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FEATURE ARTICLE

'I was raped by Santa Claus': Responding to disclosures of sexual assault in mental health inpatient facilities

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ABSTRACT: *Sexual violence is significantly higher among those with mental illness than the rest of the population. The risk of sexual violence posed to patients during inpatient admissions is now also beginning to be recognized, but remains a challenging area of practice. This paper introduces a trauma-informed care approach for responding to disclosures of sexual violence by people with serious mental illness, taking into account the complexities of caring for individuals who might be unable to provide coherent accounts of assaults and/or who might be experiencing varying degrees of psychosis. A framework for understanding and responding to disclosures of sexual violence that occur in mental health facilities is described, recognizing that such disclosures take many forms, including plausible and implausible accounts of recent sexual violence, as well as disclosures of past abuse triggered by current traumatic experiences. Illustrated by case studies, the practice implications for each type of disclosure described in the framework are explored in relation to investigation, care planning, and prevention.*

KEY WORDS: *false allegations, mental health, sexual assault, trauma, trauma informed care.*

INTRODUCTION

Sexual violence, which we define here as 'acts of a sexual nature carried out against a person's will, through the use of physical force, intimidation or coercion, or any attempts to do this', is widespread across the community. Approximately one in five women and one in 20 men have experienced physical sexual assaults from 15 years of age in Australia (Australian Bureau of Statistics 2013). Rates of all types of victimization are significantly higher among those with mental illness compared to the rest of the population (Goodman *et al*. 2001; Spataro *et al*. 2004), with one study finding that 88% of people with mental illnesses had one or more lifetime experience(s) of victimization (McFarlane *et al*. 2006). Psychiatric inpatient settings are now beginning to be recognized as high-risk sites for the sexual assault of patients, particularly women (Burdekin *et al*. 1993; Clarke and Victorian Women and Mental Health Network, 2008; Davidson 1997; National Patient Safety Agency 2006). Between 5% and 45% of mental health inpatients have experienced sexual violence during an admission, according to Australian and US research (Clarke and Victorian Women & Mental Health Network, 2008; Frueh *et al*. 2005; Grubaugh *et al*. 2007; Victorian Mental Illness Awareness Council 2013). While many assaults are perpetrated by other patients, one study found that 3% of mental health patients had experienced sexual violence by a staff member during an admission (Grubaugh *et al*. 2007).

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Growing recognition of this problem has prompted the introduction of policies and training for mental health staff (Lawn & McDonald 2009; National Patient Safety Agency 2006; Read *et al*. 2007; Stenius & Veysey 2005). In the Australian State of New South Wales (NSW), the Health Department has introduced guidelines for inpatient units (NSW Department of Health 2013), and statewide training (Education Centre Against Violence 2013). These measures reflect the growth of trauma-informed care models that recognize the links between prior trauma and mental illness (Elliott *et al*. 2005; Harris & Fallot 2001; Kezelman & Stavropoulos 2012), and with which this paper aligns.

Despite such initiatives, many mental health professionals report lacking skills and confidence to respond to patient disclosures of sexual assault in the inpatient environment, even those that are coherent and supported by evidence (McLindon & Harms 2011). Challenges include patient capacity to consent, doubts about the reliability of accounts by those in psychotic states, as well as legal implications of incidents, particularly in cases where the reported assailant is a staff member. The situation is compounded by the considerable barriers that patients face in making such disclosures. Relationships between patients and staff members are often known to be hierarchical, with health professionals holding positions of power over patients (Laugharne & Priebe 2006). Cultures of silence, fear, and discipline in institutional settings, including inpatient facilities, can prevent action from being taken, even when staff members identify and report assaults (Clark & Fileborn 2011; Davidson 1997). This can result in patients remaining at risk from perpetrators, when they are not recognized as dangerous. Alternatively, health professionals might believe allegations, but minimize the impact on patients (National Patient Safety Agency 2006). It has been long established that such minimization increases the likelihood of traumatic reactions (Burgess & Holmstrom 1985). Responding to any disclosure of institutional sexual assault is confronting. Compounding this is the lower likelihood that psychiatric inpatients can provide coherent accounts of incidents because of their illness. In such situations, managers are called on to simultaneously ensure appropriate support to a disclosing victim, address patient safety, and determine whether a recent assault has occurred in the facility, attending to legal implications. This situation poses potentially-competing interests, and health professionals require clear guidance on how to respond.

Advances in understanding traumatic memory foreground this paper. Herman's (1997) proposed diagnosis of complex post-traumatic stress disorder recognized the effects of persistent and repeated traumatic experiences. The work of van der Kolk (1994), among others, established that trauma interferes with conscious recall of experience, but not the memory system that controls emotional responses and sensorimotor sensations. This results in traumatic memories continuing to exist in dissociative states that might be re-experienced (Meares 2012; Van der Hart *et al*. 1993). Some commentators remain sceptical of the possibility that memories might be completely dissociated and then re-experienced. The postulation of false memory syndrome by an advocacy group for those accused of past sexual abuse has created ongoing controversy, although a review of the evidence for this syndrome suggests that it lacks general acceptance in the mental health field, and is based on faulty assumptions (Dallam 2002).

This paper does not attempt to address the investigative response to plausible allegations of sexual violence in mental health facilities, which is addressed elsewhere (e.g. Lawn and McDonald 2009, NSW Department of Health 2013). Instead, it focuses on an area not previously addressed in the literature, that is, disclosures of assault that are implausible or incoherent due to patients being in a psychotic or traumatized state. A logical path is provided, to assist health professionals to determine what has occurred, including a framework for responding protectively to address and prevent sexual violence and the retraumatization of patients. We recognize that under most protocols, investigation is not undertaken by clinical staff. The purpose is to provide tools to clinical staff to ensure that allegations are not minimized, and that accounts are taken seriously, which should include documenting, reporting to senior staff, and instigating an investigation. The paper draws on the authors' combined 43 years of experience at the interface of sexual violence and mental health, including participation in policy, investigation, care, and prevention responses.

FRAMEWORK OF DISCLOSURES OF SEXUAL VIOLENCE BY MENTAL HEALTH PATIENTS

When disclosures of sexual violence are made by those with a mental illness, they are often not made in plausible terms, and it can be difficult to determine whether allegations are delusional or not. In our experience, many such allegations have been dismissed on this basis. As outlined, the lack of coherence of the disclosure, however, does not correlate to the lack of veracity of

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the account, due to dissociation during the event and subsequent fragmentation of memories (Hardy *et al*. 2009).

The proposed framework provides a structured process to guide responses to disclosure, assisting to understand the nature of the complaint, working in a logical sequence from most-likely to least-probable scenario. This framework is not a hierarchy in which some patient disclosures are valued more highly than others, but recognizes the considerable challenges faced by health and investigative professionals responding to accounts given by those with mental illnesses in distinguishing events that have happened in real time from those which might be historical or represent triggered memories. The framework provides the means to consider the likelihood of each type of disclosure in order, before moving to a determination that an allegation is unfounded.

As illustrated in Figure 1, we identify five disclosure types. Each type might be either plausibly or implausibly made. Plausible accounts are coherent first-person accounts in circumstances that appear possible and logical, and usually include at least one of the following: an alleged assailant who was present at the stated time and location, witnesses to the event or surrounding circumstances, or a past history of sexual misconduct by the offender. Alternatively, the accounts might be implausible: unclear, lacking credibility, or suggesting circumstances that appear improbable or impossible. The five disclosure types are described in turn, followed by a case example.

Recent sexual assault

The first type of disclosure in the framework, if a disclosure is made at all, is recent sexual assault. In fact, sexual violence is a universally underdisclosed crime, with only six out of 10 women who experience it as adults seeking advice or support for their experience (Australian Bureau of Statistics 2013). This is compounded for mental health patients, for whom additional barriers to disclosing include dissociative amnesia; stigma; self-blame; dependency on the offender; and fear of disbelief, being perceived as homosexual, or of the offender (Davidson 1997; McLindon & Harms 2011). Physical or somatic reactions or witness accounts are the most common means by which staff are alerted to an incident. In our experience, even plausible disclosures are often met with disbelief. Three main reasons for this are: (i) most professionals are distressed to believe that such an event could occur under their care, and many doubt this could be a possibility; (ii) many individuals, including health professionals, have insufficient knowledge about the extent and nature of sexual violence. Erroneous beliefs that sexual violence is rare, that victims are responsible for assaults, that allegations are frequently fabricated, and that true victims will always manifest certain reactions, all serve to jeopardize professional responses and thorough investigation; and (iii) disclosures might also be discounted or rendered invisible if they are made by patients who respond in unexpected ways because of their mental illness (Davidson 1997).

More commonly, when assaults have occurred, disclosures are made in implausible terms, and as a result, are even more likely to be dismissed. It is difficult for mental health professionals to take seriously disclosures that do not appear to make sense. Allegations might, on first encounter, appear to be implausible because the assault has occurred in a short period of time or within close proximity of patients or staff. The reality based on our experience is that assaults can occur on patients placed on 10-min observations. Disclosures also appear implausible when they include inconsistent or apparently fantastic elements, as illustrated in Case study 1. Accounts in which the alleged assailant was not present at the time or other described details are incorrect are not unusual, however, and do not negate the substance of the allegation. Such accounts are better understood with reference to the literature on the impact of trauma on the consolidation of explicit memory (Rothschild 2000; van der Kolk 1994), which notes that recall of traumatic events might exclude important data, such as time or even the identity of an offender, if not encoded in memory. As reported by the patient, however, such a disclosure might seem bizarre and implausible.

Case study 1: Recent sexual assault, implausibly described

After spending 2 weeks in an acute inpatient unit in a psychotic state, Jay had been moved to subacute care, as she began to stabilize. Several days later, Jay returned to the unit after walking in the hospital grounds in a distressed state and told the nurses she had been 'raped by Santa Claus'. Staff assumed this was a regression of her psychosis, and initially dismissed her account. Following further investigation, eye witnesses reported seeing Jay with a groundsman who had a long white beard like Santa Claus. He was also recalled as wearing a red shirt that day. When confronted with this information, the groundsman admitted to having sex with Jay.

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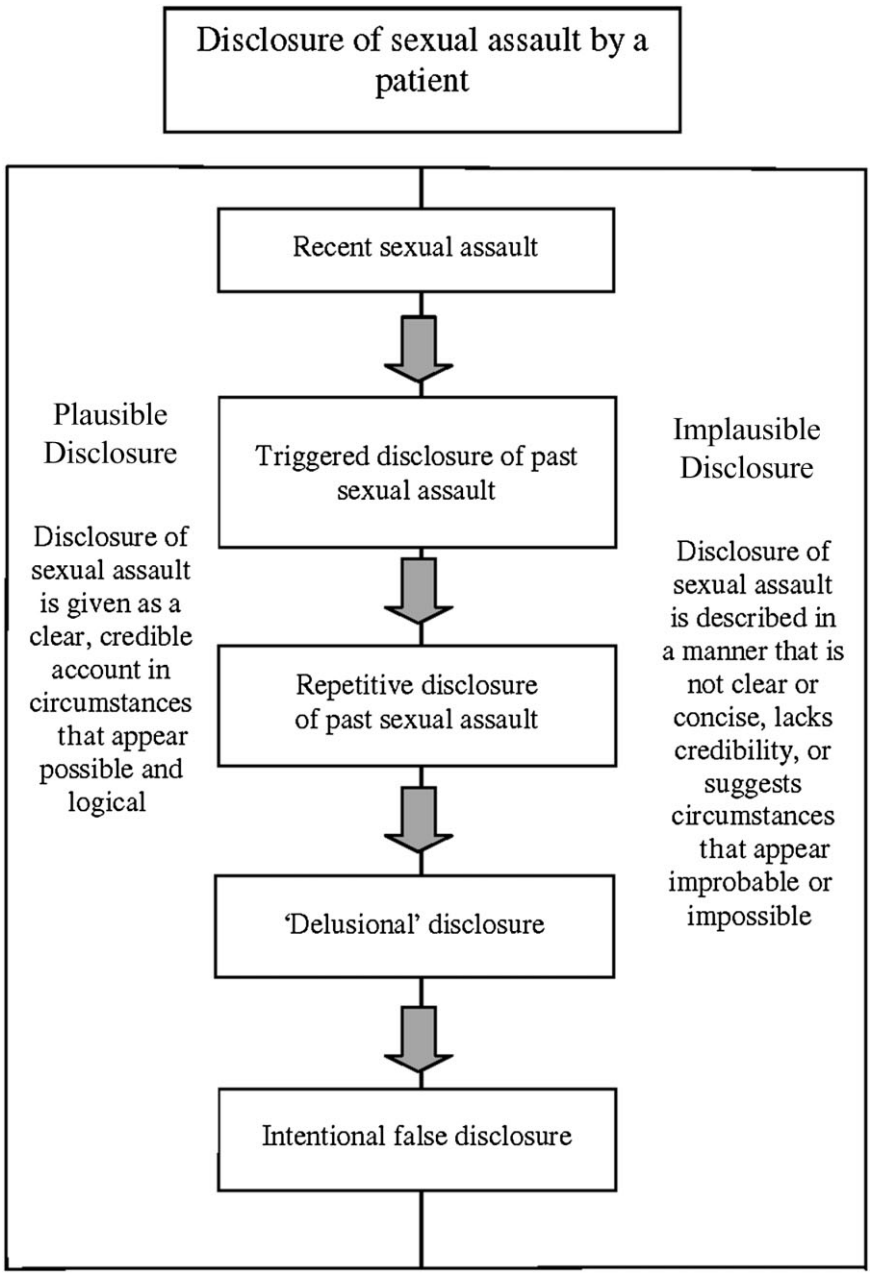

FIG. 1: *Framework for understanding disclosures of sexual assault in mental health facilities.*

Triggered disclosures of past sexual assault

If a recent sexual assault can be excluded from having occurred, progressing sequentially through the framework, we suggest the next most likely possibility is a 'triggered disclosure', in which the patient has been subjected to an assault at an earlier time, memories of which are reactivated and reported by the patient as if they had only recently occurred. Traumatic triggers are activated by cues from sensory experiences that stimulate states, such as terror or increased heart rate, with or without the conscious awareness

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of the triggering or its origin (Rothschild 2000; Williams 2006). Common traumatic triggers for past sexual assault include confined spaces, personal scents, and proximity to a person with similar physical characteristics to a past offender. As with recent sexual assault disclosures, accounts might be plausible or implausible, providing few clues to as to the veracity or timing of events. Case study 2 provides an example.

Case study 2: Triggered disclosures of past sexual assault

Alannah had been admitted 4 days previously to an acute inpatient unit following a suicide attempt. This was her first mental health admission. Alannah was often angry, but on this instance her behaviour escalated to the point of hitting one of the nurses and banging her head against a wall. She was physically restrained and placed in seclusion for 5 hours. In the days that followed, Alannah often appeared to be in a world of her own and had trouble relating to others, suggesting she was dissociating. She reported that when in seclusion, she was sexually assaulted by several nurses.

Following a full investigation and debriefing, staff recognized that the unfamiliar locked inpatient environment; being surrounded by other unwell, aggressive patients; and deprivation of liberty had combined to escalate Alannah's fear and triggered the memory of being gang raped 5 years earlier.

Repetitive disclosures

As depicted in Figure 1, the third type of disclosure in the framework occurs when a patient who has been subjected to a sexual assault in the past repeatedly discloses the same assault, as if it were a current event. We suggest that this might be an attempt by the patient to communicate an element of the trauma as a means of ensuring the assault is no longer secret or will not recur. Alternatively, repetitive disclosures might be a form of intrusive re-experiencing of the assault by the client. The repeated and unbounded nature of this type of disclosure, as illustrated in Case study 3, indicates the importance of the event to the patient, despite being a past event.

Case study 3: Repetitive disclosures of sexual assault

Emily was admitted to an acute inpatient unit four times in 1 year. On each admission, she told staff that she did not have a mental illness, but that she had been raped the previous day. On each occasion, the details of the assault in terms of location, assailants, and nature of assault were identical in every respect. She repeated the account of the assault to every team member on each shift and talked about the event at any opportunity. The repeated disclosures caused distress to some of the other young women in the unit. The team recognized that taking Emily's accounts seriously and acknowledging her distress in relation to her past sexual assault calmed her. This response resulted over time in a decrease in repetitive disclosures, as Emily felt heard and believed.

'Delusional' disclosures

Having excluded the possibility that the situation constitutes any of the first three types of disclosure in the framework, the next possibility to be considered is of a disclosure of sexual violence by a mental health patient as 'delusional'. That is, the disclosure is a result of psychosis, and is not based on a recent or historical event. In our experience, this type of disclosure is less likely than the first three types, and caution must be taken in reaching this conclusion, given the difficulties in excluding a triggered disclosure of a past assault. For this reason, we use the term 'delusional, advisedly, denoting it with inverted commas, because the allegation might in fact be based on past events. Case study 4 provides an example.

Case study 4: 'Delusional' disclosures

Cecily, 84 years old, was admitted to a general hospital after falling and breaking her hip. Following surgery, she reported that she had been abducted from her hospital bed and raped by men wearing masks. An investigation of staff, patients, and visitors present in the unit at the time was undertaken to ensure there were no times that abuse might have occurred. Clinicians spoke with Cecily about her fears and implemented actions to increase her sense of safety. Having excluded the possibility that sexual violence had occurred at that time, and taking into account age, prior mental state, and other manifested symptoms, post-general anaesthetic dementia was diagnosed.

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Intentional false disclosure

The fifth type of disclosure in our framework constitutes fabricated allegations, in which a patient deliberately concocts a false account of sexual violence. Although such allegations are often assumed to be malicious, they are better understood as being used instrumentally by patients to meet needs for which they can find no other avenue, such as transfer to another ward. Intentional false disclosures are anxiety inducing for staff, both those named as perpetrators, as well as their colleagues. Despite prevailing views that false allegations of sexual assault are common, robust data indicate that only 3% of reports to police are false (Rumney 2006). No figures specific to mental health settings are available; however, in our experience, this is the least common type of disclosure. For this reason, this possibility is placed in the framework as the last option to be considered.

Case study 5: Intentional false disclosure

Stephen was an inpatient in an acute unit for 9 weeks after admission in a seriously psychotic state, with regular episodes occurring throughout his stay. He complained to the official visitor that he had been raped while watching a particular (and named) film in the TV room by a named staff member during a night shift. An investigation established that other staff had been present throughout this period, who confirmed that no contact had occurred. On further supportive interview, Stephen described the hostile way the staff member had treated him since his arrival. This had been noted by the team leader; however, no action had been taken. Validating Stephen's experience of the staff member's approach enabled him to admit he had made up the allegation in order to leave the ward and escape the worker's harassment.

THERAPEUTIC OR INVESTIGATIVE RESPONSE?

Working with complex disclosures, such as those described here, does not require health-care providers to choose between a therapeutic response and thorough investigation; both are important and implicit in the duty of care to patients. This paper does not address all facets of investigation; however, facilities require clear procedures for reporting, referral to support services, and independent investigation and coordination, which includes protection of the mental state of the disclosing patient, referral for counselling, medical and potential forensic care and assessment, attention to precipitating factors or impacts on the unit, and criteria for involvement of the police.

In our experience, it is a minority of situations where no doubt exists about the veracity of the disclosure. From the point of view of patient recovery, best outcomes occur when staff respond respectfully, taking accounts seriously. Investigation and the care response to the patient should happen simultaneously; however, responsibility should be delegated to separate individuals working collaboratively. If investigation is the only response, secondary trauma to the patient might occur, because their psychological and physical needs are not addressed. Conversely, attending only to the patient's distress might result in inadequate investigation and planning to prevent further incidents. Key elements of a care response to disclosures are: (i) re-establishing the patient's sense of safety; (ii) care planning; and (iii) planning for prevention of further assaults. The second half of this paper describes each of these elements for the five disclosure types.

IMPLICATIONS FOR PRACTICE

Practice implications for recent sexual assault

Whether the patient's allegation is believed in the first instance, harm is done by reacting with disbelief or dismissal. For this reason, the initial response should be to accept the patient's disclosure on face value until investigation has established otherwise. Repeated questioning of the patient about implausible elements of the assault should be avoided. Inferences that the patient is fabricating the account or forcing them to prematurely disclose the identity of the offender might cause destabilization. In addition, assessment for possible trauma and psychological decompensation are indicated. Re-establishing safety, both psychological and physical, is the first priority (Herman 1997). Attentive listening to the patient and communicating that the account is taken seriously are long-established key elements of a response to sexual violence (Burgess & Holmstrom 1985). Safety in this context is a concept that we have found resonates well with patients. Asking patients if they feel safe often provides information which might be used to modify care plans or routines. Common requests include not being left alone; additional lighting at night; and removal of concealing structures, such as floor length curtains. Attending to possible injury, pregnancy, or infection enhances physical and psychological safety. Acknowledging the courage of patients who disclose is helpful, as most are fearful of the consequences. With any disclosure of abuse, it is

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important to use the same language as the patient, and not jump ahead of them in forming assumptions or conclusions. When a disclosure is made in hearing of other patients, the welfare of those individuals also requires attention to reduce risk of retriggering any past abuse they might have experienced.

The second area requiring attention following disclosure of recent sexual assault is care planning, with a focus on responding to distress. Plans should be explicit, that laying blame with the patient is unhelpful. Therapeutic responses include providing information and opportunities for patients to make their own decisions, as far as are appropriate, in relation to action on the assault. Early consultation with local sexual assault advocacy services secures timely advice on patient support, as well as the independent crisis counselling, medical and forensic assessment, and liaison with police that such services provide and which all victims of sexual assault are entitled to receive. Routine referral to these services should occur, and formalizing referral arrangements between them can be advantageous in advance of any incident occurring. In health services in the state of NSW, a standardized joint service agreement establishes processes between mental health facilities, police, and sexual assault advocacy services, allowing for local modification. Some advocacy services are able to visit facilities after incidents to assist in re-establishing the patient's sense of safety and debrief staff. Ongoing care is facilitated by documenting incidents and measures to follow up the patient in discharge plans. Files containing sensitive details should be flagged, and access limited.

The third area requiring attention is the analysis of risk factors and the introduction of preventive measures. Separating the assailant from the victim to prevent further assaults or threats occurring can also provide psychological safety. Primary prevention strategies include single-sex bathrooms, toilets, and bedrooms; separate wards for women; identification and supervision of isolated areas; and assessment of patient vulnerability on admission, with regular review and adjustment to observations. In parallel, policies should detail responses to professional misconduct and direct staff training on the issue.

Practice implications for responding to triggered disclosures of past sexual assault

For patients, such as the one described in case study 3, the triggered past event is experienced as real, occurring in the present. When such accounts are simply viewed as fabrications, the patient's distress is exacerbated. Taking accounts seriously is not collusion with delusions, but a demonstration to patients that their distress is recognized and that support is available. In our experience, many patients were not believed at the time of the original assault, and further disbelief reinforces their past thinking, putting them at risk of psychological harm. Care planning in this instance focuses on modifying environmental factors to prevent further triggering. For example, showering is a common setting for sexual assault and a frequent trigger for memories. In our experience, patients' memories are often also triggered by hostile behaviour, warranting close observation when aggressive individuals are admitted to a facility. Observation and patient discussion might assist in identifying triggers, although patients might not understand the link to their psychological state. It is not appropriate at the time of a disclosure to explore the possibility of past abuse to make these links for the patient. This should be followed up at a later time when the patient has stabilized. While it might not be possible to prevent such disclosures, staff training on the prevalence, nature, and impacts of sexual assault, particularly in mental health populations, as well as the introduction of trauma-informed care practices, can reduce triggering.

Practice implications for repetitive disclosures

Although it might appear that a patient is repeatedly recounting the same event, investigation is required to confirm that no recent assault has occurred. It is well established that sexual violence perpetrators target victims who are vulnerable due to their size, mental capacity, age, isolation, or other reasons (Conte *et al*. 1989; Elliott *et al*. 1995). Those deemed to be unlikely to be able to perform well as witnesses in a court case are also increasingly being targeted (Stern 2010). Patients who repetitively disclose assaults while inpatients in facilities are easily discredited, heightening their vulnerability to further assaults.

Establishing safety with patients who make repetitive disclosures differs little from the steps described for other disclosure types. Although health professionals might become frustrated by repeated accounts, it is helpful to be open to the possibility that the patient needs to recount the narrative of their past trauma to receive validation. However, exposure to these accounts is often unhelpful for other patients. Care responses include accompanying the patient to a quiet area and setting boundaries around the discussion, following which the staff might engage the patient in another activity. Consultation with a local sexual assault advocacy service might help identify appropriate strategies for both staff and patients.

Practice implications for 'delusional' disclosures

As with any heightened distress or psychosis, a patient experiencing thoughts that they are continuing

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to experience sexual violence, requires responses aimed at reconnecting them with the present. Although a past history of sexual assault might not have been disclosed, there is a recognized link between psychosis and past sexual assault history (Read 1997). Interventions should assume that such a history is possible, and work to reinstate a sense of safety for the patient.

Practice implications for intentional false disclosure

Known tendencies by a specific patient to make intentional false disclosures can be countered by strategies that include allocating staff time to assist in meeting the patient's needs, ensuring a minimum of two staff members present when caring for the patient, and delegating primary care to a female staff member against whom allegations are less likely to occur. When this type of disclosure is not taken seriously, patients might use more extreme attempts to get their needs met.

Care planning in these instances is often poorly attended to, once it is revealed that an intentional false disclosure has been made. Patients should continue to be treated with respect, with efforts to identify needs they might be attempting to address. Strategies to prevent reoccurrence include avoiding confrontational behaviour by staff, addressing personality conflicts through discussion or reassigning new primary care nurses, and moving the patient to another ward. Such actions should be seen in terms of minimizing the damage done to all by false disclosures.

Service capacity building and staff support

Recognizing previous trauma and working from a trauma-informed care model requires an entire paradigm shift from the current biological and behavioural model that underpins mental health service delivery. The underpinning principles of a trauma-informed mental health system include staff awareness of how trauma reactions manifest; collaborative practice; and emphases on patient safety, choice, and control (Ashmore 2013). The vulnerability of mental health patients means that sexual abuse can never be completely prevented. Both undergraduate education and ongoing staff development are needed. Preparedness for disclosures includes the development of clear procedures for responding to disclosures and referral pathways with local sexual assault advocacy services and police. It is to be expected that staff called on to respond will experience some distress. Vicarious trauma can be minimized by regular supervision and debriefing (McCann & Pearlman 1990; Trippany *et al*. 2004).

POLICY AND RESEARCH IMPLICATIONS

Despite the evidence linking mental illness and sexual violence, translating these links into practice has been slow. The introduction of trauma-informed models of care in mental health settings is a first step. In relation to our proposed framework and suggested responses, policy is needed to stipulate how both plausible and implausible disclosures are investigated and addressed in facilities and to require mandatory training of staff. Further research is required into the frequency of each type of disclosure, and to test models of intervention for each type.

CONCLUSION

Sexual violence is a serious risk to patients in mental health facilities, with extremely negative consequences for patients. Disclosures of sexual assault are distressing for staff in mental health facilities; however, need to be anticipated and addressed in ways that ensure due diligence. When a patient discloses sexual assault, it is likely not to be a straightforward disclosure, and determining whether it occurred is not the first priority. Rather, all disclosures need to be taken seriously and responded to appropriately. Although uncertainty is more challenging for staff, appropriate investigation and response are required. Our proposed framework provides a guide for determining the most likely type of disclosure and responding to patients, taking account of the reality of how disclosures of abuse are made by patients with mental illness.

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