BJPsych The British Journal of Psychiatry (2018)
213, 625–626. doi: 10.1192/bjp.2018.183

From the Editor's Desk

Violence, trauma, testimonials and truth

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Physical, sexual and gender-based violence

Revelations about historical child sexual abuse and sexual violence have raised alarm in society and public services. Such acts, of course, are taking place even today locally and globally. Estimates from 30 nations find that 28% of adolescent and 29% of young adult women reported lifetime physical or sexual violence, this being most prevalent in the East and Southern Africa region.[1] In the UK, high-profile and ostensibly respectable and well-meaning celebrities were exposed through news media as committing offences against children and vulnerable people. The scandal led to the UK government Inquiry into allegations of historical child sexual abuse that concluded pervasive and inappropriate institutional responses were common and in need of thoughtful and courageous actions. High-status individuals used their public persona as a source of power and authority to silence victims, and the institutions that should have protected the vulnerable seemingly colluded. Similar experiences are now reported in the US film industry leading to the 'me too' campaign that has global resonance. Ingrassia (pp. 571–573) gives a thoughtful account of the UK government's Inquiry to expose the truth and offer a just process for exposure, prosecution and reconciliation to restore trust in public services such as the police, criminal justice agencies, health services and local and national government. People who have experienced the most severe adversities, sometimes early in childhood, are not always able to give coherent accounts and testimonies; it is painful for them to do so in a combative and adversarial legal system. These obstacles can be misread to cast doubt on their testimonies that are an essential record on which institutions should act. The time has come to establish institutional and structural processes that are sensitive to and overcome these inherent weaknesses in investigative, legal and care procedures.

Early prevention and treatment

In this context, and awareness of the growing global burden of neuropsychiatric disorders, prevention and treatment responses should be aligned in promoting safer and more protective early-life environments for children and women. Early adversity and trauma such as interpersonal violence and beating are now established as a cause of later mental illnesses and behavioural disorders; there is also an elevated risk of substance use among adolescents who were beaten by someone.[2] Childhood trauma is associated with gender-based violence and childhood maltreatment.[3] Some reports suggest child abuse may affect women's risk of developing psychosis more than that of men, although young boys and men can also be susceptible to the lifetime consequences of violence and abuse.[4] Interpersonal violence, the use of substances perhaps as a response to violence and famine are all preventable and important risk factors for neuropsychiatric disorders as shown by two important papers in this month's *BJPsych* (see Fazel *et al* pp. 609–614 and Li *et al* pp. 579–586). The socially embedded nature of such hazards demands a connected response across care, criminal, welfare, educational and government sectors. Preventive measures must be enshrined in societal, institutional, family and interpersonal cultures, as firmly as in policies and legislation, all of which shape practices and behaviours.[1,5]

Practitioners are now encouraged to undertake systematic and routine assessments about violence and sexual abuse in order to protect and prevent further violence and treat persistent and disabling psychological distress.[6,7] A recent systematic review showed small or medium effect sizes of psychological treatments for post-traumatic stress disorder in adolescents living in low- and middle-income countries, with a call to action and further research on targeted approaches for depression.[8] Reassuringly, there is some evidence of effective treatments; a study of adolescents living in South Africa finds that prolonged exposure therapy is more effective than supportive counselling at 3 and 6 months after treatment (see Rossouw pp. 587–594).

Mental health systems, legislation and inequalities

The disquieting findings of the UK Inquiry into historical child sexual abuse have ramifications for all treatment services. We must all be open to listening more attentively and openly to accounts of abuse, injustices and wrongdoing by those in positions of power and authority. Bhui *et al* (pp. 574–578) explore similar concerns about ethnic inequalities in experiences and outcomes of severe mental illness, invoking multiple disadvantages and intersectional sources of disempowerment as central to societal, institutional and interpersonal sources of inequality. These types of felt injustices, although deeply inconvenient and troublesome for care providers, must not be hidden or censored from public discourse as they contain within them much needed accounts of how we might progressively tackle inequality and restore trust and confidence in better connected and safer systems of care.

Mental health systems in most countries provide compulsory treatment through legal provisions that are similar but practices vary from country to country.[9] Some of the legislation is subject to criticism on the basis of the United Nations Convention on the Rights of Persons with Disabilities.[10] Understandably, the Mental Health Act when applied to traumatised and multiply disadvantaged people creates a sense of further injustice. The use of mental health legislation to force treatment can lead to experiences of coercion, disempowerment and fear about safety and systems failures. There are many checks and balances and legal redress, yet the concerns raised are that these are insufficient or perhaps themselves configured in ways that do not empower nor expose structural sources of disadvantage. These concerns are particularly troubling when patterned by ethnic group (see Bhui *et al* pp. 574–578), but the general trends of escalating levels of compulsory treatment in many high-income countries are also worrisome. We must ask questions of the wider systems of mental healthcare; must these rely on fewer in-patient and voluntary hospital admissions and more compulsory forms of care (see Keown pp. 595–599) in the context of limited alternatives and insufficient investments in population-based systems of care? Compulsory admissions and treatment in hospitals that are distant from the homes and neighbourhood in which patients receive community supports is another source of dissatisfaction.[11] Out-of-area placements, especially for young people, are worryingly common and understandingly strain local social and family supports for people who may be feeling alone, frightened and distressed. Care systems continue this practice, with partial remedial efforts that do not fully accommodate the wider lens and deeper changes needed to envision new care systems stripped of structural processes that may cause, perpetuate and compound injustices. Paradoxically, research into systems of care that reduce inequality and improve outcomes is both longstanding and yet in its infancy if one considers the limited progress. Paton & Tiffin

(pp. 615–616) consider the drivers of out-of-area placements, recommending that population-serving services working with community assets must reduce both the length of in-patient stays and the rate of referral to specialist in-patient care. A more effective population-based system of care pathways that relies less on compulsory treatment is sorely needed. One approach to tackle the demands on specialist mental health services is to reinforce preventive and treatment services in primary care; this should reduce stigma, and improve access given most people are in receipt of primary care on a regular basis. Grigoroglou *et al* (pp. 600–608) show that a national primary care pay-for-performance scheme was not effective at reducing the incidence of suicide, although social fragmentation, deprivation and rural areas were of concern as important correlates of suicide. Some groups are less able or likely to receive regular primary care: rough sleepers and street homeless people, those living in temporary accommodation, those leaving care institutions or prisons, and people facing residential instability because of poverty, unemployment or when seeking asylum and refugee status. The voices of hidden groups need foregrounding to expose systems failures, remedying which may benefit entire populations and enable a more sustainable system of mental healthcare for all. The solutions lie in wider reform of geopolitical, cultural and societal structures as well as public and specialist health systems.[5,12]

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psychiatry in history

Richard Morton and anorexia nervosa

Greg Wilkinson

'Like a Skeleton only clad with skin'

Richard Morton, an English physician, writing in Latin in 1689, is usually credited with the first description of anorexia nervosa. Morton's '*A Treatise of Conſumptions*' is best known for his contribution to the solution of tuberculosis. Less well-known is that chapter 1 is entitled '*Of a Nervous Conſumption*'. Morton provides a case history (original spelling has been retained).

> Mr *Duke*'s Daughter in St. *Mary Axe*, in the Year 1684 and the Eighteenth Year of her Age, in the Month of *July* fell into a total ſuppreſſion of her Monthly Courſes from a multitude of Cares and Paſſions of her Mind, but without any Symptom of the Green-Sickneſs following upon it. From which time her Appetite began to abate, and her Digeſtion to be bad; her Fleſh alſo began to be flaccid and looſe, and her looks pale, with other Symptoms uſual in an Univerſal Conſumption of the Habit of the Body, and by the extream and memorable cold Weather which happened the Winter following, this Conſumption did ſeem to be not a little improved; for that ſhe was wont by her ſtudying at Night, and continual poring upon Books, to expoſe her ſelf both Day and Night to the injuries of the Air, which was at that time extreamly cold, not without ſome maniſeſt Prejudice to the Syſtem of her Nerves. The Spring following, by the Preſcription of ſome Emperick, ſhe took a *Vomit*, and after that I know not what *Steel* Medicines, but without any Advantage. So from that time loathing all ſorts of Medicaments, ſhe wholly neglected the care of her ſelf for two full Years, till at laſt being brought to the laſt degree of a *Maraſmus*, or Conſumption, and thereupon ſubject to frequent Fainting Fits, ſhe apply'd her ſelf to me for Advice.
>
> I do not remember that I did ever in all my Practice ſee one, that was converſant with the Living ſo much waſted with the greateſt degree of a Conſumption, (like a Skeleton only clad with skin) yet there was no Fever, but on the contrary a coldneſs of the whole Body; no Cough, or difficulty of Breathing, nor an appearance of any other Diſtemper of the Lungs, or of any other Entrail: No Looſeneſs, or any other ſign of a Colliquation, or Preternatural expence of the Nutritious Juices. Only her Appetite was diminiſhed, and her Digeſtion uneaſie, with Fainting Fits, which did frequently return upon her. Which Symptoms I did endeavour to relieve by the outward application of *Aromatick* Bags made to the region of the Stomack, and by *Stomack-Plaiſters*, as alſo by the internal uſe of *bitter* Medicines, *Chalybeates*, and Juleps made of *Cephalick* and *Antihyſterick Waters*, ſufficiently impregnated with *Spirit of Salt Armoniack*, and *Tincture of Caſtor*, and other things of that Nature. Upon the uſe of which ſhe ſeemed to be much better, but being quickly tired with Medicines, ſhe beg'd that the whole Affair might be committed again to Nature, whereupon conſuming every day more and more, ſhe was after three Months taken with a Fainting Fit, and dyed.

The British Journal of Psychiatry (2018) 213, 626. doi: 10.1192/bjp.2018.161

https://doi.org/10.1192/bjp.2018.183 Published online by Cambridge University Press