

## Evaluating and Overcoming Barriers to Taking Abuse Histories

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Psychologists are frequently faced with issues of whether, when, and how to ask clients if they have been abused. Despite the demonstrated relationship between child abuse and adult psychopathology, researchers report that many clinicians still do not routinely inquire about abuse. A questionnaire completed by 63 psychologists and 51 psychiatrists in New Zealand revealed that factors related to reluctance to ask about abuse include the following: more pressing issues, fear of disturbing clients, a diagnosis of schizophrenia, biological etiology beliefs, and fear of inducing "false memories." Significant differences were found between psychologists and psychiatrists on some of these factors. Practice guidelines for enhancing the frequency and efficacy of abuse inquiry are presented.

Psychologists and other professionals sometimes do not ask their clients whether they were abused as children. At times this will be a conscious decision, and at other times it may be an oversight. Although there are some sensible reasons for not asking some clients in some circumstances, research demonstrates that the

frequency of taking abuse histories is consistently low. Because of the extensive documentation that child abuse is related to many mental health problems in adulthood, it seems essential that clinicians know whether clients have been abused, so that they can develop accurate formulations and effective treatment plans. This study was designed to identify the circumstances under which abuse histories are unlikely to be taken, as well as to understand and evaluate the reasons practitioners give for not asking about abuse.

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Child abuse has been shown to be related to the following: eating disorders (Douzinas, Fornari, Goodman, Sitnick, & Packman, 1994); impaired interpersonal relationships (Malinosky-Rummell & Hansen, 1993), including sexual dysfunctions (Beitchman et al., 1992; Mullen, Martin, Anderson, Romans, & Herbison, 1996); borderline personality disorder (Briere & Zaidi, 1989); psychosis (Chu & Dill, 1990; Read, 1997; Swett, Surrey, & Cohen, 1990), including schizophrenia (Goodman, Rosenberg, Mueser, & Drake, 1997; Read, 1997; Read & Argyle, 1999; Ross, Anderson, & Clark, 1994) and shizotypy (Startup, 1999); depression and self-injurious and suicidal behaviors (Joiner, Walker, Rudd, & Jobes, 1999; Read, 1998; Read, Agar, Barker-Collo, Davies, & Moskowitz, 2001; Santa Mina & Gallop, 1998); substance abuse (Fergusson, Horwood, & Lynskey, 1996); posttraumatic stress disorder (Barker-Collo, Melnyk, & McDonald-Miszczak, 2000; Boney-McCoy & Finkelhor, 1996); somatoform disorders (Salmon & Calderbank, 1996); anxiety disorders (Mullen et al., 1996); dissociative symptoms (Chu & Dill, 1990); and multiple personality disorder (Goff, Brotman, Kindlon, Waites, & Amico, 1991). Those subjected to multiple or severe forms of abuse are at greater risk of psychiatric disorder, and they have higher levels of psychopathology (Chu & Dill, 1990; Fergusson et al., 1996; Mullen, Martin, Anderson, Romans, & Herbison, 1993; Mullen et al., 1996; Pettigrew & Burcham, 1997a). In studies controlling for mediating variables that might explain the relationship between child abuse and adult psychopathology (such as family dysfunction or disadvantage and parental psychiatric history or substance abuse), the relationship persists for anxiety disorders, substance abuse, depression (Fergusson, Horwood, & Lynskey, 1996; Kendler et al., 2000), suicidality (Briere, Woo, McRae, Foltz, &

Sitzman, 1997; Fergusson et al.), deliberate self-harm (Pettigrew & Burcham, 1997b), admission to psychiatric hospital (Mullen et al., 1993; Pettigrew & Burcham, 1997b), posttraumatic stress disorder (Boney-McCoy & Finkelhor, 1996), schizophrenia and "psychosis not otherwise specified" (Briere et al., 1997), and eating disorders (Kendler et al., 2000). Attempts are under way to infer the causal pathways between childhood abuse and adulthood psychopathology (Barker-Collo et al., 2000). Given the strong relationship between childhood sexual abuse and a diversity of psychiatric symptoms and diagnoses, routine inquiry by professionals seems critical to assessment and treatment.

Childhood abuse is associated with greater use of psychiatric services in terms of younger age at first treatment or admission, increased length of hospitalization, more frequent hospitalization and relapse, and greater prescription of psychotropic medications (Goff et al., 1991; Jacobson & Herald, 1990; Pettigrew & Burcham, 1997b; Read, 1997, 1998; Swett et al., 1990). The prevalence of childhood sexual abuse among clients of mental health services is between 40% and 50% (Mitchell, Grindel, & Laurenzano, 1996). A recent review found that 64% of female inpatients have been physically or sexually abused as children and that child abuse among male inpatients is twice as high as that among men in general (Read, 1997). Approximately 61% of female psychiatric outpatients have been emotionally abused during childhood (Pribor, Yutzy, Dean, & Wetzel, 1993).

Spontaneous disclosure of abuse is unlikely (Pruitt & Kappius, 1992; Read & Fraser, 1998a). Therefore, the responsibility for abuse identification frequently lies with the clinician. However, when researchers have asked psychiatric patients about childhood abuse, the proportion of the abuse that had been identified by routine clinical procedures has been consistently low: 30% (Wurr & Partridge, 1996), 28% (Lipschitz et al., 1996), 20% (Goodwin, Attias, McCarty, Chandler, & Romanik, 1988), 12% (Jacobson, Koehler, & Jones-Brown, 1987), and 12% (Briere & Zaidi 1989). None of 30 "heavy users of acute inpatient and emergency services" who disclosed child abuse to researchers had ever been asked about abuse before (Rose, Peabody, & Stratigeas, 1991, p. 500). General practitioners seem equally hesitant to take abuse histories (Wilson & Read, 2001). Emotional abuse may be similarly unrecognized by clinicians (Thompson & Kaplan, 1999). Men are particularly unlikely to spontaneously disclose child abuse (Finkelhor, 1993; Read & Fraser, 1998a) and, paradoxically, are particularly unlikely to be asked about abuse by mental health professionals (Lab, Feigenbaum, & De Silva, 2000; Read & Fraser, 1998a).

It is worthy of note that the more recent studies (Lipschitz et al., 1996; Wurr & Partridge, 1996) found slightly higher rates of abuse being identified by clinicians. The possibility that this represents a change in clinical practice over time receives support from a survey of clients' experiences of initial assessments spanning 2 decades, in which the probability of being asked about abuse was positively related to recency of contact (Lothian, 1998). Nevertheless, while 65% reported abuse to the researcher, only 20% included had been asked about abuse when assessed. An inpatient study found that even when admission forms include a section for abuse history, only 32% of patients were asked the abuse questions (Read & Fraser, 1998b). While 59% of those who were asked on admission disclosed child abuse, only 6% of those who were not asked disclosed child abuse ( $p < .001$ ).

Furthermore, inquiry does not necessarily lead to effective response. Outpatient studies found that in those cases where abuse was identified, the proportion for which the abuse was mentioned in treatment plans ranged from 33% in New Zealand (Agar, 1998) to 44% in the United States (Eilenberg, Fullilove, Goldman, & Mellman, 1996). In 91% of cases in which New Zealand inpatients had disclosed abuse, there was no evidence of the clients having been offered abuse-related information, support, or counseling (Read & Fraser, 1998b).

Research has identified numerous barriers to clinicians' inquiries about, and responses to, disclosures of childhood abuse, including the following: fear of vicarious traumatization (Eilenberg et al., 1996; Sugg & Inui, 1992); discomfort with discussing personal topics (Merrill, Laux, & Thornby, 1990); concern about client embarrassment (Mitchell et al., 1996; Pruitt & Kappius, 1992; Sugg & Inui, 1992); time constraints (Mitchell et al., 1996; Sugg & Inui, 1992); lack of training and confidence (Briere & Zaidi, 1989; Merrill et al., 1990; Mitchell et al., 1996); severity of disturbance and fear of exacerbating disturbance (Pruitt & Kappius, 1992; Read & Fraser, 1998a); clinicians' beliefs regarding the reliability of clients' accounts (Briere & Zaidi, 1989; Read & Fraser, 1998a); concern about "false memory syndrome" (Agar, 1998; Briere, 1997); clinicians' gender (Agar, 1998; Little and Hamby, 1996); clients' gender (Lab et al., 2000; Read & Fraser, 1998a); and clinicians' age (Pruitt & Kappius, 1992). It has also been hypothesized (Read, 1997) that rigid adherence to a biological-genetic etiology paradigm may be inhibiting abuse inquiry by both researchers and clinicians, but this hypothesis had not been empirically tested prior to the current study.

### Identifying and Evaluating the Reasons for Not Taking an Abuse History

#### Method

An anonymous questionnaire was sent to 220 psychologists and psychiatrists who were working with adults in New Zealand. These professions were selected (a) because of the frequency with which they have responsibility for assessments, formulations, and treatment plans, and (b) in order to assess the possibility that differences in training or etiological beliefs are related to clinical practice regarding abuse. The questionnaire (based on consultation and piloting with mental health professionals, consumer groups, and cultural advisers) elicited demographics, employment context information, and information about past training and future training needs. Participants rated the probability of their asking about abuse in relation to a case vignette describing a 27-year-old with suicidal ideation, but no intent or plan, who reports relationship difficulties and recently increased alcohol consumption. Because research suggests that being male and having a more severe diagnosis are associated with reduced probability of being asked about abuse, these two variables were varied to create four versions of the vignette. Other information gathered included clinicians' awareness of clients' abuse histories, when they feel the best time to inquire about abuse is, whether they would inquire if the client is with family members, and their reasons for sometimes not asking about childhood abuse (this question was asked on the basis of the literature about barriers to abuse inquiry reviewed above and the piloting and consultation).

To determine whether etiological beliefs can be a barrier to abuse inquiry, the questionnaire included a shortened version of the Mental Health Locus of Origin (MHLO) Scale measuring beliefs on a continuum from endogenous beliefs (genetic and physiological factors) to interactional beliefs (psychosocial factors; Hill & Bale, 1980). In addition to five of the original MHLO items, a sixth—concerning the etiological role of child abuse—was added. An eight-item short version of the MHLO (from which the six items for the current version were selected), including only those items with relatively high item-to-total scale correlations from the original study, has been validated in previous studies (Read & Harré, 2001; Read & Law, 1999). In the current study, item-to-total-scale correlations (Spearman rank) ranged from .53 to .79, producing a scale alpha of .70.

## Results

**Sample characteristics.** Of the questionnaire recipients, 114 people (52%), 63 psychologists and 51 psychiatrists, responded. Fifty-five percent were female. The average age was 43.0 ( $SD = 10.3$ ). Of the total sample, 91% identified themselves as European, 4% as Asian, 1% as Pacific Islander, and 4% indicated "other." The majority (80%) indicated that they had more than 10 years of clinical experience. With regard to place of employment, 55% reported private practice, 40% reported an outpatient unit, 18% reported an inpatient setting, 16% reported a university training program, 11% reported a community organization, and 4% reported the Justice Department.

**Workplace climate and participants' beliefs.** Only 15% of clinicians stated that their place of employment had a policy addressing abuse inquiry. A further 11% didn't know. However, on a 6-point scale indicating that inquiry is *highly discouraged* (1) to *highly encouraged* (6), the average was 4.94 ( $SD = 0.91$ ). Clinicians believed that they knew whether or not 82% of their adult clients had been emotionally abused during childhood. There were significant differences between the level of awareness for emotional abuse compared with that for physical abuse (77%,  $p < .01$ ) and for sexual abuse (75%,  $p < .001$ ). The finding that psychologists (82%) knew more often than psychiatrists (73%) whether or not their clients had been abused was not statistically significant ( $p = .054$ ).

Only 22% of the total sample scored on the Endogenous (biological-genetic causal beliefs) side of the midpoint (3.5) of the MHLO. Not surprisingly, this was true of more psychiatrists (42%) than psychologists (9%), with a significant difference ( $p < .01$ ) in means between the two professions (3.54 vs. 4.29;  $SDs = 0.79$  and 0.69, respectively). The mean response to "What percentage of disclosures do you think are probably false allegations of childhood abuse?" was 4.9%, with the majority (61%) stating 3% or lower. There was no significant difference between the two professions.

**Timing and circumstances of inquiry.** When asked to identify the "best time to inquire," the majority (62%) selected "Once rapport has been established," with 47% selecting "Usually on admission/initial assessment, unless the client is too distressed." In response to the question "Would you be more, less or equally likely to inquire about abuse if the client is with family members?" 79% responded "less," 19% responded "equally," and only 2% responded "more." When asked, "When you do ask and get a

negative response, might you ask again in the future," 85% responded, "yes" and 15% responded "no."

**Abuse inquiry.** On a 6-point Likert scale (1 = *abuse inquiry highly unlikely* and 6 = *abuse inquiry highly likely*), participants reported a high probability of asking about childhood abuse in response to the case vignette, with a mean of 5.06 ( $SD = 1.17$ ).

Table 1 shows the perceived relevance (1 = *not at all relevant*, 6 = *extremely relevant*) of 15 factors why clinicians sometimes do not inquire about abuse. The items seen as most relevant, by both professions, were the following: "There are too many more immediate needs and concerns to deal with" ( $M = 3.79$ ,  $SD = 1.61$ ) and "Concern that clients will find the issue too disturbing or that it may cause a deterioration of their psychological state" ( $M = 3.49$ ,  $SD = 1.65$ ).

A multivariate analysis of variance (MANOVA) profile analysis found that although some reasons were seen to be significantly more relevant than others,  $F(72, 42) = 28.83$ ,  $p < .01$ , no difference was found between the professions in their mean scores across the 15 items or in their pattern of high and low scores.

**Variables related to probability of inquiry.** Table 1 shows that for psychiatrists, large negative correlations were found between probability of inquiry for the case vignette and endorsement of "Lack of time" ( $p < .001$ ) and "There are too many more immediate needs and concerns to deal with" ( $p < .01$ ) as reasons not to inquire. Significant ( $p < .05$ ) negative correlations were also found with the following: "The possibility that my inquiring about childhood abuse could be suggestive, and therefore possibly induce false memories," "I am not sure how to ask appropriately," and "I feel that my training has not adequately prepared me for discussing personal/sexual issues."

For psychologists, probability of inquiry was negatively correlated with "Inquiring about childhood abuse could be suggestive, and therefore possibly induce false memories" ( $p < .001$ ) and "Childhood abuse is not something I would ask about since it is so rare" ( $p < .001$ ). When the two professions were combined, the false-memories item produced the strongest negative correlation with probability of inquiry ( $p < .01$ ).

Lower probability of inquiry was also correlated overall with the percentage of disclosures thought to be false allegations ( $p < .001$ ). This relationship, however, applied for psychologists but not psychiatrists. For the 15% of psychologists who believed that 7.5% or more of disclosures are false allegations, the average probability of inquiry was 3.78, compared with 5.44 for the remainder of the psychologists ( $p < .01$ ).

Believing that "the client may be experiencing psychotic symptoms and imagine abuse that did not actually occur" (the fifth most relevant reason for not inquiring about abuse) was highly correlated ( $p < .001$ ) with the item about fear of inducing false memories.

To examine group differences, we performed a  $2 \times 3 \times 6 \times 2 \times 4$  MANOVA (clinician gender, experience, confidence in abuse counselors, profession, and etiology beliefs [MHLO]), which revealed no significant main effects and no significant interactive effects. However, post hoc analyses (Tukey's honestly significant difference) showed a difference ( $p < .05$ ) in the probability of inquiry between the two extreme ends of the MHLO Scale. Table 2 shows that clinicians scoring at the Endogenous end of the MHLO Scale (i.e., those endorsing more biologically based ideas of etiology) were less likely to inquire about abuse with the

Table 1

*Mean Perceived Relevance of Reasons for Not Inquiring About Abuse and Correlations With Lower Probability of Abuse Inquiry*

Reason for not inquiring	Total		Psychiatrists		Psychologists	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
There are too many more immediate needs and concerns	3.79	1.61	3.68**	1.60	3.87	1.62
Clients may find the issue too disturbing, or it may cause a deterioration of their psychological state	3.49	1.65	3.49	1.58	3.49	1.71
Client would rather be asked by clinician of same gender	3.31	1.86	3.46	1.81	3.18	1.91
Client would rather be asked by clinician of same culture	3.15	1.82	3.09	1.69	3.20	1.91
Client may be experiencing psychotic symptoms and imagine abuse that did not actually occur	2.78	1.57	2.73	1.43	2.82	1.69
Lack of time	2.37*	1.50	2.67***	1.49	2.13	1.48
My inquiring could be suggestive and therefore possibly induce false memories	1.88**	1.24	1.69*	0.88	2.03***	1.46
I would not want to embarrass the client	1.71	0.92	1.98	1.01	1.48	0.72
Another professional is better placed to ask and will do so (e.g., a current therapist)	1.59	1.12	1.80	1.21	1.41	1.02
I deal predominantly with a client group for whom child abuse is less relevant than for other client groups	1.55	1.10	1.46	1.05	1.63	1.13
Abuse is of little relevance to prognosis and treatment	1.35	1.06	1.54	1.27	1.20	0.84
My training has not adequately prepared me for discussing personal/sexual issues	1.24	0.57	1.31*	0.58	1.18	0.56
I am not sure how to respond appropriately if the client disclosed abuse	1.15	0.45	1.20	0.45	1.11	0.45
I am not sure how to ask appropriately	1.12	0.38	1.18*	0.43	1.02	0.33
Childhood abuse is not something I would ask about since it is so rare	1.09*	0.45	1.08	0.44	1.10***	0.47

Note. The scale anchors for perceived relevance to abuse inquiry were as follows: 1 = *not at all relevant*, and 6 = *extremely relevant reason not to inquire*. The correlation with lower probability of inquiring about abuse was as follows.

\*  $p < .05$ . \*\*  $p < .01$ . \*\*\*  $p < .001$ .

client in the vignette ( $M = 4.62$ ,  $SD = 1.11$ ) than those scoring at the Interactional end of the scale (i.e., those endorsing psychosocial explanations;  $M = 5.65$ ,  $SD = 0.93$ ). Mean MHLO scores were correlated ( $p < .01$ ) with probability of inquiry. Of those scoring to the Endogenous side of the midpoint, only 29% were "highly likely" to inquire, compared with 70% scoring at the Interactional end of the dimension.

Although the beliefs that clients would rather be asked by a clinician of the same gender or culture were relatively strongly endorsed reasons for not inquiring, no difference was found in probability of inquiry for the case vignettes between same-sex and cross-sex scenarios. Clinician gender has previously been found to have no impact on client willingness to disclose abuse (Dill, Chu, Grob, & Eisen, 1991).

Table 2

*Mean Probability of Abuse Inquiry Analyzed by Client's Diagnosis and Gender*

Client variables	Total	Profession		Etiology beliefs <sup>a</sup>	
		Psychiatry	Psychology	Endogenous	Interactional
Total	5.06	4.90	5.20	4.62 <sup>b</sup>	5.65
Gender					
Male	5.17	5.00	5.26	4.29	5.58
Female	4.94	4.83	5.09	4.71	5.78
Diagnosis					
Major depressive disorder	5.22	5.32	5.15	5.11	5.23
Schizophrenia	4.88	4.48 <sup>c</sup>	5.26	4.25 <sup>c</sup>	5.50

Note. The scale anchors for probability of abuse inquiry were as follows: 1 = *Highly unlikely*, and 6 = *highly likely*.

<sup>a</sup> On the Mental Health Locus of Origin Scale, the range 0–3.4 represents endogenous beliefs, and the range 4.6–7.0 represents interactional beliefs.

<sup>b</sup>  $p < .01$ . Endogenous beliefs were related to lower probability of inquiry than interactional beliefs (Tukey's honestly significant difference  $p < .05$ , allowing for clinicians' gender, experience, profession, and confidence in abuse counselors).

<sup>c</sup>  $p < .001$ . There was a three-way interaction between psychiatry, endogenous beliefs, and diagnosis of schizophrenia relating to reduced probability of inquiry.

Table 2 shows the differences in probability of inquiry according to variation of client gender and diagnosis in the case vignette. To determine the significance of whether inquiries about abuse are influenced by client gender or diagnosis, a  $2 \times 2 \times 3 \times 2 \times 4$  MANOVA involved these two client variables as well as clinician experience, clinician profession, and MHLO grouping. No significant difference was found between the probability of inquiry for male and female clients. A significant three-way interaction was found between client diagnosis, profession, and etiology beliefs,  $F(91, 46) = 5.55, p < .001$ . Thus, psychiatrists with strong biological-genetic etiology beliefs are less likely to ask someone diagnosed schizophrenic about abuse than someone with major depressive disorder. This is consistent with a previous finding that more disturbed inpatients (measured by involuntary admission, time in intensive care unit, and a diagnosis of schizophrenia) tend to be less likely than other inpatients to be asked about abuse by psychiatrists (Read & Fraser, 1998a).

*Perceived training needs.* When asked, "Have you ever received any training regarding how to inquire about abuse?" 24% stated that they had not, with no significant difference between professions. Those who had received training were significantly ( $p < .05$ ) more likely to ask about abuse for the case vignette ( $M = 5.26, SD = 0.91$ ) than those who had not ( $M = 4.42, SD = 1.63$ ). When asked, "Do you feel you would benefit from receiving training on inquiring about childhood abuse," 33% agreed and 15% were unsure. There was no significant correlation between previous training and training needs. The most frequently suggested topics for training were the following: what questions to ask, the timing of inquiry, methods of inquiry least likely to distress clients, inquiry techniques for specific client groups (e.g., older clients, clients with dissociative or psychotic symptoms), the effects of child abuse, and issues relating to false allegations.

*Changes over time.* The possibility that frequency of abuse inquiry is increasing over time received little or no support. Although the younger participants were more likely to report having received abuse inquiry training ( $p < .01$ ), there was no significant correlation between age and probability of inquiry. Furthermore, although there was a positive correlation between being less experienced and probability of inquiry ( $p < .05$ ) if analyzed separately, the MANOVA showed that the significance disappears when analyzed in the context of other clinician variables.

### Limitations of the Study

Self-report is an indirect measure of actual clinical practice and allows demand characteristics such as social desirability to be influential. Despite the questionnaire being anonymous, responses may have been biased toward how participants wished to be perceived, either by themselves or the researchers. This might, for instance, be the case for the high response to probability of inquiry with the case vignette, which was in stark contrast to studies indicating a low rate of inquiry in actual practice. Furthermore, the 52% of the potential pool that responded may have had a higher awareness of the importance of abuse inquiry than those who did not respond.

The degree of generalizability of our findings beyond New Zealand, to countries with different health care delivery models, cannot be made with certainty. Nevertheless, the inpatient and outpatient studies cited earlier indicate that the low level of abuse

inquiry in New Zealand is similar to levels found in the United Kingdom and the United States. The "false-memory" debate, moreover, is common to many countries, and it would certainly be valuable to determine whether those clinicians in other countries who believe many disclosures to be false are, like their counterparts in New Zealand, particularly unlikely to take an abuse history.

The number of statistical analyses conducted may have led to Type I (false positive) errors for findings at the  $p < .05$  level, which, therefore, should be interpreted with considerable caution and should not, in the absence of replication, be the basis of clinical or policy decisions.

### Implications for Practice: Who, When, and How to Ask About Abuse

The self-reported probability of inquiry in this sample was high. If this was in part an artifact of social desirability, we should perhaps be reassured that at least clinicians now accept that it is desirable to ask about abuse histories, even if some may not yet be acting on this judgment in their clinical practice (as consistently shown by the numerous international studies reviewed earlier). The findings identifying factors related to reduced probability of inquiry, in combination with previous studies, suggest a number of recommendations for clinical practice.

It is important first, however, to stress the need for a solid knowledge base to enhance the motivation to improve practice in this area. It has been identified that enhancing abuse inquiry requires a combination of cognitive (knowledge and beliefs) and behavioral (skills deficits) components (Briere, 1999). It is desirable, for instance, to know something of the literature, summarized earlier, linking child abuse to a wide range of adult mental health problems. It is equally important to acknowledge the studies, from a number of countries, documenting low levels of abuse inquiry. It may also be necessary to examine one's own attitudes and beliefs. Biological etiological perspectives or the belief that high numbers of disclosures may be false are probably not sound reasons for failing to inquire about abuse. Regardless of one's beliefs about the causal relationship between child abuse and a specific disorder, repeated findings that roughly half of all users of mental health services have been abused suggests a professional obligation to offer appropriate treatment to those abuse survivors who wish to receive it. If, for whatever reason, we wait for spontaneous disclosures, we will fail to identify most of the abuse. If we don't ask, we cannot offer help.

This study found that the number of clinicians citing fear of inducing "false memories" as a reason for not inquiring is low. Nevertheless, those who do, and those who believe that relatively high numbers of disclosures are false, are less likely to inquire. Despite the evidence that clinicians are identifying only between 0% and 30% of abuse histories, and that mental health service users underreport rather than overreport abuse (Dill et al., 1991; Read, 1997; Read & Argyle, 2000), the argument that clinicians may be overdiagnosing abuse, "perhaps as an overcorrection for past omissions," continues to be made (Good, 2000). If one is worried about inducing false memories or inaccurate allegations, all the more reason to learn how to inquire appropriately without improperly influencing the client.

### *Who to Ask*

Psychologists should know whether each of their clients has been abused in order to make accurate formulations, thorough suicide assessments, and appropriate treatment plans. Therefore, unless client records show that an abuse history has been recently taken, it is necessary to ask every client about abuse. Given the prevalence of abuse among mental health service users and the wide range of long-term effects, it seems unwise to try and apply an equation of risk factors to decide whom to ask. It may be more helpful to remember the risk factors for not being asked, such as being male and having a more severe diagnosis such as schizophrenia. Decisions about gender or culture matching should be offered in general rather than only in relation to abuse issues.

Although it would usually be unproductive to ask about abuse while someone is acutely psychotic, the presence of the diagnosis *per se* should not be used as a reason for not asking. The only study investigating the belief that abuse disclosures by people with schizophrenia are not credible found that "The problem of incorrect allegations of sexual assaults was no different for the schizophrenics than for the general population" (Darves-Bornoz, Lemperiere, Degiovanni, & Gaillard, 1995, p. 82). It seems important that clinicians know the literature showing the strong relationship between child abuse and psychoses, including schizophrenia. For instance, Briere et al. (1997, p. 100) found childhood sexual abuse to be significantly related to nonmanic psychotic disorders, such as schizophrenia, and concluded that their findings "should alert clinicians to the potential victimization-related aspects of what otherwise might be considered solely intrapsychic or biochemical phenomena." Assessment of clients who sometimes experience psychotic symptoms should not differ substantively from other assessments and should include abuse inquiry (Read, 2000).

### *When to Ask*

Most clients should be asked about abuse as part of a routine initial assessment. The majority of participants recommended that rapport should be established first before addressing abuse issues, but half also recommended that unless the client is too distressed, inquiry should take place on admission or at initial assessment. There are indeed circumstances, besides acute psychosis, that warrant deferring the taking of an abuse history, such as strong current suicidality. The most frequently cited of 15 reasons for not asking about child abuse was that "There are too many more immediate needs and concerns to deal with."

Other possible circumstances are the following: (a) when clinicians have insufficient time to respond properly to an affirmative response to the inquiry (in which case they should probably not be conducting the assessment at this time) and (b) when family members are present.

The danger, though, is that it can be deferred indefinitely (Finkelhor, 1993; Lothian, 1998; Rose et al., 1991). If the client is not asked about abuse during assessment, the assessing clinician has a responsibility to record this in the notes and to ensure that an abuse history is taken as soon as the inhibiting circumstances have changed. In the meantime, formulations and treatment plans should be considered incomplete. Recent evidence that child abuse is a better predictor of suicidality in adults than a current diagnosis of depression also argues in favor of abuse histories being

taken as soon as possible (Read, Agar, Barker-Collo, Davies, & Moskowitz, 2001) so as to increase the accuracy of suicide assessments.

The second most commonly offered reason for not asking about abuse was fear of disturbing the client or exacerbating the client's condition. Timing, again, seems to be of the essence here. Asked sensitively, and not while the client is in acute distress, the questions need not be disturbing. Clinicians may need reassuring that users of health services do not mind being asked about abuse (Shew & Hurst, 1991) and that the abuse itself and the negative feelings created by not being asked may be more disturbing than being asked (Lothian, 1998).

### *How to Ask*

Given that not knowing how to discuss personal or sexual issues and how to ask about abuse were, for psychiatrists, negatively related to the probability of asking about abuse, and that several participants asked specifically for inquiry skills to be included in training programs, it was deemed helpful to include here some guidelines for how to ask. These guidelines are based on the research literature (Briere, 1997), including the finding that asking questions describing specific types of events produces higher disclosure rates than asking, "Were you abused?" (Dill et al., 1991). They also draw on a New Zealand training program on abuse inquiry and response developed, in conjunction with mental health professionals and consumers and with reference to the current study, by a community agency engaged in violence education (Harrison & Butterfield, 1999) and evaluated by participants as an effective program (Mahala, 2001).

Abuse inquiry should take place, following the establishing of rapport, in the context of a general psychosocial history (i.e., should not be asked "out of the blue"). Abuse issues can be approached through general questions about childhood, such as, "Would you tell me a bit about your childhood?" "What was the best thing about your childhood?" "What was the worst thing that ever happened to you as a child?" and "How was discipline dealt with?" If such questions do not elicit information about abuse, it is necessary to ask specifically. It is not advisable to ask, "Were you abused?" (because many clients clearly meeting usual abuse criteria will not have applied the term to themselves). Use specific behaviorally descriptive questions, such as, "Did a family member or other adult ever treat you in a way that left a bruise or cut or made you bleed?" and "Did anyone older than you ever do something sexual with you or to you as a child?" Ask about emotional abuse and neglect in similar fashion, and complete the abuse history by inquiring about abuse experienced since childhood, including recently.

### *How to Respond*

Recommendations on how to respond to disclosures are included in case some clinicians might be more likely to ask if they feel more confident about how to respond to positive responses to their inquiries. They are based in part on the views of clients surveyed during the design of the previously mentioned training program (Mahala, 2001).

It is not necessary, and may be unhelpful, to try to gather the details of the abuse immediately following a disclosure. It is

important, however, to ascertain if this is a first disclosure and, if not, how previous disclosures were responded to. It is necessary that the client feels that the clinician has understood the importance of the disclosure and that this will, if the client wishes, be returned to later.

Unless clients do not wish it, sources of information, support, and therapy should be communicated. Safety issues, including asking how clients feel about disclosing (and how they think they may feel later in the day or week) should be checked prior to ending the session.

### *Policies and Training*

It is of concern that only 15% of participants stated that their workplace had a policy dealing with abuse issues. A policy can help produce a set of best practice expectancies to which clinicians can refer when uncertain how to proceed. However, the introduction of a policy in the absence of staff training appears to have little or no effect on clinical practice (Read & Fraser, 1998b). If one assumes some variation across countries, professions, and agencies, development of policies and training programs may be most effective if developed through interdisciplinary consultation and if preceded by a survey of local knowledge, beliefs, and barriers along the lines of the current study.

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