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Asking and Talking About a History of Childhood Sexual Abuse

by:

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A thesis submitted in conformity with the requirements for the degree of Master of Science
Graduate Department of Nursing Science
University of Toronto

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Asking and Talking About a History of Childhood Sexual Abuse

Master of Science 1998

Rosanna Di Nunzio

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This study inquired about patients' perspective on being asked about a history of childhood sexual abuse (CSA). Three research questions were asked: (1) From the patients' perspective, who do they report should be asking about a history of CSA?; (2) How do patients wish to be asked?; and (3) If CSA was revealed, what are patients' experiences of both being asked and talking about CSA with nursing staff? Twenty-nine psychiatric inpatients from three hospitals were interviewed using a semi-structured interview schedule developed by the researcher. A thematic analysis of each research question was conducted. Analysis of research question number one identified the following qualities in those who ask: (a) consistency in caregivers, (b) being trained to deal with disclosure, and (c) doing something with the information. Analysis of research question number two identified the following themes: (a) asking in context of other relevant questions, (b) ensuring confidentiality and privacy, (c) timing inquiry appropriately, (d) ensuring clinicians have adequate time to listen, (e) presenting patients with an option to answer, and (f) creating an environment where disclosure can happen at clients' initiative. Analysis of research question number three identified two themes: (a) Task focused behaviors, and (b) authentically interested nurses. One critical implication is the need for nurses to be sensitive to the process of inquiry. Not only is it important for nurses to inquire, but how inquiry into CSA occurs is very important from the patients' perspective, and needs to be given careful consideration.
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TABLE OF CONTENTS

ABSTRACT ........................................................................................................................ ii

CHAPTER I: THE RESEARCH PROBLEM ........................................................................ 1
   Background to the Problem ......................................................................................... 1
   Problem Statement ....................................................................................................... 3
   Review of Related Research ....................................................................................... 4
   Summary ....................................................................................................................... 13
   Study Purpose ............................................................................................................. 14
   Research Questions ...................................................................................................... 15
   Conceptual Framework ............................................................................................... 15
   Definition of Terms ...................................................................................................... 17
   Assumptions ................................................................................................................. 18

CHAPTER II: METHODS ................................................................................................. 19
   Overview and Design ................................................................................................... 19
   Setting ......................................................................................................................... 19
   Sample ......................................................................................................................... 19
   Procedures for Procuring Sample ............................................................................ 20
   Data Collection .......................................................................................................... 21
   Methodological Rigor ................................................................................................. 23
   Ethical Considerations ............................................................................................... 27
   Data Analysis Procedures ......................................................................................... 29

CHAPTER III: RESULTS AND DISCUSSION ................................................................ 31
   Limitations of the study .............................................................................................. 31
   Recruiting Participants, the interview context, and characteristics of the participants .. 32
   Who asked patients about a history of childhood sexual abuse (CSA) ......................... 35
   How patients were asked about a history of CSA ..................................................... 36
   The number of nursing staff who inquired, and how they inquired ............................ 36
Question 1: Who “should” inquire about CSA?  
Theme 1: Qualities of care providers are important in those who ask.  
  Subtheme (a): Consistency in Care giver.  
  Subtheme (b): Being trained to deal with disclosure.  
  Subtheme (c): Doing something with the information.

Question 2: How “should” clinicians ask about a history of CSA?  
Theme (a): The need to ask directly and in context of other relevant questions.  
Theme (b): The need to ensure confidentiality and privacy.  
Theme (c): Timing inquiry about CSA appropriately in the admission.  
Theme (d): The need to ensure clinicians have adequate time to listen.  
Theme (e): Presenting patients with an option to answer.  
Theme (f): Do not ask directly, but focus on creating an environment  
  where disclosure can happen at clients’ initiative.

Question 3: What are patients’ experience of nurses inquiring about a history of CSA?  
Theme 3 (a): Task Focused Behaviors.  
  Subtheme i) Level 1: No care behaviors.  
  Subtheme ii) Level 2: Solution behaviors.  
Theme 3 (b): Authentically Interested Nurses.  
  Subtheme i) Level 3: Affective involvement behaviors.

CHAPTER IV: IMPLICATIONS AND CONCLUSIONS  
  Implications for nursing practice.  
  Implications for nursing education.  
  Implications for research.

REFERENCES.  
APPENDICES.
CHAPTER I: THE RESEARCH PROBLEM

Background To The Problem

The recognition of the prevalence and effects of childhood sexual abuse (CSA) is well documented in the research literature. A 1997 province-wide survey reported that a history of childhood maltreatment is common among Ontario residents. According to this survey, CSA was more commonly reported by females (12.8%) than males (4.3%), with a greater percentage of females reporting a history of severe CSA (11.1%) compared with males (3.9%) (MacMillan et al., 1997). Similarly, a 1984 national survey implied that all children in Canada are at risk. Using much broader definitions of CSA, this survey observed that about one-third of males and just over one half of females report that they had been victims of at least one unwanted sexual act (Badgely, 1984). Studies that examined the prevalence of CSA in North American samples also provide similar results. Gorey and Leslie (1997) synthesized the results of 16 North American Surveys. They found that, after adjustment for response rates and definitions, the prevalence of CSA did not vary significantly over the last three decades. They concluded that, in North America, most prevalence estimates for CSA cluster around 22.3% for females and 8.5% for males. In summary, CSA is a reality which affects children of all regions, races, religions, and socioeconomic classes of our society (MacMillan et al., 1997; Gorey & Leslie, 1997; Badgely, 1984).

The long term consequence of CSA makes it one of the most extreme disturbances facing children today. Abused children are traumatized during the most critical period of their lives: when assumptions about self, others, and the world are being formed; when their relations to their own internal states are being established; and when coping and affiliative skills are first acquired (Briere, 1992). Sexual abuse affects basic life processes, leading to disruptions in
development, affective stability, interpersonal relationships, cognition, and physical well-being (Glod, 1993).

Many studies suggest that sexually abused individuals often experience self-blame, guilt, anger, fear, depression, and suicidal ideation (Brungrabber, 1986; Bryer et al., 1987; Glod, 1993). If never treated, childhood abuse damages the self and sets into motion psychological processes that may evolve into various forms of mental illness (Carmen & Rieker, 1989). For example, Browne and Finkelhor (1986) found incest victims to experience a negative self-image, depression, eating disorders, personality disorder, self-destructive behaviour, and substance abuse. These problems may bring adult survivors into hospitalized psychiatric care. Aside from playing a role in the etiology of an illness, studies also suggest that childhood sexual abuse plays a role in the expression of an existing illness. For example, Bryer et al. (1987) found the most distressed patients in their study of female psychiatric inpatients were abused as children. As well, Surrey et al. (1990) found that abuse survivors in his sample of outpatients had symptoms that appeared more severe than non-abused patients.

Each day, psychiatric nurses are confronted with these individuals who continue to suffer from substantial symptomatology secondary to childhood trauma. When treatment recognizes the emotional and psychiatric sequelae of childhood sexual abuse, the prognosis for these patients is improved (Braun, 1989; Briere, 1992; Carmen & Rieker, 1989; Summit, 1989). However, a substantial percentage of patients today presenting with symptoms relating to childhood sexual abuse has often gone unrecognized (Doob, 1992). Briere and Zaidi (1989) note that, when abusive histories are disclosed, often information is not believed or judged important enough for charting. In their helping relationships with clients, failure by service providers to identify and appropriately respond to the experience of abuse only compounds a
client's problems.

There are many important variables in the helping relationship between nurses and clients who have experienced CSA. Engels (1996) describes a few as: feeling safe on the unit; the clinician's knowledge and skill; and trusting the other. Similarly, Reynolds (1994) describes the need to create an interpersonal climate where clinicians listen, focus, and explore concerns expressed by clients. In such a way, childhood sexual abuse is not only identified, but an empathized awareness of how that experience has affected the client is possible at some point in the relationship.

However, when the posttraumatic nature of childhood sexual abuse is disregarded in treatment, the professional response mimics the context of the original abuse and the prognosis is generally poor (Bryer et al., 1987; Carmen & Rieker, 1989; Chu & Dill, 1990; Jacobson & Herald, 1990; Summit, 1990). This reflects practice models that do not meet the needs of CSA survivors. As a result these patients continue to suffer, and are predisposed to becoming frequent users of psychiatric services.

**Problem Statement**

Many studies are now emphasizing the need for routine inquiry for abuse in psychiatric patients (Rose et al., 1991; Cole, 1989 & Bryer et al., 1987). According to Bryer et al. (1987), by not initiating a discussion of abuse, professionals may unwillingly confirm their patients' belief in the need to deny the reality of their experience. While there is increased concern about the need for routine inquiry for sexual abuse in psychiatric patients, very little attention has been paid to the important aspect of how nurses inquire about sexual abuse and what this experience is like for psychiatric patients. Therefore, this study explored this field by describing psychiatric inpatients' experience of talking about sexual abuse.
Review of Related Research

Introduction

Research that directly addresses psychiatric inpatients' experience of talking about sexual abuse is lacking in the literature. Furthermore, in the examination of related research, accurate comparisons across studies are difficult because of differences in: the definitions of sexual abuse; the populations examined; the sampling techniques; and the methods of eliciting abuse histories. Despite these methodological problems, the literature review does provide evidence that supports the importance of this investigation.

The review of research related to this topic covered four areas important in this investigation: the prevalence of childhood sexual abuse among adult psychiatric patients; childhood sexual abuse and psychiatric symptomatology; literature on how victims of childhood sexual abuse may develop psychiatric symptoms; and the current response in hospitalized psychiatric care.

Prevalence of Childhood Sexual Abuse Among Adult Psychiatric Patients

Compared to the general population, reports on the prevalence of CSA appear to be higher in psychiatric populations. In a study based on a random sample of 85 women in five Toronto hospitals, Firsten (1991) reported an 83% prevalence of physical and/or sexual abuse histories among psychiatric female patients. The prevalence of childhood sexual abuse in these 85 women was reported to be 37%.

The prevalence of assault experiences revealed by direct questioning of psychiatric patients has been found to be approximately twice what was previously documented in chart reviews (Escalona, Tupler, Saur, Krishnam & Davidson, 1997; Wurr & Partridge, 1996; Convoy, Weiss & Zverina, 1995; Bryer et al., 1987; Chu & Dill, 1990; Glod, 1993; Jacobson, 1989).
For example, using a self-administered questionnaire in an adult psychiatric inpatient population, Wurr and Partridge (1996) found 46% reported a history of CSA by questionnaire, while case note review revealed only 14% of previous documented disclosure. In contrast, Carmen et al. (1984) reported (based on chart reviews) a prevalence of 43% of physical and/or sexual assault histories among 188 adult and adolescent male and female psychiatric inpatients. Additional studies of adult female psychiatric patients document the prevalence of childhood sexual abuse, defined as genital contact between a child and a significantly older person, as between 20% and 40% (Jacobson & Herald, 1990; Surrey et al., 1990; Chu & Dill, 1990).

Only a few studies reported the prevalence of incestuous abuse. Incest was found in 14% to 23% of female psychiatric inpatients in acute care facilities (Bryer et al., 1987; Jacobson & Herald, 1990; Surrey et al., 1990). The prevalence of incest reported by caregivers or recorded in the charts of 26 female long term patients in a state hospital was 46% (Beck & van der Kolk, 1987). The highest prevalence of incest (52%) was found in a study which examined 100 patients admitted to a major urban psychiatric emergency department (Briere & Zaidi, 1989). Reported prevalences are difficult to compare across studies because of differences in populations, sampling methods, and definition of abuse.

In summary, regardless of wide variations in reported prevalences, the literature showed that substantial numbers of adult psychiatric patients report histories of incest or other childhood sexual abuse. The numbers are probably underestimated. Survivors of childhood sexual abuse often do not recall or disclose this history (Briere, 1992; Bryer et al., 1987; Chu & Dill 1990; Summit, 1989; Wurr & Partridge, 1996). Most patients view childhood sexual abuse as shameful and stigmatizing (Briere, 1992; Briere & Zaidi, 1982; Browne & Finkelhor, 1986). Therefore, under-reporting is far more likely than fabrication and over-reporting. In
addition, excluded from these studies are the most disturbed patients and those who are otherwise unable or unwilling to give informed consent. This may also lower the reported prevalences since there is evidence that the more severely disturbed patients on a unit are more likely to have been abused during childhood (Bryer et al., 1987). It appears clear that a large number of adult psychiatric patients are survivors of childhood sexual abuse.

**Childhood Sexual Abuse and Psychiatric Symptomatology**

It is generally recognized that adult psychiatric patients with histories of CSA show a characteristic pattern of symptoms (Browne & Finkelhor, 1986). In their study of 73 female psychiatric patients who had a history of CSA compared with 73 randomly selected controls, Pettigrew and Burcham (1997) found that victims of CSA had earlier onset of psychiatric disorder (in particular anxiety disorders) and a higher incidence of deliberate self-harm, rape in adulthood, and many psychiatric hospitalisations. History of CSA had an effect, independent of family psychiatric disorders. Carmen et al. (1984) also examined psychiatric inpatients and found that victims of physical and sexual assault had extreme difficulties with anger and aggression, self image, and trust. Adult survivors tend to blame themselves for their victimization, explaining that they were abused because of their "badness." The women directed their hatred and aggression against themselves in ways ranging from depression to repeated episodes of self-mutilation and suicidal attempts. Possibly as a result of their inability to trust which negatively affects the therapeutic alliance, these patients had more treatment difficulties (longer lengths of stay, high readmission rates), impaired self-esteem, and difficulty coping with aggression. Figueroa, Silk, Huth and Lohr (1997) provided similar results in their psychiatric inpatient study, which found victims of CSA to have higher scores on the Global Severity Index and difficulties with hostility, interpersonal sensitivity, and
paranoia.

Bryer et al. (1987) investigated the association between the development of psychiatric symptoms and the prevalence of childhood physical and sexual abuse in 66 female inpatients. He developed a self-report scale designed to detect nine symptom categories. Seventy-two percent of the women reported a history of either physical and/or sexual abuse at some time during their lives, with 44% reporting sexual abuse before the age of 16. Also higher symptom ratings and suicidal ideation and/or attempts of suicide were more common in abused compared with non-abused groups. The data suggested that the most distressed patients in the hospital may have been either sexually or physically abused as children. Surrey et al. (1990) also found that the sexual and physical abuse survivors in his sample of 140 women outpatients showed more severe symptomatology compared with those denying any past abuse.

Chu and Dill (1990) investigated the relationship between dissociative symptoms and a history of childhood sexual abuse in a sample of adult female psychiatric inpatients. They found survivors of incest reported more dissociative symptoms and were more likely to have auditory hallucinations, numerous diagnoses, and repeated hospitalizations than people without abuse histories.

Suicidal behaviour has also been identified as a potential long-term symptom related to past abuse. Davidson et al. (1996) investigated prevalence of attempted suicide between community members with and without a history of sexual assault. In the results, subjects reporting a history of sexual assault were more likely to be female, younger, and report higher prevalence of lifetime suicide attempts. Investigating the development of psychiatric symptomatology, Brown and Anderson (1991) conducted a retrospective chart review of 947 male and female psychiatric inpatients from whom physical and sexual abuse histories were
elicited at admission via interview techniques. Suicidal thoughts were present in 79% of the patients with histories of both forms of abuse (n=166).

In summary, adult patient survivors of childhood sexual abuse appeared to be at greater risk of experiencing symptoms that are more severe than those of non-abused patients such as: more self-destructive behaviours; chronic dysphoria; depression; dissociative symptoms; psychotic-like symptoms; substance abuse problems; anxiety; hostility interpersonal problems; and lack of diagnostic clarity (Doob, 1992; Figueroa, Silk, Huth & Lohr, 1997; Glod, 1993; Pettigrew & Burcham, 1997; Surrey et al., 1990). The symptoms may be particularly severe in survivors of incest.

**Victimization and Symptomatology**

Carmen et al. (1984) state that, although the psychosocial consequences of abuse are known, the process whereby a victim becomes a patient has not been appreciated by clinicians or adequately conceptualized by researchers. Carmen and Rieker (1989) developed a psychosocial model of the victim-to-patient process to explain how chronic abuse damages the self and sets into motion psychological processes that may evolve into various forms of mental illness. According to Carmen and Rieker (1989), after abuse occurs, the victim must accommodate to the judgements of others about the abuse. This accommodation takes the form of denying the occurrence of the abuse, altering the affective responses to the abuse, and denying the importance of the abuse by disconfirmation and transformation (Carmen & Rieker 1989; Doob, 1992).

The victim of familial child abuse is in a situation in which acknowledging the abuse means acknowledging that the world is dangerous and that those who are supposed to protect and nurture instead caused harm (Doob, 1992; Carmen & Rieker, 1989). The acute episodes of
sexual assault are overwhelming to the child and result in anxiety-related symptoms (Green, 1995). As a result, the victim transforms the abuse by assuming responsibility for the abuse, thereby suffering guilt but restoring an illusion of control, or by redefining the trauma as not abusive, thereby denying cognitive and affective experience but restoring the illusion of a safe world (Doob, 1992).

By accommodating to the judgments of the abuser, there is a profound disconfirmation of the victim's reality (Briere, 1992). The normal affective response to abuse is fear, anxiety, helplessness, and rage, but these feelings must be distorted or suppressed to conform to the abusive family's delusion of safety and nurturing (Doob, 1992). The abuse becomes interpreted by the victim as a delusion or as an appropriate response to one's own "badness" (Briere, 1992). The repressed or dissociated traumatic memories of sexual abuse carry the potential for producing future psychopathology through displacement in the form of conversion symptoms or somatization, and by generating delayed post-traumatic stress disorder (Green, 1995). In the context of adult life, such accommodations to CSA may appear as dissociative symptoms, delusion, depression, self destructiveness, irrational anxiety, paranoia, interpersonal problems, and self criticism (Doob, 1992; Tobin & Griffing, 1996). Thus, the symptoms that result in the victim becoming a patient may represent a reaction to childhood sexual trauma.

**Current Response in Hospitalized Psychiatric Care**

Within psychiatry, trends toward shorter stay, deinstitutionalisation, and pharmacological interventions have forced professionals to modify their psychosocial practice (Pothier, 1988). The rapid rehabilitation of patients to a level required for functioning outside the hospital wall, often through emphasis on pharmacological means, has lead to a devaluation of interpersonal
skills in the therapeutic milieu (Gutheil, 1985). These trends, as well as fiscal restraint and a greater emphasis on consumer participation, have contributed to a lack of clarity of the direction of mental health services. Currently, psychiatric care usually consists of assigning a diagnosis and applying a treatment appropriate to the identified disorder. This approach may be helpful in those aspects of psychiatry where diagnosis and treatment address organic factors. However, in work with abuse survivors, this approach is problematic. The devaluation of interpersonal skills in the therapeutic milieu has affected treatment outcome for sexual abuse survivors detrimentally.

With childhood sexual abuse survivors, interpersonal skills and the helping relationship are critical interventions that can be provided in the early stages of recovery (Briere, 1992; Urbancic, 1992). In particular, empathy is widely accepted as a critical component of helping relationships, and within nursing it has been put forth as an essential part of the nurse-patient interaction (Nightingale, 1946; Rogers, 1958; Griffin, 1983; Pike, 1990). Empathy is a therapeutic tool that can enable nurses to gain an understanding of the abuse survivor. And in turn, use this understanding to help clients achieve therapeutic change. Other authors argue that empathic relationships are not only used to achieve change, but also to give comfort to patients. Tyner (1985, p. 399) writes that patients will feel "satisfaction, relief as carrying the burden alone is lifted, relief from loneliness, and safety when involved in an empathic relationship." An empathic stance is seen by many as the most desirable form of the nurse-patient interaction.

Many studies are now describing the importance of empathy in the treatment of abuse survivors. For example, Urbancic (1992) describes how creating an empathic interpersonal climate is necessary to validate the patient's experience of CSA and its personal meaning to the
survivor. In a more recent study, Gallop, McKeever, Toner, Lancee and Lueck (1995) specifically asked a sample of 248 nurses, of whom 17% reported a history of childhood sexual abuse, how to respond to victims of sexual abuse. The most frequent response identified by both abused and non-abused nurses consisted of empathy and listening. In particular, the nurses who were survivors of sexual abuse identified being supportive, compassionate, and caring as additional ways to respond. Although both groups identified that bringing up the topic of sexual abuse was distressful for clients, they also felt the amount of distress experienced would depend on the nurses' level of skill, knowledge, and therapeutic approach. Again, the abused nurses were particularly concerned that the nurse knew what to say, and would be able to tolerate hearing about the abuse. Interpersonal skills and the therapeutic milieu cannot be undervalued in the treatment of sexual abuse survivors. However, it appears that the quality of empathic care, which aids in gaining an understanding of the patient, has decreased with shorter stay, and deinstitutionalization.

Research studies and accounts by survivors indicate that the experiences of seeking help are often not positive (Engels, 1996; Gibbons, 1996). As a result of our current model of care, a large percentage of patients presenting with symptoms relating to childhood sexual abuse are often unheard and unrecognized (Rose et al., 1991; Doob, 1992). Van der Kolk and colleagues (1994) explain that, as long as the trauma is experienced as speechless terror, the body continues to "keep score" and reacts to conditioned stimuli as a return of the trauma. When the mind is able to create symbolic representations of these past experiences, however, there seems to be a "taming of terror" (Van der Kolk et al., 1994). However, many patients do not volunteer the information that they have experienced childhood sexual abuse or deny the history if asked (Jacobson & Richardson, 1987; Summit, 1989; Doob, 1992). In particular,
recent studies show male victims are especially unlikely to disclose their experience of CSA, and (as a coping strategy) they deny the impact of sexual abuse on their lives (Holmes, Offen & Waller, 1997). Summit (1989) argues that in order to live through the CSA experience, the survivor acts as if nothing has happened. Several studies indicated that mental health professionals tend to hold attitudes that underestimate the frequency and effects of sexual abuse and/or discount abuse disclosures as fantasies or memory distortions (Eisenbery, Owen & Dewey, 1987; Finkelhor, 1984; LaBarbera, Martin & Dozier, 1980). According to Briere & Zaidi (1989), many patients are not asked or, if abuse is disclosed, the information is not believed or judged important enough for charting.

As documented earlier, the prevalence of abuse are seriously underestimated if the data is obtained by chart review and not subject interview. A chart review study showing prevalence of sexual and/or physical abuse experiences of 43% in male and female psychiatric patients (Carmen et al., 1984), is much lower than the reported prevalence of 72% (Bryer et al., 1987) or 81% (Jacobson & Richardson, 1987) when patients were questioned directly about sexual and/or physical abuse. Jacobson and Herald (1990) found that 56% of inpatients who were questioned directly not only stated that they had been sexually abused in childhood, but also stated that they had never disclosed the information to caregivers before that time. Briere and Zaidi (1989) discovered a sexual abuse prevalence of only 6% among 50 female psychiatric emergency department patients by chart review, but 70% in another sample of 50 charts after clinicians were requested to routinely ask patients about childhood sexual abuse. Similarly, Craine et al. (1988) and Rose et al. (1991) reported that many psychiatric patients state that they had never previously revealed their abuse histories to professionals because they had never been asked.
In ignoring or denying the existence and impact of childhood sexual abuse, professionals and patients maintain the myth of a nurturing family, a safe world, and a guilty patient (Carmen & Rieker, 1989; Chu & Dill, 1990; Doob, 1992). The adult patient's accommodation (labelled dissociative, psychotic, affective disorder, etc.) appears pathological in a world that responds with blindness to the abuse experience (Briere, 1992; Doob, 1992). Given the high prevalence of childhood sexual abuse revealed in psychiatric inpatient populations, there may be a need for routine inquiry. Professionals' failure to initiate discussion of sexual abuse sends a message to patients that such abuse does not occur, or does not matter, and confirms the patient's belief in the need to deny the reality of the experience (Bryer et al., 1987). Patients' attempts to deal with the distress of their symptoms related to the sexual abuse, and how caregivers respond to their symptoms without an awareness that it is a response to sexual abuse, may lead to the development of more severe and confusing symptoms (Bryer et al., 1987). According to Carmen and Rieker (1989), when these behavioural reenactments are unrecognized, the psychotherapy situation can become a destructive repetition of the trauma in which the patient is again disconfirmed and left alone with his or her pain. In order for treatment to be effective, it must confirm the recollections of abuse and help the patient acknowledge and recontextualize the trauma (Briere; Carmen & Rieker, 1989).

Summary

The review of existing literature revealed that childhood sexual abuse survivors comprise a substantial proportion of our patient populations, either as new patients or as those with extensive treatment histories. Researchers have found that treatment within the mental health system has often continued the denial and disconfirming responses that first confronted the abuse survivor during childhood. It is postulated that resultant accommodations to the abuse
become symptoms in adulthood (Briere, 1992). Treatment may restimulate symptoms and cause abuse survivors to appear very ill and untreatable. Many studies advocate routine inquiry (Cole, 1988; Herman & Schatzow, 1987; Rose et al., 1991), which may validate the experience of abuse victims and permit discussion and expression of feelings that were previously denied. Nurses frequently interact with victims of abuse and can potentially make a difference in the treatment of survivors, a difference that may ultimately result in healing and the prevention of persistent illness (Urbancic, 1992). Although we were aware of the need for routine inquiry, there is no literature on how nurses ask about sexual abuse and what the experience is like for psychiatric patients. This research examined the area of inquiry of sexual abuse in psychiatric patients by considering the patients' perceptions of the therapeutic relationship when being asked about a history of childhood sexual abuse.

**Study Purpose**

The purposes of this study were to investigate: (1) From the patients’ perspective, who do they report should be asking about a history of CSA?; (2) How do patients wish to be asked?; and (3) If CSA was revealed, what are patients' experiences of both being asked and talking about CSA with nursing staff?

Ultimately, the purpose of this study was to add to the body of knowledge about sexual abuse. In understanding patients’ experience, and how they wished to be asked, professionals will have increased knowledge into the therapeutic quality of the time spent with sexual abuse survivors. This will provide the opportunity to identify implications for nursing practice to improve the quality of care for psychiatric patients who are sexual abuse survivors.
Research Questions

1. From the patients’ perspective, who do they report should be asking about a history of CSA?

2. How do patients wish to be asked?

3. If CSA was revealed, what are patients’ experiences of both being asked and talking about CSA with nursing staff?

Conceptual Framework

The conceptual framework for this study was used to construct the data collection questions and analyze the data. It is based on the work of Gallop, Lancee, and Garfinkel (1989) and theories of empathy. Empathy has been considered by historical and contemporary theorists to be an integral element in nursing and a core component of a therapeutic relationship (Nightingale, 1946; Peplau, 1952; LaMonica, 1985; Gallop, Lancee, & Garfinkel 1989). Empathy has been defined as the ability to perceive the meaning and feeling of another person and to communicate that feeling to the other (Gagan, 1983). Several studies have identified that empathy was of paramount importance to patient outcomes (Hardin & Halaris, 1983; Margaret, 1981; William, 1979).

The empathic stance is also the most desirable and helpful when talking to clients about sexual abuse. In her work with sexual abuse survivors, Urbancic (1992) describes how nurses must create an interpersonal climate of trust where validation of the abuse and its personal meaning to the survivor can occur. Empathic communication helps to establish an interpersonal climate of trust. Unless clients are able to feel safe (trust) within their nurse-client relationship, it is unlikely that the abuse will be disclosed or that nurses will be able to assess accurately the needs and problems of their clients, from a client-centred viewpoint (Reynolds,
Gallop et al. (1995) provides further evidence that substantiates the importance of empathy in working with abuse survivors. In this study, a sample of abused and non-abused nurses were asked how nurses should respond to victims of sexual abuse. The most frequent response provided was specifically “with empathy and listening.”

Thus, it follows that when talking to patients about a history of sexual abuse, the creation of an interpersonal climate in which it is possible for an empathized awareness of the other person is of paramount importance. Empathy, therefore, was chosen as a framework for constructing the data collection questions and analyzing the data.

Gallop et al. (1989) described three levels of empathic care which address the experience of empathy between a nurse and his or her patient. These levels of care were the operationalization of a theoretical view of empathy as a multiphasic time sequenced process. Gallop et al. (1990) articulated this process in detail in her theoretical work. In brief, Gallop et al. (1990) described empathy is a single construct with three phases: an inducement phase, a matching phase, and a participatory-helping phase. There are numerous mediating variables that influence the outcome of each phase. Outcomes then either support continuation to the next phase or termination of the empathic process. These outcomes have been operationalized to reflect the three levels of empathic care (no care behaviours, solution behaviours, and affective involvement behaviours) that Gallop et al. (1989) used for the measurement of therapeutic empathy.

This investigation used semi-structured interview questions to assess these three levels of care. With these questions, the investigator examined the clients' perceptions of the empathic process when talking about a history of sexual abuse by assessing for evidence of these different levels of empathic care. The three levels of empathic care, as conceptualized by
Gallop et. al. (1989), are represented by ten possible response categories, which are presented below.

Level 1: No Care Behaviours

1. Responses that belittle or contradict patient.

2. Responses that offer platitudes or cliches.

Level 2: Solution Behaviours

3. Responses that explain rules or processes.

4. Responses that tell the patient what to do.

5. Responses that offer a solution.

6. Responses that invite an explanation of patient's statements.

Level 3: Affective Involvement Behaviours

7. Responses that express care or concern.

8. Responses that address patient's feelings

9. Responses that address precipitants of patient's feelings

10. Responses that address patient's self-esteem.

Definitions of Terms

Childhood Sexual Abuse: In the literature, childhood sexual abuse is often described as sexual contact, ranging from fondling to intercourse, between a child in mid-adolescence or younger and a person at least five years older (Briere, 1992). For this study, whatever the participant reported to the researcher as childhood sexual abuse was accepted.

Empathy: This construct was defined as the ability to know or understand the experience of another, as demonstrated in "affective involvement" responses defined in the conceptual framework (Gallop, et al., 1990).
Psychiatric Nurse: This term refers to a registered nurse, with direct patient contact, working on a psychiatry unit in the province of Ontario.

Assumptions Underlying the Study

1. Individuals are likely to perceive the experience of talking about sexual abuse as distressing/discomforting.

2. An empathic stance is the most desirable form of nurse-patient interaction.

3. The quality of empathy perceived by patients can be described.
CHAPTER II: DESIGN AND METHODS

Methods

Overview and Design

In order to describe patients' experience of being asked and talking about childhood sexual abuse, a sample of psychiatric inpatients from three hospitals was asked about their experience using semi-structured interview questions (see Appendix A). These questions attempted to elucidate the experience of empathy as described in the conceptual framework. The design for this study was descriptive in nature. This design was chosen since very little is known about patients' experience of nurses inquiring and talking about sexual abuse.

Setting

This study was conducted in inpatient psychiatry units of three hospitals, located in and around a large urban area. One hospital was an urban teaching psychiatric hospital. A second was a community non-teaching general hospital. The third was a community non-teaching psychiatric hospital. In all units in which data were collected, acute treatment was provided to adults over 18 years of age. Each unit contained between twenty and thirty beds. At the time of data collection, the average length of stay for the patients on these units was 10-21 days. All sites were staffed with registered nurses providing primary care. All units included a routine nursing admission history with a direct question regarding sexual abuse. These sites were chosen because they each represented a different kind of psychiatric service, and the investigator did not practice in any of these sites.

Sample: Selection Criteria

Patients who met the following criteria and agreed to participate in the study were included in the sample.
1. Person who has been admitted to a psychiatric unit.

2. Person must be English speaking.

3. Person must be on the ward for at least 24 hours.

4. Person is able to give informed consent. Nursing staff assisted the investigator in approaching patients who were deemed competent, and able to give informed consent.

Sample Size

The sample was a non-probability convenience sample which included psychiatric patients from the three hospitals. The researcher interviewed subjects with and without a history of CSA, as reported by the patient in the context of the interview. Twenty-nine participants (male and female) were obtained. Thirteen of these participants verbally reported a history of CSA, and 9 of these participants (who had an interaction with a nursing staff member about their CSA) completed part two of the interview schedule. The sample provided sufficient data to enable a preliminary description of patients’ experience of talking about childhood sexual abuse. Also, the sample was selected for practical purposes such as the length of time the investigator had for data collection, the availability of subjects, and the complexity of data collection with each patient.

Procedures for Procuring Sample

Once approval from the Office of Research Services had been received, the researcher sent a letter to the Executive Director of Nursing of the facility (see Appendix B). The purpose of this letter was to gain permission to conduct the proposed study on the psychiatric unit, within the hospital. A copy of the protocol was also enclosed with this letter.

Upon receiving permission from the facility, a letter was sent informing the unit’s Clinical Nurse Manager (CNM) that the researcher had received approval from the Office of Research
Services and from the hospital to conduct the proposed study on the unit (see Appendix C).

This letter outlined the purpose of the study and asked for assistance from the CNM to identify potential participants for the study. The researcher also requested that the interview be conducted in a room on the unit that offered privacy for the participant and the researcher.

Once the data collection period had begun, the researcher frequently contacted the Clinical Nurse Manager on the unit to inquire if eligible participants has been identified. The researcher then asked the Clinical Nurse Manager to approach the potential participants and briefly describe the purpose and nature of the study and to ask permission for the release of their names so the researcher could meet with them to explain the study further (see Appendix D).

The researcher made arrangements to meet with the potential participants who had agreed to release their names. At this time, the researcher introduced herself and explained the purpose of the study, the data collection method, and the expectations of the participant. The voluntary nature of participation, the patient's rights, and confidentiality of the data were emphasized (see Appendix E).

Patients who participated in the study were asked to sign a consent form at this time (see Appendix F). For those patients who consented to participate, an appointment was arranged at a mutually convenient time for the interview.

Data Collection and the Semi-structured Interview

Data were collected by means of a semi-structured interview. The semi-structured interview schedule is shown in Appendix A. The interview schedule was used as a guide and was administered in a face-to-face interview by the researcher. The interview took place in a room on the inpatient unit offering privacy and ensuring confidentiality for both the participant
and the researcher. Prior to initiating the interview, the researcher briefly reintroduced the purpose of the study and reminded the participants of their right to refuse to answer any questions or withdraw from the study. The interview schedule consisted of three parts, described below.

**Part One.** Questions in part one of the interview schedule addressed research question number one and two, which was "whom do patients report should be asking, and how do patients wish to be asked about CSA?" These questions were administered to all subjects and began with a question on whether or not, prior to hospitalization, any health professional had ever ask about sexual abuse. Then followed a question about whether or not had anyone asked the patient about sexual abuse during his/her hospitalization, and, if yes who had asked? If the patient was not asked directly, then how do they wish to be asked? The remainder of the interview questions (part two) were administered only to abuse victims who confirmed that they spoke to a nurse about sexual abuse.

**Part Two.** Part two of the interview schedule addressed research question number three, which explored patients experience of being asked and talking about CSA with nursing staff. The questions in part two of the interview schedule were derived from the conceptual framework and were designed to elicit information from the subjects that could then be related to the three postulated levels of empathic care. For example, three patient described nurses demonstrating "affective involvement behaviours." To initiate discussion in this area, part two of the interview schedule began with an open-ended question to elicit information from the participants: "Tell me about your experience of talking to your nurse about sexual abuse." The remainder of the questions were asked in a systematic order as prepared in the interview schedule, but the researcher also used unscheduled probes to help clients fully elaborate their
experiences.

To elicit further information on the empathic process, specific probes in question number seven of the interview schedule were designed to reflect the ten possible response categories as described in the conceptual framework.

**Part Three.** Part three of the interview schedule collected demographic data on all the participants.

**Methodological Rigour**

In an effort to achieve rigour throughout the research process, the researcher addressed the four criteria identified by Lincoln and Guba (1985) associated with qualitative data: credibility, transferability, conformability, and dependability. These criteria have been further elaborated by Sandelowski (1986).

**Credibility**

Credibility refers to the degree to which the data are a trustworthy reflection of the participant's experience. The credibility of research findings can be increased by the researcher employing techniques that make it more likely that credible findings and interpretations will be produced. To enhance credibility, the researcher used precautions, described below, to ensure that; the data collected were rich, results were true to the descriptions given by subjects, and the instruments' validity is maintained. Each of these are elaborated upon below.

**Rich data.** The generation of rich data involves understanding the subjective perceptions, experience, and feelings from the participant's perspective. The participant having lived and perceived the phenomenon under study is the "expert" and therefore the most credible source of information. For this study, the researcher clearly defined to each patient her role as the
learner who lacked knowledge regarding patients’ experiences of talking to nurses about CSA and who was authentically interested in learning about this experience from the individual’s perspective.

To ensure rich data, the researcher interviewed subjects still in the hospital using a tape recorder to capture unedited narrative descriptions. At this time, all patients reported vivid memories of their interactions with nursing staff. Secondly, the researcher used the interview questions in an attempt to elicit depth in the data (see Appendix A). Patients talked at ease and at great length about their experiences. The results demonstrate the thickness and detail in the descriptions given by patients. Finally, privacy during the interview was ensured, and confidentiality reinforced throughout the interview process, so that subjects felt more at ease to discuss all feelings, whether they were socially acceptable or not.

**True results.** To enhance the truth of the participants’ descriptions, the researcher used clarifying probes throughout the interviewing process. Also, throughout the process of analysis, the researcher paid attention to typical and atypical elements of the data to ensure that themes developed were representative of data as a whole. For example, the researcher had to clarify with participants at times that they were indeed speaking about their experience of nurses inquiring about CSA and not the abuse itself. This helped affirm that the researcher was making correct interpretations based on all data and not on preconceived themes or biases.

**Valid instruments.** A possible threat to the credibility of this study is the validity of the instrument. According to Sandelowski (1986) the researcher can be considered a research tool. Therefore, validity will depend on the researcher’s ability to ask questions of the subjects that tap into their experiences with nurses apart from simple general opinions. The interview schedule was constructed with the aim to collect such experiential data. In particular,
there were both open-ended questions to elicit information followed by more structured probes in order to have the patient more fully elaborate and/or validate previous comments. Receiving similar responses to the same questions phrased differently throughout the interview provided support to the validity of the instrument.

A second consideration is the instrument's ability to accurately describe the event/experience as it presents itself. As suggested by Sandelowski (1986), the researcher will enhance credibility in this area by describing and interpreting her own behaviour and experiences in relation to the behaviour and experiences of the participants. Therefore, fieldnotes were taken immediately following the interview; these notes included the non-verbal communication and the observed interactions between the researcher and the participant. This protected the researcher from "going native" a process whereby the researcher cannot distinguish her own experiences from those of the participants (Sandelowski, 1986).

In attempting to approach the data without bias or influence, the researcher employed "bracketing," in which beliefs, presuppositions, assumptions, and previous knowledge regarding the phenomenon under investigation are made explicit. In particular, the researcher noted she was a white middle class female with a particular view on inquiry into CSA. The researcher acknowledged that she felt that asking is important; however, using bracketing, the researcher aimed to maintain a neutral stance both verbally and non-verbally with all patients.

Data were examined to see what themes actually emerged, rather than the themes the researcher wanted to see. It is also noted that the most desirable option is to bring these themes back to the same patients to validate that they are truly capturing their beliefs; however, this was not possible in this study since patients were in hospital for short periods of time. In one instance, following careful examination of the transcripts, the researcher noted
that there was a slight indication she may have “sided” with the patient regarding an issue of discontent with a staff member; therefore, the researcher did not include this section of the transcript in the results. Finally, for recruiting subjects, the researcher chose hospitals in which she had never practised. This also helped to control for biases the researcher may have had about these settings or people.

Transferability

According to Lincoln and Guba (1985), transferability refers to the degree to which the results can be transferred to another social situation. It is the researcher’s responsibility to provide a "thick" description of the phenomena under investigation so that each reader can judge whether the results are applicable in his/her setting (Lincoln & Guba, 1985). The researcher provided a demographic profile of the patients so that readers are able to make judgements about the similarity and consequent comparability of this study’s sample to another patient group.

Dependability

Lincoln and Guba (1985) proposed that dependability, instead of the quantitative measure of reliability, be the criterion of rigour related to the consistency of qualitative observations. Dependability refers to the ability of another researcher to follow the thinking, decisions, and methods used by the original investigator. Readers adopting the viewpoint as articulated by the investigator should also see what the investigator sees, whether or not they agree with it. Dependability is demonstrated primarily in the research report. As well, the researcher reported the decisions involved in the transformation of data to thematic schema, leaving a clear decision trail concerning the study from its beginning to its end.

Other methods that enhanced the dependability of the study include the methods for
analysing the results. The researcher did repeated analysis of the transcripts. Each tape cassette was listened to at least twice to ensure accuracy in transcribing of patients' statements. The transcripts were then read repeatedly to get a sense of emerging themes. Within a time frame of a few months, the researcher reviewed the same text at different times to ensure she came up with the same themes. Finally, the researcher ensured reproducibility of the results by having a different person analyse a specific data set. The thesis supervisor was chosen for this task since this person had knowledge of the research questions. This person developed the same theme categories as the primary investigator.

**Conformability**

Conformability replaces the quantitative concept of objectivity and refers to the characteristics of data rather than those of the investigator (Lincoln & Guba, 1985). Data that are as free from bias as possible are achieved to the extent that the criteria of credibility, transferability, and dependability are met. These tests of rigour ensured that the descriptions which emerged in this study were grounded in the data from which it was derived.

**Ethical Considerations and Protection of Subjects' Rights**

**Informed Consent**

Before proceeding with the study, the researcher obtained approval from the Office of Research Services with respect to human rights. When research involves human beings as a source of information, informed consent from the participant is required.

To obtain informed consent, the researcher needed the assistance from the CNM and the nursing staff to identify potential participants who were able to make a rational decision to participate in the study. When the researcher met with the potential participants who had agreed to release their names, an explanation of the study was given (see Appendix F). They
were assured that their participation was voluntary, and that, if they chose not to participate, their care would not be affected in any way.

The participants were informed of the nature of the interview and its anticipated length. They were informed that the interview would be tape-recorded, and that they had the right to stop the tape recorder at any time. A separate consent for tape-recording the interview was provided for the participant. The participants were informed that all information given by the participant was secured under lock and key at all times by the researcher.

The participants were made aware that they had the right to refuse disclosure of any information which created discomfort for them and the right to withdraw at anytime during the study without penalty. They were informed that the information they shared with the researcher was used for research purposes and would not be shared with the unit staff, except as part of general findings. The participants were also to be informed of whom to contact if they have any comments, questions, or concerns regarding the study or their rights.

Confidentiality

The participants were assured that their privacy would be protected at all times ensuring confidentiality and anonymity. Although direct quotes were used, the participants were assured that their name and hospital name would not appear on any reports. Code numbers corresponding with the name of the respondents were used. Tape-recordings and transcripts were identified only by such code numbers. The investigator kept the master list linking code numbers to identifying data in a locked cabinet for the duration of the study. The list will be destroyed upon completion of the study, but consent forms, without identifying codes, will be kept for the required six years.

Risks and Benefits
Although the researcher approached the participant in a caring manner during the interview, a potential risk was that the participant might become distressed due to the disclosure of sensitive information. However, the researcher was vigilant in assessing the subjects' level of comfort, and none of the patients interviewed needed to stop or required help from staff. In contrast, a few patients did report that they benefited from sharing their experiences and feelings with the researcher, since it increased their awareness of their situation. When appropriate, the researcher suggested that they may want to talk with a clinician to do further work in this area.

**Data Analysis Procedures**

Ethnograph (1988), a computer software program, was used to assist with the mechanical aspects of data analysis. After the interviews, the audio-tapes were transcribed onto a computer using the Ethnograph program. Once the interviews were transcribed, the notes were reviewed again for accuracy in the data. Ethnograph prepared the data for analysis by arranging the interview data in a column on one side of the page and numbering each line of the transcript. Using the numbered lines, the data were then coded and categorized by three questions: who should inquire about CSA; How should clinicians inquire about CSA; and what are patients experience of nurses inquiring about CSA. The coded data were then entered into the computer using Ethnograph (1988) by identifying each line of the data that corresponded to those three questions. Ethnograph (1988) was then used to group all the data together under the questions into which they were coded. A thematic analysis of the transcripts was conducted. Each question was reviewed several times and examined for emergent themes. A theme was defined as an idea which may be present in a phrase or sentence. To be considered a theme, the idea had to be present in the interview context of at least three participants. The
actual frequency of themes among all participants is also reported in the results. In describing "patients' experience of nurses inquiring about CSA," the conceptual framework was used to categorize the themes into the three levels of empathic care.
CHAPTER III: RESULTS AND DISCUSSION

Limitations of The Study

This study is limited by the small non-probability convenience sample. Ninety-three percent of the patients in the sample were Caucasian. Sixty-two percent had completed post secondary education, and 83% were currently employed, or had been employed within the last five years. The patients in this study may not be representative of psychiatric inpatients on the whole, which may include: great variations in ethnic origins; more or less educational preparation; and more or less capacity to maintain employment. Possibly if random methods of collecting the sample were used, the demographic characteristics would have been different. Great caution, therefore, must be taken in making any generalizations to other psychiatric patient receiving short stay inpatient treatment. The selection criteria also presents a limitation to the study. The study is limited to those English-speaking patients who were able to give informed consent. A bias also exists in those who did agree to hear about the study and participate. The majority of patients approached by nurses, refused to be approached by the researcher to hear more about the study. It is not clear why these patients did not want to hear more about the study. Possibly, just hearing that the topic involved questions about CSA aroused concerns and/or anxieties that lead to refusal. Also, those who did agree to participate may not have disclosed their sexual abuse history to the researcher. Those who did hear about the study were eager to participate. Participants of the study may have been biased to those who were at a stage of their healing where they could speak comfortably with strangers and/or felt they had a message to get across to others.

Results And Discussion

The results are reported in two parts. The first part presents the observations and
descriptions related to: the recruitment of participants; the interview context; the characteristics of the participants; who and how patients were asked about a history of CSA; and the number of nurses who inquired. The second part looks at themes which emerged from the three research questions that were asked of patients: Who should inquire about CSA?; How should clinicians inquire about CSA?; and What is your experience of nurses inquiring about a history of CSA? Themes are considered within each of these three questions and, when appropriate, subthemes are illustrated and discussed. The discussion interpreting the results occurs in segments directly following the relevant themes. In the responses, similar themes emerged between the two groups of patients; however, sexual abuse survivors’ answers had more detail and depth. Quotations from different participants are used to highlight the themes which emerged from the data. When several quotations are used to illustrate a theme, each quotation is from a different participant. Percentages are presented for the full sample, except where specified otherwise (n=29 all participants; n=16 nonabused participants; n=13 abused participants). Nine of the abused participants had an interaction with their nurse about their sexual abuse history.

The study was descriptive in nature and used a non-probability convenience sample. The researcher, therefore, was interested in understanding the themes which emerged from the sample as a whole, and comparisons between different sites and genders were not investigated for the purposes of this study. However, from the researcher’s experience in collecting and transcribing the data, it was noted that similar themes emerged in all three sites and in the responses provided by both men and women.

Recruiting Participants, the Interview Context, and Characteristics of the Participants

In order to recruit participants for the study, the researcher made herself available on the
unit to talk to various nurses and to help assess which patients on the unit would be eligible to participate. The nurse then approached the potential participants, briefly described the purpose and nature of the study, and asked for their permission for the researcher to meet with them to further explain the study (see Appendix D). Among all the patients identified as eligible potential participants, only about 20-30% agreed to have the researcher approach them to further explain the study. However, all but one of the patients to whom the researcher explained the study agreed to participate. The reason a patient declined to be approached by the researcher was investigated when opportunity allowed. Common responses given by nurses were: “I don’t know”, “The patient is too tired,” or “The patient has a history of sexual abuse and does not want to address the topic in any way.” The actual incidences of these responses were not recorded.

All of the interviews occurred on a weekday in the morning or afternoon. The interview took place in a private room on the unit and lasted anywhere from fifteen minutes to one hour. Data on the characteristics of the participants were obtained at the end of the interview, using the demographic data sheet (see Appendix A). In total, 29 patients agreed to participate. The patients ranged in age from 20 to 64 years, with a mean age of 42 years. Table 1 tabulates the demographic data collected on the sample.
Table 1: Demographic Description of Sample (n=29)

<table>
<thead>
<tr>
<th>Sex</th>
<th>Female - 19</th>
<th>Male - 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed Ethnicity</td>
<td>Caucasian - 27</td>
<td>Asian - 2</td>
</tr>
<tr>
<td>Current Marital Status</td>
<td>Single (never married) - 6</td>
<td>Married - 9</td>
</tr>
<tr>
<td>Highest Education Completed</td>
<td>University - 10</td>
<td>College - 8</td>
</tr>
<tr>
<td>Employment</td>
<td>Presently Employed - 12</td>
<td>Employed within the last year - 4</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Depressive Mood Disorder - 20</td>
<td>Bipolar Mood Disorder - 7</td>
</tr>
<tr>
<td>Past Psychiatric Admissions</td>
<td>First admission - 6</td>
<td>Five or fewer admissions -12</td>
</tr>
</tbody>
</table>

The majority of the participants were eager to describe their experiences, often with much detail. It was as if they had agreed to participate because they had something to say. At the conclusion of the interview, the participants often thanked the researcher for listening, wished her luck in her work, and hoped that they had helped with the study. One patient stressed “Make sure you get something done with this, make sure you get it published.” This came from a man who was healing from a long history of childhood trauma.
Who and How Patients Were Asked About a History of CSA

Figure One below illustrates who and how patients were asked about a history of CSA. This is followed by a more detailed description.

Figure 1. Who and how patients were asked about a history of CSA.

During current hospitalization:

17 patients had an interaction with a clinician regarding CSA (includes patients with and without a history of CSA)

Who asked?
9 nurse
4 doctor
3 social worker
1 psychologist

How asked?
8 Direct
2 indirect
6 patient
1 unknown

Prior to Hospitalization:

16 patients had an interaction with a clinician regarding CSA

Who asked?
8 doctor
3 nurse
2 social counselor
2 unknown
1 social worker

How asked?
9 Direct
4 patient
3 unknown

Who Asked Patients About a History of CSA

During the current hospital admission, 17 patients reported that they were asked about a history of childhood sexual abuse. Nine of these patients reported they were asked by nursing staff; 4 reported they were asked by their doctor; 3 reported they were asked by a social counselor.
worker, and 1 reported being asked by a psychologist.

Prior to the current admission, 16 patients reported that they were asked about a history of childhood sexual abuse. Eight of these patients reported they were asked by medical staff; 3 reported they were asked by a nurse, 2 reported they were asked by a social workers; another 2 reported they were asked by counsellors; and one other patient they were not sure of the status of the professional who asked.

**How Patients Were Asked About a History of CSA**

Of the 17 patients who reported that they discussed CSA during the current admission, 8 patients stated that the clinician asked directly. In this study, “asking directly” refers to the clinician asking a question which uses the words “childhood sexual abuse.” Two patients reported that the professional asked indirectly. “Asking indirectly” refers to the professional initiating a discussion around childhood trauma, but without using the words “childhood sexual abuse.” Six patients reported that they initiated the topic of childhood sexual abuse. “Patient initiated topic” refers to the patient initiating the topic of childhood sexual abuse, outside any discussion of childhood trauma. One patient reported that he/she did not remember how the topic was initiated.

Of the 16 patients who reported that they discussed CSA previous to hospitalization, 9 stated that the clinician asked directly. Four patients had to initiated the topic on their own, and 3 did not remember how the topic was initiated.

**The Number of Nursing Staff Who Inquired, and How They Inquired.**

Although all 29 patients were in units in which the routine nursing history included a direct question regarding childhood sexual abuse, only 9 patients recalled being asked or discussing CSA with a nursing staff member. Of these, 6 patients recalled being asked directly, 2
indirectly, and one patient initiated the topic. Since one patient initiated the topic, 8 (or 28% of the participants sample) patients recall that a nurse inquired about a history of childhood sexual abuse during their current admission.

The next section looks at themes which emerged from the three research questions that were asked of patients: Who should inquire about CSA?; How should clinicians inquire about CSA?; and What is your experience of nurses inquiring about a history of CSA? Themes are considered within each of these three questions and, when appropriate, subthemes are illustrated and discussed.

**Research Question 1: Who “Should” Inquire About a History of CSA?**

Patients who indicated that they were not “asked directly” about CSA, were asked to identify whom they felt “should” inquire about a history of CSA. The flow of the interview is described below.

The investigator asked all patients whether, either previous to or during the current hospitalization, any health professional asked about a history of CSA. If the patient indicated she or he was not asked, then the investigator asked “who” should ask. If the patient indicated she or he did have a discussion regarding CSA, but was not asked directly about it, then the investigator asked “who” should ask directly. Eight patients indicated that they were asked directly about CSA. To facilitate the interview, the investigator asked these 8 patients questions which lead to an understanding of that experience, hence these patients were not asked “who should ask about CSA?” Therefore, the remaining 21 patients indicating that they had not been asked directly about CSA, were asked “whom” they felt should be asking about CSA.

The theme that emerged from the question “Who should inquire about a history of CSA”
was "qualities of care providers are important in those who ask." This theme is described in
detail in four subthemes that describe the qualities that patients wanted in those who ask.
These subthemes are: having time to listen; consistency in care giver; being trained to deal
with disclosure; and those who do something with the information. While for the sake of
clarity these themes are discussed separately, they are not truly distinct and often overlap. The
first subtheme, "having time to listen," emerged many times throughout the data in this study.
In order to address this subtheme only once, it will be discussed in the next section which
examines "how clinicians should be asking about CSA." Before discussing the other three
subthemes, a brief description of the theme "qualities of care providers are important in those
who ask" is presented.

**Theme 1: Qualities Of Care Provider Are Important In Those Who Ask**

The responses of both abused and non-abused patients did not focus on the professional
status of the clinician. Out of 21 patients who were asked the question "who should ask," 18
suggested that it did not matter "who" was asking but rather "how" they were asking. As the
following quotations illustrate, patients did not always have a clear answer as to "who" should
ask.

Are you talking about a role, like a doctor or a nurse or something like that?...I haven’t
thought about it like that at all.

****

Nurse, doctor, social worker, I can talk to almost every one of them. But sometimes
with the nurses I talk more often, not so much with the doctors. But then again the
nurses give the information to the doctors anyway..I don’t know..I guess anyone of
them could ask.
Any authoritarian figure from whom you can receive help—that would be any therapist that knows how to respond.

The professional status that the patient chose to ask about CSA, depended on patients' experiences with different professionals. However, abused and non-abused patients made it clear that certain qualities were required of clinicians inquiring about childhood sexual abuse. These qualities that emerged from the data are captured into three subthemes.

**Subtheme (a): Consistency in caregiver.**

Seventeen patients talked about the importance of developing a relationship with someone. According to their experiences, this could be achieved only by having a consistent person to be in contact with on a daily basis. It is through this consistent caregiver that patients develop enough comfort, and trust, to discuss sensitive topics such as childhood sexual abuse. The following quotation illustrates this:

> It would also seem to me that, ahm, it would have to be one person, not this nurse this night and another nurse tomorrow morning and another nurse another day. The inconsistency that causes in creating, ah, in making a relationship I think could be very destructive in a very vulnerable time. So there would have to be some kind of sense that this person would be there tomorrow or maybe the next day and next day. One would hope that in that relationship that person could help the patient to then seek other avenues of help.

Since nurses provide 24 hour care, and are often the people a patient sees the most during hospitalization, nurses were suggested by 11 patients as the ideal people to ask about a history of childhood sexual abuse. The following quotes illustrate three such accounts:
I would think the person that you spend most time with, and that might even be your nurse, might even be your social worker and again it depends....I prefer my nurse, any of the nurses that have been on staff with me; and that's probably been the only stable part of my stay here. Being that it’s March break also hasn’t helped, ahm, the situation with the doctors because everybody is replacing everybody, I’ve seen nine psychiatrists in 18 days of which I’ll only end up being with two or one or a team of three. The nurses have been pretty routine and I feel comfortable with them.

*****

I get in contact most with the nurses so I think it should be the nurses... Some duties are better suited to the nurses because they’re around you more often. And then once you meet somebody (nurse) you want to stay with her so you can work on that area.

*****

Well I guess the primary nurse would be, I think that would be a good person to have share that with, yeah....Well cause that’s the person you deal the most with; like you deal with your doctor, but you see your primary nurse everyday, pretty well, and usually you have—he or she puts aside some time to touch base with you and that’s why I think—because you’re more—it’s a more, ah, continuing thing like, you know, whereas the doctor you might see three times a week, the primary nurse you see every day.

For these patients, what was important in asking or providing treatment with abuse survivors was that the person would be available to the patient on a consistent basis. This would assist in creating a trusting relationship where the patient would feel safe to disclose and talk about an abuse history. Four patients specifically cited that the first person you see when
you enter the hospital should not be asking such intimate questions (for example the person working at the emergency desk or an intake coordinator) since these are people the patient is unlikely to see again during the hospital treatment. The following quotes illustrate this point.

I don’t think it should be with the first person you see; it should be higher up the chain in a . . . . not higher up in power necessarily but I don’t think it should be at the intake desk; you should be more involved in the process before it’s asked.

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Certainly it had to be a person that I trust. So whoever can make me feel comfortable. Often times in my opinion it’s not the person at the Emergency desk because at that time I don’t know what’s going on and I need to be a little more comfortable. Somewhere along the line, in my personal case, it had to be the person I am with working very closely.

To have a consistent care giver, with whom a patient can develop a sense of trust, is consistent with recent research findings which examined the practice of routine inquiry. Finkelhor and Browne (1985) describe how the decision to trust others is often difficult for victims of CSA. Victims of CSA may not only feel betrayed by the abuser who misused his/her position of trust, but the victim may also feel betrayed by those they trusted would offer protection (Finkelhor & Browne, 1985). Developing a trusting relationship before inquiry, therefore, is essential in this practice. Engels (1996), in her research on female psychiatric inpatients, also found patients described establishing trust as crucial to the practice of routine inquiry. Her study provided further evidence to support that the admission interview was not a suitable time to explore issues of CSA, given that patients have not yet had adequate time to establish a trusting relationship with the admitting nurse (Engels, 1996).
Furthermore, Engels (1996) found patients requested the assessment of CSA be done by only the consistent care giver. Since primary nurses are often the most consistent care givers patients have during hospitalization, they are often in an ideal position to establish a trusting relationship and make routine inquiry a reasonable practice.

**Subtheme (b): Being trained to deal with disclosure.**

Fifteen patients suggested that those who ask about a history of childhood sexual abuse, should be those who are trained to deal with the disclosure of this information. Patients used words such as “professional”, “authority”, “responsible” and “experienced” to describe clinicians who should be asking this question. For example, the following patients felt that those who ask should be:

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Any authoritarian figure from whom you can receive help...that would be any therapist that knows how to respond. That would be a psychologist, doctor, but not necessarily a nurse. (Why?) Just because you hold more confidence with someone the more important they are. That is like a psychologist, psychiatrist. You need a lot of experience and degree to draw that out of a patient. It would take a doctor’s experience and degree to draw that out.

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Someone with some sort of degree anyway. Psychiatrist, psychologist, someone who’s able maybe to interpret what the person is actually saying. It might not come out directly and give a full answer. Like giving it in a roundabout way and you might have to ask more questions to get the truth from that person.

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Just...as long as it's a professional, ah, that works for the institution. Nurses here are quite professional and so are the doctors so... it wouldn't matter to me either way.

For these patients, as with others, it was important that the clinician asking the question was a professional with a “title.” This meant to the patients that the clinician had a higher level of education and adequate training, which they presumed included training on obtaining a sexual abuse history. These professionals were also often described as having “authority” to ask, implying that those who did not have training, titles or degrees should not be allowed to ask this important question.

Remarkably similar to the results of this study, Engels (1996) also found patients to describe “characteristics of clinicians” which made them better able to inquire about CSA. One such characteristic included a professional title. Patients’ perceptions of what were common elements practice under a professional title, determined whether they supported routine inquiry or not. Therefore, some patients supported psychiatric nurses inquiring about CSA, since they felt clinicians under that title had the knowledge and training to deal with disclosure. Others did not support nurses inquiring, because they felt clinicians under the title “psychiatric nurse” would not have knowledge and training in this area.

These patients reported that being trained to deal with disclosure is an important quality for clinicians to have. For this reason, another patient clearly articulated that clinicians should not be asking about CSA. In this patient’s experience, although clinicians are starting to recognize the role of CSA in psychiatric illness, clinicians are not trained on how to deal with disclosure and are not incorporating these questions into nursing histories, or care plans, in a thoughtful way:
I think what we've done is we've gone from a state of... I think it's fair to say generalized ignorance among health care professionals, treating symptoms, ahm, ignoring the possibility that behind all of that symptomology there's a great deal of else that may be going on in there. I think we have come from that and in a best intentions and an explanation going by the knowledge of research which shows us how many women end up on psychiatric wards and in other wards based on this issue, I mean this is part of their background. We have almost swung to seeing the boogie man behind every potential particularly mental patient. And what we've done with the pendulums swung is we seem to be hurrying to include that kind of question so that we cannot be accused of missing that; so that we cannot be accused of being insensitive to that; so that we cannot be accused of ignoring what clearly is something the research tells us. But we haven't—we haven't added the training as to how to foster the disclosure if it's a good thing that disclosure happened, particularly in these circumstances, and what to do with disclosure if it does.

Being trained to deal with disclosure, therefore, also includes the important role of doing something meaningful with the information. This is described in the next subtheme.

Subtheme (c): Doing something with the information.

Five other patients (four who had a history of childhood sexual abuse) made comments that suggested that asking the question is not enough, someone had to be accountable for that information, often suggesting that asking is useless if nothing is done with that information. The following quotes provide some illustrations:

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Ahm, like I said, I'm so used to people asking me questions now that it does not
necessarily do any harm, but it doesn’t do any good to you because they don’t do anything about it.

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The nurse, the doctor...it’s the confidence I have in these people, I guess these are the people I deal with easily and these are the people who will do something with it, like talk about it, or refer people for follow up and counselling.

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If the clinicians are not doing something with the information, then patients suggest that asking may be useless. Furthermore, patients may feel frustrated when nursing staff are inquiring about CSA because it may not be clear how he/she used that information. The following quotes illustrate:

Not really (I don’t think clinicians should ask) since I know my treatment wouldn’t of changed at all, especially knowing how long the process takes to recover from. In my case it (the abuse) was not over a long period of time and I never really thought about it either as to how important, that is to my condition. After she asked the question and I replied..She did not inquire more into it, other than make a comment--“that must of been quite painful”

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Well, you know, the way I look upon it is, ahm... the doctor is the person solely in charge of the patient, ..that’s where I put all my trust....not the nurse, and... You just don’t hand over somebody’s life and emotions to somebody who works a late shift and, you know, I’m going home now...and then nothings gets done.... I mean, somebody has to be accountable and that is the professional (the physician), the one who’s got the
initials after his name and before. He’s the one that’s responsible, nobody else.

In the first quote, the patient that articulates that she did not understand how gathering this information was used in her inpatient stay. If asking about a history of abuse during admission is just for the sake of asking, and not incorporated in a way that is useful for the patient, then asking is useless and even unethical. In the second quote, the patient states the physician should ask because he/she is the only one who is “responsible.” To this patient, this meant that the physician is responsible for the patients’ care and that somehow the physician would use or do something with the information regarding CSA. This is compared to the nurse who “just goes home” at the end of his/her shift. For this patient, the nurse does not use this information in any way that was clear to him, therefore, it was very difficult to “hand over his life and emotions” to someone who did not do something with the information.

Interestingly, for these groups of patients who had a history of abuse, it was very important that someone was accountable for this information. Their thoughts went beyond merely asking the question properly, but what seemed more important was that something was done with the information once it was disclosed. Finkelhor and Browne (1985) explain how, as children, victims of CSA often felt betrayed by those they disclosed the abuse to, because these people failed to offer protection or even believe their disclosure. Similarly, the experience of hospitalization may also be accompanied by feelings of betrayal as the patient once again discloses this information and nothing is done with it (Fromuth & Burkhart, 1992).

In summary, both patients with and without a history of CSA described similar qualities in care providers which are important in those who ask. These qualities are described in the three subthemes, and are consistent with what is found in the current research in this area. For example, many studies now suggest that implementation of inquiry into CSA should be
accompanied by relevant education and supervision to ensure clinicians understand the
diagnostic and treatment implications (Eilenberg, Fullilove, Goldman & Mellman, 1996;
Engels, 1996; and Walker, Torkelson, Katon & Koss, 1993). In particular, the subtheme
“being trained to deal with disclosure” is described in many recent studies which examined
inquiry into CSA. Both Engels (1996) and Gallop et al. (1995) report a need for clinicians to
have further knowledge and skill related to inquiring about CSA. In a survey of nurses,
Gallop et al. (1995) found nurses to report that they did not inquire about CSA because, they
were unsure as how to respond to disclosure of CSA.

Training on, how to deal with CSA disclosures will no doubt include “doing something
with the information.” Those patients with a history of CSA were quick to recognize that
they did not understand how this information was going to be used. This result is also
consistent with what is found in the current research in examining how CSA histories are used.
For example, Eilenberg, Fullilove, Goldman and Mellman (1996) found that although
mandated inquiry led to the detection of substantial abuse and trauma, this information was
rarely used in the assessment and treatment planning for these same patients. Similarly, other
studies report that clinicians do not act upon or respond to disclosure of abuse (Briere & Zaidi,
1989; Hoff & Rosenbaum, 1994). It is strongly supported in the literature, therefore, that
those clinicians treating patients who enter psychiatric inpatient units have the qualities
described in these three subthemes. In particular, this is important when dealing with victims
of CSA, since these patients understand hospitalization in the context of their abuse history
(Fromuth & Burkhart, 1992). If the hospitalization is a negative experience, the patients may
feel once again unprotected by those they trusted.
Research Question 2: How Should Clinicians Ask About A History Of CSA?

The second research question asked "how" clinicians should be asking about a history of CSA. Twenty-eight patients provided a response to the question how clinicians should ask about a history of childhood sexual abuse.

Six themes emerged from the data, which are the following: the need to ask directly, in context of other relevant questions; the need to ensure confidentiality and privacy; timing inquiry about CSA appropriately in the admission; the need to ensure clinicians have adequate time to listen; presenting patients with an option to answer; and do not ask directly, but focus on creating an environment where disclosure can happen at clients' initiative. Unless otherwise specified, both abused and non abused patients gave similar answers, however, responses of the abused patient were longer and more detailed. All six themes will be described in further detail below.

Theme (a): The Need To Ask Directly And In Context Of Other Relevant Questions.

Twenty-three patients clearly stated that clinicians should ask directly about a history of childhood sexual abuse. This included eight patients with an abuse history and fifteen without an abuse history. Compared with those with a history of CSA, those without an abuse history gave answers which were usually brief, spontaneous and with little detail. The following quotes from nonabused patients illustrate:

I think in general if they don't have access to that information they should be asking directly. I think it's an important question.

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Yes, I think this would be a major influence in one's neurosis and psychotic and manic depressive episode. It is something that needs to be shared with qualified people in a
clinical setting for what it’s worth, so just ask directly, black and white.

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Yeah, Why not?...I think it’s a good thing for a professional to ask. Unless they ask, well, it may never come up and I think it’s an important issue, you know, in a person’s history.

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Just ask directly, it’s better directly, and it might hurt sometimes but it’s better to get it out, you have to talk to get better. Quite straightforward, I don’t think there’s any other way really.

Seven of the non abused patients were able to give more detail when prompted by the interviewer, while all of the patients with a history of abuse offered more detail in their initial response. The more detailed responses provided by patients with or without an abuse history did specify that clinicians need to ask directly, but this had to be in the context of other relevant questions. The following quotes provide some illustrations:

I think probably if I had to picture a spectrum from most direct to most indirect, I would lean more towards indirect to give the patient some time to digest the fact that this topic is even being raised as opposed to being hit over the head with a two-by-four. Eventually, ask directly.

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I think it should be introduced gradually rather than just direct out of the blue. You know, it should be built up to somehow. You know, just like prepping someone for surgery. You have to go through those steps before it will be successful. Same thing here; it’s a sensitive topic. I think you have to introduce it gradually then directly
You just can't go up to a person and say "So, ahm, hey have you ever been...." you know, like that wouldn't be kind. So you just have to come out and ask slowly and when the question comes up, ask in a nonchalant way, that didn't sound like you would be shocked by the answer.

Well, I think they should go about it sort of indirectly, you know, probably starting to talk about family situation, various different questions; and I think that questions should be eventually brought out directly.

Well, I think they—-it should come up in a context that is sort of part of an initial interview; and I think that it should be approached in a fairly , ahm, you know, soft and non-threatening way, by bringing it up slowly with a lot of other similar question. There needs to be a lot of compassion in this kind of a subject.

These quotes describe why asking in context of other relevant questions is important. By building up to the questions of abuse, rather than asking suddenly in a routine history, or out of context of other questions lets the patient know what is happening, and allows the patient time to prepare and assess the appropriateness of answering to that clinician. This, in turn, leads to the patient feeling safer to answer.

Four patients, all who had an abuse history, felt more inclined to give much more detail in their responses. The following quotes illustrate:

Well, if I were doing it I would say, you know, I'm going to take a history, short history of your childhood. Is there anything that stands out and so forth. Ask
specifically, how was your relationship with your mother, your father? Were they abusive towards you, did they hit you, and then go on to say did they, you know.

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And I always defined sexual abuse it was like a father sexually abusing a daughter or something like that, not really I learned that was... that's not the whole definition of it.

Ahm, I think maybe they could say, 'Have you...' ah, you know, they ask you questions about yourself or something, so have you had any... any, ah, sexual abuse in your past and whether it be like you explained to me it could be whether a father or an uncle or something like that, or amongst young people just experimenting with sex.

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The only thing I can think of is perhaps the nurse who is taking up the information, instead of looking at the paper, reading it from there and writing up, looking at the patient and saying that 'One of the questions we do have here is that we do have to cover, is the question of, ah, of sexual abuse and I have to ask you this for the records. It is not that I'm, ahm, I don't wanna be nosy or want to find out your affair, it is for your own benefit and we need this information', sort of explain it in a manner of person-to-person manner instead of clinically reading, clinically asking about incest, or any other sexual activity before you were ten...

This patient touched upon the fact that bringing a piece of paper into the interview seems to create a different way of being with the patient, where gathering information seems to be for "job reasons" rather then really wanting to know.

Overall, these patients gave specific examples of how a clinician can ask in a way that
would seem as if he/she was authentically interested in the topic and this would be more
inviting for the patient to answer the question truthfully. In particular, patients made reference
to be very specific about the different kind of abuse. This allows the patient to feel safer to
answer to topics they would never bring up otherwise. Also some patients may be unfamiliar
with what constitutes sexual abuse, clinicians may need to be very specific when inquiring and
define sexual abuse.

Three of the abused patients further specified that asking directly is important because they
would not volunteer the information:

I think they should raise it because, in my case, I feel like I shouldn't really complain
because it's not like I was being thrown against the wall or something like it, so people
have some real horror stories out there I'm sure. And like the total effect was
traumatic for me; for me it was traumatic, but I think it's because as N. says, psycho...
mental health problems are caused by things that happened to you, losses that were not
properly dealt with at the time, your inheritance and three, the stone that you're cut
from. And I think that I was cut from a very fragile stone so things were difficult, it
was very difficult as a child but they weren't the terrible things that you hear from
somebody that's got a multiple personality or something like that. Sometimes I feel
that I've no business complaining, you know. So if somebody made it easier for me to
complain by asking directly and specifying on all the different kinds of abuse from mild
to severe, it might be nice. Like I said to my doctor I'm seeing now, I said, ahm, I
just—all I did was I went into - I have this feeling - I went into Emergency one night
and I changed my mind before they got to me 'cause I'm no good at complaining, I
don't really—I'm not really that upset, I can carry on, what am I doing here. But, you
know, I did need it. But--and then somehow I went back to work and I got okay and I phoned my doctor, I said I'm okay, but I was in the Emergency Department last week during the end. And then I just sort of joked about it and saying, ahm - I can't find the words I want to say - I said maybe all I need to do is make a little noise once in a while and I feel better. ...my story is not as bad as most people, but--it's still bad.

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I think just as they did in the rehab (from substance abuse)., it's just a part of the overall questionnaire when they ask these questions about our childhood, ahm, and the rest of our life, about our relatives and whether they was such a--whether you were diabetic, whether your parents were diabetic, if you were depressed, were your parents or anybody else in the family depressed. And this should be just part of the regular questionnaire, have you ever had--do you have allergies, for instance, or have you ever been abused? You could start off to make people comfortable by, ahm, physically or have you ever been abused, have you ever been robbed, have you ever been a victim, and then somewhere along the line this could be a question, have you ever been sexually abused. I think a lot of people wouldn't volunteer that information because of society, the way we are, it's some sort of stigma which shouldn't be there. And I think the more we start asking these questions, the more people will be willing to respond.

These patients articulate the difficulty in disclosing a history of abuse if one is not invited to talk about the issue. Many studies support these results. Briere & Zaidi (1989), for example, reviewed 100 charts of nonpsychotic female patients in a psychiatric emergency room to locate reference to sexual abuse history. Seventy percent of patients reported a history of sexual abuse when asked directly. This is compared to only 6% of patients reporting sexual
abuse history when they were not asked. Similarly, Wurr & Partidge (1996) surveyed 120 psychiatric patients and found 46% reported a history of CSA by questionnaire. Case notes review on these same patients revealed a rate of 14% of previously documented disclosure.

The perceived stigma associated with abuse often plays a role in the decision to disclose (Limandri, 1989). In a study conducted by Limandri (1989), patients describe how if they are not invited to talk about the issue they have tendencies to minimize the experience as “not bad enough” to talk about, or simply feel too humiliated to initiate the topic. Patients in this study support that having the clinician ask, in context of other relevant questions, opens a door into exploring these issues which may not have been opened otherwise.

**Theme (b) The Need To Ensure Confidentiality And Privacy**

Four patients with a history of abuse, and two without a history of abuse, described the need to ensure confidentiality and privacy when asking about a history of childhood abuse. Four of these patients that spoke to this category were men. This category also speaks to the stigma and shame associated with sexual abuse. The following two quotes speak about confidentiality and how patients assess the clinician prior to responding:

They kept emphasizing in no uncertain terms, they made me feel very sure that things were confidential and the next-door guy wasn't going to know all about it. And that was very important for me and I believe for other clients, to know that things are confidential... And this is, I think, a very important issue, that you be able to trust the person you're talking to. In my own life, a lot of things that led me to addiction were because I could not talk to people about things bothering me and keeping a lot of things to myself became very uncomfortable, and I sought relief in drinking. So I realize the importance of confidentiality......I always like to stop and say, look, I—should I let this
person, what is this person going to think about me if I let the person into my world? There's some privacy I want, but certain things are disturbing and I'm dying to tell at the same time, 'I don't know if I should let you or this person into my world.' And I think the key we have discussed to that is confidentiality, I should be comfortable with that trust and make me comfortable. And then for the person to be able to realise that I have that comfort and trust that's really important. And that person is most likely to succeed...It is important that we get that information, it could be very crucial to the diagnosis and getting the right treatment.

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No. I was never asked and I wouldn't ask, and I would not - what's the word - volunteer the information. I wouldn't walk up to the nurse and say that, oh, by the way when I was four years old I was raped......I would have to trust the nurse for some time, okay..(So she would have to ask? If you trust her you think maybe you could bring it up?)....Yes, I think I would. It would be hard to start off the conversation because I would be the one who would have to start off the conversation. I'd have to take one hell of a deep breath and say by the way (nurse's name) or whoever the nurse was, right? Like I say, I would have to trust her and this is as far as it goes. If it leaves this room, I'd disown you, I'd never come back to this hospital again, you were my friend, and now you're not my friend no more. If I see you walking down the street I won't even say hello to you.

These patients spoke about the difficulty of revealing such intimate information about oneself to a clinician who is a total stranger. One important way for a clinician to let the client feel safe in releasing this information, is to state that the information is highly confidential to
the treatment team, and it would never be released without the patient’s consent. Although this would seem obvious to many clinicians, restating this policy when addressing CSA helps the client feel safe in his/her environment, where they can trust that clinician and feel comfortable to engage in such topics.

Feelings of stigmatization and difficulty in trusting others are critical dynamics in understanding patients who were victims of CSA, and why the subtheme “ensuring confidentiality and privacy” is particularly important to these patients. Patients who are sexual abuse survivors often feel shame over their experience and suffer a loss of self-esteem (Fromuth & Burkhart, 1992). As a result, sexual abuse experiences are typically hidden from others in order to avoid expected rejection or negative remarks. Additionally, these patients have difficulty trusting others. Having been betrayed in the past by a significant person they trusted, the patient may again expect betrayal and therefore do not trust easily (Finkelhor & Browne, 1985).

Knowing these dynamics are at play, ensuring confidentiality and privacy when asking about an abuse history helps in establishing trust, and lets these patients know the clinician will hold this information in a sacred way. De Young and Corbin (1994) describe the humiliation involved in exposing private life to others. In their study, participants described the need to feel safe in the context of the relationship before disclosing an abuse history. Similarly, in this study, confidentiality seems to address the patients’ concerns of how to feel safe in disclosing an abuse history. This requires clinicians to create environments and respond in ways that assure the patient that the information will be held very confidential in the team, and will be used in a way which is meaningful to the patient.

Not to be forgotten, clinicians need to ensure confidentiality in the surrounding
environment. One patient spoke about feeling very embarrassed for a roommate when she could hear the nurse ask her questions related to an abuse history. "I was embarrassed for the... I was embarrassed for the young lady...that she was a survivor and stuff like that." So that it is not enough to let the patient know you will be confidential, if you are conducting the interview in a semi private room where other patients or family may hear contents of the interview. Finally, patients talked about ensuring privacy by not addressing such information in a group setting, the following quote illustrates:

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In a private room like this, no phone, one-to-one, not in front of... maybe the lady next to me, okay; she is not in that session for sexual abuse. She was there because she's got anxiety attacks, she can't breathe, she can't get on the bus because there are too many people...

Bringing up such stigma-laden topics such as sexual abuse in any context that does not build up to or focus specifically on the sexual abuse history is perceived as insulting, embarrassing, and maybe even traumatic for the patient. This would include bringing the topic up out of context in a history, or in a group setting as the above quote illustrated, or addressing it any way with other less stigma-laden topics.

Theme (c) Timing Inquiry About CSA Appropriately In The Admission

A third theme which emerged from the data addressed timing inquiry about CSA appropriately in the admission. Twelve patients talked about "timing" and how clinicians need to carefully consider when is the "right time" to ask directly about CSA. The "right time" seemed to encompass a time when the clinician assesses the patient is ready and settled enough to talk about the issue, has had time to know the clinician, and is then comfortable to talk
about personal issues. Six patients specifically described this as clinicians needing to be sensitive and assess the comfort level of the patient when asking about CSA. The following quote provides some illustration:

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Ah, sometimes, ahm, when the nurse goes through these questions it's a person that you've never met. You don't know the person and neither does the nurse know you as a person or your history so, ah, don't at the time feel like dwelling in it because, ahm, it's almost like a total stranger; unless it's a nurse who knows you, knows your history or if it's your doctor or someone who is--you know that is sort of working on your case and is trying to help you, not just that it's their duty to go through the paper work. So it makes a difference with that.

In the above quote, the patient describes wanting time to know the clinician before talking about personal issues. This patient talked about the difficulty in revealing intimate details to a "total stranger." Psychiatric patients must often reveal the most intimate details of their life to clinicians, therefore being comfortable and trusting the other is probably central to all psychiatric patients. However, this is even more important when addressing issues concerning CSA, since victims of CSA often have difficulty trusting others because they were abused by those they trusted in the past. Additionally, this patient also seemed to suggest the need to be authentically interested in "trying to help" the patient, and not ask about CSA just because "its a duty to go through the paper work." When asking about sensitive topics such as CSA, clinicians need to allow sufficient time to explore a response. Otherwise, clinicians may appear "task focused" and not authentically interested in what the patient has to say.

The following three quotes address the issue of "timing" and when is the right time during
a patient’s stay to ask about CSA. In particular, the quotes illustrate the need for clinicians to assess the patient’s readiness to talk about the issue:

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but the nurse down in Emergency came and took a brief history and kind of the same way you would say, ah, do you get nose bleeds, do you have, ah, heart disease in your family, have you ever suffered from physical, emotional or sexual abuse? it just actively struck me that it, ah, that can be a pretty loaded question to lump along with a whole bunch of other kinds of more nondescript questions. It just struck that, ah, what would have happened if I'd just fallen apart and started unloading some terrible history? What would this poor person have done? And would that be the most appropriate, in the middle of the Emergency Ward, would that have been the most appropriate environment for that to come out. So I just thought it was, in retrospect, like an inappropriate place, time and fashion and person. I certainly would not admit to it then.

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Right. And that’s one of the things that struck me, in this kind of, you know, do you smoke, do you drink? Have you ever suffered from, ahm, emotional, physical, sexual abuse? Ah, I neither smoke nor drink nor have suffered. But what if I have? And... and in a state; I mean people who come to this floor are in a state or they wouldn’t be here. So taking a first history, it would seem to me that taking a first history whether it’s in Emerge or up here, it would seem that would be most inappropriate to ask that question. It has to occur later on, in a more personal way.

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...I guess, yeah; I guess you have to take in the situation at the time. Downstairs (emerge) for him to have asked me that out of the blue, I don't know, I may have resented it and backed off and maybe not of been here, you know. I did not feel safe enough to just, like I said, just came out and said yeah, I was sexually abused when I was young, you know.......it was really hard that day because I was so upset, like I mean, I had a thousand things going on in my head so, you know, I could remember hardly anything even though the doc, I couldn't remember his name, I just.... I didn't know anything. I was upset but, ahm... No, I'm kind of glad he didn't go into the topic that time. I was a basket case on the whole experience. I would have backed off, it's better when you're more settled and you've had a chance to know the person.......Yeah, because if the nurse walked in on us like that, I was, you know, upset about having to be here in the first place and I'd sit in my bedroom, and if S. would walk in and say, "Oh, were you sexually abused", Whoa, you know. I probably would have said no and we would not have had communication about my sexual abuse after that.

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These patients talked about how the first history, whether it is in the emergency unit or on the floor, is not an appropriate time to ask about sensitive issues such as CSA. It would appear that clinician's poor timing in asking about CSA is due to clinicians not assessing the readiness of the patient to talk about these issues. The right time, or a time when patients may be more ready to talk about CSA, seems to be when the patient is settled on the floor and has had time to know the clinician asking this question. In the first quote, the patient describes being shocked when the question regarding CSA came up in context of other less emotionally
laden questions. The patient describes "not willing to admit to it then" because she did not know "what would this person have done?" Not having any time to know the clinician, the patient was unable to assess if this person would respond appropriately to any distress that was revealed. Similarly, in the second quote, the patient describes how inquiry into CSA needs to occur "later on in the admission," in a "personal way." Having a stranger ask about CSA with other less emotionally laden questions seemed to constitute poor timing. Finally, the third quote also describes how he would not feel "safe enough" to admit or talk about CSA if he was asked during the initial history, when a patient is still adjusting to being in the hospital. He describes a better time as when "you are more settled and you've had a chance to know the person asking."

These patients described how not having time to know the clinician in any way, that is to say, to know that this clinician would be his/her primary therapist, or that this clinician would come back to follow up on their discussion, makes it very difficult to feel comfortable and answer honestly to the sensitive question of CSA. This validates previous results of this study on "who should ask," since patients specify again that asking should occur somewhere removed from the admission process, which is usually done by a clinician they do not know and will never deal with again throughout treatment.

Theme (d): The Need To Ensure Clinicians Have Adequate Time To Listen

A common theme which emerged from the questions "who" should inquire, and "how" should clinicians inquire about CSA, was "the need to ensure clinicians have adequate time to listen." Sixteen of the 21 patients, when asked "who" should inquire, suggested that having time to listen was an important quality in those asking about CSA. Similarly, when asked "how" should clinicians inquire, ten patients again addressed the need to have sufficient time
to talk. Having time meant something very important to the patients interviewed. Time was often equated with “caring” for the patient. This encompasses being an empathic listener where spending time with the patient helps him/her to feel comfortable and trust the health professional. Patients who felt that clinicians did not have time to listen, equated this lack of time to not really caring about the patient. As the following quotes illustrate, this was not specific to any discipline.

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Well, because half the nurses here don’t care...they are always in a hurry you know...too busy to listen to you. There is no feeling of warmth from...well I guess it doesn’t matter, I mean some of the nurses are lovely but it’s hard to talk to them about that. But I think nurse doesn’t know how to react...I don’t feel as comfortable. Well they are not pleasant to talk to. It takes a while from when you call for them to approach you and talk, sometimes they rush you...I’ve been to so many psychiatric wards and I think half the nurses really don’t care.

Similar comments were made in reference to psychiatrists,

And what I’ve seen on this ward is very disheartening with respect to the relationship between psychiatrist and patients on this floor, ahm, in terms of both a system that seems to shunt people from psychiatrist to psychiatrist. Ahm, I see patients chasing psychiatrists down the hall to get two minutes of their time. Ahm, virtually not seeing the doctor for days on end; ahm, my fellow patients tell me about having no time to sit and talk to the doctor.

Gallop (1990) has described empathic listening as the ability to “know” the experience of another and that there is some degree of matching of emotions. Understanding the experience
of another requires, among other things, time with the patient. Patients indicated that clinicians asking about a history of childhood sexual abuse “have time to listen” and suggested that there needs to be an authentic wanting to know the experience of the other. As the following quote illustrates, patients were able to perceive when clinicians are being genuine when asking questions in terms of really wanting to ‘know’ the patient’s experience, versus spending time with the patient just to get a task done.

They’re (nurses) too matter-of-fact when they ask questions...

Well, I think such a delicate topic like that, someone has to show a little bit of... a little bit of caring, and little bit of, ah, I don’t know, understanding. It’s not something you can rush, you can’t rush a question like that. When the nurses ask you questions they just go through the whole thing and want to get it over with, you know. When you start asking questions like that, if you want the truth I believe, you know, it takes time to get it from the person and you have to be genuine when you ask, and caring. I don’t think just anyone would open up that way if you just ramble through the question expecting some sort of a truthful answer. I wouldn’t.

As the above quotation illustrates, routine paper work, such as completing a long assessment and history form, seems to draw attention away from the patient and toward finishing a certain task. Therefore, according to this patient, any nurse completing an assessment form is not in the ideal position to be asking about a history of childhood sexual abuse.

Furthermore, when addressing “how to ask about CSA,” having sufficient time was important in increasing the chance for disclosure of CSA to occur. Ten patients described feeling reluctant or maybe even guarded about answering the question regarding CSA because the clinician was very rushed when asking the question; appeared very task focused; and was
gathering information for charting purposes only. These patients did not perceive that there was an authentic interest to know about their experience of sexual abuse. The following quotes provide some illustration:

*****

They asked directly. Like if they-- they're taking notes because it's on the form, it's the only reason they ask, they have to fill out a form. And... at one time I remember saying, ahm, 'not really', another time I said yes, and then she asked in what way and I think I said it was with a Catholic priest and they don't like that; they're a little shocked when they hear that. And so they just get over the shock reaction and then they go into the next question, maybe as if they were a little bit too busy for me.

*****

if the patient won't talk to them (nurses) they'll say, oh, good; they get to write down 'refuse to talk' and they go on, they got out of it. They gave the offer but they really don't want to hear anything. Don't make sense; you can't do that; you've got to sit down and say, okay, but this is our time together so I'm going to sit here, the time that..... And within five minutes they'll (patients) will be talking to you. Like I would never tell a person like that stuff about my abuse.

*****

What they do is they--around here they just, ahm, they just want to make it as fast and easy for themselves as they can. And half the nurses don't talk to you at all; and the other half when they do, ah, they just want to get a brief overview so they can chart. Just enough to put something in the chart to cover themselves, that's the way I see it. I think that they don't know what's happening and I'm keeping that quiet
because if it ever came up I'd be very critical of them.

These patients describe how they are assessing their environments to see if it was safe to discuss intimate topics such as CSA. "Having time to listen" speaks to patients' wish for clinicians to take time to be authentically interested in their history and offer empathic responses. Many studies support how inquiry into CSA should be accompanied by validating, supportive and empathic responses by the therapist (Drauker, 1993; Doob, 1992; Urbancic, 1992). Responses that are perceived as empathic are a clear way for patients to see that the clinician was listening and has understood their distress. Patients interpret the lack of time and empathic responses expressed by the clinicians quickly as not caring. This is consistent with research which examines the empathic process. In her theoretical work, Gallop et al. (1990) describes empathy as a process (divided into three phases) arising from the interaction between two individuals over time. In the first phase, an event is observed and the observer must be "interested" in wanting to understand the other, before the empathic process can proceed. Lack of interest is an outcome which quickly terminates the empathic process and, as described in the conceptual framework of this study, can be labelled as a "no care behaviour" (Gallop, et al. 1989). The above quotes illustrate how patients do not feel inclined to discuss CSA if they sense that clinicians are not authentically interested, are asking because it's on the form but do not really want to have a conversation, or do not have sufficient time to talk. Having enough time to talk, therefore, seemed to facilitate the creation of an empathic environment where the patient feels safe, and is therefore more likely to disclose a stigmatizing condition such as CSA.

Between the two themes, "timing inquiry about CSA appropriately" and "ensuring clinicians have adequate time to listen," the results of this study suggest that time plays an
important role when addressing “how to ask about CSA.” Although patients may feel there is a need to ask directly, these patients also recognized that there needs to be careful consideration of when is the appropriate time to ask, as well as allowing sufficient time to address and talk about CSA. For patients who were victims of CSA, these issues around time play an important role. Having been betrayed by those they trusted in the past, survivors of CSA find the decision to trust others a difficult choice. Patients may again expect betrayal by others and are quick to perceive it. Disclosing CSA therefore on admission or in the first history, therefore, would appear unsafe from the eyes of the survivors. Clinicians asking this question then must find ways to create an environment for these patients to feel safe to discuss sensitive issues such as CSA. To start, timing the inquiry at a point where the patient knows the clinician, and is developing a therapeutic relationship, will help the patient start to trust the clinician. Furthermore, making sufficient time to talk about the issue is one way to demonstrate to the patient an authentic interest in their history. In this way, the clinician may become a “significant other” who begins the establishment of a safe environment in order to encourage the survivor to disclose a traumatic history and experience the many feelings he/she may have repressed. Time, therefore, is an important element in the construction of a safe environment for patients and especially for CSA survivors.

Theme (e) Presenting Patients With An Option To Answer

Fifteen patients, 9 without an abuse history and 6 with an abuse history, alluded to the fact that, when clinicians inquire into CSA, patients have or should have an option to answer.

Following are some simple statement demonstrating patients’ responses:

*****

It’s always easier if you ask first, I guess it’s a good idea to routinely ask and just give
people the option to answer yes or no, especially if the person is going through a lot of problems, give them the option. But they wouldn’t talk about it unless people bring it up.

*****

I don’t know. I guess just in a very gentle way that you don’t have to answer if you don’t want to, in an easy way, you know how to do that; like if you’re not comfortable answering it, you have that option. But that opens it up for you to talk about it if you want to.

*****

Just straight out. Have you ever been sexually abused. Patients can say “I don’t want to talk about it” or no when you ask them. After all, they are not going to force you to talk about it.

Patients who spoke to this subtheme felt asking clearly and directly about a history of childhood sexual abuse is appropriate because they have an option to answer. Having an option appeared to be an empowering statement, which is important to hospitalized psychiatric inpatients who may suffer from a sense of powerlessness.

Fromuth and Burkhart (1992) describe how the hospitalization process may evoke feelings of powerlessness. For the psychiatric patient, hospitalization may mean loss of control over basic aspects of one’s life. For example, an involuntary patient may lose his/her freedom. Furthermore, the inherent power differential between staff and patient also contributes to feelings of powerlessness. These feeling of powerlessness during hospitalization, however, are more salient to patients who were victims of CSA.

Powerlessness is a critical dynamic in understanding survivors of CSA, as there are many
aspects of the CSA experience that contribute to the victim’s sense of powerlessness. Finkelhor and Browne (1985) describe how not only have sexual abused children had their body invaded, which contributes to feelings of powerlessness, but also these feelings may increase if the child is unable to stop the abuse or elicit help from others. Furthermore, there is a power differential between adults and children, similar to that between staff and patients which contributes to powerlessness. An example of this is when patients have to ask permission to perform routine task such as showering or using the phone. Also, patients may be expected to “behave” in order to gain privileges or be released. This unilateral use of control may recall past similar contexts existing between the abused and victimized child.

In the clinical management of psychiatric patients, therefore, clinicians need to be aware and sensitive to the powerlessness dynamics. For this reason, patients who spoke to this theme “presenting patients with an option to answer” may have felt empowered in feeling they have an option to answer, which may have not existed if the clinician did not ask this question directly, leaving the patient to struggle with how, when, and if to bring up this topic. To further empower patients who were victims of CSA, Courtois (1988) describes the need for the therapist to do everything possible to encourage the patient to assume control and responsibility during a hospital admission. Clinicians should offer an explanation as to why the question about CSA is being asked, and then should ask permission to ask this question. Patients then would have an option as to whether the question should be asked, where declining to be asked would not reveal whether or not the patient had an abuse history. Such methods would further empower patients.

These first five themes under the question “How should clinicians ask about a history of CSA” really speaks to methods in which clinicians can help patients feel safe in their
environment before asking directly about the sensitive topic of CSA. The large number of respondents supporting asking directly may be related to the fact that these patients, both with and without an abuse history, recognized that talking about personal issues assists in healing. However, the patients provide specifications as “how to ask” in a way that assists clients to feel safe to answer. These results are consistent with other studies which found that patients are not likely to disclose spontaneously a history of CSA, therefore, routine inquiry ought to be a standard practice (McFarlane et al., 1991; Briere & Zaidi, 1989, Jacobson, 1989). Routine inquiry, provided clinicians consider the criteria described in these themes, is supported by the results in this study.

Theme (f): Do Not Ask Directly. But Focus On Creating An Environment Where Disclosure Can Happen At Clients’ Initiative

The sixth theme that emerged from the question “How should clinicians ask about CSA” was “do not ask directly.” Five female patients, all who have a history of childhood sexual abuse, reported that clinicians should not ask directly, but should focus on creating an environment where disclosure can happen at the client’s initiative. These patients reported feeling this way because asking directly seemed useless when clinicians are not trained to deal with disclosure, and treatment in the inpatient unit does not change as a result of disclosing.

In particular, these five patients with an abuse history addressed an important issue which was never articulated in the group that suggested clinicians ask directly. That is, how prepared is the receiver for the disclosure of this information? Once this disclosure happens, these patients feel the relationship is changed, therefore, an inappropriate response, lack of incorporation of this information into the patient’s inpatient treatment, and/or lack of follow up care, may make asking directly useless and may invalidate and retraumatize the patient. The
following quotes illustrate:

I felt embarrassed for even bringing it up, you know, they could ask would you like to talk to someone about it. Would you feel comfortable talking about it with somebody because I know sexual abuse can really affect your life. Just like with the spiritual question they always ask would you like to speak to a chaplin, the same with sexual abuse, ask if you would like to talk to somebody. For me that would of helped since in all the years I have gone to psychiatrist and been hospitalized no one ever took an interest in this. My family denies, they never talk about it.

*****

I think there's an opportunity for psychiatric nurses to create an environment where again disclosure can happen. The direct question, depending on the condition of the patient,... So the kind of forceful, 'do you want to talk about sexual abuse', or 'have you ever been sexually abused', ahm, unless we're going to give psychiatric nurses a whole lot of training in dealing with the disclosure aspect of it, and then should we give our psychiatrists that much training. My sense of it is that a direct question may, in fact, be the most inappropriate thing. I think what can happen and what training can allow is to create a climate where the patient feels comfortable in a discussion or dialogue alluding to that, psychiatric nurse can then follow up in terms of saying to the patient, you know, you're referring to things that seem to speak to this issue. Do you want to talk about it more? Do you want to talk about it with somebody else? Do you want to talk about it with your doctor? .... But to really look carefully at the preparedness of the receiver for that disclosure. And with all due respect to your colleagues, ahm, my sense of it is it's a... a very unequal terrain, their ability to
engage in meaningful discussion with psychiatric patients on any topic, ahm, let alone one that could be loaded like sexual abuse. So I just--I guess my feeling is that the best possible thing you could do for health professionals is to help them, number one, to learn how to tease out those issues if in fact there's some indication that they need to be teased out. And then a whole lot more training as to what to do with that. Because once the disclosure happens, that relationship is forever changed. So if in fact I am a victim of sexual abuse and I share that with you and you may be in fact the first person I share it with, what happens after that is going to colour everything else that happens too. So I just think it needs to be handled with great care.

These patients felt that clinicians who were asking directly were not well prepared to receive this information, and this may jeopardize the well-being of the client. In particular, the first patient describes how she felt embarrassed because the nurse asked her directly about the abuse, but then did not provide follow up care; the second patient also describes a similar concern about doing something with the information. Therefore, the results in this theme would suggest that the most useful stance may be to not ask about CSA, but focus on creating a relationship with the patient. The patient would then be in the position to reveal what s/he desired. That is, the clinician needs to work on creating a safe environment for the patient. The patient may then disclose information directly, or send out cues to the clinician to assess how the clinician is receiving this information. Limandri (1989) also found patients to describe this as a helpful way to disclose a stigmatizing condition such as CSA. According to Limandri (1989), the nurse may facilitate disclosure by acknowledging cues and gently exploring them by inquiring about specific stigmatizing conditions. When the client denies any such conditions, the nurse must remain open to the possibility while allowing the client to
retract temporarily (Limandri, 1989). Either way, this may empower patients by allowing him or her to assess how safe the environment is to disclose and whether there is a high likelihood of having a useful response to the disclosure, for example, the offer of follow up care.

The recent research conducted by Engels (1996) supports these results that clinicians should not ask directly, but create an environment for clients to feel safe to disclose. Engels (1996) found female psychiatric inpatients did not support the routine use of explicit means of inquiry into CSA. In particular, a theme that emerged from her study was the need for the patient to “feel safe on the unit,” meaning a certain environment needed to be created before a patient would disclose such information. Engels (1996) connects this result to the sense of powerlessness experienced by victims of CSA, which is reinforced during hospitalization when the patient is in a position of lesser power in an unknown environment. Similar to the patients in the current study, patients described conditions in the unit environment which would help them feel safer to disclose or discuss such information. Having clinicians focus on creating an environment where disclosure or discussion of CSA can happen in a way that is safe for the patient, acknowledges that patients should have some control as to how and when they would like to reveal such information.

Creating an environment where the patient feels safe and has some control during their treatment, were important issues for patients who spoke to this theme, who were all victims of CSA. Literature that examines the experience of abused patients in psychiatric hospitals has often found patients to report feeling unsafe and may experience hospitalization as retraumatizing (Harris, 1994; Jennings, 1994; Fromuth & Burkhart, 1992). Thus, all clinicians must be especially mindful when working with patients in order to avoid retraumatization of those who were victims of CSA. Jennings (1994) provides further insight
as to why hospitalization may be retraumatizing for sexual abuse survivors. She explains how the experience of CSA does not fit in the biological based understanding of the nature of mental illness, which is the dominant paradigm in mental health treatment. As such, CSA experiences are unseen, rejected, or distorted to fit within the parameters of the accepted biological based model of treatment (Jennings, 1994). This “inability to see” or validate the CSA experience in the inpatient setting, coupled with the paternalistic structure and powerlessness inherent in inpatient treatment, may recall for the survivor previous victimizations. For this reason, the patients in this theme may have felt clinicians need to focus on creating safe environment, and then patients may be willing to disclose. Direct inquiry into CSA is not enough, if the tools and support necessary to respond adequately are not available.

Research Question 3: What Are Patients’ Experience Of Nurses Inquiring About A History Of Childhood Sexual Abuse?

Nine patients with an abuse history, 8 female and 1 male, were interviewed about what was their experience of talking to their nurse about their abuse history after the nurse inquired. The conceptual framework of empathy was used to analyze the data in this question, to understanding of how patients viewed staff nurses responses. In particular, results fell into the three levels of empathic responses, “no care behaviours”, “solution behaviours,” and “affective involvement behaviours” as previously described in the conceptual framework of this study.

From the nine patients, two major themes emerged; these were task focused behaviours and authentically interested behaviours. Six patients reported feeling staff nurses were very task focused in their interactions with the patient. Task focused behaviour seemed to describe
two levels of empathic responses on the nurse’s part; that is, the “no care behaviours” and the “solution behaviours.” The other three patients described how they felt nurses were authentically interested in them, and exhibited many “affective involvement behaviours” in their interaction. The two themes and the evidence describing the three levels of empathic care will be discussed in further detail.

**Theme 3 (a): Task Focused Behaviours**

Six patients clearly described the nurse’s behaviour as extremely task focused when inquiring about an abuse history. All six patients insisted that the only reason she/he inquired was because it was on the history form, not at all because they were interested in the patient’s experience related to the sexual abuse. The following quotes illustrate some of their comments:

*****

They asked directly. Like if they-- they’re taking notes because it’s on the form, it’s the only reason they ask, they have to fill out a form. And... at one time I remember saying, ahm, ‘not really’, another time I said yes...she just asked me as if it was a tick answer.

*****

Ahm, well he asked just--he asked like question after question and it was like just going (check, check, check) down a list and stuff whereas, ah, if he had to put a little emphasis on his voice to be more compassionate, then it would certainly make a difference, sure.

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Yeah! It’s like I think it’s on one of the forms, actually.....the admitting form
I don't know how it could have been better because when you ask a question like that you’re going to stir a lot of emotions no matter what you do. And, ahm, maybe if they won’t go through it like so quickly, like it was just part of the initial form so they just go through it like check, like it’s this like your name and address, check, you know what I’m saying? You know, really if they... I don't know what they could do better, but instead of just checking it off and going on to another question, maybe, ahm, I’m not sure what else they could do, but it's not a very good feeling when you--it's okay because you go “phew” (sigh of relief) they’re not asking any questions, but on the other hand it's just like they're asking you for your address, it’s the same thing, it’s on the same level, you know what I’m saying... Yeah, yeah. It's on the same level as your name and your--are you a vegetarian, kind of thing?

*****

I did not feel very comfortable, I know she was sitting there with a very long history form and every one of those questions needed an answer. She did not inquire more into it, other than make a comment “that must of been quite painful”, and then went on to the next question.

These patients describe how the nurse is inquiring into such a sensitive and important topic, yet appears totally disinterested in the response the patient gives. That is, the nurse was totally focused on the task of completing the form and not focused on the patient. The patients described how surprised they were when they revealed a history of childhood sexual abuse to the nurse, who then made no attempt to engage with the patient, exhibits a total lack of wish to help, or make any effort to try to understand what that experience meant to the patient. These lack of responses, and task focused behaviours on the part of the nurse are understood as “no
care behaviours”, which according to the conceptual framework, are the least empathic behaviours an individual can demonstrate.

Subtheme i) Level 1: no care behaviours.

Four patients provided descriptions in their interactions with the nursing staff which spoke to “no care behaviours.” According to the conceptual framework, “no care behaviours” are responses by the nursing staff that belittle, contradicts, or speak in cliches to the patient. An example of a cliche response is “that must have been quite painful” which was given in an above quote. The patient perceived this response as cliche and not empathic because the nurse did not invite any discussion and made no attempt to try to understand what that experience was like for the patient, hence the comment seemed to be a very non specific form of emotional support and not authentic to the patient, but rather forced out just so the nurse could continue completing the history. The following quote illustrates another example where there were few words exchanged in the nurse-patient dyad, however there was much conveyed:

There's one that did ask me in what way; I said, you know, with a Catholic priest, you could see shocked look on her face, but she didn't--she was too busy and she just went on with the next question..... I felt embarrassed by telling her because I felt like--this is my lowest self-esteem talking, maybe, I don't know, that I don't really have a right to complain. And what I was saying was so minor compared to the horrors she must have heard in her career by now......I guess I was not too comfortable because all she said was what happened then I said it was a Catholic priest. And that's all I said. Like, "oh"(was the nurse’s reply), I never met her before...So, ahm, and then she didn't respond, because she didn't respond I felt even worse about it.....  It put me off, it made me stop mentioning it for a long time. Gee, I don't even think my present
doctor knows that.......She could have delved in and asked me more about it, and asked me 'do you think this has got anything to do with the way you felt today? How do you think it affected you?' I mean it totally ruined my relationships with men.

The quote illustrates the impact of asking this seemingly small question on the patient and how the lack of empathic response can affect therapy outcomes detrimentally. The patient describes how she felt belittled by the simple “oh” response after revealing such emotionally laden information about herself. The nurse’s lack of effort or attempt to engage with the patient to try to understand her is quickly interpreted and generalized to the whole population of clinicians, where it is not safe to reveal this information, because her intrinsic “bad” feelings are reinforced. To some extent, she may have felt retraumatized. Fromuth and Burkhart (1992) describe this retraumatization as a result of recollections of past abuse, where significant others failed to offer protection or believe the victim’s disclosure, hence they also did not understand the person.

Having gone through this experience the patients in this sample felt inclined to articulate what they would have preferred to see happen. The patient in the above quote illustrates some comments she would have like to hear from the nurse. These comments can be seen as being more empathic, since they require the nurse to become engaged with the patient, in order to demonstrate an understanding of the patient’s statements. Specifically, the patients in the above quotes cite some questions which would have invited an explanation of the patient’s statement. According to the conceptual framework, these are “solution behaviours.” “Solution behaviours” would have allowed the nurse an opportunity to understand the patient’s experience and offer a response. This in turn would have been an “affective involvement behaviour,” which may enable the patient to feel connected, authentically listened to, and
validated. All these characteristics are critical in the therapeutic response to the disclosure of CSA (Jennings, 1994; Urbancic, 1992; Fromuth & Burkhart, 1992).

Similar issues arose in the other three patients in this sample of "no care behaviours." Patients talk about how task focused the nurses appear; when questions are asked in the admission history, the nurses do not seem interested in the response. Patients interpret this as unempathic. At times when patients are asked to speak further on the topic of CSA, they find the nurses are not well trained to handle this information, and/or they find the process of speaking on this topic, when others tell them to, disempowering. The following illustrates:

Because it's like routine (admitting history), all I had to say was Yes, and go on to another question. They didn't ask any 'what was it, what happened' they didn't ask what happened, they didn't ask who it was, they didn't ask anything. It was just say yes or no.......so I talked to one of my nurses, ahm, my associate nurse about it one night.....So we started to talk about it and I didn't like her reaction and I haven't talked about it since.

(Nurse's reaction?) She said it was stupid. It could have been avoided. And I said, ahm, my reaction was like that and I'm not talking to anybody else about it again.... she seemed to laugh it off at first, and then she said it was stupid and then she came up with this idea that was totally off base and it really made me angry. That's why I've never talked to her again. That was the first and last time.

She should have made me talk about it more and she should have made me tell her how I felt about her reaction. And how stupid it made me feel...she came up to talk to me again, but I wouldn't talk about it.

This patient articulates another example of a response for which the patient felt belittled. In
this case, however, it appeared that the nurse was engaged in a conversation with the patient and interested in learning more about the sexual abuse experience. Perhaps the nurse also had a wish to help the client by demonstrating understanding through empathic comments. However, from the patient's perspective the empathic process was quickly terminated with a comment for which the patient felt invalidated. As an adaptive defense, to not re-experience this traumatization, the patient then refuses to further address the issue.

Following is another example where the patient perceives the nurses' lack of interest in exploring the important issues of CSA as a "no care behaviour." The patient perceives most nurses as demonstrating "no care behaviours" and describes nurses documenting interactions in a way that reflects positively on themselves:

(When asking about CSA) she (nurse) was in a hurry; she wanted to get the form filled out so she could go....Dr. McK. up at (hospital), he told me "Be careful how you treat the nurses because, believe me, they know how to get back at you"...They will write down in your chart whatever is convenient for them to cover their own self and to make you look bad so that they don't get in trouble for not doing their job...I'm telling you the truth. And I even had it verified at one point. There was a male nurse that was attracted to me, it should not be happening, it's against the rules. But he offered to have a look at my resume, to help me with my resume, so I just gave it to him. And then it was found on his personal belongings later on, and he came over to me and said "I have to give this back to you because the nurses said if I give this back to you I won't be reported. But they told me that you were a very highly manipulative person (chuckling) and that I must stay as far away from you as I can get". (Laughs)

This patient explains how she feels that nurses are very task focused, and not genuinely
interested. The nurses make no attempt to engage or demonstrate any understanding, and then contradict the intentions of her behaviours because they have made false assumptions in treatment plans. Assistance in completing the resume was seen by the patient as something valuable, however when another nurse was authentically interested in helping her, she was belittled by the treatment team’s refusal to complete this task. A split in the treatment team is noted. Also, the patient’s anger towards not being heard by the treatment team, is hidden in her defence of laughter.

Jennings (1994) describes how the needs of CSA survivors are often not well met during inpatient hospitalization. As a consequence of the abuse, survivors have difficulty relating to others because of their profound sense of mistrust, betrayal and powerlessness (Briere, 1989). Clinicians, therefore, have an important role in acknowledging the prevalence of abuse and recognizing these behaviours and the therapeutic significance during inpatient treatment. Perhaps for the patient in the above quote, a sense of trust had developed between her and the clinician. Assistance with the resume would have aided in her sense of control, hope for future, and development of self-esteem. However, often the experience of CSA is not well conceptualized in the biological treatment models of psychiatry. As such, these patients’ needs are often unseen, rejected, or distorted to fit within the parameter of the conceptual framework from which clinicians in the inpatient work. Hence, this patient’s request was seen as manipulative. Worse still, clinicians who do recognize the specific needs of these patients are often denied the tools and support necessary to respond adequately.

Subtheme ii) Level 2: solution behaviours.

Within the task focused theme, two patients provided descriptions in their interactions which demonstrated “solution behaviours” on the part of the nursing staff. Solution
behaviours are those that explain rules or processes, tell the patient what to do, offer a
solution, or invite explanation of patient’s statement. Although these behaviours are less
detrimental than “no care behaviours,” they do not reflect affective involvement, since they
are not focused on demonstrating understanding of the patient’s feelings. The following quotes
provide some illustrations:

Talking to my nurse, she was very supportive and very confronting, she pick out a lot
of my behavioural patterns and that I was... uhm... manipulative and that I needed to
control situations. They keep telling me that I can keep being the victim or I can start
changing my life. I want to change my life but it’s very hard...I’m comfortable with
talking to her, I’m not comfortable with her response. Her response was like
...uhm...the attitude like so it happened so deal with it. Nurse was helpful by my
learning how I was affected and how to grieve. And sort of...offering help like “now
you are in the hospital, so let’s deal with this and this crisis.” (Long pause) But I think
she should listen to what you are saying and they see the way you behave but they
don’t ask why, what made you like this.

I know she should of just let me talk, let me voice my concerns without being
interrupted or summarized and just listen. Instead of just looking for quick fixes, like
“you’re agitated let me give you a drug”, “you’ll have to think about that tomorrow”,
or “that does not have to go on the rest of your life”, ..you know those quick fixes is
not what I want.

This patient describes her mixed feelings in her interaction with the nurse, where she can see
the nurse cares, yet the nurse’s response is not totally empathic. The above quote illustrates
how the nurse is interested and engaged in a discussion with the patient. In her attempt to
help, the nurse tells the patient what to do and offers many problem solving solutions or some non specific emotional support. The conceptual framework describes these solution behaviours as non empathic. The patient’s perception that this is not empathic is seen clearly in the comments that “she should just let me talk,” instead of looking for quick fixes and solutions, and try to demonstrate an understanding of the patient’s story.

Solution behaviours seem to occur when nurses are very focused on getting all their task done during their shift, hence it seem quicker to offer solutions. The other patient in the solution behaviour group talks about similar feelings as described above, in a different situation:

The first night that I was in here I had a flashback and, ahm, and that was really upsetting. The nurse came in and she told me that... that I was safe and that perhaps I need something to help me relax. And if I couldn't promise that I wasn't going to, ahm, be self-destructive, then they would have to send me to another floor. And I said to her, "All I want you to do is hold my hand". Because that's what I do with my therapist. But this woman just was... she was frigid as far as the touching. So she put her hand on the bed and I took her hand; and, her hand was like this and mine was like this, she would like fold her fingers in; and usually I don't need drugs after flashbacks. All I need is some TLC. I wasn't comfortable because I knew she wasn't comfortable

........There was practically no expression on her face whatsoever. Ahm... and no compassion. I think she just wanted to give me the drugs and, ahm, let the drugs work. It came—it came across loud and clear that she was uncomfortable. I mean her body language. She sat far away from me; I had to ask her to move closer. And I think she was more comfortable holding my hand near the end of it. Because the next
day she was a completely different person.

It is easy to see how a staff nurse being very busy on the floor may go into a situation with a solution in mind, rather than first examining what would be helpful from the patient’s perspective. It is ironic how the patient in the above example has to help the nurse relax when it was the nurse’s task was to help the patient regain control. Again, the example illustrates how the patient felt the nurse was trying to help, but when she started to explain the rules and the process that will happen if she did not guarantee safety, the patient felt upset at this unempathic remark, since the nurse never examined what the patient thought would help.

Asking about sexual abuse in an initial history can be helpful in exactly the way the above example illustrates. If a patient acknowledges an abuse history in an initial assessment, there is an opportunity for clinicians to investigate how they can create a safe environment for this patient, for example, how would the patient like to see staff respond to a flashback. This would allow more opportunities for the nurse to be empathic with the patient, and avoid walking into a situation as the above, with no knowledge of the patient.

**Theme 3 (b): Authentically Interested Nurses**

**Subtheme i) Level 3: affective involvement behaviours.**

Three patients described affective involvement behaviours on the part of nurses that were seen as nurses being authentically interested in the patient. According to the conceptual framework affective involvement behaviours include responses that: express care or concern; address the patient’s feelings; address precipitants of the patient’s feelings; and address the patient’s self-esteem. These patients could not always find words to explain why they knew the nurse was truly authentically interested in the patient, but it usually came down to a remark the nurse made that, according to the patient, showed that the nurse truly understood, or as the
conceptual framework outlines, was a true empathic helper. The following quote illustrates:

Nothing really. She approached it really great because as I was talking about it and it was really bothering me that...because of this happening it was always my understanding that when it happened and because it happened, now I'm gay, you know. And me finding out, coming to terms with that, it really bothered me because I don't want to be homosexual and I always blamed it on what happened from the very beginning. And because of that, like I just--at one time I grew religious, and for me to talk about and say something like that, like I'm going to hell, straight to hell for the homosexuality. And she was really great, she said no, you know, she talked to me through that part of it and that was the part that was bothering me. I can accept myself, you know, and not worry about what's gonna happen after I die.

Ahm, yeah, like she never... never backed off, she never blinked, you know, she just took it in stride. And I was watching her face, she had this kind of serene look on her face as I was talking about it, you know. And she just let me talk, too, and that was good; at that point she sat there and just begun. Like I said, I watched her face for some kind of reaction, you know, and I'd say it was more empathy than sympathy. I felt comfortable. Now, like I really trusted, she's fantastic, you know.

Every time she's on if we're talking she'll ask me how are you feeling, you know. She's trying to get me over this dealing with the past and looking more towards the future.

Patients in the affective involvement behaviour category describe how they could see the nurse was truly authentically interested in them. This came across in words, behaviour, or just the nurses’ way of being with the patient. The patients struggled to find words to describe the
feeling, nonetheless, they were sure of the authenticity of the nurses' empathy. The conceptual framework is helpful in articulating the empathic behaviours demonstrated in the above quote.

Nurses that were described by patients as authentically interested seemed to come in and work "with" the patient, rather than coming in the interaction "doing" something to the patient, such as completing a task. The above quote illustrates that the main issue from the patient's perspective was his self-esteem as related to his homosexuality. The patient had very positive feelings toward the interactions with this nurse because the nurse "talked through that part of it, the part that bothered him." Empathic responses require time, and this patient describes how the nurse really took time to listen. He then describes the look on her face, as if to say he could see that she was working very hard to understand, working hard to take his perspective. Empathic responses require an observer to be engaged and to be able to generate hypothetical situations in an attempt to understand the other. This patient describes how he could see her thinking and trying to understand, he describes a serene look on her face, not "a blank look," and he watched for a reaction, as he knew she wanted to help. The patient notes it was empathy and not sympathy. The empathic responses demonstrated and validated that the nurse understood. The patient describes a trusting relationship, where there is also discussion around the future, which shows growth in the relationship.

The other patients also describe how nurses were authentically interested. The example below shows how the nurse was able to make a few empathic comments that allowed the patient to feel safe to begin to explore this topic:

We started talking and I said to her, 'I was sexually abused when I was a child and I want to talk about it'. So she let me talk, and she says, "You're being very brave for
telling me all this stuff; takes a lot of guts to bring up these childhood memories and
tell someone about it". I thought I was going to be punished, but ..... I was very
comfortable with her because I had known her for a while. I had known her for a
while and we had had a lot of chats about it. She was very nice. She understood.
She was telling me it was okay that these things happen, almost like my GP, these
things happen among younger children. She was sort of - I don't know what the word
is - ahm, she's more sympathetic to my plight and seemed like she really understood
what I was talking about.
I knew she understood just by her reaction to me, and she had known me for a long
time. It was painful, but I felt a lot better once I talked to her.
(what's someone's reaction when they understand?) She said, "That's okay, C. " what I
was just telling you, "that's okay, you know. Like she didn't say, 'oh, that's terrible'
or something like that. She's very soothing.

This patient chose to reveal her history of abuse to a nurse for which she assessed was safe to
talk, since she seemed to have a fear of receiving a non empathic response. Note how the
patient states the nurse "let me talk" which was consistent with all three patients in this
sample. Giving the patient time to tell his or her story allows the nurse to be sensitive to cues
from the patient. The nurse may then begin to understand and empathize with the patient by
thinking of some hypothetical situations that have the same affect the patient is expressing
(Gallop et al., 1990). For this patient, the nurse then demonstrated she understood by simple
empathic responses that addressed how difficult it was to raise the issue, and that this could be
normal. These comments seemed to help contain the patient's worst fears. These are
responses that express care, concerns, and directly address the patients' feelings. All empathic
responses are unique and can only be meaningful when they are specific to the patient's comment at that time. The nurse involved in the above interaction was engaged in a conversation with the patient where she could understand that, in order to help the patient, she needed to address this fear of disclosure. The patient describes feeling safe and soothed by the nurse, who was authentically interested in her, and "she understood". The nurse was, therefore, successfully empathic from the patients' perspective and this positive experience of receiving this empathy could be this patient's first steps to healing.

The two themes which emerged from examining patients' experience of nursing inquiring about CSA, "task focused behaviours" and "authentically interested nurses," demonstrate the important role of empathy with CSA survivors. Urbancic (1992) describes psychological support in the form of listening and an understanding presence as the most critical interventions to be used with a CSA survivor. These forms of empathy are important because survivors have most likely been disbelieved and discouraged from disclosing about abuse when they were children. It is expected that many survivors will be reluctant to disclose because of past negative experiences in this regard. Urbancic (1992), therefore, explains how empathy in the form of validation of the abuse and its personal meaning to the survivor is the single most critical intervention that can be provided in early stages of recovery.

Those nurses who were described as "authentically interested" were able to create this empathic holding environment that empowered the patient to disclose in a way that felt safe and in control. This empowerment was achieved in a way that Urbancic (1992) describes as being open, sensitive to cues, willing to listen, and validates the survivor's perception and details of the event. Nurses in this sample were also able to assist the survivor to recognize that self-disclosure is a strength and requires great courage. In doing this, these nurses
provided an effective intervention to assist these patients.

However, when dealing with CSA survivors, lack of empathic understanding by the staff, and a failure to respond appropriately, risks injury to the patient and may be interpreted by the patient as a lack of concern and as neglect (Jennings, 1994; Fromuth & Burkhart, 1992). When describing the experience of nursing staff inquiring about CSA, two-thirds of the nine patients felt that nurses were unempathic and demonstrated “task focused behaviours.” To CSA survivors, the nurse’s failure to be sensitive to such an issue will often have an adverse impact, as they are more acutely aware of feelings of betrayal and powerlessness as it is reminiscent of past abuse experiences. As such, these patients may have felt retraumatized.

There could be many reasons why the nurse’s behaviour was interpreted as unempathic and task focused. The literature suggests that too often the nurse is uncomfortable with the topic of CSA (Boutcher & Gallop, 1996; Urbancic, 1992). This discomfort can be communicated nonverbally to the patient and interpreted as a sign that s/he is not to discuss the CSA experience. If the nurse shows horror, shock, or disgust, it may also add to the patient’s existing feeling of being alienated, different, shameful, and unworthy (Urbancic, 1992). Still, other studies point to the fact that nurses are not well trained to deal with disclosure, and as such do not respond therapeutically (Engels, 1996; Gallop et al., 1995). Finally, nurses may know how to respond, but may find themselves in a working environment that lacks the tools, support, and time necessary to respond adequately (Jennings, 1994). Whatever the reason, the patients in this study suggest that there is a need to respond empathically when inquiring about CSA in the nursing history.
CHAPTER IV: SUMMARY, IMPLICATIONS AND CONCLUSIONS

The growing awareness of the effects of trauma has prompted clinicians to include inquiry about sexual abuse in nursing assessments. This study was conducted to examine patients’ perspective on being asked about a history of childhood sexual abuse (CSA). Three research questions were asked: (1) From the patients’ perspective, who do they report should be asking about a history of CSA?; (2) How do patients wish to be asked?; and (3) If CSA was revealed, what are patients’ experiences of both being asked and talking about CSA with nursing staff?

Twenty-nine psychiatric inpatients from three hospitals were interviewed using a semi-structured interview schedule developed by the researcher. A thematic analysis of each research question was conducted. Analysis of research question number one identified the following qualities in those who ask: (a) consistency in care givers, (b) being trained to deal with disclosure, and (c) doing something with the information. Analysis of research question number two identified the following themes: (a) asking in context of other relevant questions, (b) ensure confidentiality and privacy, (c) timing inquiry appropriately, (d) ensure clinicians have adequate time to listen, (e) present patients with an option to answer, and (f) create an environment where disclosure can happen at clients’ initiative. Analysis of research question number three identified two themes: (a) Task focused behaviors, and (b) authentically interested nurses.

Although inclusion of questions regarding CSA in nursing assessments was done with good intentions, the results in this study suggest these questions need to be given more careful consideration. This chapter will address the implications to nursing practice, education and research.
**Implications for Nursing Practice**

Within psychiatry, inpatient treatment places an emphasis on ensuring patients are safe, stabilized, and discharged in a timely fashion. This rapid stabilization of patients is most often accomplished through pharmacological intervention alone, and can lead to a devaluation of interpersonal skills in the therapeutic inpatient milieu (Gutheil, 1985). Clinicians practising in this short stay model of treatment are required to modify their psychosocial interventions to meet the needs of a short stay setting. Although inpatient admissions are much shorter, it is still important for nurses to continue to focus on the establishment of a therapeutic nurse-patient relationship. Perhaps, the lack of empathic qualities in nurses, described by patients in this study, may be related to the fact that nurses have not modified their practice to meet the needs of a short stay treatment model.

In this study, patients suggested that some nurses were very task focused in their behaviours, interested only in completing their paperwork and not authentically interested in their experiences. A major concern reported throughout the results was that clinicians did not have time for patients. Time represents something very valuable to patients. Patients felt that those clinicians who made time for them were the ones that cared. Patients further specified how nurses exhibited a variety of “no care” behaviours and offered quick “solutions” to the issues they addressed. These patients described how some nurses were not able to manage the disclosure of CSA in a way that was supportive or empathic, and sometimes their responses were detrimental to their healing process. For example, when receiving an unempathic response to CSA disclosure, some patients stated they would never bring the topic up again. However, patients were able to describe how they would have preferred the nurse to respond in a way that demonstrated understanding of their feelings.
In contrast, a few patients described how the therapeutic and empathic nurse-patient relationship was central to the kind of care they wanted. These patients described nurses as authentically interested in their experiences. This was demonstrated by the fact that they spent time “with” the patient rather than “doing” something to the patient, such as completing a task. These nurses seemed well suited to explore sensitive topics with the patient.

However, with the changes to increasingly shorter stay, more acute patients, as well as fewer nurses due to budget cuts, there is a lack of clarity of the direction of mental health services in the inpatient setting. As psychiatric nurses struggle to modify practice which still espouses the establishment of a therapeutic nurse-patient relationship, they have also decided (whether it be for political, social or therapeutic reasons) to incorporate questions regarding CSA in their routine nursing histories. However, the results of this study suggest nurses have not given careful consideration on how to incorporate questions regarding CSA in a short stay setting.

Psychiatric nurses need to consider “how” gathering this information affects the care they will then provide to these patients during their short stay. In the results of this study, patients talked about the uselessness of asking about CSA because they could not see how the information was used in their inpatient treatment. In fact, for most patients, after that initial answer, the topic was never raised again. If nurses are asking this question, then nurses need to consider how they are going to use this information during the inpatient stay and then articulate this back to the patient such that he/she is aware and an active participant in the treatment plans.

The results from this study and previous studies suggest that asking about a history of CSA needs to be accompanied by relevant education and supervision to ensure clinicians understand
the diagnostic and treatment implications (Eilenberg, Thompson, Goldman & Mellman, 1996; Engels, 1996; Gallop et al., 1995; Gallop et al., 1998). Given the high prevalence of trauma in psychiatric patients, the patients in this study support that those nurses inquiring about CSA need to have a certain amount of knowledge and skills in this area. Many studies support the results of this study that specify if clinicians are going to ask about CSA, then certain conditions must be met (Engels, 1996; Gallop et al., 1998; Gallop et al., 1995). In an investigation of nurses' opinion of routine inquiry about sexual abuse, Gallop et al. (1995) found that nurses felt there is a need for more skills and knowledge in this area. The nurses also reported that the amount of discomfort and distress a woman experiences after disclosure of sexual abuse is influenced by the amount of education and skill of the nurses inquiring. The nurses felt there was a need for additional education regarding how to ask questions about sexual abuse as well as how to respond (Gallop et al., 1995). In a more recent study which examined nurses' comfort and educational needs in dealing with sexually abused patients, Gallop et al. (1998) again found many of the nurses believed that they lacked adequate knowledge or skills in many domains related to caring for CSA clients. Few of the nurses in that study identified specific therapeutic strategies related to counselling CSA patients. Gallop et al. (1998) argued that many nurses may be compelled to provide counselling even though they believed their skills were inadequate. Similarly, in a study which examined female psychiatric inpatients perceptions of routine inquiry about CSA, Engels (1996) found nurses may not be knowledgeable about CSA. More specifically, participants felt nurses may not be aware of the long term effect of CSA and the manifestations of psychiatric illness. These participants indicated that nurses may not be able to manage the disclosure of CSA in a way that is supportive. Until nurses are committed to obtaining this information and training,
Engels (1996) argued that routine inquiry into CSA should not be practised.

Given the many criteria which should be met before inquiry into CSA occurs, is it realistic for nurses to include inquiry about CSA in their practice in a short stay setting? Many dilemmas face clinicians who ask themselves this question. First of all, not asking will present a problem. Not asking does not make the abuse experience disappear, and some authors have acknowledged that not to inquire may further revictimize the client (Doob, 1992). For patients who are survivors of CSA, hospitalization may always be traumatic. Feelings of powerlessness, lack of trust, stigmatization, and betrayal are critical dynamics in understanding the sexual victimization experience (Finkelhor & Browne, 1985). Many aspects of the hospitalization process may evoke these same feelings in patients (Fromuth & Burkhart, 1992). Unless clinicians are sensitive and aware of these dynamics and intervene appropriately, hospitalization may serve to retraumatize the survivor. Asking and being aware about CSA, therefore is required for effective treatment.

Secondly, asking without knowledge also presents a problem. The growing awareness of trauma has prompted institutions to include inquiry into CSA, without carefully considering the educational needs of nurses. Many studies have found that nurses believe their knowledge and skills in caring for CSA patients are inadequate, yet they may feel compelled to inquire and provide counselling (Gallop et al., 1998; Gallop et al., 1995). The results from this study, and others, provide evidence to support that patients may once again feel retraumatized by the unempathic remarks they receive from clinicians (Engels, 1996; Jennings, 1994).

Finally, asking without administrative support presents a problem. Clinicians who are asking and are knowledgeable about CSA, including its etiological and therapeutic significance, may feel they are unable to practice with integrity when they are denied the tools,
support, and time necessary to respond adequately. Literature which examines the CSA survivors' experience of hospitalization has found that patients frequently feel that clinicians are "unable to see" their problem. Jenning (1994) explains how when someone does finally understand the needs of CSA survivors, they are denied the means to intervene because it does not fit with the biologically based understanding of mental illness.

Although there are obstacles to overcome, it is important to inquire about CSA in a short stay inpatient treatment setting. To provide relevant and necessary health care, providers must know the patient's problems, and to do so requires that clinicians inquire, and the patient discloses the problem. Regardless of how short the patients stay is, the most critical intervention to be used with survivors is the availability of an empathic listener with an understanding presence (Urbancic, 1992). This is important since survivors most likely have been disbelieved, discouraged from disclosing, and/or blamed for the behaviour if she/he did disclose in the past. Therefore, nurses' validation of the abuse is the single most critical intervention that can be provided in early stages of recovery. Limandri (1989) describes how, if a patient receives a positive, empathic response to disclosure of a stigmatizing condition, he or she will then continue to disclose and may feel safe to work on that issue. However, as the results of this study found, when a patient discloses with negative outcomes, he or she will continue to conceal for possibly even longer periods of time. Nurses in short stay inpatient settings, therefore, play an important role in inquiring and facilitating disclosure of CSA. Once this information is obtained, nurses may play an important role in helping CSA survivors link current symptoms with past abuse (Urbancic, 1992). These are the essential first steps to recovery, and a part of the role of the psychiatric nurse. Patients in this study described the essential qualities in individuals necessary for inquiry about disclosure of CSA. It is the
professional responsibility of each nurse in a psychiatric setting to meet these conditions and to find ways in their practice to support inquiry into CSA.

**Implications for Nursing Education**

The results from this study have implications for clinical education. Nurses practicing, or planning to practice, in a psychiatric setting have an obligation to become knowledgeable about the prevalence and long term effects of CSA. At the most basic level, psychiatric nurses must become skilled and knowledgeable about current research including: the prevalence of CSA; the impact of CSA; how and when to inquire about a history of CSA; how to respond and manage disclosure in a supportive manner; and how to provide a safe environment, that fosters a therapeutic nurse-patient relationship, to allow patients who are victims of CSA to explore this issue. Educational opportunities, which include clinical supervision by expert practitioners, should be provided specifically for nurses. Gallop et al. (1998) found that nurses identify self study as a major source of knowledge acquisition. Therefore, self learning modules (e.g. videotapes and interactive study modules) should be developed and make available to nurses. For educators, content about the links between CSA and mental disorders needs to be included in orientation programs, continuing education, and in-service education programs. However, providing this and other didactic information on this issue will not be enough. Psychiatric nurses must truly value this aspect of their role, and only then will they begin to restructure their work to ensure they are available to serve those who suffer from CSA and its psychiatric manifestations.

**Implications For Research**

This study provides evidence that the practice of routine inquiry about CSA arouses many feelings in patients. Outcomes of routine inquiry depend on how the question was asked, and
the type of response provided by the clinician. Furthermore, the study provides evidence that
the practice of routine inquiry requires careful consideration before it is introduced in the
clinical setting. Further research is needed to understand this relatively new practice.
Although this study began to explore the perceptions of male and female psychiatric patients,
there is a need to examine the difference between the needs of male versus female survivors in
terms of inquiry. Needs of male sexual abuse survivors are not well understood in the
research literature in comparison to females. Further investigation is needed to understand
specifically the perceptions of males hospitalised in psychiatric settings about the practice and
their experience of inquiry.

It is still not clear if patients support the practice of routine inquiry. Although the majority
of patients in this study support this practice, other studies report that patients do not support
this practice (Engels, 1996). There is a need for further investigation on understanding why
patients may or may not support this practice. In particular, what variables (for example
personality style and or presenting symptoms) influence whether a patient would like to be
asked. With this information, clinicians can then place themselves strategically with clients
who are at very different stages of the healing process.

There also a need for more detailed research on how patients ought to be asked. For
example, understanding the timing of inquiry is important. Exactly when and how should the
question of CSA be incorporated into assessment is not totally clear. In this study, many
patients supported inquiring at the beginning of the assessment as long as certain conditions
were met. Still others suggested that it takes weeks to develop a trusting relationship before
the timing is right and the patient can address the topic at his/her own initiative. Although this
study acknowledged that there is a difference in timing preference, the variables or
mechanisms in action which affect timing preference are not well understood. Trying to
understand what affects timing preference will be important in assisting abuse survivors.

Further outcome research is also very important. There is a need to understand if and how
inquiry in CSA has affected treatment. Inquiry into CSA has been incorporated into
assessments with the hope of improving treatment. However, once this information is
gathered, it is not well understood how the information is being used, and if there was an
appropriate evaluation of the trauma history. Eilenberg, Fullilove, Goldman and Mellman
(1996) found in their study of psychiatric outpatients that the detection of abuse was rarely
used in the assessment and treatment planning. All clinical practice settings need to evaluate
these initiatives. In particular, what are the different outcomes, if any, between patients who
were asked and not asked about CSA?

Another important aspect to investigate and understand is the clinicians’ role and concerns
regarding inquiry into CSA. Inquiry into CSA will never be a successful practice if clinicians
do not feel understood and supported regarding the difficulties they may experiencing in this
area. Gallop et al. (1998) have begun to examine this area, but more research is needed.

Finally, although it is not the role of the inpatient setting, there is more research required
to understand how to prevent CSA. Public awareness, and research into understanding why
CSA occurs, and the effects it has on its victims is necessary to prevent the occurrence of
abuse. Further research which develops and evaluates prevention strategies is also required.
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APPENDICES
APPENDIX A  PART one

INTERVIEW SCHEDULE:  QUESTION TO BE ADMINISTERED TO ALL SUBJECTS

1. Before you were asked to participate in this study and before you were admitted into the hospital, did the topic of childhood sexual abuse ever come up between you and any health professional (e.g. case manager, physician, nurse)?
   If yes........a) Who?
      b) How did the topic come up?
      c) If you were asked about sexual abuse, what was that experience like?
         (Probes) How did you feel?  How comfortable were you?
      d) If you were not asked, would you of liked to have been asked about it?
         How would you suggest asking?
   If No........a) Would you have liked to have been asked about it? How?
      b) From whom would you prefer to have been asked? Please explain.

2. During your hospitalization did the topic of sexual abuse ever come up between you and any health professional?
   If yes........a) Who?
      b) How did the topic come up?
      c) If you were asked about sexual abuse, what was that experience like?
         (Probes) How did you feel?  How comfortable were you?
      d) If you were not asked, would you of liked to have been asked about it?
         How would you suggest asking?
   If No........a) Would you have liked to have been asked about it? How?
      b) From whom would you prefer to have been asked? Please explain.
APPENDIX A  PART TWO

PROBES FOR SEMI-STRUCTURED INTERVIEW

1. Tell me about your experience of talking to your nurse about sexual abuse.

2. How comfortable were you discussing the topic?

3. How did the nurse's behaviour or response effect how comfortable you were discussing this topic? Please explain.

4. How was the nurse's behaviour helpful in discussing the topic? Please explain.

5. How could the nurse have handled the situation more effectively?

6. Did you ever mention abuse to your nurse and feel s/he did not pay attention or did the nurse ignore the topic?

7. When you were talking with your nurse about childhood sexual abuse how did s/he make you feel?
   (The following will be used as guides)

   Did you feel the nurse:
   a. listened to you? Heard you?
   b. believed you?
   c. thought what you said was important? Not important?
   d. understood?
   e. cared?
   f. made you feel comfortable?
   g. ignored you?
   h. put you down?
   i. thought you should avoid the topic?
   j. was interested?
   k. wanted to know more about it?
   l. was concerned?
   m. knew how you felt?
   n. knew what made you feel that way?
   o. could see how this experience has affected your life?

8. After your initial interaction, did the topic of sexual abuse ever come up again between you and your nurse?

9. How can nurses be more helpful to patients who have experienced sexual abuse?
APPENDIX A PART THREE

Demographic Data

Sex: Female ______ Male ______

1. What is your present age ______ years.

2. What is your present marital status? (Circle Number)
   1. single
   2. married
   3. divorced
   4. separated
   5. widowed
   6. living with someone

3. Have you ever been employed? YES ______ NO ______

   If YES, please give the date of your last employment ________.

4. Please circle the last grade completed in:
   
   Elementary school 1 2 3 4 5 6 7 8
   High School 9 10 11 12 13
   College 1 2 3
   University 1 2 3 4
   Other ______

5. How many psychiatric admissions have you had in the past? _________
APPENDIX B

LETTER TO THE NURSING DIRECTOR AT THE PARTICIPATING HOSPITAL

Dear __________,

I am a registered nurse currently enrolled in the graduate program in the Department of Nursing Science at the University of Toronto. In partial fulfilment of the Masters of Science in Nursing program at the University of Toronto, I am conducting a study under the supervision of Dr. Ruth Gallop, Associate Professor, University of Toronto. I have received approval from the office of research services and I am now writing to ask your permission to conduct this study in your psychiatric inpatient unit.

The purpose of the study is to gain a better understanding of patients' experiences of inquiry about a history of sexual abuse. It is hoped that the information gained from this study will assist nurses in their provision of care for psychiatric patients who are survivors of childhood sexual abuse. Participants in the study will undergo a semi-structured interview that will focus on their experience of talking about sexual abuse. If available, I would like to ask to conduct the interview in a room on the unit that offers privacy for the researcher and the participant.

If you agree to participate, I would like to ask the Clinical Nurse Manager (CNM) of the unit to assist me to identify potential participants for the study.

I am enclosing a copy of my thesis proposal for your consideration. I would greatly appreciate the opportunity to conduct the study at your agency and I would be glad to meet you and answer any questions you may have. I can be reached at (905) 430-6023. Additional concerns may be directed to Dr. Ruth Gallop at (416) 978-2852. Thank-you for your time and I look forward to hearing from you at your earliest possible convenience.

Sincerely,

Rosanna DiNunzio, R.N., B.Sc., B.Sc.N., MSc(N) Candidate
Graduate Faculty of Nursing
University of Toronto
Dear [Name],

I am a registered nurse currently enrolled in the graduate program in the Department of Nursing Science at the University of Toronto. In partial fulfilment of the Masters of Science in Nursing program at the University of Toronto, I am conducting a study under the supervision of Dr. Ruth Gallop, Associate Professor, University of Toronto. I have received permission from the Director of Nursing to conduct this study in your psychiatric inpatient unit. I would like to request your assistance in the recruitment of prospective subjects for the study.

The purpose of the study is to gain a better understanding of inquiry about a history of sexual abuse. It is hoped that the information gained from this study will assist nurses in their provision of care for psychiatric patients who are survivors of childhood sexual abuse.

The inclusion criteria for the sample are patients who: (1) have been admitted to a psychiatric unit; (2) are able to speak English; (3) have been on the ward for at least 24 hours and (4) are able to give informed consent. Participants in the study will undergo a semi-structured interview that will focus on their experience of talking about sexual abuse. A copy of the interview schedule has been enclosed (Appendix A). It is anticipated that the interview will be conducted in a room on the unit that offers privacy for the researcher and the participant.

If you are interested, I will be asking you to assist me in identifying potential participants for the study. I will be contacting the unit frequently to see if potential participants have been identified. When a suitable participant has been identified, I will ask you to approach the patient and briefly describe the purpose and nature of the study and ask permission for the release of their name so the researcher may meet with the participant to explain the study further. I will provide you with the explanation for the patient (appendix D). I will be contacting the unit periodically to see if the participant is willing to meet with me.

I would be very glad to meet with you to answer any questions or concerns you may have. I can be reached at (905) 430-6023. Additional concerns may be directed to Dr. Ruth Gallop at (416) 978-2852. If there are no questions or concerns, then I'd like to thank-you for your assistance with my study.

Sincerely,

Rosanna DiNunzio, R.N., B.Sc., B.Sc.N., MSc(N) Candidate
Graduate Faculty of Nursing
University of Toronto

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APPENDIX C
EXPLANATION FOR THE CLINICAL NURSE MANAGER

Dear [Name],

I am a registered nurse currently enrolled in the graduate program in the Department of Nursing Science at the University of Toronto. In partial fulfilment of the Masters of Science in Nursing program at the University of Toronto, I am conducting a study under the supervision of Dr. Ruth Gallop, Associate Professor, University of Toronto. I have received permission from the Director of Nursing to conduct this study in your psychiatric inpatient unit. I would like to request your assistance in the recruitment of prospective subjects for the study.

The purpose of the study is to gain a better understanding of inquiry about a history of sexual abuse. It is hoped that the information gained from this study will assist nurses in their provision of care for psychiatric patients who are survivors of childhood sexual abuse.

The inclusion criteria for the sample are patients who: (1) have been admitted to a psychiatric unit; (2) are able to speak English; (3) have been on the ward for at least 24 hours and (4) are able to give informed consent. Participants in the study will undergo a semi-structured interview that will focus on their experience of talking about sexual abuse. A copy of the interview schedule has been enclosed (Appendix A). It is anticipated that the interview will be conducted in a room on the unit that offers privacy for the researcher and the participant.

If you are interested, I will be asking you to assist me in identifying potential participants for the study. I will be contacting the unit frequently to see if potential participants have been identified. When a suitable participant has been identified, I will ask you to approach the patient and briefly describe the purpose and nature of the study and ask permission for the release of their name so the researcher may meet with the participant to explain the study further. I will provide you with the explanation for the patient (appendix D). I will be contacting the unit periodically to see if the participant is willing to meet with me.

I would be very glad to meet with you to answer any questions or concerns you may have. I can be reached at (905) 430-6023. Additional concerns may be directed to Dr. Ruth Gallop at (416) 978-2852. If there are no questions or concerns, then I'd like to thank-you for your assistance with my study.

Sincerely,

Rosanna DiNunzio, R.N., B.Sc., B.Sc.N., MSc(N) Candidate
Graduate Faculty of Nursing
University of Toronto
APPENDIX D

CLINICAL NURSE MANAGER’S EXPLANATION OF THE STUDY TO THE PATIENT

Hello Mr./Ms. ____________.

A nurse, Rosanna DiNunzio, at the University of Toronto, is conducting a study to see if you were asked about a history of sexual abuse. If you were asked she would like to learn what that experience was like for you. She is interested in speaking to people with and without a history of childhood sexual abuse to find out how staff are asking about the absence or presence of abuse histories. She would like to tell you more about the study to see if you might be interested in participating. Hearing more about the study does not obligate you to participate. Would it be all right to give your name to Ms. DiNunzio so she can arrange a time to tell you about the study?
APPENDIX E

EXPLANATION OF STUDY FOR THE PARTICIPANT

Hello Mr./Ms.____________. My name is Rosanna DiNunzio. I am a nurse and a graduate student in the Department of Nursing Science at the University of Toronto. My supervisor is Dr. Ruth Gallop, Associate Professor at the University of Toronto. Thank-you for agreeing to meet with me so that I can explain my study to you and answer any questions you may have.

As part of my program, I am doing a study on patients' experience of psychiatric nursing staff inquiring about a history of sexual abuse. It is hoped that the results of this study will help professionals to understand what this experience is like for patients.

If you would like to participate, I will arrange a one hour interview with you at your convenience. At this interview, you will be asked if a staff person ever asked you about sexual abuse and if a nurse asked you then what was this experience like. The interview may take the whole hour or it may be shorter if you want. I anticipate it might be about a half-hour long. Our conversation will take place in a private room. I would like your permission to tape record our conversation so I can better remember what you have told me. You can stop the tape-recorder at anytime if there is something you prefer not to have taped. The tape will be destroyed after the information is put into written form. Information you share with me will be kept in a locked file. Although some direct quotes may be used in some cases, any information that might identify you will be removed. Your name will not appear in any report of the study. Nothing you tell me will be shared with the unit staff, unless you say something that leads me to believe your safety and/or the safety of others is at risk.

The decision to participate is entirely up to you. Your care here will not be affected if you do not wish to participate. If you agree to participate, you can change your mind and stop the interview at any time. You can refuse to answer any questions or talk about any issues. Although you may benefit from sharing your experiences and expressing your feelings, there is no direct benefit to you in participating in the research. The study may, however, provide information which will be useful to future patients.

Do you have any questions about the study? (If yes, answer questions). (If no questions are voiced); Would you be willing to take part in the study? (If no) Thank-you for your time (If yes) can we arrange a time for the interview?
APPENDIX F

PARTICIPANT CONSENT FORM

I have been asked to participate in Rosanna DiNunzio's study of patient's experience of nursing staff inquiring about sexual abuse. I understand this study is under the supervision Dr. Ruth Gallop, Associate Professor in the Department of Nursing Science at the University of Toronto. I understand that the information might help professionals to understand what this experience is like for patients.

I understand that my participation will involve one interview (approximately half hour) to talk about being asked about a history of childhood sexual abuse. If a nurse asked, I will be asked about my experience of nursing staff inquiring about a history of sexual abuse. Rosanna DiNunzio has asked for my permission to tape record the interview so she can better remember what I have told her. I can stop the tape-recorder at anytime. I understand that the tape will be destroyed once the information has been put into written form.

I understand that what I say in the interview will be kept confidential and be will be kept in a locked cabinet. I understand that my name will not appear on any report of the study. I understand that direct quotes may be used in the reports. Although I may recognize my own words, any information which might identify me to others will be removed. The unit staff will not be informed of anything I say unless I say something that leads Rosanna DiNunzio to believe that my safety and/or the safety of others is at risk.

I understand that the decision to be involved in this study is entirely up to me. I understand that if I do not wish to participate, my care will not be affected in any way.

I understand that I can stop the interview at any time and refuse to answer questions I do not wish to answer. Although I may benefit from sharing my experiences and expressing my feelings, I understand that there are no direct benefits for me in participating in the research. The study may, however, provide information which will be useful to future patients.

I have been given a copy of the explanation and consent form to keep. If any questions about my participation in the study occurs to me, I may contact Rosanna DiNunzio at (905) 430-6023.

I agree to participate in the study
Date__________________ Signature_____________________________________

I agree to have the interview tape-recorded.
Date__________________ Signature_____________________________________

I agree to participate in the study
Date__________________ Signature_____________________________________

I agree to have the interview tape-recorded.
Date__________________ Signature_____________________________________