systems should have 24 crisis support that can be flexibly available to assist consumers in crisis.

While these strategies offer a means for inpatient services to respond to sexual abuse survivors in a way that minimises re-traumatisation, such an approach requires significant staff and resources and is built on the assumption of a well-staffed, responsive community sector. Given the gradual dismantling of acute crisis and assessment teams, and the shifting of resources away from community care (Rosen et al., 2010; Rosenberg, 2011), Australian mental health services may not have resources to respond effectively to sexual abuse survivors in the community. The lack of resources may also have an impact on inpatient care. Effective de-escalation strategies can

require more staffing contact that may be difficult to implement in an under-resourced inpatient unit. Bloom and Farragher (2011) argue that it is more costly for services to deal with crises without resorting to punitive measures. For example, they argue that services tend towards restricting consumers' ability to leave inpatient units as it is cheaper to have locked doors than to have enough staff to de-escalate crises. Consequently, the result of an underfunded, crisis focused mental health system, is a system that can keep consumers physically safe from themselves, but this comes at the cost of emotional safety.

The use of community treatment orders can also be seen to inhibit the ability for professionals to work with consumers in a power-sensitive manner. The dual role of case managers in supporting recovery, and monitoring and enforcing treatment orders can be seen entrench power imbalances between professionals and consumers (Courtney & Moulding, 2014). This power imbalance was evident in the interviews with interviewees commenting that being on treatment orders, or being aware of the statutory power of treating professionals negatively impacted on their relationship with professionals. This poses a barrier to empowering practice. Even if professionals work to enhance control as much possible in their relationships with consumers, holding statutory powers will always maintain a significant power imbalance.

Quality relationships

The nature of the relationships between consumers and professionals featured heavily throughout the interviews. What is apparent is that quality relationships are an essential element of effective service delivery. Several features of quality relationships were evident in the results. Interviewees consistently referred to the value of relationships with professionals where there was a shared sense of humanity. They spoke positively about feeling treated like a human, and this was juxtaposed with experiences where they felt seen as less than a whole person. Interviewees also talked about valuing professionals who were authentic and did not hide behind professional distance.

Effective relationships are seen to be crucial when helping survivors of sexual abuse. Herman (1992b, p. 133) argues that "Recovery can take place only within the context of relationships; it cannot occur in isolation". Trauma-informed care literature characterises effective service relationships as open, trusting, collaborative and respectful (Elliott et al., 2005; Harris & Fallot, 2001b). Effective therapeutic relations are frequently found to be the common factor involved with improved outcomes in therapy, regardless of treatment modality (Kezelman & Stavropoulos, 2012).

A unique feature of quality relationships evident in the interviews was the value placed on therapeutic practices that viewed interviewees as human or whole. This feature of holism was contrasted with experiences where interviewees felt treated or seen as less than human. Engel (1980, p. 538) attributes this to the reductionist nature of the biomedical model and argues that this inhibits the ability of professionals to understand the whole person:

> The orientation of the reductionist scientist, for whom confidence in the ultimate explanatory power of the factor-analytic approach in effect inhibits attention to what characterises the whole. For medicine in particular the neglect of the whole inherent with the reductionism of the biomedical model is largely responsible for the physician's preoccupation with the body and with diseases and the corresponding neglect of the patient as a person.

From this perspective, interviewees felt seen as less than human by service providers because the reductionist lens of the biomedical model reduces the human experience down to illness and disease.

When discussing positive relationships, interviewees spoke about appreciating workers who revealed some personal information about themselves, expressed their vulnerability, and where there was a sense of reciprocity in the relationship. This raises some questions about the role of boundaries in professional relationships with abuse survivors. Creating clear boundaries that demarcate the therapeutic relationship as

different from other intimate relationships is consistently described as the hallmark of good practice (Herman, 1992a; Kezelman & Stavropoulos, 2012). Clear boundaries are seen as beneficial for both the consumer and the professional. For consumers, the understanding of what the relationship is, and what it is not, supports the trust building processes and creates a sense of predictability within the relationship (SAMHSA, 2014b). Given the emotional labour involved in supporting sexual abuse survivors, clear boundaries are also seen to help professionals manage self-care and prevent burnout (Kezelman & Stavropoulos, 2012). Exactly where these limits should lay is unclear. While there are clear guidelines regarding sexual contact or having dual relationships (SAMHSA, 2014b) it is unclear where boundaries lie regarding self-disclosure. Is it ok to disclose personal information in the therapeutic relationship or should this be avoided as it creates the notion that the relationship is akin to a friendship? From the interviewee's perspective, boundaries that prevented workers from revealing parts of their selves were seen as unhelpful, with interviewees feeling that they struggled to relate or confide in their workers as they showed nothing of themselves. As Geraldine commented: "*How was I going to talk about emotion when he showed nothing?"*. Interviewees considered more flexible boundaries as helpful as it created a sense of reciprocity in the relationship. The Substance Abuse and Mental Health Services Administration's protocol for trauma-informed care in behavioural health services (2014b) suggests some flexibility when it comes to professional boundaries when working with trauma survivors. They stress that practices such as sharing personal disclosure that depart from customary norms of counselling and therapy can often be beneficial when working with trauma survivors. However, it is essential that professional judgement be used to ensure that there is a clear therapeutic benefit to such disclosures and that crossing these boundaries does not harm to both the consumer and the professional.

Voice hearer's perceptions service provision

The results of this study shed some light on what voice hearers who have survived sexual abuse identify as helpful or unhelpful when using mental health services.

Interviewees spoke in depth about their experiences of not being screened for sexual abuse and the struggle they had to voluntarily disclose. The barriers to voluntary disclosure of sexual abuse, and the impacts of not being asked about abuse, highlight the importance of effective, sensitive trauma and abuse screening by mental health professionals.

Developing an understanding of experiences of distress was described by interviewees was fundamental in their recovery. Given that both the experience of voice hearing and experience of sexual abuse are profoundly disruptive, there is a need to make sense of these experiences. Interviewees reflected that connecting distress to context and experiences of trauma were fundamental in their recovery. The Hearing Voices Approach, along with trauma-informed approaches to care can be seen to assist in this process.

The results of this study reinforce the value of power-sensitive, empowering relationships when working with sexual abuse survivors. This is complicated by the statutory role of some mental health services. While this statutory role is aimed at protecting consumers from harm, the implementation of involuntary treatment can be seen to potentially re-traumatise and disempower sexual abuse survivors. While some measures can be implemented to temper the negative impacts of involuntary treatment, these tend to be resource heavy. Given the under-resourced nature of the Australian mental health system, there may be limited scope for Australian mental health services to adopt processes to effectively support sexual abuse survivors who are in crisis.

Finally, quality therapeutic relationships are frequently cited as a common factor that supports positive outcomes in therapeutic relationships (Kezelman & Stavropoulos, 2012). This is especially the case for sexual abuse survivors who have frequently had their trust in relationships fractured by their experiences of abuse. It is, therefore, unsurprising that the nature of relationships featured so heavily in both the interviews and surveys. The results indicate that relationships that focus on the whole person, and

that carefully negotiate professional boundaries are markers of quality relationships when working with sexual abuse survivors.

9.4 Practitioner and organisation level changes

This study has revealed several avenues for service improvement at a practitioner and organisation level.

A consideration of screening practices is needed to ensure that voice hearers have an opportunity to disclose experiences of sexual abuse. As discussing experiences of past trauma can be distressing, it is important for professionals to consider how, and when, to screen for sexual abuse. As described earlier, Fallot and Harris (2001) outline a sensitive approach to trauma screening that may minimise distress. Given the gendered nature of interpersonal trauma, consumers should be offered a choice in the gender of the worker who is assessing them, and throughout their engagement with the service. As screening for trauma and abuse may not be possible due to the acuity of presenting distress, clear processes should be in place to ensure that screening does occur once the consumer is no longer in acute crisis. While a consumer is deemed too unwell to be screened, services should be delivered in a way that assumes that trauma has occurred.

Professionals can work to consider the impacts of sexual abuse in treatment planning and service provision. Mental health services can work to establish closer ties to sexual assault counselling services and attempt to work more collaboratively with these services. Sensitivity when working with families is important. As sexual abuse often occurs within families, informed consent to communicate with families is essential. When a consumer is unable to give informed consent, possible trauma histories must be taken into account when liaising with families. If there is a lack of information from the consumers about past experiences of trauma, it is unwise to communicate with family members unless there are duty of care issues at hand. In addition to this, practitioners can aim to help consumers develop a coherent, meaningful understanding of both their experiences of distress and past experiences of abuse. Issues relating to

relationship are also valuable to consider– power-sensitive relationships based on authenticity and trust are important features of the therapeutic relationship with trauma survivors

Finally, effective organisational leadership can be a major avenue for change. Organisational leadership can be used to improve rates of screening, support staff in managing disclosures, creating trauma-sensitive processes, and support staff to prevent vicarious trauma.

9.5 A systemic model of service provision

While there are several avenues for change on a practitioner and organisational level, there are some systemic issues that prevent organisations from responding to sexual abuse survivors effectively. As detailed earlier, this study has found that there are notable paradigmatic and system level barriers in the current Australian mental health service system that can be seen to inhibit services from responding effectively to sexual abuse survivors who hear voices. This section outlines the key weaknesses of the current implementation of trauma-informed care in mental health services and proposes a systemic model of service provision that incorporates the lived experience perspective as a more effective approach to meeting the needs of sexual abuse survivors who hear voices.

The limitations to effective service provision raised earlier in this chapter raises questions about the current implementation of trauma-informed care in Australian mental health services. Harris and Fallot (2001b) argued that a paradigm shift is needed for mental health services to respond to survivors of trauma effectively. Bloom (1997) also contended that the biomedical paradigm is incapable of meeting the needs of trauma survivors and that a paradigmatic change is required. She referenced Thomas Kuhn (1962) who argued that it is impossible for an old scientific paradigm to be overturned without a new paradigm being born. Trauma-informed care has emerged as an attempt at a new paradigm, however, the ambiguities with its implementation raise

questions about its robustness as a new paradigm.

Current Australian policy positions mental health services as trauma-informed but does not guide them to deliver trauma-specific treatment, rather this is a role for external sexual assault or trauma counselling services (Department of Health, 2011b). Trauma-informed care in Australia, therefore, is primarily interested in raising awareness of the impacts of trauma rather than substantially altering how treatment is delivered. This positioning is best captured by Isobel (2016, p. 590):

> Understanding the impact of trauma on individuals does not discount their current or future diagnosis, nor alter the course of care, but rather contextualises them, their diagnosis, their behaviours and their experiences, while informing practice in a way that aids effective treatment and recovery.

The use of trauma-informed care to contextualise the experience of mental illness using a trauma lens is an improvement on the lack of consideration of trauma that the interviewees and many other consumers have faced in the past, but it is a far cry from a true paradigm shift. If trauma-informed care is simply tacked on to the existing system without any change to the siloed nature of service delivery and the primacy of the biomedical model, it is doubtful that this approach will result in services more effectively meeting the needs of voice hearers who have survived abuse. Just as clinical services have adopted the recovery model while essentially continuing to deliver services in a way that is antithetical to the principles of personal recovery (Bateman & Smith, 2011; Courtney & Moulding, 2014), so too may mental health services work under the banner of trauma-informed care whilst doing little to implement the dramatic shift that is needed. There is a danger that the increasing rhetoric of services adopting trauma-informed models of care may shift attention away from the real systemic change that needs to occur to adequately meet the needs of sexual abuse survivors.

The results from this study indicate that a model of service provision that incorporates systems theory may be a more effective way to respond to the needs of voice hearers who have experienced sexual abuse. As detailed in Chapter 3, systems theories offer

scope to understand voice hearing as emergent from the interaction between an individual's biology, psychology and their environment (Barker, Gumley, Schwannauer, & Lawrie, 2015; Bentall et al., 2014; Read et al., 2008). They also offer a unique way to understand the complex impacts of sexual abuse. From a systems perspective, an individual's experience of sexual abuse is not only affected by their neurobiological and psychological make-up, but also their belief systems, their relational world, the economic and political structures they exist within, their culture, and their place in history. The multitude of factors within these systems interact and create the unique, individual impacts of sexual abuse (R. Campbell et al., 2009; Lasser & Bathory, 1997; Neville & Heppner, 1999).

There are several ways this approach to understanding the voice hearing and the impacts of sexual abuse could better meet the needs of voice hearers who have survived abuse than current systems of care. A systems approach to assessment shifts the focus on to the whole person; therefore, it necessitates collecting information about notable past experiences including trauma and abuse (Germain & Gitterman, 1996). This approach to assessment may have the impact of increasing the rates of abuse screening amongst mental health professionals. Beyond this, there is scope to understand the subjective experience of the consumer. A whole picture of an individual's situation can be reached by linking presenting issues with personal biography, culture, meaning making systems, relational systems, and political and economic structures. From this point, intervention plans can be developed that target factors across the system rather than focusing solely on alleviating mental health symptoms.

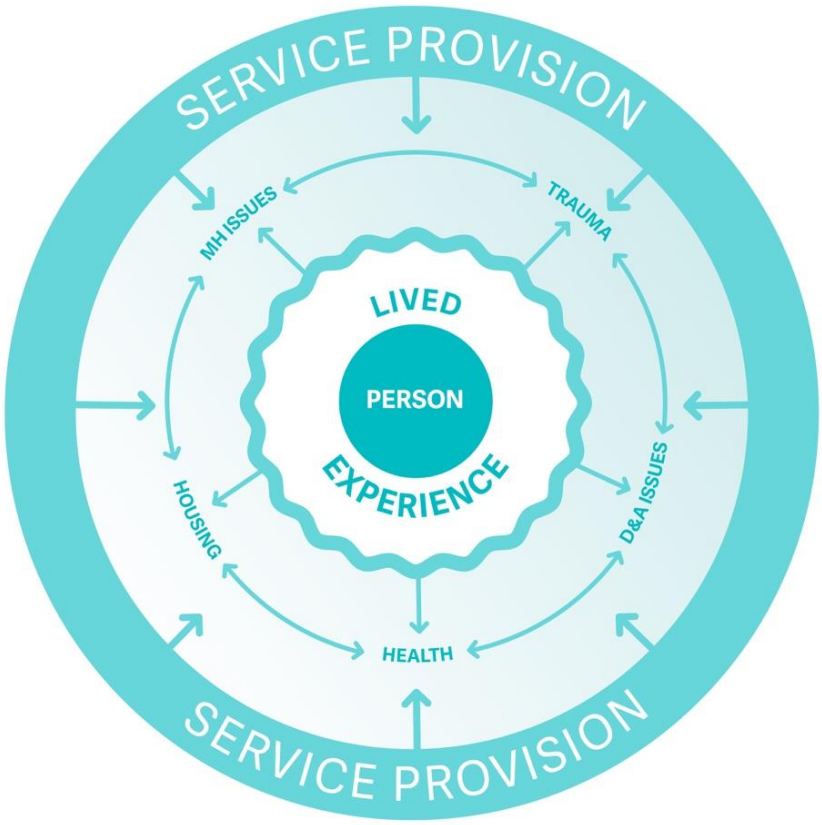
The focus on holism not only provides professionals with a nuanced way of understanding each consumer, leading to more effective intervention, it also provides scope for the consumer to understand their situation better. As outlined in the interviews, consumers made sense of their experiences of distress by connecting them with the biography, their meaning systems, and their culture. Systems models provide scope to move away from rigid approaches to treatment, allowing for approaches that

are more responsive to the individual, subjective experience of the consumer.

A systemic approach to responding to sexual abuse survivors who hear voices highlights the need for integrated models of care. From a systemic approach, change in one systemic level influences all other levels. Therefore, interventions must take into consideration the system in its entirety. As detailed in the surveys and interviews, there appears to be a need for services that concurrently address voice hearing and past experiences of sexual abuse. Due to the complex psychosocial issues experienced by many survivors of abuse, integrated services may be the most effective way of meeting the needs of this group. Integrated care is supported by the evidence from the Women, Co-occurring Disorders, and Violence (WCDV) study (Cocozza et al., 2005) that indicates that an integrated approach to counselling that addresses issues relating to trauma, drug use, and mental illness concurrently is effective in reducing mental health symptoms, and drug and alcohol use. When considering the interrelationship between experiences of sexual abuse and voice hearing, it would be beneficial to have service providers address both issues together rather than mental health and trauma services working in a parallel fashion. This feature of a systemic model of service provision is illustrated in Figure 9.2 (overleaf). Here, service provision targets mental health, trauma, and other psychosocial issues in an integrated fashion.

The incorporation of the lived experience perspective is important to consider within a systemic approach to service provision. The value of the lived experience perspective is evident in the results of this project. Interviewees spoke of the value of hearing other peer stories of recovery and learning from peers about their approach to understanding voice hearing and its connection to trauma. The phenomenon of voice hearing often lies outside the experiences of most mental health practitioners, and consequently the wisdom and subjective viewpoint of those who hear voices should be invaluable (Adame & Knudson, 2007; Bassman, 1997). Surviving sexual abuse is also relatively outside normative experience and the understanding the impacts of sexual abuse from the perspective survivors is equally important (Gilfus, 1999).

Figure 9.2 - A systemic model of service provision



Lived experience perspectives, such as the Hearing Voices Approach, offer a way of incorporating the knowledge that can be gained from understanding the first-hand experiences of voice hearers and sexual abuse survivors into service delivery. For example, the Hearing Voices Approach incorporates a range of strategies to help voice hearers better cope with their voices that are derived from the successful coping strategies of other voice hearers (Corstens et al., 2014). Lived experience perspectives also responsive to subjectivity – an individual's experience of voice hearing, or the impacts of sexual abuse, are uniquely shaped by their environmental context. Consequently, this shapes the way in which they understand their experiences. This responsiveness to subjectivity integrates well with a systemic understanding of distress.

As indicated in Figure 9.2, the proposed systemic model of service provision places the lived experience of the consumers at the centre. The consumer jointly constructs an

understanding of their presenting issues with the service provider, much like the formulations developed in the Maastricht Interview (Romme & Escher, 2010). In turn, this guides the focus of the work done with the consumer and service provider. The positioning of the lived experience perspective in the centre of service provision may support consumers to develop an understanding of their experiences of distress and de-centres the power relationship between service provider and consumer.

There are two notable programs that provide an example of similar approaches to integrated care for co-occuring issues. One example is the Women's Centre (Duffy & Hyde, 2011) in the United Kingdom. They found that the majority of women using their service were struggling with multiple co-occurring health and psychosocial issues. Based on this, they designed their program to deliver integrated care aimed at addressing the whole women and the numerous issues that they may be grappling with, rather than assigning women to different programs to address different issues. This program has staged levels of case management that can be responsive to the changing needs of women using their service. Another notable example of a program that delivers integrated care is Wadamba Wilam (Waring & Burns, 2016), a program that works with Aboriginal Australians in Melbourne's North. It is based on a systemic model that addresses interrelated psychosocial and health issues such as mental illness, drug and alcohol use and homelessness. A trauma-informed approach to practice informs the program model that acknowledges the high level of personal and inter-generational trauma experienced by Aboriginal Australians. It also uses a Social and Emotional Wellbeing model of support that incorporates connection to land, culture, ancestors, and family into a multidimensional approach to health and mental health that takes into consideration to relevant social, political and historical issues such as racism and transgenerational trauma Both programs are premised on the idea that issues such as trauma, mental illness, and substance abuse are interrelated and are best addressed in a unified way that frames these issues within the whole person's experience. Both programs have undergone preliminary evaluation with positive outcomes and provide good examples for integrated approaches to care (Duffy & Hyde, 2011; Waring & Burns,

2016).

Finally, a systemic perspective is useful in understanding what pressures face the whole of the mental health system. While mental health services may be able to adopt some of the organisational level changes described earlier, the systemic pressures can be seen to inhibit their capacity to effectively meet the needs of abuse survivors. The awareness of the impacts of broader systemic issues is considered by Bloom and Farragher (2011) who identify how systemic pressures impact on organisations' ability to respond effectively to abuse survivors. Budget cuts, risk aversion, and poor policy planning all impact on how an organisation is run and will consequently impact on how it can respond to survivors of abuse. A systemic perspective provides scope for viewing the strengths and weaknesses in the whole system that can support or inhibit organisations wishing to respond effectively to sexual abuse survivors. Given the poorly funded and fractured nature of the Australian mental health system and the need for integrated models of care described above, a systemic perspective points to the need for whole of system change rather than solely organisational change.

9.6 Strengths and limitations of this project

This section will detail the some of the strengths and limitations of this project with a focus on issues relating to sampling, recruitment, and research with vulnerable populations.

One of the key limitations of this project was the sample for the survey. The sample was non-random as it relied on the self-selection of respondents. While the survey was promoted using a purposive approach to recruitment in order to recruit respondents from a cross section of Australian mental health services, the sample may still not be representative of the work force. This is most notable in the spread of professional groups who answered the survey. The majority of respondents were social workers, followed by psychiatric nurses with only two psychiatrists responding to the survey. This is not representative of the professional make up the mental health sector (Australian

Institute of Health and Welfare, 2016b) which means that the trends found in this survey cannot be generalised to the whole mental health sector. In addition to this, the very low response rate from psychiatrists means that a professional group that holds significant power and influence within the mental health system was excluded from the analysis of how the system is responding. However, many of the trends evident in the survey results mirrored other literature investigating how mental health services are responding to trauma. For example, trends regarding concerns about upsetting consumers, concerns about screening consumers with disturbing symptoms, trends relating to gender and screening, trends relating to beliefs about the cause of voices, and trends relating to organisational leadership were all replicated in other literature. This may mean that the skewed sample of professional groups in this survey does not significantly misrepresent trends relating to work practices amongst professionals who work with voice hearers.

As this study relied on mental health professionals voluntarily choosing to complete the survey, it is likely that the sample favours professionals who have an interest in the issues of voice hearing and trauma. In addition to this, respondents who have an interest in this area are more likely to have an awareness of how they *should* be practising and this may have influenced them to report their behaviours that mirrored this expectation, rather than what they do in practice. This may mean that the trends regarding work practices may not accurately reflect what is occurring in the sector.

The use of an online survey also poses potential limitations to research design. While online surveys offer the benefit of reaching a geographically broad and diverse population there are several limitations. One limitation is that there is limited scope for measuring non-response rates within the sample, making it impossible to determine any non-response bias (De Leeuw & Hox, 2014). A further limitation of this method was that the anonymity of this survey restricted the ability to validate the identity of the respondents. While the project was advertised through mental health services it could technically be completed by anybody and it could be completed by the same person

multiple times. In addition to this, the nature of online surveys makes it difficult to guarantee the trustworthiness and authenticity of answers. Hooley et al. (2012) raise questions about identity manipulation within online research. They suggest the anonymous nature of online surveys minimises the ways in which the researcher can assess the trustworthiness and authenticity of answers provided. However, there is some research to suggest that the anonymity inherent in online surveys has the effect of generating more honest responses that are less influenced by social desirability (Cantrell & Lupinacci, 2007; Henderson, Evans-Lacko, Flach, & Thornicroft, 2012; Krumpal, 2013). Therefore, the anonymity in this online survey may have helped mitigate the social desirability bias described above.

While there are limitations involved with using online surveys in this project, there were several benefits in using this method. The use of online surveys allowed for a much broader scope of respondents due to its ability to be delivered remotely (Hooley et al., 2012). This enabled this project to collect data from a range of different services across varied geographical locations. In addition to this, the choice of a short survey enabled the collection of a much larger number of responses than what would have been possible with face to face to interviews which enabled this project to capture a broad picture of the work practices of mental health professionals.

The survey asked respondents about their work practices regarding sexual abuse or assault. While the terms are often interchangeable in the vernacular around sexual abuse, the actual definitions of sexual abuse and sexual assault are different. It is therefore difficult to determine if respondents were answering with child sexual abuse or adult sexual assault in mind.

A further limitation of this survey was a lack of consideration for how potential trauma histories of mental health professionals, both through direct exposure or through vicarious trauma, may have impacted on how they responded to voice hearers who had survived sexual abuse. For example, one reason behind respondents' concerns about upsetting consumers by asking about sexual abuse may be related to respondents' own

concerns about being upset discussing sexual abuse due to past experiences. An awareness of the respondents' trauma histories would have opened scope to better understand whether past experiences of trauma had a role in shaping these concerns.

There were several limitations involved with the sample and recruitment of participants for the interviews. I struggled to recruit participants for the interviews for several reasons. The sensitive nature of the interview topic may have prevented voice hearers from volunteering to participate. In order to recruit participants ethically and effectively the researcher employed Elam and Fenton's (2003) strategy of engaging with the community being studied to aid with recruitment. To do this the researcher worked closely with Voices Vic to promote the study amongst a community of voice hearers. Part way through the study there was a management change at Voices Vic, alongside a competitive tendering process that involved all non-government mental health providers in Victoria. As a result, there were less resources available to help recruit for this project and less ability to be closely connected with the voice hearing community. This resulted in a low number of interviews which impacted on the conclusions that were drawn from them. While several common themes arose in all of the interviews, the small size of the sample means that it was difficult to assess the level of saturation. There is also the possibility that those who chose to be interviewed represent an outspoken minority. The consumers who volunteered to be interviewed may have done so as they had particularly negative experiences with service use. Consumers who had positive experiences with service use may not be as inclined to volunteer for such a study. This means that the perspective of consumers who had positive experiences with service use may have been excluded from this project. Further, as recruitment occurred through Voices Vic the sample may be skewed towards consumers who have particular perspectives on voice hearing. The sample was also made up of mostly women and all interviewees were middle aged. The age of this group may have contributed to a greater focus on retrospectively understanding their experiences of sexual abuse and mental illness. This could account for the strong theme around understanding distress. Finally, the retrospective nature of the interviews meant that the descriptions of service use, while providing an in-depth understanding of the nature of the service system over

many years, did not represent the current nature of the service system.

Moore and Miller (1999) reflect that researching vulnerable populations, such as voice hearers, if often challenging due to the difficulty accessing the populations for participation. They argue that this difficulty often results in researchers neglecting research into the perspectives of these groups, resulting in substantial gaps in the knowledge base around vulnerable groups. While the small number of interviewees in this study poses some limitations to the conclusions that can be drawn from the interviews, the inclusion of perspectives of voice hearers who have experienced sexual abuse is valuable given that these perspectives are typically excluded from research. The inclusion of the interviews with voice hearers meant that the project was able to incorporate the lived experience perspective as a means of answering how mental health services can better meet the needs of sexual abuse survivors. As argued by Gilfus (1999), the impacts of trauma are inherently subjective and consequently there is a need to incorporate a survivor epistemology into understanding the impacts of trauma. This project has attempted to incorporate a survivor epistemology into understanding how services are responding to abuse survivors who hear voices. The lived experience perspective has shone light on several issues within service provision; barriers to disclosure of abuse – highlighting the need for routine screening, the complexities involved with referring to legal systems, the need for the choice in gender of workers, and the lack of accessible appropriate services. In addition to this, the lived experience has provided the basis for conceptualising elements of supportive practice including the importance of understanding experience, the need for power-sensitive work practices, and the importance of quality therapeutic relationships.

Each interview detailed experiences of service use in-depth, and provided a good basis for understanding the impacts of the trends in service provision found in the surveys. In addition to this, the themes evident in the interviews were frequently reflected by survey respondents as well as in the wider literature. Therefore, the inclusion of these perspectives adds a depth of understanding about the nature of service provision to

voice hearers who have survived abuse that would be unachievable without the interviewee perspectives.

A limitation of both the survey and the interviews was a lack of consideration for cultural issues and the role of transgenerational trauma in shaping how services respond to sexual abuse survivors. Both the interview schedule and survey did not ask questions about culture and did not enquire about an awareness of the role of transgenerational trauma in the experience of Indigenous Australians seeking support from services. As a result there was a lack of ability to analyse how these issues impact mental health service responses to sexual abuse survivors.

A final limitation of this study is that this it often attempted to compare staff practices with findings from other studies investigating staff practices from different jurisdictions. The unique nature of the Australian mental health service settings made it difficult to directly compare results. However, many themes in this study were reflected across the literature indicating some commonality in issues that affect how mental health professional respond to sexual abuse survivors.

9.7 Summary

This chapter has considered the findings of this project in the light of the practice, policy and theoretical issues described in Chapter 2 and 3. What is evident is that while there are avenues for practitioners and organisations to effectively respond to sexual abuse survivors who hear voices, there are notable systemic and paradigmatic issues that may serve to inhibit effective service system responses. The lack of appropriate, accessible services to work with voice hearers who have survived abuse is reflective of the under-resourced, fractured nature of the Australian service system. When mental health services do not provide trauma-specific treatment and trauma counselling services are unable to meet the needs of individuals with complex mental health issues, consumers are left to access support privately which is frequently inaccessible due to cost or

location. This amounts to a notable gap in services available for survivors of sexual abuse who hear voices. In addition to this is the impact of an under resourced community sector that is unable to respond effectively to voice hearers who are in crisis. With a lack of responsive care in the community, voice hearers often must resort to hospitalisation which can be disempowering and re-traumatising.

The biomedical model that guides most Australian mental health service delivery was also found to impact negatively on voice hearers who have experienced sexual abuse. This model limits the understanding of what can be considered post-traumatic symptoms, and can therefore be seen to inhibit professionals' responses to sexual abuse survivors who hear voices. Within this model voice hearing is decontextualised and largely associated with psychotic diagnoses. The results from this study indicate that this can have the effect of inhibiting voice hearers' ability to make sense of their experiences of distress.

The current application of trauma-informed care in Australian mental health services involves increasing awareness of the impacts of trauma amongst mental health professionals but does not guide any significant alterations in service provision. While this is a step forward from the silence around sexual abuse noted in past mental health policy, without addressing the systemic and paradigmatic issues that prevent effective service provision, services are likely to fall short of meeting the needs of survivors of sexual abuse who hear voices.

A systemic approach service provision that incorporates the lived experience perspectives of sexual abuse survivors and voice hearers offers an alternative approach to service delivery that may better meet the needs of sexual abuse survivors. Systemic approaches to assessment are likely to capture past experiences of sexual abuse more accurately than biomedical driven assessments. Systemic approaches to care also highlight the need for integrated care that works with the whole person and the co-occurring issues that they may be grappling with. This approach also locates mental

health services within a broader policy context, emphasising the need for system wide change. Finally, the inclusion of lived experience perspectives enables service provision to be more responsive to unique, subjective experiences of voice hearers who have survived abuse.

Chapter 10 – CONCLUSION

10.1 Overall aim of this study

This project was born out of an awareness that, while a substantial proportion of consumers of mental health services have past experiences of sexual abuse and other forms of trauma (Bengtsson-Tops et al., 2005; Chen et al., 2010; Coverdale & Turbott, 2000; Rossiter et al., 2015), mental health services are failing to adequately include an awareness of trauma in diagnosis, treatment, and service provision (Agar & Read, 2002; Rossiter et al., 2015; Xiao et al., 2016). This is particularly the case for consumers with a psychotic diagnosis (Agar & Read, 2002; Lab et al., 2000; Read et al., 2016; M. Young et al., 2001). Consequently, there is an apparent need for mental health services to better respond to survivors of sexual abuse, particularly those presenting with symptoms commonly associated with psychosis such as voice hearing.

The overarching aim of this project was to contribute to an understanding of how the mental health system can better respond to sexual abuse survivors who hear voices. To achieve this, it sought to understand the work practices of mental health professionals working with voice hearers who had experienced sexual abuse. In addition to this, it was interested in how voice hearers who had survived abuse experienced service provision, with a focus on what was helpful or unhelpful when they accessed services.

The project used a critical realist perspective to guide the research design and analysis. Critical realism has a focus not only on understanding *what* is happening in the phenomenon being studied, but seeks understand *why* it is happening by attempting to explain what processes, structures or mechanisms give rise to the phenomenon (Bhaskar, 1979). This approach is naturally transformative as it can reveal oppressive or dysfunctional processes that lie at the root of social problems (Bhaskar, 2009). In seeking to create change in the mental health system this project sought to not only understand *what* was occurring when voice hearers who had survived abuse used

mental health services, but also what was shaping how services responded to sexual abuse survivors. In developing an awareness of what was shaping effective or ineffective professional practices, there was scope for understanding what needs to change in order for services to better meet the needs of this group.

This approach to social research shaped the multi-strand mixed research design that was aimed at understanding the service provision relationship from both the perspective of consumers and service providers. Voice hearers who had past experiences of sexual abuse were interviewed about their experiences using services, with a focus on how issues relating to sexual abuse were dealt with, and what they found helpful or unhelpful about service responses. Mental health professionals were surveyed about their work practices, attitudes and beliefs about working with voice hearers.

The results from this project indicated that around half of the survey respondents were not routinely screening voice hearers for sexual abuse. A number of factors were evident that seemed to influence rates of screening including the presentation of the voice hearer, the gender of the professional, concerns regarding upsetting voice hearers by asking about abuse, beliefs about the causes of voice hearing, organisational requirements for screening, and length of time working in the mental health sector. While many respondents were routinely screening voice hearers for sexual abuse, they faced challenges when attempting to incorporate trauma related responses in treatment plans. The results from this study indicate that a lack of accessible services and a fractured service system pose a serious barrier to effective responses for voice hearers who have experienced sexual abuse.

The interviews with voice hearers revealed that substantial consequences flow from sexual abuse not being identified in the mental health system and a corresponding lack of effective service responses. Interviewees spoke about numerous barriers to voluntarily disclosing sexual abuse which highlighted the need for effective screening

practices by mental health professionals. Further, interviewees found that a lack of integrated support around voice hearing and experiences sexual abuse hampered their recovery and frequently resulted in a loss of life opportunities. Interviewees also spoke of the value of authentic, power-sensitive relationships with mental health professionals that supported them in making sense of their experiences of distress. This was complicated by the role of involuntary treatment, the lack of acute care in the community, and the devaluing of consumer wisdom and expertise.

10.2 Implications of this study

The results from this study, viewed against the backdrop of the theoretical and policy context of the Australian mental health system, reveal potential avenues for service system improvement, as well as possible barriers to change.

The results indicate several practitioner and organisational level changes could occur to better meet the needs of sexual abuse survivors who hear voices. These include developing more effective screening processes for staff, incorporating histories of abuse in formulations and treatment plans, liaising carefully with families and carers, and developing authentic, power-sensitive relationships with consumers.

While there are avenues for change evident, there are also several limitations to change that exist within the Australian mental health system. The under resourced, fractured nature of the mental health system presents several limitations. This study indicates that there is a lack of available, appropriate services to concurrently address voice hearing alongside past experiences of sexual abuse. While services can improve their rates of screening, if there are no services available to support consumers with these issues, this improvement may have limited impact. In addition to this, the resource pressure experienced by the service system, and the focus on acute care at the expense of care in community, can be seen to inhibit the ability of services to respond effectively to survivors of abuse who are in crisis. Often the only option available is hospitalisation, an option that frequently serves to re-traumatise and disempower abuse survivors.

This raises questions about the implementation of trauma-informed care in mental health services. If mental health services are not delivering trauma-specific treatment, without available, effective services in the community, trauma-informed care becomes a band-aid on a service system that is unable to meet the needs of trauma survivors.

This study confirmed the well-known limitations of the biomedical model. The focus on the PTSD diagnosis as the parameters for understanding the impacts of sexual abuse can be seen to restrict the capacity to understand and respond to the broad and far reaching impacts on sexual abuse. This study indicates that this may shape how professionals screen for abuse which could result in an underreporting of abuse experiences.

This points to the need to reconceptualise the model of trauma-informed care that is being implemented in the Australian mental health system. Bloom (1997) and Harris and Fallot (2001b) argued that there is a need for a paradigm shift in mental health services in order to effectively meet the needs of sexual abuse survivors. The tacking on of trauma-informed care to services that are governed by a biomedical approach to mental illness and exist within a chronically under resourced service system does not represent this paradigm change and is unlikely to effectively meet the needs of sexual abuse survivors who hear voices. A model of care that is based on a systemic view of the human condition that privileges knowledge gained from the lived experience of mental illness and trauma may be a more effective approach.

10.3 Future directions

There are several potential avenues for research based on the issues that have emerged from this study. Given the small number of voice hearers interviewed for this study, further research could be conducted to further investigate what voice hearers identify as effective practice around the issue of sexual abuse. This could be used to further inform approaches to care for voice hearers who have experienced sexual abuse.

As this project was explorative, research could be conducted to test the explanations of mental health practice developed in this study. For example, this study supposed that practitioners who are guided by the biomedical conceptualisation of voice hearing and the impacts of sexual abuse tend to refrain from screening voice hearers who do not present with symptoms that seem related to sexual abuse. Research could be conducted to further assess the beliefs practitioners have about the impacts of sexual abuse and how this shaped their work practices. This study also found that many respondents were concerned about upsetting consumers by asking about sexual abuse. Further research is needed to understand if these concerns are warranted, and if they are, what strategies can be implemented to minimise distress upon screening.

This study has identified several strategies that could assist services and professionals to better respond to voice hearers who have experienced sexual abuse. Further research could be conducted to evaluate the effectiveness of these strategies when implemented in the workplace. In addition to this, the systemic model of service provision described in Chapter 9 could be further developed and subsequently evaluated.

This results from this project point to the need for a greater consideration for, and research into, the current implementation of trauma-informed care in the Australian mental health system. While the consideration of trauma-informed care in Australian mental health policy and practice is a notable improvement from the previous silence around abuse and trauma, there is a need for more clarity around the implementation of trauma-informed care in mental health settings. In particular there is a need to consider the complexities of this approach when it intersects with the use of involuntary treatment, the primacy of the biomedical model, and a fractured, under resourced service system.

The voice hearers interviewed in this study exemplified the necessity for mental health services to adequately respond to the needs of sexual abuse survivors. The experience

of sexual abuse is one of the most profoundly disruptive experiences that a human can face and mental health services are in a unique position where they can help ameliorate the devastating consequences of sexual abuse. The awareness of the impacts of trauma and how mental health services can best respond to trauma survivors has advanced significantly since Judith Herman (1992b) argued that the psychiatric system is largely made up of trauma survivors. There is an increasing understanding of the links between mental illness and experiences of trauma, and a growing interest in delivering services in a way that is responsive to the needs of trauma survivors. However, the results from this study indicate that there is still significant progress to be made.

References

ABS. (2013). *Australian Aboriginal and Torres Strait Islander Health Survey: First results, Australia 2012-2013* (No. 4727.0.55.001). Canberra, Australia: Australian Bureau of Statistics.

Adame, A. L., & Knudson, R. M. (2007). Beyond the counter-narrative: Exploring alternative narratives of recovery from the psychiatric survivor movement. *Narrative Inquiry*, *17*(2), 157–178. https://doi.org/10.1075/ni.17.2.02ada

Agar, K., & Read, J. (2002). What happens when people disclose sexual or physical abuse to staff at a community mental health centre? *International Journal of Mental Health Nursing*, *11*(2), 70–79. https://doi.org/10.1046/j.1440-0979.2002.00230.x

al-Issa, I. (1995). The illusion of reality or the reality of illusion. Hallucinations and culture. *The British Journal of Psychiatry*, *166*(3), 368–373. https://doi.org/10.1192/bjp.166.3.368

Alsawy, S., Wood, L., Taylor, P. J., & Morrison, A. P. (2015). Psychotic experiences and PTSD: exploring associations in a population survey. *Psychological Medicine*, *45*(13), 2849–2859. https://doi.org/10.1017/S003329171500080X

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., … Giles, W. H. (2005). The enduring effects of abuse and related adverse experiences in childhood. *European Archives of Psychiatry and Clinical Neuroscience*, *256*(3), 174–186. https://doi.org/10.1007/s00406-005-0624-4

Andrews, G. (2005). The crisis in mental health: the chariot needs one horseman. *Medical Journal of Australia*, *182*(8), 372–3.

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, *16*(4), 11.

APA. (2013). *Diagnostic and statistical manual of mental disorders, (DSM-5®)*. Washington, DC: American Psychiatric Association.

Australian Health Ministers' Advisory Council. (2013). *A National framework for recovery-oriented mental health services: policy and theory* (No. 10287). Canberra, Australia: Australian Government Department of Health and Ageing. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovpol

Australian Healthcare Associates. (2011). *Evaluation of the Victorian Dual Diagnosis Initiative*. Melbourne, Australia: Department of Health.

Australian Institute of Health and Welfare. (2016a). *Mental health services—in brief 2016* (No. Cat. no. HSE 180). Canberra, Australia: AIHW.

Australian Institute of Health and Welfare. (2016b). Mental Health Workforce. Retrieved March 3, 2017, from https://mhsa.aihw.gov.au/resources/workforce/

Australian Institute of Health and Welfare. (2017). Use of restrictive practices during admitted patient care. Retrieved May 5, 2017, from https://mhsa.aihw.gov.au/services/admitted-patient/restrictive-practices/

Baker, W. (1992). Positivism versus people: What should psychology be about? In C. W. Tolman (Ed.), *Positivism in Psychology: Historical and Contemporary Problems* (pp. 10–16). New York, NY: Springer New York.

Barker, V., Gumley, A., Schwannauer, M., & Lawrie, S. M. (2015). An integrated biopsychosocial model of childhood maltreatment and psychosis. *The British Journal of Psychiatry*, *206*(3), 177–180. https://doi.org/10.1192/bjp.bp.113.143578

Bassman, R. (1997). The mental health system: Experiences from both sides of the locked doors. *Professional Psychology: Research and Practice*, *28*(3), 238–242. https://doi.org/10.1037/0735-7028.28.3.238

Bateman, J., & Smith, T. (2011). Taking our place. *International Journal of Mental Health*, *40*(2), 55–71. https://doi.org/10.2753/IMH0020-7411400203

Battle, C. L., Shea, M. T., Johnson, D. M., Yen, S., Zlotnick, C., Zanarini, M. C., … Morey, L. C. (2004). Childhood maltreatment associated with adult personality disorders: Findings from the Collaborative Longitudinal Personality Disorders Study. *Journal of Personality Disorders*, *18*(2), 193–211.

Bazeley, P., & Jackson, K. (2013). *Qualitative data analysis with NVivo*. London, Great Britain: Sage Publications Limited.

Bebbington, P., Bhugra, D., Bhugra, T., Singleton, N., Farrell, M., Jenkins, R., … Meltzer, H. (2004). Psychosis, victimisation and childhood disadvantage: Evidence from the second British National Survey of Psychiatric Morbidity. *The British Journal of Psychiatry*, *185*(3), 220–226. https://doi.org/10.1192/bjp.185.3.22

Bebbington, P., Cooper, C., Minot, S., Brugha, T. S., Jenkins, R., Meltzer, H., & Dennis, M. (2009). Suicide Attempts, Gender, and Sexual Abuse: Data From the 2000 British Psychiatric Morbidity Survey. *American Journal of Psychiatry*, *166*(10), 1135–1140. https://doi.org/10.1176/appi.ajp.2009.09030310

Bengtsson-Tops, A., Markström, U., & Lewin, B. (2005). The prevalence of abuse in Swedish female psychiatric users, the perpetrators and places were abuse occurred. *Nordic Journal of Psychiatry*, *59*(6), 504–510. https://doi.org/10.1080/08039480500360732

Bentall, R. P., Sousa, P. de, Varese, F., Wickham, S., Sitko, K., Haarmans, M., & Read, J. (2014). From adversity to psychosis: pathways and mechanisms from specific adversities to specific symptoms. *Social Psychiatry and Psychiatric Epidemiology*, *49*(7), 1011–1022. https://doi.org/10.1007/s00127-014-0914-0

Bentall, R. P., Wickham, S., Shevlin, M., & Varese, F. (2012). Do specific early-life adversities lead to specific symptoms of psychosis? A study from the 2007 the adult psychiatric morbidity survey. *Schizophrenia Bulletin*, *38*(4), 734–740. https://doi.org/10.1093/schbul/sbs049

Berg, S. H. (2002). The PTSD diagnosis: Is it good for women? *Affilia*, *17*(1), 55–68. https://doi.org/10.1177/0886109902017001004

Berliner, L., & Kolko, D. J. (2016). Trauma informed care: A commentary and critique. *Child Maltreatment*, *21*(2), 168–172. https://doi.org/10.1177/1077559516643785

Bhaskar, R. (1975). *A realist theory of science*. London, Great Britain: Verso.

Bhaskar, R. (1979). *The possibility of naturalism: a philosophical critique of contemporary human sciences*. London, Great Britain: Routledge.

Bhaskar, R. (1998). Philosophy and scientific realism. In *Critical realism: Essential readings* (pp. 16–47). New York, NY: Routledge.

Bhaskar, R. (2009). *Scientific realism and human emancipation* (1st ed.). Hoboken, NJ: Taylor and Francis.

Blackman, L. (2007). Psychiatric culture and bodies of resistance. *Body & Society*, *13*(2), 1–23. https://doi.org/10.1177/1357034X07077770

Bland, R., Farhall, J., Fernbacher, S., Fossey, E., Happell, B., Kazantzis, N., … Wilshire, D. (2012). Assessment: Specialised Assessment Skills. In J. Farhall, G. Meadows, F. McDermott, M. Grigg, & E. Fossey (Eds.), *Mental health in Australia* (3rd ed., pp. 394–427). South Melbourne, Australia: Oxford University Press.

Bloom, S. (1997). *Creating sanctuary*. New York: Routledge.

Bloom, S., & Farragher, B. (2011). *Destroying sanctuary*. New York, NY: Oxford University Press.

Boyle, M. (2011). Making the world go away, and how psychology and psychiatry benefit. In M. Rapley, J. Moncrieff, & J. Dillon (Eds.), *De-medicalizing misery* (pp. 27–43). Hampshire, Great Britain: Palgrave Macmillan.

Bracken, P. (2002). *Trauma: Culture, meaning and philosophy.* London, Great Britain: Whurr Publishers.

Bracken, P., & Thomas, P. (2001). Postpsychiatry: a new direction for mental health. *British Medical Journal*, *322*(7288), 724. https://doi.org/10.1136/bmj.322.7288.724

Bradley, R., Jenei, J., & Westen, D. (2005). Etiology of borderline personality disorder: Disentangling the contributions of intercorrelated antecedents. *Journal of Nervous and Mental Disease*, *193*(1), 24–31. https://doi.org/10.1097/01.nmd.0000149215.88020.7c

Bransford, C. L., & Blizard, R. A. (2016). Viewing psychopathology through a trauma lens. *Social Work in Mental Health*, *15*(1), 1–19. https://doi.org/10.1080/15332985.2016.1173161

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Brewin, C. R., & Patel, T. (2010). Auditory pseudohallucinations in United Kingdom war veterans and civilians with posttraumatic stress disorder. *The Journal of Clinical Psychiatry*, *71*(4), 419–425. https://doi.org/10.4088/JCP.09m05469blu

Briere, J., Kaltman, S., & Green, B. L. (2008). Accumulated childhood trauma and symptom complexity. *Journal of Traumatic Stress*, *21*(2), 223–226. https://doi.org/10.1002/jts.20317

Briere, J., & Zaidi, L. Y. (1989). Sexual abuse histories and sequelae in female psychiatric emergency room patients. *The American Journal of Psychiatry*, *146*(12). https://doi.org/10.1176/ajp.146.12.1602

Bronfenbrenner, U. (1992). *Ecological systems theory.* London: United Kingdom Jessica Kingsley Publishers.

Brown, L. S. (1992). A feminist critique of the personality disorders. In L. S. Brown & M. Ballou (Eds.), *Personality and psychopathology: Feminist reappraisals* (pp. 206–228). New York, NY: The Guilford Press.

Bryer, J., Nelson, B., Miller, J., & Krol, P. (1987). Childhood sexual and physical abuse as factors in adult psychiatric illness. *American Journal of Psychiatry*, *144*(11), 1426–1430. https://doi.org/10.1176/ajp.144.11.1426

Burgess, A. W., & Holmstrom, L. L. (1974). Rape trauma syndrome. *American Journal of Psychiatry*, *131*(9), 981–986.

Burstow, B. (2003). Toward a radical understanding of trauma and trauma work. *Violence Against Women*, *9*(11), 1293–1317. https://doi.org/10.1177/1077801203255555

Burstow, B. (2005). A critique of posttraumatic stress disorder and the DSM. *Journal of Humanistic Psychology*, *45*(4), 429–445. https://doi.org/10.1177/0022167805280265

Campbell, J., Brophy, L., Healy, B., & O'Brien, A. M. (2006). International perspectives on the use of community treatment orders: Implications for mental health social workers. *British Journal of Social Work*, *36*(7), 1101–1118. https://doi.org/10.1093/bjsw/bch423

Campbell, R., Dworkin, E., & Cabral, G. (2009). An ecological model of the impact of sexual assault on women's mental health. *Trauma, Violence, & Abuse*, *10*(3), 225–246. https://doi.org/10.1177/1524838009334456

Cantrell, M. A., & Lupinacci, P. (2007). Methodological issues in online data collection. *Journal of Advanced Nursing*, *60*(5), 544–549. https://doi.org/10.1111/j.1365-2648.2007.04448.x

Chalmers, D. J. (2006). Strong and weak emergence. In P. Clayton & P. Davies (Eds.), *The reemergence of emergence* (pp. 244–256). Oxford, Great Britain: Oxford University Press.

Chen, L. P., Murad, M. H., Paras, M. L., Colbenson, K. M., Sattler, A. L., Goranson, E. N., … Zirakzadeh, A. (2010). Sexual abuse and lifetime diagnosis of psychiatric

disorders: systematic review and meta-analysis. *Mayo Clinic Proceedings*, *85*(7), 618–629.

Cheung Chung, M., & Nolan, P. (1994). The influence of positivistic thought on nineteenth century asylum nursing. *Journal of Advanced Nursing*, *19*(2), 226–232. https://doi.org/10.1111/j.1365-2648.1994.tb01075.x

Clark, C., Classen, C. C., Fourt, A., & Shetty, M. (2014). *Treating the trauma survivor*. Hoboken, NJ: Taylor & Francis.

Cleary, M., Freeman, A., & Walter, G. (2006). Carer participation in mental health service delivery. *International Journal of Mental Health Nursing*, *15*(3), 189–194. https://doi.org/10.1111/j.1447-0349.2006.00422.x

Cleary, M., Horsfall, J., O'Hara-Aarons, M., & Hunt, G. E. (2013). Mental health nurses' views of recovery within an acute setting. *International Journal of Mental Health Nursing*, *22*(3), 205–212. https://doi.org/10.1111/j.1447-0349.2012.00867.x

Cloitre, M., Stolbach, B. C., Herman, J. L., van der Kolk, B., Pynoos, R., Wang, J., & Petkova, E. (2009). A developmental approach to complex PTSD: Childhood and adult cumulative trauma as predictors of symptom complexity. *Journal of Traumatic Stress*, *22*(5), 399–408. https://doi.org/10.1002/jts.20444

Cocozza, J. J., Jackson, E. W., Hennigan, K., Morrissey, J. P., Reed, B. G., Fallot, R., & Banks, S. (2005). Outcomes for women with co-occurring disorders and trauma: Program-level effects. *Journal of Substance Abuse Treatment*, *28*(2), 109–119. https://doi.org/10.1016/j.jsat.2004.08.010

Collin-Vézina, D., Daigneault, I., & Hébert, M. (2013). Lessons learned from child sexual abuse research: prevalence, outcomes, and preventive strategies. *Child and*

Adolescent Psychiatry and Mental Health, *7*(22), 1–9. https://doi.org/10.1186/1753-2000-7-22

Comte, A. (1876). *Course of positive philosophy*. London, Great Britain: John Chapman.

Cooper, R. (2014). *Diagnosing the Diagnostic and Statistical Manual of Mental Disorders*. London, Great Britain: Karnac Books.

Corstens, D., & Longden, E. (2013). The origins of voices: links between life history and voice hearing in a survey of 100 cases. *Psychosis-Psychological Social and Integrative Approaches*, *5*(3), 270–285. https://doi.org/10.1080/17522439.2013.816337

Corstens, D., Longden, E., & May, R. (2012). Talking with voices: Exploring what is expressed by the voices people hear. *Psychosis*, *4*(2), 95–104. https://doi.org/10.1080/17522439.2011.571705

Corstens, D., Longden, E., McCarthy-Jones, S., Waddingham, R., & Thomas, N. (2014). Emerging perspectives from the hearing voices movement: implications for research and practice. *Schizophrenia Bulletin*, *40*(Suppl 4), S285–S294. https://doi.org/10.1093/schbul/sbu007

Courtney, M., & Moulding, N. T. (2014). Beyond balancing competing needs: Embedding involuntary treatment within a recovery approach to mental health social work. *Australian Social Work*, *67*(2), 214–226. https://doi.org/10.1080/0312407X.2013.829510

Courtois, C. A., & Ford, J. D. (Eds.). (2009). *Treating complex traumatic stress disorders: an evidence-based guide*. New York, NY: Guilford Press.

Courtois, C. A., & Ford, J. D. (2012). *Treatment of complex trauma: A sequenced, relationship-based approach*. New York, NY: Guilford Publications.

Coverdale, J. H., & Turbott, S. H. (2000). Sexual and physical abuse of chronically ill psychiatric outpatients compared with a matched sample of medical outpatients. *The Journal of Nervous and Mental Disease*, *188*(7), 440–445.

Crowe, M. (2006). Psychiatric diagnosis: some implications for mental health nursing care. *Journal of Advanced Nursing*, *53*(1), 125–131. https://doi.org/10.1111/j.1365-2648.2006.03691.x

Cusack, K. J., Grubaugh, A. L., Knapp, R. G., & Frueh, B. C. (2006). Unrecognized trauma and PTSD among public mental health consumers with chronic and severe mental illness. *Community Mental Health Journal*, *42*(5), 487–500. https://doi.org/10.1007/s10597-006-9049-4

Cutajar, M. C., Mullen, P. E., Ogloff, J. R., Thomas, S. D., Wells, D. L., & Spataro, J. (2010). Schizophrenia and other psychotic disorders in a cohort of sexually abused children. *Archives of General Psychiatry*, *67*(11), 1114–1119. https://doi.org/10.1001/archgenpsychiatry.2010.147

Day, A., Thurlow, K., & Woolliscroft, J. (2003). Working with childhood sexual abuse: a survey of mental health professionals. *Child Abuse & Neglect*, *27*(2), 191–198. https://doi.org/10.1016/S0145-2134(02)00540-9

de Bont, P. A. J. M., van der Berg, D. P. G., van der Vleugel, B. M., de Roos, C., de Jongh, A., van der Gaag, M., & van Minnen, A. (2015). Predictive validity of the Trauma Screening Questionnaire in detecting post-traumatic stress disorder in patients

with psychotic disorders. *The British Journal of Psychiatry*, *206*(5), 408–416. https://doi.org/10.1192/bjp.bp.114.148486

De Leeuw, E., & Hox, J. (2014). Survey Mode and Survey Effects. In U. Engel, B. Jann, P. Lynn, A. Scherpenzeel, & P. Sturgis (Eds.), *Improving survey methods- Lessons from recent research* (pp. 22–34). New York, NY: Routledge.

Deacon, B. J. (2013). The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research. *Clinical Psychology Review*, *33*(7), 846–861. https://doi.org/10.1016/j.cpr.2012.09.007

Deering, R., & Mellor, D. (2011). An exploratory qualitative study of the self-reported impact of female-perpetrated childhood sexual abuse. *Journal of Child Sexual Abuse*, *20*, 58–76. https://doi.org/10.1080/10538712.2011.539964

Department of Employment. (2016). Health and Community Services. Retrieved March 3, 2017, from https://australianjobs.employment.gov.au/occupation-matrix/health-and-community-services

Department of Health. (2011a). *Framework for recovery-orientated practice*. Melbourne, Australia: Department of Health, State Government of Victoria.

Department of Health. (2011b). *Service guideline for gender sensitivity and safety*. Melbourne, Australia: Mental Health, Drugs and Regions Division, Victorian Government. Retrieved from http://docs.health.vic.gov.au/docs/doc/Service-Guideline-for-Gender-Sensitivity-and-Safety

Department of Health. (2013). Aboriginal and Torres Strait Islander suicide: origins, trends and incidence. Retrieved September 17, 2017, from

http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-natsisps-strat-toc~mental-natsisps-strat-1~mental-natsisps-strat-1-ab

Department of Health & Human Services. Mental Health Act 2014, 26 § (2014). Retrieved from https://www2.health.vic.gov.au:443/mental-health/practice-and-service-quality/mental-health-act-2014

Department of Health and Aging. (2009). *Fourth National Mental Health Plan- An agenda for collaborative government action in mental health 2009–2014*. Canberra, Australia: Commonwealth of Australia.

Ditman, T., & Kuperberg, G. R. (2005). A source-monitoring account of auditory verbal hallucinations in patients with schizophrenia. *Harvard Review of Psychiatry*, *13*(5), 280–299. https://doi.org/10.1080/10673220500326391

Doerner, K. (1977). *Madmen and the bourgeoisie*. Oxford, England: Urizen Books.

Draucker, C. B., & Martsolf, D. S. (2008). Storying childhood sexual abuse. *Qualitative Health Research*, *18*(8), 1034–1048. https://doi.org/10.1177/1049732308319925

Dube, S. R., Anda, R. F., Whitfield, C. L., Brown, D. W., Felitti, V. J., Dong, M., & Giles, W. H. (2005). Long-term consequences of childhood sexual abuse by gender of victim. *American Journal of Preventive Medicine*, *28*(5), 430–438. https://doi.org/10.1016/j.amepre.2005.01.015

Dudgeon, P., & Walker, R. (2015). Decolonising Australian psychology: Discourses, strategies, and practice. *Journal of Social and Political Psychology*, *3*(1), 276–297. https://doi.org/10.5964/jspp.v3i1.126

Duffy, S., & Hyde, C. (2011). *Women at the centre*. Sheffield, Great Britain: The Centre for Welfare Reform. Retrieved from http://www.centreforwelfarereform.org/uploads/attachment/273/women-at-the-centre-summary.pdf

Elam, G., & Fenton, K. A. (2003). Researching sensitive issues and ethnicity: lessons from sexual health. *Ethnicity and Health*, *8*(1), 15–27. https://doi.org/10.1080/13557850303557

Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology*, *33*(4), 461–477. https://doi.org/10.1002/jcop.20063

Engel, G. L. (1980). The clinical application of the biopsychosocial model. *American Journal of Psychiatry*, *137*(5), 535–544.

Epstein, M., Olsen, A., & Grey, F. (2012). How communities respond to mental distress: A consumer perspective. In G. Meadows, J. Farhall, E. Fossey, M. Grigg, F. McDermott, & B. Singh (Eds.), *Mental health in Australia* (pp. 18–30). South Melbourne, Australia: Oxford University Press.

Ezzy, D. (2013). *Qualitative analysis*. Hoboken, NJ: Taylor and Francis.

Fallot, R. D., & Harris, M. (2001). A trauma-informed approach to screening and assessment. *New Directions for Mental Health Services*, *2001*(89), 23–31. https://doi.org/10.1002/yd.23320018904

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., … Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction

to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, *14*(4), 245–258. https://doi.org/10.1016/S0749-3797(98)00017-8

Fernbacher, S. (2008). *Abuse and mental health policy- a (dis)connection? (unpublished doctoral dissertation)*. Latrobe University, Melbourne, Australia.

Fletcher, A. J. (2017). Applying critical realism in qualitative research: methodology meets method. *International Journal of Social Research Methodology*, *20*(2), 181–194. https://doi.org/10.1080/13645579.2016.1144401

Foote, B., Smolin, Y., Kaplan, M., Legatt, M. E., & Lipschitz, D. (2006). Prevalence of dissociative disorders in psychiatric outpatients. *The American Journal of Psychiatry*, *163*(4), 623–9.

Forbes, D., Creamer, M., Phelps, A., Bryant, R., McFarlane, A., Devilly, G. J., … Newton, S. (2007). Australian guidelines for the treatment of adults with acute stress disorder and post-traumatic stress disorder. *Australian & New Zealand Journal of Psychiatry*, *41*(8), 637–648. https://doi.org/10.1080/00048670701449161

Frith, C. (2005). The neural basis of hallucinations and delusions. *Comptes Rendus Biologies*, *328*(2), 169–175.

Galletly, C., Castle, D., Dark, F., Humberstone, V., Jablensky, A., Killackey, E., … Tran, N. (2016). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders. *Australian and New Zealand Journal of Psychiatry*, *50*(5), 410–472.

Gaweda, L., Holas, P., & Kokoszka, A. (2012). Dysfunctional meta-cognitive beliefs and anxiety, depression and self-esteem among healthy subjects with hallucinatory-like experiences. *Psychiatria Polska*, *46*(6), 933–949.

Gee, G., Dudgeon, P., Schultz, C., Hart, A., & Kelly, K. (2014). Aboriginal and Torres Strait Islander Social and Emotional Wellbeing. In P. Dudgeon, H. Milroy, & R. Walker (Eds.), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* (pp. 55–68). Barton, ACT: Commonwealth of Australia.

Germain, C. B., & Gitterman, A. (1996). *The life model of social work practice: Advances in theory & practice*. New York, NY: Columbia University Press.

Gerrand, V. (2005). Can deinstitutionalisation work? Mental health reform from 1993 to 1998 in Victoria, Australia. *Health Sociology Review*, *14*(3), 255–271. https://doi.org/10.5172/hesr.14.3.255

Gerrand, V., Singh, B., Nagel, T., Ash, D., Turnbull, C., Meadows, G., … Benson, A. (2013). Mental health services in Australia. In G. Meadows, J. Farhall, E. Fossey, & M. Grigg (Eds.), *Mental health in Australia* (3rd ed.). South Melbourne, Australia: Oxford University Press.

Gilfus, M. E. (1999). The price of the ticket: A survivor-centered appraisal of trauma theory. *Violence Against Women*, *5*(11), 1238–1257. https://doi.org/10.1177/1077801299005011002

Giller, E., Vermilyea, E., & Steele, T. (2006). Risking connection: Helping agencies embrace relational work with trauma survivors. *Journal of Trauma Practice*, *5*(1), 65–82. https://doi.org/10.1300/J189v05n01_05

Goldstein, J. (1999). Emergence as a construct: History and issues. *Emergence*, *1*(1), 49–72.

Greenberg, G. (2013). *The book of woe*. New York, NY: Plume.

Groom, G., Hickie, I., & Davenport, T. (2003). *Out of hospital, out of mind! A report detailing mental health services in Australia in 2002 and community priorities for national mental health policy for 2003-2008*. Canberra, Australia: Mental Health Council of Australia. Retrieved from https://mhaustralia.org/sites/default/files/imported/component/rsfiles/publications/Out_of_Hospital_Out_of_Mind.pdf

Guarino, K., Soares, P., Konnath, K., Clervil, R., & Bassuk, E. (2009). *Trauma-informed organizational toolkit*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, and the Daniels Fund, the National Child Traumatic Stress Network, and the W.K. Kellogg Foundation. Retrieved from www.homeless.samhsa.gov

Guze, S. B. (1992). *Why psychiatry is a branch of medicine.* New York, NY: Oxford University Press.

Hammersley, P., Fox, R., Larkin, W., Morrison, A., Larkin, W., & Morrison, A. P. (2006). Childhood trauma and psychosis in the major depressive disorders. In W. Larkin & A. P. Morrison (Eds.), *Trauma and psychosis: New directions for theory and therapy* (pp. 148–161). Hoboken, NJ: Taylor & Francis.

Hardy, A., Fowler, D., Freeman, D., Smith, B., Steel, C., Evans, J., … Dunn, G. (2005). Trauma and hallucinatory experience in psychosis. *The Journal of Nervous and*

Mental Disease, *193*(8), 501–507. https://doi.org/10.1097/01.nmd.0000172480.56308.21

Harris, M., & Fallot, R. D. (2001a). Designing trauma-informed addictions services. *New Directions for Mental Health Services*, *2001*(89), 57–73. https://doi.org/10.1002/yd.23320018907

Harris, M., & Fallot, R. D. (2001b). Envisioning a trauma-informed service system: A vital paradigm shift. *New Directions for Mental Health Services*, *2001*(89), 3–22. https://doi.org/10.1002/yd.23320018903

Harris, M., & Fallot, R. D. (2001c). Trauma-informed inpatient services. *New Directions for Mental Health Services*, *2001*(89), 33–46. https://doi.org/10.1002/yd.23320018905

Healy, K. (2005). *Social work theories in context*. New York, NY: Palgrave Macmillan.

Heckman, J., Hutchins, F. A., Thom, J. C., & Russel, L. A. (2005). Allies. *Alcoholism Treatment Quarterly*, *22*(3–4), 161–180. https://doi.org/10.1300/J020v22n03_09

Henderson, C., Evans-Lacko, S., Flach, C., & Thornicroft, G. (2012). Responses to mental health stigma questions: The importance of social desirability and data collection method. *The Canadian Journal of Psychiatry*, *57*(3), 152–160. https://doi.org/10.1177/070674371205700304

Herman, J. (1992a). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, *5*(3), 377–391. https://doi.org/10.1007/BF00977235

Herman, J. (1992b). *Trauma and recovery: The aftermath of violence from domestic violence to political terror*. New York, NY: Basic Books.

Hill, K., Varese, F., Jackson, M., & Linden, D. E. J. (2012). The relationship between metacognitive beliefs, auditory hallucinations, and hallucination-related distress in clinical and non-clinical voice-hearers. *British Journal of Clinical Psychology*, *51*(4), 434–447.

Hooley, T., Marriot, J., & Wellens, J. (2012). *What is online research? : Using the internet for social science research*. London, Great Britain: Bloomsbury Academic. https://doi.org/10.5040/9781849665544

Hopper, E. K., Bassuk, E. L., & Olivet, J. (2009). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal*, *3*(2), 131–151.

Houston, S. (2001). Beyond social constructionism: Critical realism and social work. *The British Journal of Social Work*, *31*(6), 845–861.

Howe, D. (2009). *A brief introduction to social work theory*. London, Great Britain: Palgrave Macmillan.

Human Rights and Equal Opportunity Commission. (1997). *Bringing them home: Report of the national inquiry into the separation of Aboriginal and Torres Strait Islander children from their families*. Sydney, Australia: Human Rights and Equal Opportunity Commission.

Humphreys, C., & Joseph, S. (2004). Domestic violence and the politics of trauma. *Women's Studies International Forum*, *27*(5–6), 559–570. https://doi.org/10.1016/j.wsif.2004.09.010

Humphreys, C., & Thiara, R. (2003). Mental health and domestic violence: “I call it symptoms of abuse.” *The British Journal of Social Work*, *33*(2), 209–226.

Huntington, N., Moses, D. J., & Veysey, B. M. (2005). Developing and implementing a comprehensive approach to serving women with co-occurring disorders and histories of trauma. *Journal of Community Psychology*, *33*(4), 395–410. https://doi.org/10.1002/jcop.20059

Intervoice. (2013). Why call it ’Hearing Voices? Retrieved from http://www.intervoiceonline.org/2238/voices/what-is-hearing-voices/why-call-it-hearing-voices.html

Isobel, S. (2016). Trauma informed care: a radical shift or basic good practice? *Australasian Psychiatry*, *24*(6), 589–591. https://doi.org/10.1177/1039856216657698

Isobel, S., & Edwards, C. (2017). Using trauma informed care as a nursing model of care in an acute inpatient mental health unit: A practice development process. *International Journal of Mental Health Nursing*, *26*(1), 88–94. https://doi.org/10.1111/inm.12236

Janssen, I., Krabbendam, L., Bak, M., Hanssen, M., Vollebergh, W., Graaf, R. de., & Os, J. van. (2004). Childhood abuse as a risk factor for psychotic experiences. *Acta Psychiatrica Scandinavica*, *109*(1), 38–45. https://doi.org/10.1046/j.0001-690X.2003.00217.x

Jaynes, J. (1976). *The origins of consciousness in the breakdown of the bicameral mind*. Boston, MA: Houghton Mifflin.

Jennings, A. (2004). *Models for developing trauma-informed behavioral health systems and trauma-specific services*. Alexandria, VA: National Association of State Mental Health Program Directors, National Technical Assistance Centre for State Mental Health Planning. Retrieved from http://transformation-center.org/wp-content/uploads/2012/06/Trauma-Model-update-2007.pdf

Johns, L. C., & van Os, J. (2001). The continuity of psychotic experiences in the general population. *Clinical Psychology Review*, *21*(8), 1125–1141. https://doi.org/10.1016/S0272-7358(01)00103-9

Johnstone, L. (2012). Voice hearers are people with problems, not patients with illnesses. In M. Romme & S. Escher (Eds.), *Psychosis as a personal crisis- An experience based approach* (pp. 27–36). New York, NY: Routledge.

Joseph, S., & Murphy, D. (2014). Trauma: A unifying concept for social work. *British Journal of Social Work*, *44*(5), 1094–1109. https://doi.org/10.1093/bjsw/bcs207

Kezelman, C., & Stavropoulos, P. (2012). *Practice guidelines for treatment of complex trauma and trauma informed care and service delivery*. Sydney, Australia: Adults Surviving Child Abuse.

Kingdon, D. G., Ashcroft, K., Bhandari, B., Gleeson, S., Warikoo, N., Symons, M., … Mehta, R. (2010). Schizophrenia and borderline personality disorder: similarities and differences in the experience of auditory hallucinations, paranoia, and childhood trauma. *Journal of Nervous and Mental Disease*, *198*(6), 399–403. https://doi.org/10.1097/NMD.0b013e3181e08c27

Kruger, A. (2000). Schizophrenia: Recovery and hope. *Journal Summer 2000*, *24*(1), 29–37. https://doi.org/10.1037/h0095126

Krumpal, I. (2013). Determinants of social desirability bias in sensitive surveys: a literature review. *Quality and Quantity*, *47*(4), 2025–2047. https://doi.org/http://dx.doi.org.ezp.lib.unimelb.edu.au/10.1007/s11135-011-9640-9

Kuhn, T. (1962). *The structure of scientific revolutions*. Chicago, Ill: The University of Chicago Press.

Kvale, S. (2008). *Doing interviews*. London, Great Britain: Sage.

Lab, D. D., Feigenbaum, J. D., & De Silva, P. (2000). Mental health professionals' attitudes and practices towards male childhood sexual abuse. *Child Abuse & Neglect*, *24*(3), 391–409. https://doi.org/10.1016/S0145-2134(99)00152-0

Lakeman, R. (2008). Family and carer participation in mental health care: perspectives of consumers and carers in hospital and home care settings. *Journal of Psychiatric and Mental Health Nursing*, *15*(3), 203–211. https://doi.org/10.1111/j.1365-2850.2007.01213.x

Lasser, C. J., & Bathory, D. S. (1997). Reciprocal causality and childhood trauma: An application of chaos theory. In F. Masterpasqua & P. Perna (Eds.), *The psychological meaning of chaos: Translating theory into practice* (pp. 147–173). Washington, DC: American Psychological Association.

Le Boutillier, C., Leamy, M., Bird, V. J., Davidson, L., Williams, J., & Slade, M. (2011). What does recovery mean in practice? A qualitative analysis of international recovery-oriented practice guidance. *Psychiatric Services*, *62*(12), 1470–1476. https://doi.org/10.1176/appi.ps.001312011

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry*, *199*(6), 445–452. https://doi.org/10.1192/bjp.bp.110.083733

Lieb, K., Zanarini, M. C., Schmahl, C., Linehan, M. M., & Bohus, M. (2004). Borderline personality disorder. *The Lancet*, *364*(9432), 453–461. https://doi.org/10.1016/S0140-6736(04)16770-6

Little, L., & Hamby, S. L. (1996). Impact of a clinician's sexual abuse history, gender, and theoretical orientation on treatment issues related to childhood sexual abuse. *Professional Psychology: Research and Practice*, *27*(6), 617.

Lobban, F., Haddock, G., Kinderman, P., & Wells, A. (2002). The role of metacognitive beliefs in auditory hallucinations. *Personality and Individual Differences*, *32*(8), 1351–1363. https://doi.org/10.1016/S0191-8869(01)00123-4

Longden, E., Madill, A., & Waterman, M. G. (2012). Dissociation, trauma, and the role of lived experience: Toward a new conceptualization of voice hearing. *Psychological Bulletin*, *138*(1), 28–76. https://doi.org/10.1037/a0025995

Lothian, J., & Read, J. (2002). Asking about abuse during mental health assessments: Clients' views and experiences. *New Zealand Journal of Psychology*, *31*(2).

Luhrmann, T. M., Padmavati, R., Tharoor, H., & Osei, A. (2014). Differences in voice-hearing experiences of people with psychosis in the USA, India and Ghana: interview-based study. *The British Journal of Psychiatry*, *206*(1), bjp.bp.113.139048. https://doi.org/10.1192/bjp.bp.113.139048

Maguire, C., McCusker, C. G., Meenagh, C., Mulholland, C., & Shannon, C. (2008). Effects of trauma on bipolar disorder: the mediational role of interpersonal difficulties and alcohol dependence. *Bipolar Disorders*, *10*(2), 293–302. https://doi.org/10.1111/j.1399-5618.2007.00504.x

Mansfield, Y., Meehan, T., Forward, R., & Richardson-Clarke, F. (2017). Asking the question: childhood sexual abuse in adults with mental illness. *Australian Social Work*, *70*(3), 1–9. https://doi.org/10.1080/0312407X.2016.1213873

Markoff, L. S., Reed, B. G., Fallot, R. D., Elliott, D. E., & Bjelajac, P. (2005). Implementing trauma-informed alcohol and other drug and mental health services for women: Lessons learned in a multisite demonstration project. *American Journal of Orthopsychiatry*, *75*(4), 525–539. https://doi.org/10.1037/0002-9432.75.4.525

McCarthy-Jones, S. (2011). Voices from the storm: A critical review of quantitative studies of auditory verbal hallucinations and childhood sexual abuse. *Clinical Psychology Review*, *31*(6), 983–992. https://doi.org/10.1016/j.cpr.2011.05.004

McCarthy-Jones, S., & Longden, E. (2015). Auditory verbal hallucinations in schizophrenia and post-traumatic stress disorder: common phenomenology, common cause, common interventions? *Psychopathology*, 1071. https://doi.org/10.3389/fpsyg.2015.01071

McEvoy, P., & Richards, D. (2006). A critical realist rationale for using a combination of quantitative and qualitative methods. *Journal of Research in Nursing*, *11*(1), 66–78. https://doi.org/10.1177/ 1744987106060192

McFarlane, A. C. (2000). Traumatic stress in the 21st century. *Australian and New Zealand Journal of Psychiatry*, *34*(6), 896–902. https://doi.org/10.1080/000486700264

McLindon, E., & Harms, L. (2011). Listening to mental health workers' experiences: Factors influencing their work with women who disclose sexual assault. *International Journal of Mental Health Nursing*, *20*(1), 2–11. https://doi.org/10.1111/j.1447-0349.2010.00697.x

McNally, R. J. (2004). Conceptual problems with the DSM-IV criteria for posttraumatic stress disorder. In G. Rosen (Ed.), *Posttraumatic Stress Disorder* (pp. 1–14). West Sussex, England: John Wiley & Sons.

Meadows, G., Cavill, M., Fossey, E., Epstein, M., Leggatt, M., Olsen, A., … Willshire, D. (2012). Assessment: Essential skills. In G. Meadows, J. Farhall, B. Singh, M. Grigg, F. McDermott, & E. Fossey (Eds.), *Mental health in Australia* (3rd ed., pp. 342–393). South Melbourne, Australia: Oxford University Press.

Mellinan, L. (1996). Through Mandated Inquiry. *Psychiatric Services*, *47*(2), 165. https://doi.org/10.1176/ps.47.2.165

Mental Health Council of Australia. (2005). *Not for service*. Canberra, Australia: Mental Health Council of Australia. Retrieved from https://www.humanrights.gov.au/sites/default/files/content/disability_rights/notforservice/documents/NFS_Finaldoc.pdf

Meyer, A. (1952). *The collected papers of Adolf Meyer* (Vol. 3). Baltimore, MD: Johns Hopkins Press.

Milroy, H. (2005). Preface. In S. Zubrick, S. Silburn, D. Lawrence, F. Mitrou, R. Dalby, E. Blair, … J. Li (Eds.), *The West Australian Aboriginal Child Health Survey: The Social and emotional wellbeing of Aboriginal children and young people* (pp. xiii–xxviii). Perth, Australia: Curtin University of Technology and Telethon Institute for Child Health Research.

Mingers, J. (2014). *Systems thinking, critical realism and philosophy: A confluence of ideas*. New York, NY: Routledge.

Moncrieff, J. (2010). Psychiatric diagnosis as a political device. *Social Theory & Health*, *8*(4), 370–382. https://doi.org/http://dx.doi.org.ezp.lib.unimelb.edu.au/10.1057/sth.2009.11

Moore, L. W., & Miller, M. (1999). Initiating research with doubly vulnerable populations. *Journal of Advanced Nursing*, *30*(5), 1034–1040. https://doi.org/10.1046/j.1365-2648.1999.01205.x

Moskowitz, A., & Corstens, D. (2008). Auditory hallucinations: Psychotic symptom or dissociative experience? *Journal of Psychological Trauma*, *6*(2–3), 35–63. https://doi.org/10.1300/J513v06n02_04

Mueser, K. T., Bellack, A. S., & Brady, E. U. (1990). Hallucinations in schizophrenia. *Acta Psychiatrica Scandinavica*, *82*(1), 26–29. https://doi.org/10.1111/j.1600-0447.1990.tb01350.x

Muskett, C. (2014). Trauma-informed care in inpatient mental health settings: A review of the literature. *International Journal of Mental Health Nursing*, *23*(1), 51–59. https://doi.org/10.1111/inm.12012

National Health and Medical Research Council. (2012). *Clinical practice guidelines for the management of borderline personality disorder*. Melbourne, Australia: National Health and Medical Research Council.

National Mental Health Commission. (2013). *A contributing life: The 2013 national report card on mental health and suicide prevention.* Sydney, Australia: NMHC.

National Mental Health Commission. (2014). *The national review of mental health programmes and services*. Sydney, Australia: NMHC.

Neville, H. A., & Heppner, M. J. (1999). Contextualizing rape: Reviewing sequelae and proposing a culturally inclusive ecological model of sexual assault recovery. *Applied and Preventive Psychology*, *8*(1), 41–62. https://doi.org/10.1016/S0962-1849(99)80010-9

Noorani, T. (2013). Service user involvement, authority and the "expert-by-experience" in mental health. *Journal of Political Power*, *6*(1), 49–68. https://doi.org/10.1080/2158379X.2013.774979

O'Connell, M., Tondora, J. P., Croog, G., Evans, A., & Davidson, L. (2005). From rhetoric to routine: assessing perceptions of recovery-oriented practices in a state mental health and addiction system. *Journal Spring 2005*, *28*(4), 378–386. https://doi.org/10.2975/28.2005.378.386

Patel, G. (2008). Community treatment orders in Victoria: A clinico-ethical perspective. *Australasian Psychiatry*, *16*(5), 340–343. https://doi.org/10.1080/10398560802233017

Perry, B. D., Pollard, R. A., Blakley, T. L., Baker, W. L., & Vigilante, D. (1995). Childhood trauma, the neurobiology of adaptation, and "use dependent" development of

the brain: How “states” become “traits.” *Infant Mental Health Journal*, *16*(4), 271–291.

Pilgrim, D. (2002). The biopsychosocial model in Anglo-American psychiatry: Past, present and future? *Journal of Mental Health*, *11*(6), 585–594. https://doi.org/10.1080/09638230020023930

Pilgrim, D. (2007). The survival of psychiatric diagnosis. *Social Science & Medicine*, *65*(3), 536–547. https://doi.org/10.1016/j.socscimed.2007.03.054

Posner, J., Eilenberg, J., Friedman, J. H., & Fullilove, M. (2008). Quality and use of trauma histories obtained from psychiatric outpatients: a ten-year follow-up. *Psychiatric Services*, *59*(3), 318–321.

Pruitt, J. A., & Kappius, R. E. (1992). Routine inquiry into sexual victimization: A survey of therapists’ practices. *Professional Psychology: Research and Practice*, *23*(6), 474.

Ralph, N., Hamaguchi, K., & Cox, M. (2006). Transgenerational trauma, suicide and healing from sexual abuse in the Kimberley Region, Australia. *Pimatisiwin: A Journal of Aboriginal & Indigenous Community Health*, *4*(2). Retrieved from http://www.pimatisiwin.com/uploads/386689234.pdf

Read, J. (1998). Child abuse and severity of disturbance among adult psychiatric inpatients. *Child Abuse & Neglect*, *22*(5), 359–368. https://doi.org/10.1016/S0145-2134(98)00009-X

Read, J., Agar, K., Barker-Collo, S., Davies, E., & Moskowitz, A. (2001). Assessing suicidality in adults: Integrating childhood trauma as a major risk factor. *Professional Psychology: Research and Practice*, *32*(4), 367. https://doi.org/10.1037/0735-7028.32.4.367

Read, J., Fink, P. J., Felitti, V., & Whitfield, C. L. (2008). Child maltreatment and psychosis: A return to a genuinely integrated bio-psycho-social model. *Clinical Schizophrenia & Related Psychoses*, *2*(3), 235–254. https://doi.org/10.1016/S0191-8869(01)00123-4

Read, J., Fosse, R., & Perry, B. (2014). The traumagenic neurodevelopmental model of psychosis revisited. *Neuropsychiatry*, *4*(1), 65–79. https://doi.org/http://dx.doi.org.ezp.lib.unimelb.edu.au/10.2217/npy.13.89

Read, J., & Fraser, A. (1998). Abuse histories of psychiatric inpatients: To ask or not to ask? *Psychiatric Services*, *49*(3), 355–359. https://doi.org/10.1176/ps.49.3.355

Read, J., Hammersley, P., & Rudegeair, T. (2007). Why, when and how to ask about childhood abuse. *Advances in Psychiatric Treatment*, *13*(2), 101–110. https://doi.org/10.1192/apt.bp.106.002840

Read, J., McGregor, K., & Thomas, D. R. (2006). Mental health services and sexual abuse: The need for staff training. *Journal of Trauma and Dissociation*, *7*(1), 33–50. https://doi.org/10.1300/J229v07n01_04

Read, J., Perry, B. D., & Connolly, J. (2001). The contribution of early traumatic events to schizophrenia in some patients: a traumagenic neurodevelopmental model. *Psychiatry: Interpersonal and Biological Processes*, *64*(4), 319–345.

Read, J., Sampson, M., & Critchley, C. (2016). Are mental health services getting better at responding to abuse, assault and neglect? *Acta Psychiatrica Scandinavica*, *134*(4), 287–294. https://doi.org/10.1111/acps.12552

Resick, P. A., Bovin, M. J., Calloway, A. L., Dick, A. M., King, M. W., Mitchell, K. S., … Wolf, E. J. (2012). A critical evaluation of the complex PTSD literature: Implications for

DSM-5. *Journal of Traumatic Stress*, *25*(3), 241–251. https://doi.org/10.1002/jts.21699

Roberts, B. M., & Maybery, D. (2014). Dual diagnosis discourse in Victoria Australia: The responsiveness of mental health services. *Journal of Dual Diagnosis*, *10*(3), 139–144. https://doi.org/10.1080/15504263.2014.929332

Romme, M., & Escher, A. D. (1989). Hearing voices. *Schizophrenia Bulletin*, *15*(2), 209–216.

Romme, M., & Escher, S. (2010). Personal history and hearing voices. In F. Laroi & A. Aleman (Eds.), *Hallucinations- a guide to treatment and management* (pp. 150–223). Oxford, Great Britain: Oxford University Press.

Rose, D., Trevillion, K., Woodall, A., Morgan, C., Feder, G., & Howard, L. (2011). Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study. *The British Journal of Psychiatry*, *198*(3), 189–194. https://doi.org/10.1192/bjp.bp.109.072389

Rosen, A., Gurr, R., & Fanning, P. (2010). The future of community-centred health services in Australia: lessons from the mental health sector. *Australian Health Review*, *34*(1), 106–115. https://doi.org/10.1071/AH09741#sthash.QifTDlaY.dpuf

Rosenberg, S. (2011). True north? *International Journal of Mental Health*, *40*(2), 8–24. https://doi.org/DOI 10.2753/IMH0020-7411400201

Rossiter, A., Byrne, F., Wota, A. P., Nisar, Z., Ofuafor, T., Murray, I., … Hallahan, B. (2015). Childhood trauma levels in individuals attending adult mental health services: An evaluation of clinical records and structured measurement of childhood trauma.

Child Abuse & Neglect, *44*(1), 36–45. https://doi.org/10.1016/j.chiabu.2015.01.001

Rudnick, A. (2002). The molecular turn in psychiatry: A philosophical analysis. *Journal of Medicine and Philosophy*, *27*(3), 287–296. https://doi.org/10.1076/jmep.27.3.287.2979

Russell, D. (1984). *Sexual exploitation: Rape, child sexual abuse, and sexual harassment*. Beverley Hills, LA: SAGE Publications.

SAMHSA. (2014a). *SAMHSA's concept of trauma and guidance for a trauma-informed approach* (No. HHS Publication No. (SMA) 14-4884). Rockville, MD: Substance Abuse and Mental Health Services Administration.

SAMHSA. (2014b). *Trauma-informed care in behavioral health services* (Treatment Improvement Protocol (TIP) Series 57 No. HHS Publication No. (SMA) 14-4816). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Sanjuan, J., Toirac, I., Gonzalez, J., Leal, C., Molto, M., Najera, C., & De Frutos, R. (2004). A possible association between the CCK-AR gene and persistent auditory hallucinations in schizophrenia. *European Psychiatry*, *19*(6), 349–353.

Sar, V., Taycan, O., Bolat, N., Oezmen, M., Duran, A., Oeztuerk, E., & Ertem-Vehid, H. (2010). Childhood trauma and dissociation in schizophrenia. *Psychopathology*, *43*(1), 33–40. https://doi.org/http://dx.doi.org.ezp.lib.unimelb.edu.au/10.1159/000255961

Schrank, B., & Slade, M. (2007). Recovery in psychiatry. *The Psychiatrist*, *31*(9), 321–325. https://doi.org/10.1192/pb.bp.106.013425

Scott, W. J. (1990). PTSD in DSM-III: A case in the politics of diagnosis and disease. *Social Problems*, *37*(3), 294–310. https://doi.org/10.2307/800744

Scull, A. T. (1989). *Social order/mental disorder: Anglo-American psychiatry in historical perspective*. Berkeley, CA: University of California Press, c1989.

Shergill, S. S., Samson, G., Bays, P. M., Frith, C. D., & Wolpert, D. M. (2005). Evidence for sensory prediction deficits in schizophrenia. *American Journal of Psychiatry*, *162*(12), 2384–2386. https://doi.org/10.1176/appi.ajp.162.12.2384

Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., … Whitley, R. (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*, *13*(1), 12–20. https://doi.org/10.1002/wps.20084

Slade, M., Pinfold, V., Rapaport, J., Bellringer, S., Banerjee, S., Kuipers, E., & Huxley, P. (2007). Best practice when service users do not consent to sharing information with carers. *The British Journal of Psychiatry*, *190*(2), 148–155. https://doi.org/10.1192/bjp.bp.106.024935

Spauwen, J., Krabbendam, L., Lieb, R., Wittchen, H. U., & Van Os, J. (2006). Impact of psychological trauma on the development of psychotic symptoms: relationship with psychosis proneness. *The British Journal of Psychiatry*, *188*(6), 527–533. https://doi.org/10.1192/bjp.bp.105.011346

Spielvogel, A., & Floyd, A. (1997). Assessment of trauma in women psychiatric patients. In M. Harris & C. L. Landis (Eds.), *Sexual abuse in the lives of women diagnosed with a serious mental illness* (pp. 39–64). Amsterdam, Netherlands: Harwood Academic Publishers.

Stanhope, V., & Solomon, P. (2008). Getting to the heart of recovery: Methods for studying recovery and their implications for evidence-based practice. *British Journal of Social Work*, *38*(5), 885–899. https://doi.org/10.1093/bjsw/bcl377

Stone, H., & Stone, S. (2011). *Embracing our selves: The voice dialogue manual*. Novato, CA: New World Library.

Strout, T. D. (2010). Perspectives on the experience of being physically restrained: An integrative review of the qualitative literature. *International Journal of Mental Health Nursing*, *19*(6), 416–427. https://doi.org/10.1111/j.1447-0349.2010.00694.x

Sutton, D., Wilson, M., Van Kessel, K., & Vanderpyl, J. (2013). Optimizing arousal to manage aggression: A pilot study of sensory modulation. *International Journal of Mental Health Nursing*, *22*(6), 500–511. https://doi.org/10.1111/inm.12010

Teddlie, C., & Tashakkori, A. (2009). *Foundations of mixed methods research: Integrating quantitative and qualitative approaches in the social and behavioral sciences*. Thousand Oaks, CA: Sage Publications Inc.

Tener, D., & Murphy, S. B. (2015). Adult disclosure of child sexual abuse: A literature review. *Trauma, Violence, & Abuse*, *16*(4), 391–400. https://doi.org/10.1177/1524838014537906

Thomas, P., & Longden, E. (2015). Phenomenology in a different key: Narrative, meaning, and madness. *Philosophy, Psychiatry, & Psychology*, *22*(3), 187–192. https://doi.org/10.1353/ppp.2015.0031

Tien, A. Y. (1991). Distribution of hallucinations in the population. *Social Psychiatry and Psychiatric Epidemiology*, *26*(6), 287–292. https://doi.org/10.1007/BF00789221

Toh, W. L., Thomas, N., & Rossell, S. L. (2015). Auditory verbal hallucinations in bipolar disorder (BD) and major depressive disorder (MDD): A systematic review. *Journal of Affective Disorders*, *184*(1), 18–28. https://doi.org/10.1016/j.jad.2015.05.040

Tseris, E. J. (2013). Trauma theory without feminism? Evaluating contemporary understandings of traumatized women. *Affilia*, *28*(2), 153–164. https://doi.org/10.1177/0886109913485707

Ullman, S. E. (2007). Relationship to perpetrator, disclosure, social reactions, and PTSD symptoms in child sexual abuse survivors. *Journal of Child Sexual Abuse*, *16*(1), 19–36.

Upthegrove, R., Broome, M. R., Caldwell, K., Ives, J., Oyebode, F., & Wood, S. J. (2015). Understanding auditory verbal hallucinations: a systematic review of current evidence. *Acta Psychiatrica Scandinavica*, *133*(5), 352–367. https://doi.org/10.1111/acps.12531

van der Hart, O., Nijenhuis, E. R. S., & Steele, K. (2005). Dissociation: An insufficiently recognized major feature of complex posttraumatic stress disorder. *Journal of Traumatic Stress*, *18*(5), 413–423. https://doi.org/10.1002/jts.20049

van der Kolk, B. A. (2008). Developmental trauma disorder: towards a rational diagnosis for chronically traumatized children. *Praxis Der Kinderpsychologie Und Kinderpsychiatrie*, *58*(8), 572–586.

van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress*, *18*(5), 389–399. https://doi.org/10.1002/jts.20047

van Os, J., Hanssen, M., Bijl, R. V., & Ravelli, A. (2000). Strauss (1969) revisited: a psychosis continuum in the general population? *Schizophrenia Research*, *45*(1–2), 11–20. https://doi.org/https://doi.org/10.1016/S0920-9964(99)00224-8

Varese, F., Barkus, E., & Bentall, R. P. (2012). Dissociation mediates the relationship between childhood trauma and hallucination-proneness. *Psychological Medicine*, *42*(5), 1025–36. https://doi.org/10.1017/S0033291711001826

Varese, F., Smeets, F., Drukker, M., Lieverse, R., Lataster, T., Viechtbauer, W., … Bentall, R. (2012). Childhood adversities increase the risk of psychosis: A meta-analysis of patient-control, prospective- and cross-sectional cohort studies. *Schizophrenia Bulletin*, *38*(4), 661–671. https://doi.org/10.1093/schbul/sbs050

Von Bertalanffy, L. (1968). *General systems theory*. New York, NY: George Braziller.

Walker, E. F., & Diforio, D. (1997). Schizophrenia: a neural diathesis-stress model. *Psychological Review*, *104*(4), 667–685.

Waring, J., & Burns, A. (2016). Wadamba Willam (online). *Parity*, *29*(8), 43–44.

Watkins, J. (2008). *Hearing voices- A common human experience*. South Yarra, Australia: Michelle Anderson Publishing Pty Ltd.

Weathers, F. W., & Keane, T. M. (2007). The criterion a problem revisited: Controversies and challenges in defining and measuring psychological trauma. *Journal of Traumatic Stress*, *20*(2), 107–121. https://doi.org/10.1002/jts.20210

Woods, A. (2013). The voice-hearer. *Journal of Mental Health*, *22*(3), 263–270. https://doi.org/10.3109/09638237.2013.799267

Wurr, C. J., & Partridge, I. M. (1996). The prevalence of a history of childhood sexual abuse in an acute adult inpatient population. *Child Abuse & Neglect*, *20*(9), 867–872. https://doi.org/10.1016/0145-2134(96)00074-9

Xiao, C. L., Gavrilidis, E., Lee, S., & Kulkarni, J. (2016). Do mental health clinicians elicit a history of previous trauma in female psychiatric inpatients? *Journal of Mental Health*, *25*(4), 1–7. https://doi.org/10.3109/09638237.2016.1139074

Yehuda, R., & McFarlane, A. (1995). Conflict between current knowledge about posttraumatic stress disorder and its original conceptual basis. *American Journal of Psychiatry*, *152*(12), 1705–1713. https://doi.org/10.1176/ajp.152.12.1705

Young, A. (1997). *The harmony of illusions: Inventing post-traumatic stress disorder*. Princeton, NJ: Princeton University Press.

Young, M., Read, J., Barker-Collo, S., & Harrison, R. (2001). Evaluating and overcoming barriers to taking abuse histories. *Professional Psychology: Research and Practice*, *32*(4), 407–414. https://doi.org/10.1037/0735-7028.32.4.407

Zanarini, M. C., Williams, A., Lewis, R., Bradford Reich, B., Vera, S., Marino, M., … Frankenburg, F. (1997). Reported pathological childhood experiences associated with the development of borderline personality disorder. *American Journal of Psychiatry*, *154*(8), 1101–1106. https://doi.org/10.1176/ajp.154.8.1101

Appendices

Appendix 1 – Project advertising for interviews

Research Project

Voice Hearing, Sexual Assault and Service System Responses

THE UNIVERSITY OF MELBOURNE

We are looking for voice hearers who have had an experience of sexual assault or abuse and want to participate in a project seeking their feedback about their experiences using mental health and other social services.

What is this research project about?

This research project is seeking feedback about mental health and other social services from voice hearers who have experienced sexual assault. The project aims to get a better picture of how the service system responds to consumers with these experiences and to find out what consumers identify as helpful or unhelpful practice. The University of Melbourne Research & Ethics Committee has approved this research project.

Who can be involved?

Anyone over the age of 18 who lives in Victoria, has had the experience of hearing voices (otherwise known as auditory hallucinations) and has had an experience of sexual abuse or assault.

What is involved in participation?

We are looking for people who are willing to be interviewed about their experiences. The interview will last between 45 minutes to an hour. Interviews will take place at either Prahran Mission or the University of Melbourne. Interviews will be transcribed. If you wish to verify the transcriptions or provide additional feedback about the issues discussed a second meeting time with the researcher will be organised. Participants will be reimbursed for travel costs up to a total cost of $10.

Where can I get further information?

Please contact Kath Sellick on **0477 006 496** or at **ksellick@student.unimelb.edu.au**

Appendix 2 – Plain language statement for interviews

Department of Social Work
School of Health Sciences

Plain Language Statement

Introduction

You have been invited to participate in this research project as you have responded to an advertisement calling for participants and you have the relevant life experiences that we are looking for as part of this research. This project aims to investigate the service seeking experiences of voice hearers who are also survivors of sexual assault. We are particularly interested in your experiences when accessing mental health services and other social services. This research project will be written as a thesis for Kath Sellick's PhD at the University of Melbourne. Kath is an experienced practitioner in the mental health field and has been working in the field for a number of years.

What will you be asked to do?

Should you agree to participate, you will be asked to participate in an interview exploring your experiences accessing mental heath and other social services. The interview will take between 45 minutes and one hour and will take place either at Prahran Mission, the University of Melbourne or via Skype. The interview will be audiotaped and will be stored in a secure electronic file for five years. The interview will be transcribed and you will invited to verify the transcription and provide any additional information about the issues discussed.

Will I receive counselling or any other kind of treatment by participating in this project?

No, this project is for research and should not be mistaken for counselling or any other kind of treatment. If, whilst participating in this project, you decide that you would like some more support around the issues discussed, the researcher will help you find appropriate support.

Are there any risks in participating in this project?

Discussing topics such as voice hearing and sexual assault may be distressing for some people and there is a chance that you will experience unexpected emotional distress. For this reason, the interviews are primarily focused on your experiences accessing services rather than discussing in detail your experiences of sexual assault.

You will be asked to provide details of a supporter (such as a friend, family member or mental health worker) who the researcher can contact if they are concerned about your safety and wellbeing.

How will my confidentiality be protected?

Information that you provide in the interview will be stored in secure electronic files. The confidentiality of the information you provide will be safeguarded as much as possible within the confines of the law. There are some occasions where information must be released

when the researcher has a duty of care to protect your safety. This would only occur if the researcher had serious concerns about your safety.

Quotes from the interview may be used in the final reporting of this project. You can elect to nominate a pseudonym or your own name.

Will I receive feedback?

When this research project has been completed you will be emailed or posted a summary of results. A full copy of the thesis will be available from Prahran Mission. Information from this project may also be used in conference presentations and other academic papers.

Can I withdraw from this project?

Participation in this project is voluntary and you can withdraw from participation at any time without explanation or prejudice before the data has been processed. You can also withdraw any information you have given in the interviews before it has been processed. If it has been processed you can withdraw consent to have any excerpts from the transcription published.

Will participation in this project prejudice me in any way?

Participation in this project is strictly voluntary and your decision to participate will not be disclosed to any organisation without your consent and will not impact on any service that you receive.

Where can I get additional information?

If you would like any additional information please contact Kath Sellick on 0477006496. If you have any concerns about the conduct of this project please contact either Dr David Rose on 8344 9421, Associate Professor Louise Harms on 8344 9413 or the University of Melbourne Office for Research Ethics and Integrity on 9035 8957.

How can I participate in this project?

If you have read this statement and feel that you would like to participate in this project please get in contact with Kath Sellick on 0477006496. She will then organise a time and place to meet to start the interviews.

Kath Sellick
Phd Candidate
Ph: 0477006496
E: **ksellick@student.unimelb.edu.au**

Dr David Rose
Supervisor
Ph: 8344 9421
E:drose@unimelb.edu.au

Appendix 3 – Interview schedule

Introduction

This interview will explore your experiences when you have engaged with a variety of services. Can you tell me which of the following services you have accessed?

- Public mental health inpatient services (such as Royal Melbourne Hospital, The Alfred etc)
- Private mental health inpatient services (such as Melbourne Clinic, Victoria Clinic etc)
- Public mental health outpatient services (such as Waratah Clinic, Junction clinic)
- Private mental health outpatient services (such as Clarendon Clinic, Victoria Clinic etc)
- Community managed mental health services (such Mind, Prahran Mission, community health services)
- Centres Against Sexual Assault (such as CASA, SeCASA etc)
- Private Psychiatrists, psychologists or counsellors
- Peer support groups (such as hearing voices groups or GROW)

For each service that you have used I will ask you a series of questions about your experiences when using the service. As I am interested in comparing the different services, the questions may seem repetitive.

Inpatient Services

When accessing these services, did staff ask you whether or not you had experienced serious trauma such as sexual assault or abuse?

OR did you disclose voluntarily?

If so, who was the staff member (nurse, psychiatrist, OT, etc) and when did they ask you/did you disclose?

Can you tell me more about this experience?

The following questions may be useful in expanding on this question;

- How did the staff member respond?
- Did you feel safe discussing your experiences with the staff member?
- What support was offered to you following the disclosure of sexual assault/abuse?
- Were you referred to any other services?
- Did they discuss your previous trauma in relation to your presenting mental health issues?
- Did you feel safe when you were on the ward?
- Did you feel that staff ensured that you felt safe on the ward?
- What was helpful or unhelpful about the experience?
- How else did the staff member respond?
- Did staff believe your disclosure?

If you did not disclose or were not asked about sexual abuse or assault can you tell me more about this?

The following questions may be useful in expanding on this question;

- What was the impact of not disclosing?
- Why did you not feel comfortable discussing these experiences with staff?
- What would have helped you disclose your experiences to staff?

Clinical Outpatient services

When accessing these services, did staff ever ask you whether or not you had experienced serious trauma such as sexual assault or sexual abuse?

OR did you disclose voluntarily?

If so, who was the staff member (nurse, psychiatrist, OT, etc) and when did they ask you/did you disclose?

Can you tell me more about this experience?

The following questions may be useful in expanding on this question;

- How did the staff member respond?
- Did you feel safe discussing your experiences with the staff member?
- What support was offered to you following disclosure of sexual assault or abuse?
- Were you referred to any other services?
- Did they discuss your previous trauma in relation to your presenting mental health issues?
- What was helpful or unhelpful about the experience?
- How else did that staff member respond?
- Did staff believe your disclosure?

If you did not disclose or were not asked about sexual abuse or assault can you tell me more about this?

The following questions may be useful in expanding on this question;

- What was the impact of not disclosing?
- Why did you not feel comfortable discussing these experiences with staff?
- What would have helped you disclose your experiences to staff?

Community Managed Mental Health Services

When accessing these services, did staff ever ask you whether or not you had experienced serious trauma such as sexual assault or abuse?

OR did you disclose voluntarily?

If so, who was the staff member (case manager, social worker etc) and when did they ask you/did you disclose?

Can you tell me more about this experience?

The following questions may be useful in expanding on this question;

- How did the staff member respond?
- Did you feel safe discussing your experiences with the staff member?
- What support was offered to you following disclosure of sexual assault or abuse?
- Were you referred to any other services?
- Did they discuss your previous trauma in relation to your presenting mental health issues?
- What was helpful or unhelpful about the experience?
- How else did that staff member respond?
- Did staff believe your disclosure?

If you did not disclose or were not asked about sexual abuse or assault can you tell me more about this?

The following questions may be useful in expanding on this question;

- What was the impact of not disclosing?

- Why did you not feel comfortable discussing these experiences with staff?

- What would have helped you disclose your experiences to staff?

CASA and other trauma counselling services

When did you access these services and for how long?
Were you referred to these services or did you self refer?

Can you tell me more about this experience?

The following questions may be helpful

- Did you discuss your voice hearing with the staff in these services?
- Did you discuss any other mental health concerns with staff?
- Did you feel safe talking about your voices or other symptoms with these staff?
- Did the staff discuss your mental health in relation to your experiences of sexual assault?
- What did you find helpful/unhelpful?
- How else did that staff member respond?
- Did staff believe your disclosure?

If you did not disclose or were not asked about sexual abuse or assault can you tell me more about this?

The following questions may be useful in expanding on this question;

- What was the impact of not disclosing?

- Why did you not feel comfortable discussing these experiences with staff?

- What would have helped you disclose your experiences to staff?

Private Psychologists, Psychiatrists or Counsellors

When accessing these services, did staff ever ask you whether or not you had experienced serious trauma such as sexual assault?

OR did you disclose voluntarily?

If so, who was the staff member (case manager, social worker etc) and when did they ask you/did you disclose?

Can you tell me more about this experience?

The following questions may be useful in expanding on this question;

- How did the staff member respond?
- Did you feel safe discussing your experiences with the staff member?
- What support was offered to you following disclosure of sexual assault?
- Were you referred to any other services?
- Did they discuss your previous trauma in relation to your presenting mental health issues?
- What was helpful or unhelpful about the experience?
- How else did that staff member respond?
- Did staff believe your disclosure?

If you did not disclose or were not asked about sexual abuse or assault can you tell me more about this?

The following questions may be useful in expanding on this question;

- What was the impact of not disclosing?
- Why did you not feel comfortable discussing these experiences with staff?
- What would have helped you disclose your experiences to staff?

Peer Support Groups

When accessing these services, did staff ever ask you whether or not you had experienced serious trauma such as sexual assault?

OR did you disclose voluntarily?

If so, who did you disclose too?

Can you tell me more about this experience?

The following questions may be useful in expanding on this question;

- How did the person/people respond?
- Did you feel safe discussing your experiences?
- What support was offered to you following disclosure of sexual assault?
- Were you referred to any other services?
- Did they discuss your previous trauma in relation to your presenting mental health issues?
- What was helpful or unhelpful about the experience?
- How else did that staff member respond?
- Was your disclosure believed?

If you did not disclose or were not asked about sexual abuse or assault can you tell me more about this?

The following questions may be useful in expanding on this question;

- What was the impact of not disclosing?
- Why did you not feel comfortable discussing these experiences?
- What would have helped you disclose your experiences?

Other Services

Have you accessed any other services to receive support around your voice hearing or your experience of sexual assault or abuse (including other trauma counselling services such as Foundation House)?

If the participant answers yes, proceed with the following questions.

What services did you access? When? For how long?

Can you tell me more about our experiences with the services?

Probing questions;

- What was the focus of the service you received?
- What did you find helpful/unhelpful?

Additional Questions

From your experience, what has been the most helpful experience when accessing support around your voices or your experience of sexual assault or abuse? Why?

Ideally, what would you find most helpful when accessing support around these issues?

Do you have any additional comments or ideas on the topic?

Did you receive support about your experiences of abuse from anyone outside of the service system (family member, friend etc)? Can you tell me what was helpful or unhelpful about these experiences?

Appendix 4 – Debrief sheet for interview

Thank you for participating in this research project!

I will be transcribing this interview, if you are interested in meeting again to verify this transcription or provide any additional feedback about the issues we discussed today please let me know and we will organise another meeting time.

As we have discussed a range of sensitive topics today, you may feel some emotional distress over the next few days. If this occurs, please consider the following options;

- Remind yourself of the coping strategies that you have used the past when you have felt distressed.
- Reach out and talk to someone about how you're feeling.
- Do something relaxing such as taking a bath, practice some deep breathing or go for a walk.
- Do something distracting such as watching a movie, listening to music or focusing on a project.
- Call a telephone counselling line such as;
    - **Victorian Sexual Assault Crisis Line 1800 806 292 (after hours)**
    - **Lifeline 13 11 14 (24 hours)**
    - **Suicide Call Back Service 1300 659 476 (24 hours, if you are having thoughts of suicide)**
- If you have any further questions about the research or would like to be linked to any additional supports around the issues we have discussed please contact me on 0477006496
- If you are feeling like you are unable to keep yourself safe, or if you have an active plan to harm yourself please contact **000.**

If you would like any more support around the issues we have discussed today, please get in contact with me who can support you in getting help.

If you have any further questions about this research please contact either myself, Dr David Rose on 8344 9421 or Prof Louise Harms on 8344 9413.

Thanks again for your participation!

Kath Sellick

Appendix 5 – Consent form for interview

Consent Form **Voice Hearing, sexual assault and service responses.**

Name of Participant: _____

Name of investigators: Kath Sellick, David Rose, Louise Harms

1. I consent to consent to participate in the project named above, the particulars of which, including details of the interviews, have been explained to me. A written copy of the information has been given for me to keep.

2. I authorise the researcher to use my responses from the interview referred to under (1) above.

3. I acknowledge that;

    a. The possible effects of the participating in the interview have been explained to me;

    b. I am free to withdraw from the study at any time without prejudice and explanation and to withdraw any unprocessed data previously supplied to the researcher;

    c. The purpose of this project is for research and is not counselling, therapy or other treatment.

    d. I have been informed that the confidentiality of the information I provide will be safeguarded subject to legal requirements;

    e. That the interview will be audiotaped and kept as a secure file for up to 5 years;

    f. That the recording will be transcribed and a copy returned to me for verification;

    g. That the researcher may use excerpts from the transcribed interview;

    h. That I will be referred to in the study using a pseudonym or any name that I nominate;

    i. I understand that participating in this project will not impact on any service that I receive;

    j. I consent for the researcher to contact my support person …… if the researcher is concerned about my wellbeing

Participant: _____ Date: _____

Signature

Appendix 6 – Project advertising for survey

Are you an Australian mental health professional who works with voice hearers?

We are looking for your feedback about how you work with people who hear voices and have experienced sexual abuse or assault in the past.

This survey will take approximately 15 minutes to complete and respondents will go into the draw to win a $100 Coles Myer gift card

Information gathered will help Australian mental health services improve trauma informed care practices.

If you are interested in the survey please go to the following link
https://www.surveymonkey.com/r/897K6VP.

For information about the project go to
www.ksellickresearch.wordpress.com.

THE UNIVERSITY OF MELBOURNE

This project has received clearance from UoM Ethics Committee (No: 1340208)

Appendix 7 – Plain language statement for survey

Department of Social Work
School of Health Sciences

Plain Language Statement

Introduction

You are invited to participate in this survey that is investigating mental health professional's practices, beliefs and opinions held when working with voice hearers who have had previous experiences of sexual assault or abuse.

The aim of this project is to investigate how the Victorian mental health system is responding to voice hearers who have experienced sexual abuse or assault with the objective of improving how the service system responds to trauma.

This research project will be written as a thesis for Kath Sellick's PhD at the University of Melbourne. Kath is an experienced practitioner in the mental health field and has been working in the field for a number of years.

This research project has been approved by the University of Melbourne Ethics Committee (insert approval number).

What is involved in participating in this project?

Participation in this project involves completing this online/paper survey. This survey will ask you a number of questions based around the following areas;

- How you and your organisation screen and respond to voice hearers who have experienced sexual abuse or assault
- How you share information with families and carers
- Your beliefs and opinions that you hold when working with voice hearers who have experienced sexual abuse or assault
- Your experience of any training that you have received around trauma
- Support received from your organisation around adequately responding to voice hearers who have experienced sexual abuse or assault
- Practice wisdom you may have developed when working with voice hearers who have experienced sexual abuse or assault

The questions are a mixture of multiple choice and open answers and you are given ample space to write your own feedback about the issues discussed. The survey should take between 15 and 20 minutes.

You will also be given an opportunity to add your email address to go into the running to win a $100 gift voucher. Your contact details will be stored separately from your responses to the survey in order to protect your anonymity.

Are there any risks in participating in this project?

Discussing topics around sexual violence may be distressing for some people and there is a chance that you will experience unexpected emotional distress. If this distress is severe it is recommended that you cease completing the survey. There is an information sheet detailing relevant support services and distress coping strategies available from this link as well as the end of the survey. Please utilise this if you feel you need more support. You are also able to contact Kath Sellick on 0477006496 during business hours if you need help accessing additional support.

How will my confidentiality be protected?

The information collected in this survey asks for very general demographic information and consequently you should be able to remain anonymous when you complete the survey. Information that you provide in the survey will be stored in secure electronic files. Any hardcopies of the survey will be locked securely at the University of Melbourne. The confidentiality of the information you provide will be safeguarded as much as possible within the confines of the law. This information will be securely stored for five years. After this time it will be destroyed.

Will I receive further information about this project?

Once the survey is complete the data collected is anonymous. If you are interested in receiving further information about the project please contact Kath Sellick on the details listed below. A full copy of the thesis will be available from Prahran Mission and the University of Melbourne. A summary of the findings of the thesis as well as other information about the research project will be available at the website http://ksellickresearch.wordpress.com. Information from this project may also be used in conference presentations and other academic papers.

Can I withdraw from this project?

Participation in the survey is strictly voluntary and you can cease participation at any point whilst completing the survey. However, once the survey has been submitted is will become anonymous and it will not be possible to withdraw your responses.

Where can I get additional information?

More information about the project is available at http://ksellickresearch.wordpress.com. If you would like any additional information please contact Kath Sellick on 0477006496. If you have any concerns about the conduct of this project please contact either Dr David Rose on 8344 9421, Associate Professor Louise Harms on 8344 9413 or the University of Melbourne Office for Research Ethics and Integrity on 9035 8957.

How do I give consent to participate in this study?

By clicking OK at the end of this page you are consenting to participate in the study.

By submitting a completed survey to the researchers you are consenting to participate in the study.

Appendix 8 – Screen shots of survey

Working with voice hearers who have experienced sexual abuse or assault

Plain Language Statement-Part one

Department of Social Work
School of Health Sciences
Plain Language Statement

Introduction

You are invited to participate in this survey that is investigating mental health professional's practices, beliefs and opinions held when working with voice hearers who have had previous experiences of sexual assault or abuse. The aim of this project is to investigate how the Victorian mental health system is responding to voice hearers who have experienced sexual abuse or assault with the objective of improving how the service system responds to trauma. This research project will be written as a thesis for Kath Sellick's PhD at the University of Melbourne. Kath is an experienced practitioner in the mental health field and has been working in the field for a number of years. This research project has been approved by the University of Melbourne Ethics Committee (insert approval number).

What is involved in participating in this project?

Participation in this project involves completing this online survey. This survey will ask you a number of questions based around the following areas;

- How you and your organisation screen and respond to voice hearers who have experienced sexual abuse or assault
- How you share information with families and carers
- Your beliefs and opinions that you hold when working with voice hearers who have experienced sexual abuse or assault
- Your experience of any training that you have received around trauma
- Support received from your organisation around adequately responding to voice hearers who have experienced sexual abuse or assault
- Practice wisdom you may have developed when working with voice hearers who have experienced sexual abuse or assault.

The questions are a mixture of multiple choice and open answers and you are given ample space to write your own feedback about the issues discussed. The survey should take between 15 and 20 minutes. You will also be given an opportunity to add your email address to go into the running to win a $100 gift voucher. Your contact details will be stored separately from your responses to the survey in order to protect your anonymity.

Are there any risks in participating in this project?

Discussing topics around sexual violence may be distressing for some people and there is a chance that you will experience unexpected emotional distress. If this distress is severe it is recommended that you cease completing the survey. There is an information sheet detailing relevant support services and distress coping strategies available from this link as well as the end of the survey. Please utilise this if you feel you need more support. You are also able to contact Kath Sellick on 0477006496 during business hours if you need help accessing additional support.

How will my confidentiality be protected?

The information collected in this survey asks for very general demographic information and consequently you should be able to remain anonymous when you complete the survey. Information that you provide in the survey will be stored in secure electronic files. Any hardcopies of the survey will be locked securely at the University of Melbourne. The confidentiality of the information you provide will be safeguarded as much as possible within the confines of the law. This information will be securely stored for five years. After this time it will be destroyed.

Working with voice hearers who have experienced sexual abuse or assault

Plain language statement- Part Two

Will I receive further information about this project?

Once the survey is complete the data collected is anonymous. If you are interested in receiving further information about the project please contact Kath Sellick on the details listed below. A full copy of the thesis will be available from Prahran Mission and the University of Melbourne. A copy of the thesis as well as other information about the research project will be available at the website http://ksellickresearch.wordpress.com. Information from this project may also be used in conference presentations and other academic papers.

Can I withdraw from this project?

Participation in the survey is strictly voluntary and you can cease participation at any point whilst completing the survey. However, once the survey has been submitted is will become anonymous and it will not be possible to withdraw your responses.

Where can I get additional information?

More information about the project is available at http://ksellickresearch.wordpress.com. If you would like any additional information please contact Kath Sellick on 0477006496. If you have any concerns about the conduct of this project please contact either Dr David Rose on 8344 9421, Associate Professor Louise Harms on 8344 9413 or the University of Melbourne Office for Research Ethics and Integrity on 9035 8957.

How do I give consent to participate in this study?

By clicking NEXT at the end of this page you are consenting to participate in the study.

Working with voice hearers who have experienced sexual abuse or assault

Introduction and Demographics

This survey will begin by asking you a number of demographic questions, followed by asking you to consider how you would screen for trauma in four vignettes. You will then be asked a series of questions about your practices working with consumers who hear voices who have also experienced sexual abuse or assault. You will be asked about the beliefs and opinions that you hold when working with this demographic, your thoughts about trauma informed training and support from management and finally some questions about any practice wisdom you have developed when working with this group. Most of the questions are multiple choice however there are regular optional opportunities throughout the survey to write your own responses. The survey should take between 10 and 15 minutes.

1. What is your gender?

- ◯ Male
- ◯ Female
- ◯ Transgender
- ◯ Other

2. What is your age?

- ◯ 18-25
- ◯ 26-35
- ◯ 36-45
- ◯ 46-55
- ◯ 56-65
- ◯ 66-75
- ◯ Over 75

3. What is your highest level of education?

- ◯ Part secondary high school
- ◯ Completed secondary high school
- ◯ Certificate (up to IV)
- ◯ Diploma
- ◯ Advanced Diploma
- ◯ Bachelors
- ◯ Masters
- ◯ Doctorate

4. Where do you currently reside?

- ◯ Metropolitan Melbourne
- ◯ Rural Victoria (urban centre population over 10,000 people)
- ◯ Remote Victoria (urban centre population less than 10,000 people)

5. What type of mental health service do you work for? (tick as many as appropriate)

- ☐ Public mental health inpatient facility
- ☐ Public mental health outpatient service
- ☐ Community managed mental health service (formally known as PDRSS)
- ☐ Personal Helpers and Mentors (PHAMS)
- ☐ Peer support group
- ☐ Day to Day living Program
- ☐ Private mental health service
- ☐ Other (please specify)

6. What is your current occupation? (if you work in multiple roles, specify the occupation that you spend most of your time working in)

- ◯ Psychiatric nurse
- ◯ Social worker
- ◯ Psychiatrist
- ◯ Occupational Therapist
- ◯ Psychologist
- ◯ Peer worker
- ◯ Community support worker
- ◯ Other (please specify)

7. How often do you work?

- ◯ Full time
- ◯ Part time
- ◯ Casual
- ◯ Not currently employed

Working with voice hearers who have experienced sexual abuse or assault

8. How long have you worked in the mental health field?

- ◯ Less than 12 months
- ◯ Between 1-2 years
- ◯ Between 2-5 years
- ◯ Between 5-10 years
- ◯ Over 10 years

9. Which of the following statements best describes your role?

- ◯ Working with a specific caseload of consumers
- ◯ Working with consumers as needed in an inpatient or residential service
- ◯ Working with consumers in a group setting
- ◯ Providing secondary consultation to staff working directly with consumers
- ◯ Supervising staff who work directly with consumers
- ◯ Other (please specify)

10. If you work with a caseload of consumers, what is your usual caseload?

- ◯ 0-5
- ◯ 6-10
- ◯ 11-15
- ◯ 16-20
- ◯ 21-25
- ◯ 26-30
- ◯ Over 30
- ◯ I don't have a caseload of consumers

11. In you work with mental health consumers, what percentage of your work involves working with voice hearers?

- ◯ 0%
- ◯ 1-25%
- ◯ 26%-50%
- ◯ 51%-75%
- ◯ 76%-100%

Working with voice hearers who have experienced sexual abuse or assault

Vignettes- Screening for Trauma

Please read the following vignettes and rate how likely you are to ask the described consumers about previous experiences of sexual abuse or assault.

12. A 29 year old female presents at your service. She reports hearing voices telling her that she is "dirty" and a "whore". She says that she is not suicidal and communicates clearly with staff however is observably distressed by her voices.

Very unlikely	Unlikely	Neutral	Likely	Very Likely
◯	◯	◯	◯	◯

13. A 45 year old man presents at your service. He reports hearing the voice of god telling him that he is evil and is a sinner. His behaviour and communication are erratic.

Very Unlikey	Unlikely	Neutral	Likely	Very Likely
◯	◯	◯	◯	◯

14. A 65 year old woman presents at your service and reports hearing voices of a dictatorial government through the air vents. She is highly suspicious of staff and is particularly guarded around men.

Very Unlikely	Unlikely	Neutral	Likely	Very Likely
◯	◯	◯	◯	◯

15. A 21 year old man presents to your service. He has never used mental health services before. He reports hearing voices commanding himself to harm various body parts. These voices started after his first sexual experience with his girlfriend. He also reports very high levels of anxiety and at times a feeling of being disconnected with himself.

Very Unlikely	Unlikely	Neutral	Likely	Very Likely
◯	◯	◯	◯	◯

16. Please comment on why you have chosen your ratings for different consumers.

Working with voice hearers who have experienced sexual abuse or assault

Screening and responding to trauma

This section will ask you about how you and your organisation screen and respond to trauma.

17. How often do you ask consumers who hear voices about previous experiences of sexual abuse or assault?

Never	Rarely	Sometimes	Often	Always
◯	◯	◯	◯	◯

18. What influences you to ask voice hearers about sexual abuse this often?

19. Does your organisation require you to screen consumers for previous experiences of trauma?

- ◯ Yes
- ◯ No
- ◯ I don't know

20. If Yes, how does your organisation communicate this requirement? (tick as many as appropriate)

- ☐ Trauma screening questions are included on assessment forms
- ☐ There are policies and/or procedures in place that require staff to enquire about trauma
- ☐ Supervisors or team leaders encourage staff to screen for trauma
- ☐ My organisation does not require me to screen consumers for previous experiences of trauma
- ☐ Other (please specify)

21. Please comment on the effectiveness/ lack of effectiveness of your organisations requirements for screening trauma.

Working with voice hearers who have experienced sexual abuse or assault

22. Does your organisation have information (posters, pamplets etc) about trauma and trauma related services readily available for consumers?

- ◯ Yes
- ◯ No
- ◯ I don't know

23. If yes, please describe the information available.

Working with voice hearers who have experienced sexual abuse or assault

Responding to disclosures of abuse

The following questions will ask you how you respond to voice hearers who disclose past experiences of sexual assault or abuse.

24. When working with consumers who hear voices, have any consumers disclosed experiences of sexual abuse or assault to you?

- ◯ No
- ◯ Yes

25. When a consumer who hears voices has disclosed experiences of sexual abuse or assault, has this changed how you have worked with them?

No change	Some change	Neutral	Moderate level of change	Significant change	N/A
◯	◯	◯	◯	◯	◯

26. If you changed how you worked, how?

27. When a consumer who hears voices has disclosed experiences of sexual abuse or assault how often would you include this in your professional formulation?

Never	Rarely	Neutral	Sometimes	Always	N/A
◯	◯	◯	◯	◯	◯

28. What influences you to include information about abuse this often?

29. When a consumer who hears voices has disclosed that they have experienced sexual abuse or assault how often would you include a trauma related response in your treatment plan/intervention/program plan?

Never	Rarely	Sometimes	Often	Always	N/A
◯	◯	◯	◯	◯	◯

Working with voice hearers who have experienced sexual abuse or assault

30. What kind of trauma related responses are you including in your treatment/intervention/program plans? (tick as many as appropriate)

- [ ] Referral to trauma counselling services such as CASA
- [ ] Providing trauma related counselling directly
- [ ] Providing information about trauma services available
- [ ] Providing psycho-education about trauma
- [ ] N/A
- [ ] Other (please specify)

31. If you are not including trauma related responses in your treatment/intervention/program plans, why?

32. Please comment here about anything else regarding how you include disclosures of sexual abuse or assault in treatment/intervention/program plans.

33. When a consumer who hears voices has disclosed that they have experienced sexual abuse or assault, how often have you provided trauma related counselling?

Never	Rarely	Sometimes	Often	Always	N/A
◯	◯	◯	◯	◯	◯

Working with voice hearers who have experienced sexual abuse or assault

34. If you have provided trauma related counselling, please detail the counselling approaches you have used (tick as many as appropriate).

- [ ] Cognitive behavioural
- [ ] Behavioural
- [ ] Psychodynamic
- [ ] Psycho-education
- [ ] Narrative
- [ ] Feminist
- [ ] A combination of approaches best suited to the consumer
- [ ] Other (please specify)

35. Please comment here about anything else regarding your provision of trauma related counselling.

36. When a consumer who hears voices has disclosed that they have experienced sexual abuse or assault how often have you referred them to trauma related counselling?

Never	Rarely	Sometimes	Often	Always	N/A
○	○	○	○	○	○

37. If you have referred a voice hearer to trauma related counselling where did you refer them to? (tick as many appropriate)

- [ ] CASA (Centre Against Sexual Assault)
- [ ] Private psychologist
- [ ] Counsellor outside your service
- [ ] A psychologist employed by your service
- [ ] A counsellor employed by your service
- [ ] Private social worker
- [ ] Private psychiatrist
- [ ] Private counsellor
- [ ] Other (please specify)

Working with voice hearers who have experienced sexual abuse or assault

38. Please comment on how effective you feel your referrals were.

39. If you don't refer voice hearers to trauma related counselling, why?

40. Please comment here about anything else related to referring to trauma related counselling.

41. When a consumer who hears voices has disclosed that they have experienced sexual abuse or assault how often do you did you report abuse or help the consumer report the abuse to legal authorities?

Never	Rarely	Sometimes	Often	Always	N/A
◯	◯	◯	◯	◯	◯

42. What has influenced you to report or help report abuse this often?

Working with voice hearers who have experienced sexual abuse or assault

Working with families and carers

These questions relate to how you communicate with family members and carers of the consumers that you work with.

43. When communicating with consumer's family members about their treatment or inquiring about their history, how often do you check with consumers if they are comfortable with these discussions taking place?

Never	Rarely	Sometimes	Often	Always	N/A
◯	◯	◯	◯	◯	◯

44. Are there times when you do not seek a consumer's consent when consulting with family members/carers?

◯ Yes

◯ No

45. If Yes, please check the following reasons why you would not seek a consumer's consent before consulting with family members/carers?

◯ If I feel that the consumer is too unwell to consent to treatment

◯ If I feel that the consumer is too unwell to provide accurate details about their life

◯ If I feel I need more information about the consumer

◯ If the family members/carers ask about the consumer's care and treatment

◯ If I felt that the consumer was at risk of harming themselves or others and speaking with family/carers would help prevent harm from occurring

◯ Other (please specify)

Working with voice hearers who have experienced sexual abuse or assault

Beliefs and opinions when working with voice hearers who have experienced a...

This section will ask you some questions about some beliefs and opinions that may be involved with how you work with consumers who hear voices and have experienced sexual abuse or assault. Please rate to which degree you agree with the following statements.There will be space at the end of these questions to comment on your answers.

46. I am reluctant to ask a consumer of the opposite gender about their experiences of sexual abuse or assault

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
◯	◯	◯	◯	◯

47. I am reluctant to ask a consumer of the same gender about their experiences of sexual abuse or assault

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
◯	◯	◯	◯	◯

48. I am reluctant to ask a consumer about sexual abuse or trauma who I feel is presenting with disturbing symptoms

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
◯	◯	◯	◯	◯

49. I am concerned that asking consumers about sexual abuse or assault will negatively impact on my engagement with the consumer

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
◯	◯	◯	◯	◯

50. I am concerned about upsetting consumers by asking about their experiences of sexual abuse or assault

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
◯	◯	◯	◯	◯

51. I am concerned about eliciting false memories if I ask consumers about sexual abuse or assault

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
◯	◯	◯	◯	◯

52. I do not ask consumers who hear voices about their experiences of sexual assault or abuse as I believe that trauma is not related to the experience voice hearing

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
◯	◯	◯	◯	◯

Working with voice hearers who have experienced sexual abuse or assault

53. I believe that hearing voices is related to biological causes and so do not feel the need to enquire about sexual abuse or assault

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
◯	◯	◯	◯	◯

54. What do you think are the causes of voice hearing?

- ◯ Biological factors (genetics, brain structure, etc)
- ◯ Environmental factors (trauma, poverty, hostile family environment etc)
- ◯ A mixture of both biological and environmental causes
- ◯ The causes of voice hearing vary from person to person
- ◯ Other (please specify)

55. I do not believe it is my role to ask consumers who hear voices about their experiences of sexual abuse or assault

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
◯	◯	◯	◯	◯

56. Please comment here on any of your responses to the above questions.

Working with voice hearers who have experienced sexual abuse or assault

Training and knowledge of working with trauma

The following questions will ask about the role of training and knowledge in helping you support voice hearers who have experienced sexual assault or abuse.

57. I feel that adequate training is important to help me respond well to consumers who hear voices and have experienced sexual abuse or assault

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
◯	◯	◯	◯	◯

58. I have received training around trauma informed care

◯ Yes

◯ No

59. If Yes- What training have you received?

60. I feel adequately trained to respond to consumers who hear voices and have been sexually abused or assaulted

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
◯	◯	◯	◯	◯

61. Please comment here on anything else related to trauma related training.

62. I feel confident enough to ask voice hearers if they have experienced sexual abuse or assault

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
◯	◯	◯	◯	◯

63. I don't know where to refer voice hearers who have disclosed experiences of sexual abuse or assault

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
◯	◯	◯	◯	◯

64. What would increase your awareness of where to refer voice hearers who have experiences abuse?

Working with voice hearers who have experienced sexual abuse or assault

65. I don't feel that there are any appropriate services to support voice hearers who have experienced sexual abuse or assault

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
◯	◯	◯	◯	◯

66. Please comment on anything else you would like to add about knowledge of available services.

Working with voice hearers who have experienced sexual abuse or assault

Support from management and your organisation

The following questions will ask you about support received from management and your organisation when supporting voice hearers who have experienced sexual assault or abuse.

67. I feel that support from management is important in helping me adequately respond to consumers who hear voices and have experienced sexual abuse or assault

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
◯	◯	◯	◯	◯

68. I feel adequately supported by management to respond to consumers who hear voices and have experienced sexual abuse or assault

Strongly Disagree	Diagree	Neutral	Agree	Strongly Agree
◯	◯	◯	◯	◯

69. I feel like I don't have enough time to adequately support consumers who hear voices who have experienced sexual abuse or assault

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
◯	◯	◯	◯	◯

70. What prevents you from having enough time to adequately support consumers who hear voices and have experienced sexual abuse or assault?

71. The size of my workload prevents me from adequately supporting consumers who hear voices who have experienced sexual abuse or assault

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
◯	◯	◯	◯	◯

72. I am worried I will find talking about sexual abuse or assault with consumers too personally confronting

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
◯	◯	◯	◯	◯

73. I feel it is important that I have access to supportive debriefing after I discuss sexual abuse or assault with consumers

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
◯	◯	◯	◯	◯

Working with voice hearers who have experienced sexual abuse or assault

74. I feel that my workplace provides adequate supportive debriefing after I discuss sexual abuse or assault with consumers

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
◯	◯	◯	◯	◯

75. If you don't feel like your workplace provides adequate supportive debriefing, what could they be doing differently?

Working with voice hearers who have experienced sexual abuse or assault

Practice Wisdom

The next questions will ask you about your practice wisdom when working with voice hearers who have experienced sexual abuse or assault.

76. When working with voice hearers who have experienced sexual abuse or assault, what have you found are the most challenging aspects of the work?

77. When working with voice hearers who have experienced sexual abuse or assault what have you found most helpful?

78. What practice wisdom have you developed when working with voice hearers who have experienced sexual abuse or assault?

79. Please add any additional comments you would like to make about this topic here.

Contact details for $100 gift card prize

80. Please add your email to go into the running to win a $100 Coles Myer gift voucher (this email address will be detached from your responses to this survey)

Email Address