Administration and Policy in Mental Health, Vol. 30, No. 5, May 2003 (© 2003)

REPORTS

TRAUMA WITHIN THE PSYCHIATRIC SETTING: A PRELIMINARY EMPIRICAL REPORT

Karen J. Cusack, B. Christopher Frueh, Thom Hiers, Samantha Suffoletta-Maierle, and Sandy Bennett

Recent studies show that trauma victimization (51%–98%) and posttraumatic stress disorder (42%) are highly prevalent among persons with severe mental illness (schizophrenia, bipolar disorder) who are served within public-sector mental health clinics (Mueser et al., 1998; Switzer et al., 1999). Posttraumatic stress disorder (PTSD) is considered to be chronic and debilitating, with high rates of co-occurring Axis I and Axis II mental health disorders (Keane & Wolfe, 1990), and with serious adverse effects on social, familial, and occupational functioning (Frueh, Turner, Beidel, & Cahill, 2001). Furthermore, evidence indicates that PTSD is associated with nearly the highest rate of medical and mental health service use, making it one of the costliest mental disorders (Greenberg et al., 1999). Given this, it is clear that trauma has a prominent impact on public health and it should be of great interest to those concerned with public mental health administration and policy. However, trauma survivors tend to receive inadequate mental health services (Amaya-Jackson et al., 1999; Frueh et al., 2002) and they may, in fact, be especially vulnerable to additional traumatic and/or iatrogenic experiences that may routinely occur within the psychiatric setting (Cohen, 1994; Frueh et al., 2000).

Clearly, modern psychiatric hospitals are a far cry from the "Old Bedlam" of London, where "Inmates were chained, whipped, and

Karen J. Cusack, Ph.D., is a Project Director in the South Carolina Department of Mental Health. B. Christopher Frueh, Ph.D., is an Associate Professor in the Department of Psychiatry and Behavioral Sciences at the Medical University of South Carolina, and a Staff Psychologist at the Veterans Affairs Medical Center, Charleston, South Carolina. Thom Hiers, Ph.D., is Executive Director of the Charleston/Dorchester Mental Health Center. Samantha Suffoletta-Maierle, Ph.D., is a Project Coordinator in the Department of Psychiatry and Behavioral Sciences at the Medical University of South Carolina. Sandy Bennett, BSW, LMSW, is a Social Worker and Consumer Affairs Coordinator in the South Carolina Department of Mental Health.

This work was partially supported by a grant from the Ensor Foundation to Dr. Cusack, and a grant from the National Institute of Health (MH01660) to Dr. Frueh.

Address for correspondence: Karen J. Cusack, Ph.D., Charleston/Dorchester Community Mental Health Center, 701 East Bay St., MSC/1110, Charleston, SC 29403. E-mail: KJC42@CHAMHC.DMH.STATE.SC.US.

beaten; fed only slop; given purges and emetics; and subjected to bloodletting. Their keepers were not paid but earned small fees by displaying their charges for the entertainment of the general public." (Hothersall, 1990). Although the psychiatric setting has evolved into a far more humane treatment environment—one that in no way resembles Bedlam—to assume that traumatic or harmful events cannot occur in psychiatric settings would be a potentially egregious error. From a scientific viewpoint, it seems important to address the experiences within psychiatric settings, especially when one considers the culture from which modern psychiatry emerged.

Recently there has been a national trend among mental health organizations (e.g., the National Association of State Mental Health Program Directors and the National Alliance for the Mentally Ill) to express concern about this issue, moving it to the forefront of policy discussions; and the Health Care and Financing Administration has recently released new regulations limiting the use of seclusion and restraint. Furthermore, our own statewide trauma initiative (South Carolina Department of Mental Health Trauma Initiative Taskforce), which includes direction from mental health consumers and other key stakeholders, has identified the problem of trauma within the psychiatric setting ("sanctuary trauma") as one of four crucial priority areas to be addressed by this initiative (Cusack & Frueh, 2001; Frueh, Cusack, et al., 2001).

THE "SANCTUARY TRAUMA" LITERATURE

In our own recent review of the literature, we noted that there had been virtually no empirical investigation of trauma within the psychiatric setting (Frueh et al., 2000). Most of the literature includes case reports or experiential commentary on the matter (Cohen, 1994; Jennings & Ralph, 1997). While there is a broad literature pertaining to seclusion and restraint (Appelbaum, 1999; Forster, Cavness, & Phelps, 1999), it has focused primarily on patient and/or staff safety, staff training, and legislative issues, rather than having an empirical focus on the psychological consequences of these experiences. Some authors have suggested that routine clinical procedures on inpatient units (e.g., being on a locked unit) may represent a highly distressing or traumatic experience for the consumer (Meyer, Taiminen, Vuori, Aijala, & Helenius, 1999; Mohr, Mahon, & Noone, 1998; Shaw, McFarlane, & Bookless, 1997). However, the empirical data to support this are also limited and suggest that the psychiatric symptoms themselves were more distressing than the coercive measures used to control them. In sum, there is currently no body of research that broadly addresses the issue of trauma within the psychiatric setting (Frueh et al., 2000).

An important step toward improving our understanding of adverse events within the psychiatric setting is developing our conceptualization of what types of events and experiences we are concerned about. We have previously suggested that a distinction should be made between events that are *traumatic* and those that are merely *harmful* to avoid trivializing the most severe experiences (e.g., sexual assault) or unfairly labeling the appropriate use of measures of last resort (e.g., seclusion and restraint). Specifically, we suggested that the term "sanctuary trauma" should be applied rigorously only to the events occurring in psychiatric settings that meet the *Diagnostic and Statistical Manual for Mental Disorders* (*DSM-IV*, American Psychiatric Association, 1994) criteria for a traumatic event. We suggested that the term "sanctuary harm" should be applied to those events that do not meet the *DSM-IV* criteria for trauma, which are, nevertheless, distressing, frightening, or humiliating, given the vulnerability of mental health consumers. Such events may result in new or exacerbated psychiatric symptoms and/or less participation in later mental health treatment (Frueh et al., 2000).

Because empirical data on the phenomena of "sanctuary trauma" and "sanctuary harm" are virtually non-existent, the present study was designed to gather prelimi-

nary empirical data related to (a) the frequency of such experiences among mental health consumers with a history of psychiatric hospitalization and outpatient treatment in a state-funded mental health system, (b) the perceptions that these consumers have regarding such experiences, and (c) the consequences of these experiences, as measured by the association between hospital experiences, subjective reactions to these experiences, and PTSD symptoms.

METHOD

Participants

Subjects were men and women with a history of psychiatric hospitalization who were attending one of five mental health center clinics in a state public mental health system. All subjects were adults between the ages of 19 and 73 (*Mean*=43.24, *SD*=11.58). Fifty-nine percent of the subjects were male, 55% were Caucasian, and 53% were single. Most subjects had completed high school or beyond (90%). Subjects had been hospitalized in the South Carolina public mental health system an average of 4.33 times (*SD*=4.75), and in private or other state hospitals 2.75 times (*SD*=3.89). The mean number of total hospitalizations was 7 (*SD*=5.27). Fifty-seven out of 100 potential subjects agreed to participate in the study. Of the 43 who did not participate, 4 were later identified as being in the hospital on the date of the appointment, and 10 had changed addresses or were deceased. Therefore, the overall participation rate was 57/86 (66%). Potential subjects were not limited by psychiatric diagnosis. Exclusion criteria included active psychosis, intoxication, or cognitive impairments that would interfere with the ability to participate in the assessment. Two subjects were unable to complete the interview due to active psychosis, and they were paid for their efforts.

Assessment Instruments

Demographic information was collected for each subject. There was no instrument for assessing experiences of sanctuary trauma and sanctuary harm as defined above. Therefore, the principal investigators developed an assessment instrument, the Psychiatric Experiences Questionnaire, for this study. The development of this instrument was based on focus groups with Consumer Affairs Coordinators throughout the state mental health system, whose purpose was to generate a list of experiences that consumers found to be harmful in the inpatient setting. The items in the current scale were taken from these groups (e.g., "put in restraints of any kind," "medication used as a threat or punishment") with the addition of some items that described *DSM-IV* traumatic events (e.g., "another patient using threat or force to engage in any type of sexual activity with you in the psychiatric setting").

Information on traumatic events that were experienced *outside* the hospital setting was collected using the Trauma Assessment for Adults (TAA; Resnick, Best, Kilpatrick, Freedy, & Falsetti, 1993). The TAA inquires about 13 specific events. A series of four simple follow-up questions assesses the number of times each type of event has occurred, the respondent's age when the first incident and the most recent incident occurred, and the respondent's report of fear of death or injury during any experience of a given type of event. The validity of this measure is supported by findings on the rates of general trauma and crime exposure that were highly consistent with those previously observed in this population using a different structured assessment measure of traumatic events (Saunders, Kilpatrick, Resnick & Tidwell, 1989). In addition, archival data from mental health center records were compared with TAA data, and in each case the TAA identified the presence of traumatic events.

In order to assess the potential posttraumatic reactions, the PTSD Checklist (PCL-C; Weathers, Litz, Herman, Huska, & Keane, 1993) was used. The PCL measures the frequency of all 17 *DSM-IV* PTSD symptoms. Good reliability and validity were reported for the scale. Evidence for internal consistency includes a coefficient alpha

ranging from .89 to .97 for Criterion B, C, D, and total score. Compared with the Structured Clinical Interview for *DSM-IV* Axis I disorders, the sensitivity rate for a sample of Vietnam veterans was .82 and the specificity was .84.

Procedure

Clinic rosters at five community mental health centers in the state public mental health system were used to recruit subjects. From these rosters, consumers with at least one prior hospitalization were randomly selected to serve as subjects in the study. Letters were mailed to all potential participants. These letters, which were mailed two weeks in advance to allow adequate time for transportation arrangements, described the study and specified a date and time for the clinic appointment, mentioned the confidential and scientific nature of the interview, and indicated that subjects would receive $25 compensation for their time.

Before the assessment, a consent form describing participation, potential risks or benefits, and the confidential nature of the study was reviewed by the interviewer. Potential subjects were informed that no identifying information (e.g., name and address) would appear directly on the forms. The consent form also explained that participation is strictly voluntary and that the subject has the right to refuse to participate or to stop the assessment at any time.

The interviewers conducting the assessments were trained, paid assistants on the project who were also consumers or expatients. Their training involved instruction in confidentiality, objectivity, recognizing when a consumer is in crisis, the definitions of sanctuary harm and sanctuary trauma, and administration of the specific measures used in the study.

Interviewers were trained to monitor the subjects for any signs of distress while completing the assessments. Interviewers were instructed that, if at any time a subject appeared to be significantly upset, they were to have the subject either take a break or abandon the study, at the request of the subject. Arrangements were made for a mental health clinician on staff to be available if the subject became too upset. However, these precautions turned out to be unnecessary.

Data Analyses

Descriptive analyses were conducted for all variables, including lifetime trauma history, sanctuary harm/trauma, and PTSD symptom scores. Responses on the Psychiatric Experiences Questionnaire referring to how unsafe, helpless, afraid, and upset subjects felt were summed to form a "subjective distress" score (range=0–16). One-way ANOVAs were conducted to compare groups on variables such as subjective distress and PTSD score. A multiple regression analysis was used to determine the relative contribution of previous trauma history and sanctuary trauma to the dependent variable of subjective distress.

RESULTS

Trauma and Harm in the Psychiatric Setting

Data from the Psychiatric Experiences Questionnaire were grouped according to the type of event. For instance, items such as being handcuffed, put in restraints, and placed in seclusion were grouped under "institutional events and procedures." Items such as being forced to take medications against one's will, or being threatened with medications or involuntary commitment were grouped together as "coercive measures." Items such as experiencing staff using derogatory names toward the subject (e.g., crazy or stupid) or toward other patients were grouped under verbal intimidation/abuse. Summarized below are the percentages of subjects reporting any event in these categories:

- Institutional events and procedures: 86.0%
- Sexual or physical assault: 43.9%

- Coercive measures: 38.6%
- Witnessing traumatic events: 26.3%
- Verbal intimidation/abuse: 22.8%

A complete description of items and data from the Psychiatric Experiences Questionnaire is available on request from the first author.

One of the goals of the study was to determine rates of traumatic events, as defined by the *DSM-IV* criteria for PTSD, occurring in the psychiatric setting (sanctuary trauma). Forty-seven percent of subjects reported experiencing a *DSM-IV*-defined traumatic event while in the hospital. Witnessing physical assaults (22%) and experiencing a physical assault (18%) were the most frequent events. While there were no reports of staff-perpetrated sexual assaults, 7% of subjects reported being sexually assaulted by another patient, and 5% witnessed another patient being sexually assaulted. Subjects who experienced sanctuary trauma had higher subjective distress scores ($F[1, 52]=21.58$, $p<.001$), a greater number of events producing fear, helplessness or horror ($F[1, 52]=49.60$, $p<.001$), and a longer period of feeling upset after discharge from the hospital ($F[1, 52]=4.29$, $p<.05$), than subjects who did not experience sanctuary trauma. Although the mean score on the PCL for subjects experiencing sanctuary trauma (39.48) was higher than the mean score of subjects without such experience (32.48), this difference was not significant.

Events that were not traumatic, but were nevertheless thought to be harmful or capable of producing or exacerbating symptoms from previous traumas were also assessed. The events reported most frequently by subjects included being placed in seclusion (58%), being around other patients who were very sick and/or frightening (56%), being handcuffed and placed in a police car (53%), and witnessing other patients being taken down (47%). Thirty-three percent of the subjects had been put in restraints (of any kind).

Subjects consistently reported experiencing fear, helplessness, or horror in response to these events. In addition, when subjects were asked to rate overall how unsafe, helpless, afraid, and upset they felt while in the hospital, on a scale from 0 (not at all) to 4 (extremely) the mean responses were 1.56, 1.98, 2.00, and 1.22, respectively. The mean total of theses items, the "subjective distress" score, was 6.72, (SD=5.12). Forty-seven percent of subjects reported feeling upset about events that occurred in the hospital for a period of one month or longer after being discharged; 14% were still currently bothered. The experiences that were most likely to cause subjective distress included staff name-calling, use of physical force, being around sick or frightening patients, witnessing physical assaults, and experiencing unwanted sexual advances. Only 24% of subjects had ever been asked about these types of events by mental health staff.

Lifetime Trauma and PTSD History

Based on the TAA, the lifetime prevalence of experiencing a traumatic event was 96%. Due to the high rates of lifetime trauma, no comparisons could be made between subjects with a previous trauma history and those without. Subjects reported a mean of 3.95 types of traumatic events. Using the recommended cutoff score of 51 on the PCL, 27% of subjects met criteria for PTSD. The amount of fear, helplessness, or horror experienced in the hospital was correlated with the number of lifetime traumatic events ($r=.55$, $p<.001$). Sixty-five percent of subjects had experienced physical or sexual abuse in their lifetime. Subjects with a history of physical or sexual abuse reported higher subjective distress scores ($F[1, 52]=7.95$, $p<.01$) than subjects without such history. These subjects also had a greater cumulative number of negative experiences in the hospital ($F[1, 53]=4.34$, $p<.05$) and greater number of events producing fear, helplessness, or horror ($F[1, 53] = 6.57$, $p<.01$). Based on a multiple regression analysis, both

having a history of trauma ($F[1, 51] = 5.82$, $p<.05$) and experiencing sanctuary trauma ($F[1, 51] = 18.74$, $p<.001$) independently contributed to the variance in subjective distress score.

DISCUSSION

This study provides initial empirical support for concerns raised by consumer and advocacy groups that the psychiatric setting often can be a frightening and/or dangerous environment. In general, the results of this study indicate that mental health consumers have experienced a number of traumatic, humiliating, or distressing events during their hospitalization. In addition, results indicate that consumers are adversely affected by these experiences. These findings are consistent with related studies on patients' perceptions of coercive practices (Gardner et al., 1999; Outlaw & Lowery, 1994; Sheline & Nelson, 1993). In addition, the results provide a strong basis for the need to further investigate the issue of sanctuary trauma and sanctuary harm. Subjects were affected not only by practices already considered to be harmful (e.g., restraints), but a number of other experiences also contributed to the feeling of being unsafe, helpless, and frightened.

As expected, subjects with a history of sexual or physical abuse were more psychologically affected by the events in the hospital. One explanation for this finding is the psychological reactivity that people with PTSD experience when they are exposed to reminders of the traumatic event. It may be that certain coercive or violent events in the hospital (e.g., restraints, physical assaults) are capable of triggering emotions from past traumatic events (e.g., rape). Subjects who reported actual experiences of sanctuary trauma also reported greater distress, independent of whether they had a history of abuse. The group that experienced both types of events had the highest PTSD severity score. These findings are consistent with research indicating more severe outcomes for victims of multiple traumas in the general population (Brown & Anderson, 1991; Resnick & Kilpatrick, 1994) and public mental health consumers with serious mental illness (Mueser et al., 1998).

Although 91% of subjects reported experiencing at least one negative hospital experience, and 70% had experienced three or more negative hospital events, few subjects (24%) had ever been asked about these events by mental health staff. There seems to be a clear need to begin addressing such experiences in the psychiatric setting. Research indicates that the assessment of any type of trauma history is lacking in public mental health clinics, let alone the assessment of events occurring within the psychiatric setting (Frueh et al., in press; Saunders et al., 1989; Switzer et al., 1999).

A commonly held belief among clinicians is that asking vulnerable consumers detailed questions about their trauma history may be too upsetting to the consumer. However, none of the subjects in this study were significantly upset over questions related to their trauma history. In fact, many subjects reported at the conclusion of the interview that they found it helpful; some even indicated that they would like to further address these issues in their treatment. The notion that the interview is helpful for subjects is consistent with other studies conducted with public mental health consumers (Goodman et al., 1999).

It should be noted that this study inquired about events occurring at any point during subjects' psychiatric treatment and did not specifically assess for recent events. Therefore, the extent to which hospitalized consumers may be currently experiencing these events is unknown. In addition, while most consumers had been hospitalized within the South Carolina state system (87%), subjects were not asked to indicate which experiences had occurred at which hospitals. Therefore, these results are not indicative of experiences at any particular hospital. The generalizability of these findings is limited due to potential sampling bias. Subjects were volunteers from community mental health clinics and may be different from other previously hospitalized con-

sumers who are not actively involved in outpatient treatment. The sample was also small, and few outcome measures were used in this study. Many questions remain, such as how sanctuary trauma and harm influence future mental health functioning and participation in treatment, and how the level of distress compares between hospitalized consumers who have and have not experienced any harmful events in the hospital. We plan to address these issues in a larger, more comprehensive study, which is being funded by the National Institute of Mental Health (R01-MH65517).

CONCLUSIONS

While this study provides only a preliminary look at a complex issue worthy of further study, the data clearly indicate that the phenomenon of sanctuary harm and trauma warrants increased attention from mental health administrators and staff. In light of these findings, it is recommended that mental health service providers make an extra effort to ensure that services delivered within psychiatric settings (i.e., *sanctuary*) are delivered in a manner that is most sensitive to the potentially adverse consequences of traumatic, frightening, or humiliating (i.e., *harmful*) experiences. Increased hospital monitoring, staff sensitivity training, and reduction of coercive measures have been introduced in some psychiatric settings, often as part of state department of mental health trauma initiatives (e.g., South Carolina, Maine, Massachusetts), as a means of preventing further harm. Additional mental health policies, procedures, and clinical training programs seem necessary to ensure that providers of mental health services meet what is perhaps their most important objective: Do no harm.

REFERENCES

Amaya-Jackson, L., Davidson, J.R., Hughes, D.C., Swartz, M., Reynolds, V., George, L.K., & Blazer, D.G. (1999). Functional impairment and utilization of services associated with posttraumatic stress in the community. *Journal of Traumatic Stress, 12*, 709–724.

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Appelbaum, P.S. (1999). Seclusion and restraint: Congress reacts to reports of abuse. *Psychiatric Services, 50*, 881–882, 885.

Brown, G.R. & Anderson, B. (1991). Psychiatric morbidity in adult inpatients with childhood histories of sexual and physical abuse. *American Journal of Psychiatry, 148*(1), 55–61.

Cohen, L.J. (1994). Psychiatric hospitalization as an experience of trauma. *Archives of Psychiatric Nursing, 8*, 78–81.

Cusack, K.J., & Frueh, B.C. (2001). Who needs trauma initiatives? South Carolina! (Letter). *Psychiatric Services, 52*, 1104–1105.

Forster, P.L., Cavness, C., & Phelps, M.A. (1999). Staff training decreases use of seclusion and restraint in an acute psychiatric hospital. *Archives of Psychiatric Nursing, 13*, 269–271.

Frueh, B.C., Cousins, V.C., Hiers, T.G., Cavanaugh, S.D., Cusack, K.J., & Santos, A.B. (2002). The need for trauma assessment and related clinical services in a state public mental health system. *Community Mental Health Journal, 38*, 351–356.

Frueh, B.C., Cusack, K.J., Hiers, T.G., Monogan, S., Cousins, V.C., & Cavenaugh, S.D. (2001). Improving public mental health services for trauma victims in South Carolina. *Psychiatric Services, 52*, 812–814.

Frueh, B.C., Dalton, M.E., Johnson, M.R., Hiers, T.G., Gold, P.B., Magruder, K.M., & Santos, A.B. (2000). Trauma within the psychiatric setting: Conceptual framework, research directions, and policy implications. *Administration and Policy in Mental Health, 28*, 147–154.

Frueh, B.C., Turner, S.M., Beidel, D.C., & Cahill, S.P. (2001). Assessment of social functioning in combat veterans with PTSD. *Aggression and Violent Behavior, 6*, 79–90.

Gardner, W., Lidz, C.H., Hoge, S.K., Monahan, J., Eisenberg, M.M., Bennett, N.S., Mulvey, E.P., & Roth, L.H. (1999). Patients' revisions of their beliefs about the need for hospitalization. *American Journal of Psychiatry, 156*, 1385–1391.

Goodman, L.A., Thompson, K.M., Weinfurt, K., Corl, S., Acker, P., Mueser, K.T., & Rosenberg, S.D. (1999). Reliability of reports of violent victimization and posttraumatic stress disorder among men and women with serious mental illness. *Journal of Traumatic Stress Disorder, 12*, 587–599.

Greenberg, P.E., Sisitsky, T., Kessler, R.C., Finkelstein, S.N., Berndt, E.R., Davidson, J.R., Ballenger, J.C., & Fyer, A.J. (1999). The economic burden of anxiety disorders in the 1990s. *Journal of Clinical Psychiatry, 60*, 427–435.

Hothersall, D. (1990). *History of psychology* (2nd ed.). New York: McGraw-Hill.

Jennings, A., & Ralph, R.O. (1997). In their own words: Trauma survivors and professionals they trust tell what hurts, what helps, and what is needed for trauma services. *The Maine Trauma Advisory Group Report*. Portland, ME: The Maine Trauma Advisory Group.

Keane, T.M., & Wolfe, J. (1990). Comorbidity in Post-Traumatic Stress Disorder: An analysis of community and clinical studies. *Journal of Applied Social Psychology, 20*, 1776–1788.

Meyer, H., Taiminen, T., Vuori, T., Aijala, A., & Helenius, H. (1999). Posttraumatic stress disorder symptoms related to psychosis and acute involuntary hospitalization in schizophrenic and delusional patients. *Journal of Nervous and Mental Disease, 187*, 343–352.

Mohr, W.K., Mahon, M.M., & Noone, M.J. (1998). A Restraint on restraints: The need to reconsider the use of restrictive interventions. *Archives of Psychiatric Nursing, 12*, 95–106.

Mueser, K., Goodman, L.A., Trumbetta, S.L., Rosenberg, S.D., Osher, F.C., Vidaver, R., Auciello, P., & Foy, E.W. (1998). Trauma and posttraumatic stress disorder in severe mental illness. *Journal of Consulting and Clinical Psychology, 66*, 493–499.

Outlaw, F.H., & Lowery, B.J. (1994). An attributional study of seclusion and restraint of psychiatric patients. *Archives of Psychiatric Nursing, 8*, 69–77.

Resnick, H.S., Best, C.L., Kilpatrick, D.G., Freedy, J.R., & Falsetti, S.A. (1993). *Trauma assessment for adults–Self report version*. Unpublished scale. Charleston, SC: Crime Victims Research and Treatment Center, Medical University of South Carolina.

Resnick, H.S., & Kilpatrick, D.G. (1994). Crime-related PTSD: Emphasis on adult general population samples. *PTSD Research Quarterly, 5*, 1–3.

Saunders, B.E., Kilpatrick, D.G., Resnick, H.S., & Tidwell, R.P. (1989). Brief screening for lifetime history of criminal victimization at mental health intake: A preliminary study. *Journal of Interpersonal Violence, 4*, 267–277.

Shaw, K., McFarlane, A., & Bookless, C. (1997). The phenomenology of traumatic reactions to psychotic illness. *Journal of Nervous and Mental Disease, 185*, 495–502.

Sheline, Y., & Nelson, T. (1993). Patient choice: Deciding between psychotropic medication and physical restraints in an emergency. *Bulletin of the American Academic Psychiatry & the Law, 21*, 321–329.

Switzer, G.E., Dew, M.A., Thompson, K., Goycoolea, J.M., Derricott, T., & Mullins, S.D. (1999). Posttraumatic stress disorder and service utilization among urban mental health center clients. *Journal of Traumatic Stress, 12*, 25–39.

Weathers, F.W., Litz, B.T., Herman, D.S., Huska, J.A., & Keane, T.M. (1993). *The PTSD checklist (PCL): Reliability, validity, and diagnostic utility*. Paper presented at the 9th Annual Conference of the International Society for Traumatic Stress Studies, San Antonio, TX.