The CRAFFT Screening Interview

Begin: "I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential."

Part A

During the PAST 12 MONTHS, did you:	No	Yes
1. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")	☐	☐

For clinic use only: Did the patient answer "yes" to any questions in Part A?

No ☐ → **Ask CAR question only, then stop**

Yes ☐ → **Ask all 6 CRAFFT questions**

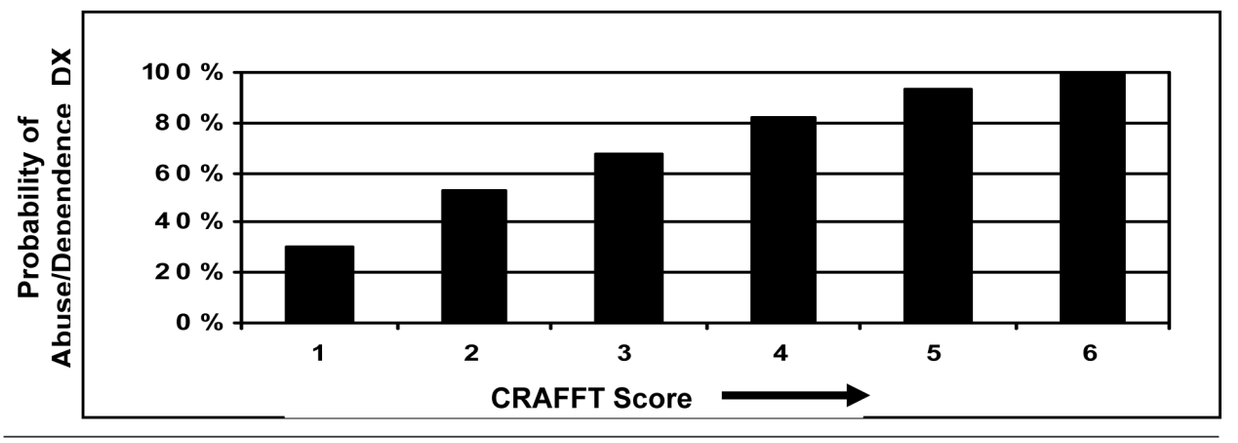
Part B

	No	Yes
1. Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	☐	☐
4. Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
5. Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	☐	☐

SCORING INSTRUCTIONS: FOR CLINIC STAFF USE ONLY

CRAFFT Scoring: Each "yes" response in **Part B** scores 1 point.
A total score of 2 or higher is a positive screen, indicating a need for additional assessment.

Probability of Substance Abuse/Dependence Diagnosis Based on CRAFFT Score[1,2]



Chestnut Health Systems

GAIN
GLOBAL APPRAISAL OF INDIVIDUAL NEEDS
Coordinating Center

GAIN Short Screener (GAIN-SS)

Version [GVER]: GAIN-SS ver. 3.0

What is your name? a._____ b. ____ c. _____
(First name) (M.I.) (Last name)

What is today's date? (MM/DD/YYYY) |__|__| / |__|__| / 20 |__|__|

The following questions are about common psychological, behavioral, and personal problems. These problems are considered **significant** when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

IDScr 1. **When was the last time** that you had **significant** problems with…

a. feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	4	3	2	1	0
b. sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?	4	3	2	1	0
c. feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?	4	3	2	1	0
d. becoming very distressed and upset when something reminded you of the past?	4	3	2	1	0
e. thinking about ending your life or committing suicide?	4	3	2	1	0
f. seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?	4	3	2	1	0

EDScr 2. **When was the last time** that you did the following things **two or more times**?

a. Lied or conned to get things you wanted or to avoid having to do something	4	3	2	1	0
b. Had a hard time paying attention at school, work, or home.	4	3	2	1	0
c. Had a hard time listening to instructions at school, work, or home.	4	3	2	1	0
d. Had a hard time waiting for your turn.	4	3	2	1	0
e. Were a bully or threatened other people	4	3	2	1	0
f. Started physical fights with other people	4	3	2	1	0
g. Tried to win back your gambling losses by going back another day.	4	3	2	1	0

SDScr 3. **When was the last time** that…

a. you used alcohol or other drugs weekly or more often?	4	3	2	1	0
b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g., feeling sick)?	4	3	2	1	0
c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	4	3	2	1	0
d. your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events?	4	3	2	1	0
e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?	4	3	2	1	0

(Continued) After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

CVScr 4. **When was the last time** that you…

a. had a disagreement in which you pushed, grabbed, or shoved someone?	4	3	2	1	0
b. took something from a store without paying for it?	4	3	2	1	0
c. sold, distributed, or helped to make illegal drugs?	4	3	2	1	0
d. drove a vehicle while under the influence of alcohol or illegal drugs?	4	3	2	1	0
e. purposely damaged or destroyed property that did not belong to you?	4	3	2	1	0

5. Do you have other **significant** psychological, behavioral, or personal problems that you want treatment for or help with? (**Please describe**) ..... Yes 1 No 0

v1. _____

_____

6. What is your gender? (If other, please describe below) 1 - Male 2 - Female 99 - Other

v1. _____

7. How old are you today? |__|__| Age

7a. How many minutes did it take you to complete this survey? |__|__|__| Minutes

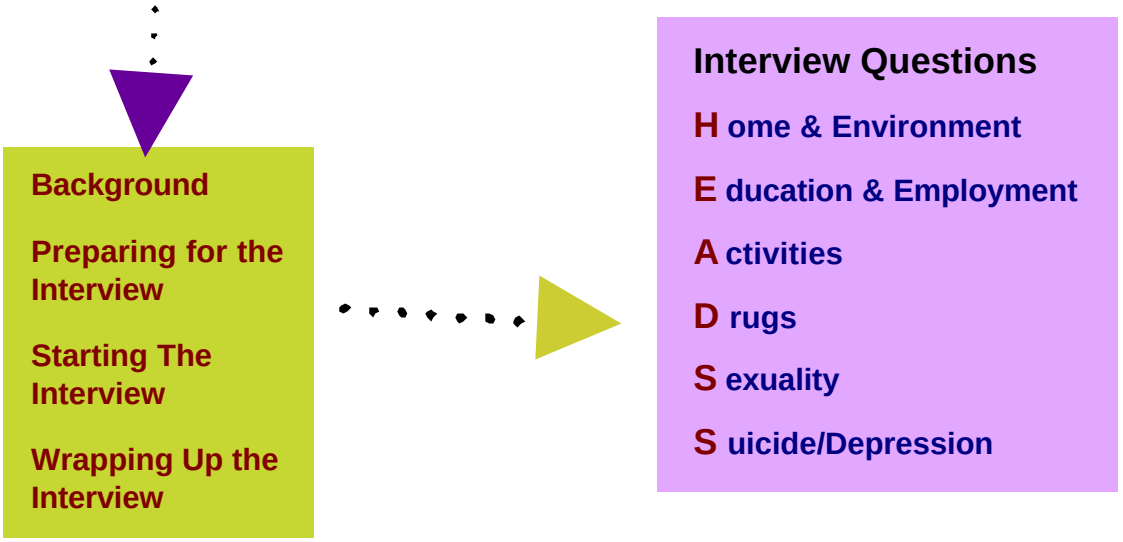
Staff Use Only

8. Site ID: _____ Site name v. _____
9. Staff ID: _____ Staff name v. _____
10. Client ID: _____ Comment v. _____
11. Mode: 1 - Administered by staff 2 - Administered by other 3 - Self-administered
13. Referral: MH ____ SA ____ ANG ____ Other ____ 14. Referral codes: _____
15. Referral comments: v1. _____

Scoring

Screener	Items	Past month (4)	Past 90 days (4, 3)	Past year (4, 3, 2)	Ever (4, 3, 2, 1)
IDScr	1a – 1f				
EDScr	2a – 2g				
SDScr	3a – 3e				
CVScr	4a – 4e				
TDScr	1a – 4e				

H.E.A.D.S.S. - A Pyschosocial Interview For Adolescents

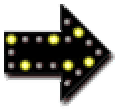


Adapted from Contemporary Pediatrics,, Getting into Adolescent Heads (July 1988), by John M. Goldenring, MD, MPH, & Eric Cohen, MD

Background

The major cause of morbidity and mortality in adolescents is unintentional injuries, including motor vehicle accidents, more than half related to drug or alcohol use. Next in importance are other causes of morbidity including unwanted pregnancy, sexually transmitted disease (STD), eating disorders, and mood disorders. All of these situations are not easily amenable to the intervention of a physiologically-oriented health care provider. In fact, they may not even show up on the standard interview that health care providers are taught to perform.

The health care provider who sees adolescents must be willing to take a developmentally-appropriate psychosocial history. While a fellow at Los Angeles Children's Hospital, Dr. Cohen refined a system for organizing the psychosocial history that was developed in 1972 by Dr. Harvey Berman of Seattle. The system has been used successfully around the world, in the adolescent health care field. This method structures questions so as to facilitate communication and to create a sympathetic, confidential, respectful environment where youth may be able to attain adequate health care. The approach is known as the acronym **HEADSS** (**H**ome, **E**ducation/employment, peer group **A**ctivities, **D**rugs, **S**exuallity, and **S**uicide/depression).



Currently, the HEADSS assessment tool is being used in the Youth Health Consultation Service and the Adolescent Care inpatient Unit (ACU) at C&W, and is being taught as part of the regular undergraduate curriculum to UBC medical and dentistry students.

Preparing for the Interview

The note a health care provider strikes at the outset of the assessment interview may affect the entire outcome. Parents, family members, or other adults should not be present during the HEADSS assessment unless the adolescent specifically gives permission, or asks for it.

Confidentiality

It is not reasonable to expect an adolescent to discuss sensitive and personal information unless confidentiality can be assured. **All adolescents and families, including caregivers (most commonly a parent or both parents), should be told about confidentiality** at the beginning of the interview. Each health care provider must determine the nature of his/her own confidentiality statement.

Belief Systems

As a health care provider, your own set of beliefs, based on your knowledge, experience, and level of tolerance in dealing with particular situations, will set the standard in providing developmentally-appropriate health care to youth and their families. Health care providers interfacing with youth may be confronted with difficult situations where this particular belief system may be "tested", if not challenged. Particular examples relate to health risk-taking behaviors; 80% of adolescents in North America are deemed to be physically and psychologically healthy, and the rate of chronic illness is quoted in the literature as up to 10%.

When a health care provider is confronted with a particularly challenging situation that causes him/her to be in a 'dilemma', *i.e. a youth is seeking options counselling due to unwanted pregnancy*, it is suggested that the health care provider consult with a colleague or refer the youth for developmentally-appropriate care.

Assumptions

Based on particular individual belief systems, these are some "assumptions" that many of us may have about youth:

- youth live in a home with two parents
- all youth go to school and get along with peers and teachers
- all youth are heterosexual

It is of significant importance not to "assume", but rather to ask non-judgemental questions in a respectful, caring fashion.

Starting The Interview

1. **Introduction:** Set the stage by introducing yourself to the youth and parents.

> ***Suggestion:*** If the parents are present before the interview, always introduce yourself to the adolescent first. In fact, ask the adolescent to introduce you to the other people in the room. This gives the adolescent a clear message that you are interested in him/her.

2. **Understanding of Confidentiality:** Ask either the parents or the youth to explain their understanding of confidentiality or confidential health care.

3. **Confidentiality Statement:** After the youth and family have given you their views (from step 2), acknowledge their responses and add your views accordingly (confidentiality statement), based on the particular situation.

Home

Opening Lines: (Less/More) Developmentally-Appropriate

	Less	More	Reason
Home	Tell me about mom and dad.	Where do you live, and who lives there with you?	Parent(s) may have separated, divorced, died, or left the home. Open-ended question enables one to collect "environmental" as well as personal history.

Examples of Questions

- Who lives at home with you? Where do you live? How long? Do you have your own room?
- How many brothers and sisters do you have and what are their ages? Are your brothers and sisters healthy?
- Are there any new people living in your home?
- Are your parents healthy? What do your parents do for a living?
- What are the rules like at home?
- How do you get along with your parents, your siblings? What kinds of things do you and your family argue about the most? What happens in the house when there is a disagreement?
- Is there anything you would like to change about your family?

Asking about parental abuse or substance use (also see *Drugs* section) may be difficult. Using a scenario may facilitate this line of questioning, i.e. "Working with youth I have learned from some "kids" that their relationship with their parents is a difficult one; by this I mean they argue and fight. Some youth have told me that they wish their parents did not drink so much or use drugs. Is this a situation in your household? Has anything like it happened to you? "

Education & Employment

Opening Lines: (Less/More) Developmentally-Appropriate

	Less	More	Reason
Education & Employment	How are you doing in school?	Are you in school? What are you good at in school? What is hard for you? What grades do you get?	Poor questions can be answered "okay". Open-ended question ask for information about strengths and weaknesses and allow for quantification / objectification.

Examples of Questions

- Which school do you go to? What grade are you in? Any recent changes in schools?
- What do you like best and least about school? Favourite subjects? Worst subjects?
- What were your most recent grades? Are these the same or different from the past? Have you ever failed or repeated any years?
- How many hours of homework do you do daily?
- How much school did you miss last/this year? Do you skip classes? Have you ever been suspended?
- What do you want to do when you finish school? Any future plans/goals?
- Do you work know? How much? Have you worked in the past?
- How do you get along with teachers, employers?

- How do you get along with your peers? Inquire about “bullying”.

Activities

Opening Lines: (Less/More) Developmentally-Appropriate

	Less	More	Reason
Activities	Do you have any activities outside of school?	What do you do for fun? What things do you do with friends? What do you do with your free time?	Good questions are open-ended and allow youth to express him/herself.

Examples of Questions

- Are most of your friends from school or somewhere else? Are they the same age as you?
- Do you hang out with mainly people of your same sex or a mixed crowd?
- Do you have one best friend or a few friends? Do you have a lot of friends?
- Do you spend time with your family? What do you do with your family?
- Do you see your friends at school and on weekends, too? Are there a lot of parties?
- Do you do any regular sport or exercise? Hobbies or interests?
- Do you have a religious affiliation, belong to a church, or practice some kind of spiritual belief?
- How much TV do you watch? What are your favourite shows?
- Do you read for fun? What do you read?
- What is your favourite music?
- Do you have a car – use seat belt?
- Have you ever been involved with the police? Have you ever been charged? Do you belong to a group/gang?

Drugs

Opening Lines: (Less/More) Developmentally-Appropriate

	Less	More	Reason
Drugs	Do you do drugs?	Many young people experiment with drugs, alcohol, or cigarettes. Have you or your friends ever tried them? What have your tried?	Good question is an expression of concern with specific follow-up. With younger teens, it is best to begin by asking about friends.

Examples of Questions

- When you go out with your friends or to party, do most of the people that you hang out with drink or smoke? Do you? How much and how often?
- Do any of your family members drink, smoke or use other drugs? If so, how do you feel about this - is it a problem for you?
- Have you or your friends ever tried any other drugs? Specifically, what? Have you ever used a needle?
- Do you regularly use other drugs? How much and how often?
- Do you or your friends drive when you have been drinking?
- Have you ever been in a car accident or in trouble with the law, and were any of these related to drinking or drugs?
- How do you pay for your cigarettes, alcohol or drugs?

Sexuality

Opening Lines: (Less/More) Developmentally-Appropriate

	Less	More	Reason
Sexuality	Have you ever had sex? Tell me about your boyfriend/girlfriend.	Are you involved in a relationship? Have you been involved in a relationship? How was that experience for you? How would you describe your feeling towards guys or girls? How do you see yourself in terms of sexual preference, i.e. gay, straight, or bisexual?	What does the term "have sex" really mean to teenagers? Asking only about heterosexual relationships closes doors at once.

Examples of Questions

- Have you ever been in a relationship? When? How was it? How long did it last?
- Have you had sex? Was it a good experience? Are you comfortable with sexual activity? Number of partners?
- Using contraception? Type and how often (10, 50, or 70% of the time).
- Have you ever been pregnant or had an abortion?
- Have you ever had a discharge or sore that you are concerned about? Have you ever been checked for a sexually transmitted disease? Knowledge about STDs and prevention?
- Have you ever had a pap smear?
- Do you have any concerns about Hepatitis or AIDS?
- Have you had an experience in the past where someone did something to you that you did not feel comfortable with or that made you feel disrespected?
- If someone abused you, who would you talk to about this? How do you think you would react to this?
- *For females:* Ask about Menarche, last menstrual period (LMP), and menstrual cycles. Also inquire about breast self examination (BSE) practices.
- *For males:* Ask about testicular self-examination (TSE) practices.

Suicide / Depression

We suggest that every psychosocial interview seek to identify elements that correlate with anxiety or depression, a common precursor to suicide. Many of the items in the **suicide screen** (see box below) have already been determined in the psychosocial history:

- Severe family problems
- Changes in school performance
- Changes in friendship patterns
- Preoccupation with death
- Acting-out behavior and health risk behaviors, including drug, alcohol and substance abuse

Suicide Risk/Depression Screening

1. Sleep disorders (usually induction problems, also early/frequent waking or greatly increased sleep and complaints of increasing fatigue).
2. Appetite/eating behavior change.
3. Feelings of “boredom”.
4. Emotional outbursts and highly impulsive behavior.
5. History of withdrawal/isolation.
6. Hopeless/helpless feelings; two significant predicators of depression and suicide risk.
7. History of past suicide attempts, depression, psychological counselling.
8. History of No. 7 in family or peers.
9. History of drug/alcohol abuse, acting out/crime, recent change in school performance.
10. History of recurrent serious “accidents”.
11. Psychosomatic symptomatology.
12. Suicidal ideation (including significant current and past losses).
13. Decreased affect on interview, avoidance of eye contact – depression posturing.
14. Preoccupation with death (clothing, music, media, art).
15. History of psychosocial/emotional trauma.
16. Gay, lesbian, bisexual, transgender youth.

Other items seek to include a family history of psychological problems or suicide, or a history of similar behaviour in close friends or relatives. There is also a high correlation between psychological disturbances and a family history of substance abuse. We also suggest asking about two other areas that are often forgotten:

1. **Sleeping Habits**
   Teenagers who are anxious or depressed have difficulty falling asleep. Generally, it takes them more than 30 minutes to fall asleep, and often more than one hour. Though many adolescents have occasional sleep problems, difficulties occurring more that once or twice a month is significant. Adolescents are often willing to discuss a sleep disturbance. Sleep problems tend to make adolescents feel miserable in the morning and are a considerable nuisance to the otherwise healthy and active adolescent.

2. **Eating Habits**
   Frequent fad dieting, crash diets, anorexic or bulimic behaviour, and obesity with significant overeating or bingeing are all indicators of significant psychological distress. Enquiring about a youth’s body image perceptions and whether or not she/he pursues thinness, fears being fat, or has poor dietary and/or abnormal eating habits or compensatory behaviour, may lead to identified disordered eating habits and, ultimately, eating disorders.

Wrapping Up The Interview

Suggestions For Ending Interviews With Teenagers:

- Ask them to sum up their life in one word or to give the overall "weather report" for their life (sunny with a few clouds, very sunny with highs all the time, cloudy with rain likely, etc.).
- Ask them to tell what they see when they look in the mirror each day. Specifically, look for teenagers who tell you that they are "bored". Boredom in adolescents may indicate that the youth is depressed.
- Ask them to tell you whom they can trust and confide in if there are problems in their lives, and why they trust that person. This is especially important if you have not already identified a trusted adult in the family. We always tell the adolescent that he/she now has another adult —the health care provider – who can be trusted to help with problems and to answer questions. Let them know you are interested in them as a whole person and that you are someone who wants to help them lead a fuller, healthier life.
- Give them an opportunity to express any concerns you have not covered, and ask for feedback about the interview. If they later remember anything they have forgotten to tell you, remind them that they are welcome to call at any time or to come back in to talk about it.
- For teenagers who demonstrate significant risk factors, relate your concerns. Ask if they are willing to change their lives or are interested in learning more about ways to deal with their problems. This leads to a discussion of potential follow-up and therapeutic interventions. Many adolescents do not recognize dangerous life-style patterns because they see their activities not as problems but as solutions. Your challenge lies in helping the adolescent to see health risk-taking behaviours as problems and helping to develop better strategies for dealing with them.
- If the adolescent's life is going well, say so. In most cases, you can identify strengths and potential or real weaknesses, and discuss both in order to offer a balanced view.
- Ask if there is any information you can provide on any of the topics you have discussed, especially health promotion in the areas of sexuality and substance use. Try to provide whatever educational materials young people are interested in.

6-ITEM Kutcher Adolescent Depression Scale: KADS-6

NAME: _____ CHART NUMBER: _____

DATE: _____ ASSESSMENT COMPLETED BY: _____

OVER THE LAST WEEK, HOW HAVE YOU BEEN "ON AVERAGE" OR "USUALLY" REGARDING THE FOLLOWING ITEMS:

1. **Low mood, sadness, feeling blah or down, depressed, just can't be bothered.**

☐ 0 - Hardly Ever ☐ 1 - Much of The Time ☐ 2 - Most of The Time ☐ 3 - All of The Time

2. **Feelings of worthlessness, hopelessness, letting people down, not being a good person.**

☐ 0 - Hardly Ever ☐ 1 - Much of The Time ☐ 2 - Most of The Time ☐ 3 - All of The Time

3. **Feeling tired, feeling fatigued, low in energy, hard to get motivated, have to push to get things done, want to rest or lie down a lot.**

☐ 0 - Hardly Ever ☐ 1 - Much of The Time ☐ 2 - Most of The Time ☐ 3 - All of The Time

4. **Feeling that life is not very much fun, not feeling good when usually (before getting sick) would feel good, not getting as much pleasure from fun things as usual (before getting sick).**

☐ 0 - Hardly Ever ☐ 1 - Much of The Time ☐ 2 - Most of The Time ☐ 3 - All of The Time

5. **Feeling worried, nervous, panicky, tense, keyed up, anxious.**

☐ 0 - Hardly Ever ☐ 1 - Much of The Time ☐ 2 - Most of The Time ☐ 3 - All of The Time

6. **Thoughts, plans or actions about suicide or self-harm.**

☐ 0 - Hardly Ever ☐ 1 - Much of The Time ☐ 2 - Most of The Time ☐ 3 - All of The Time

TOTAL SCORE: ☐

6-ITEM Kutcher Adolescent Depression Scale: KADS-6

OVERVIEW

The Kutcher Adolescent Depression Scale (KADS) is a **self-report** scale specifically designed to diagnosis and assess the severity of adolescent depression, and versions include a 16-item, an 11 item and an abbreviated 6-item scale.

SCORING INSTRUCTIONS

TOTAL SCORE	SCORE INTERPRETATION
0 – 5	Probably not depressed
6 and ABOVE	Possible depression; more thorough assessment needed

REFERENCE

LeBlanc JC, Almudevar A, Brooks SJ, Kutcher S: Screening for Adolescent Depression: Comparison of the Kutcher Adolescent Depression Scale with the Beck Depression Inventory, Journal of Child and Adolescent Psychopharmacology, 2002 Summer; 12(2):113-26.

Self-report instruments commonly used to assess depression in adolescents have limited or unknown reliability and validity in this age group. We describe a new self-report scale, the Kutcher Adolescent Depression Scale (KADS), designed specifically to diagnose and assess the severity of adolescent depression. This report compares the diagnostic validity of the full 16-item instrument, brief versions of it, and the Beck Depression Inventory (BDI) against the criteria for major depressive episode (MDE) from the Mini International Neuropsychiatric Interview (MINI). Some 309 of 1,712 grade 7 to grade 12 students who completed the BDI had scores that exceeded 15. All were invited for further assessment, of whom 161 agreed to assessment by the KADS, the BDI again, and a MINI diagnostic interview for MDE. Receiver operating characteristic (ROC) curve analysis was used to determine which KADS items best identified subjects experiencing an MDE. *Further ROC curve analyses established that the overall diagnostic ability of a six-item subscale of the KADS was at least as good as that of the BDI and was better than that of the full-length KADS. Used with a cutoff score of 6, the six-item KADS achieved sensitivity and specificity rates of 92% and 71%, respectively—a combination not achieved by other self-report instruments. The six-item KADS may prove to be an efficient and effective means of ruling out MDE in adolescents.*

Screen for Child Anxiety Related Disorders (SCARED)

PARENT Version—Page 1 of 2 (to be filled out by the PARENT)

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pittsburgh *(October, 1995)*. *E-mail:* birmaherb@upmc.edu

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(10), 1230–6.

Name: _____ Date: _____

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then, for each statement, fill in one circle that corresponds to the response that seems to describe your child *for the last 3 months*. Please respond to all statements as well as you can, even if some do not seem to concern your child.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
1. When my child feels frightened, it is hard for him/her to breathe	O	O	O	**PN**
2. My child gets headaches when he/she am at school.	O	O	O	**SH**
3. My child doesn't like to be with people he/she does't know well.	O	O	O	**SC**
4. My child gets scared if he/she sleeps away from home.	O	O	O	**SP**
5. My child worries about other people liking him/her.	O	O	O	**GD**
6. When my child gets frightened, he/she fells like passing out.	O	O	O	**PN**
7. My child is nervous.	O	O	O	**GD**
8. My child follows me wherever I go.	O	O	O	**SP**
9. People tell me that my child looks nervous.	O	O	O	**PN**
10. My child feels nervous with people he/she doesn't know well.	O	O	O	**SC**
11. My child gets stomachaches at school.	O	O	O	**SH**
12. When my child gets frightened, he/she feels like he/she is going crazy.	O	O	O	**PN**
13. My child worries about sleeping alone.	O	O	O	**SP**
14. My child worries about being as good as other kids.	O	O	O	**GD**
15. When my child gets frightened, he/she feels like things are not real.	O	O	O	**PN**
16. My child has nightmares about something bad happening to his/her parents.	O	O	O	**SP**
17. My child worries about going to school.	O	O	O	**SH**
18. When my child gets frightened, his/her heart beats fast.	O	O	O	**PN**
19. He/she child gets shaky.	O	O	O	**PN**
20. My child has nightmares about something bad happening to him/her.	O	O	O	**SP**

Screen for Child Anxiety Related Disorders (SCARED)

PARENT Version—Page 2 of 2 (to be filled out by the PARENT)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
21. My child worries about things working out for him/her.	O	O	O	**GD**
22. When my child gets frightened, he/she sweats a lot.	O	O	O	**PN**
23. My child is a worrier.	O	O	O	**GD**
24. My child gets really frightened for no reason at all.	O	O	O	**PN**
25. My child is afraid to be alone in the house.	O	O	O	**SP**
26. It is hard for my child to talk with people he/she doesn't know well.	O	O	O	**SC**
27. When my child gets frightened, he/she feels like he/she is choking.	O	O	O	**PN**
28. People tell me that my child worries too much.	O	O	O	**GD**
29. My child doesn't like to be away from his/her family.	O	O	O	**SP**
30. My child is afraid of having anxiety (or panic) attacks.	O	O	O	**PN**
31. My child worries that something bad might happen to his/her parents.	O	O	O	**SP**
32. My child feels shy with people he/she doesn't know well.	O	O	O	**SC**
33. My child worries about what is going to happen in the future.	O	O	O	**GD**
34. When my child gets frightened, he/she feels like throwing up.	O	O	O	**PN**
35. My child worries about how well he/she does things.	O	O	O	**GD**
36. My child is scared to go to school.	O	O	O	**SH**
37. My child worries about things that have already happened.	O	O	O	**GD**
38. When my child gets frightened, he/she feels dizzy.	O	O	O	**PN**
39. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport).	O	O	O	**SC**
40. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well.	O	O	O	**SC**
41. My child is shy.	O	O	O	**SC**

SCORING:

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific. **TOTAL =**

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**. **PN =**

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**. **GD =**

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety SOC**. **SP =**

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**. **SC =**

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**. **SH =**

The SCARED is available at no cost at www.wpic.pitt.edu/research under tools and assessments, or at www.pediatric bipolar.pitt.edu under instruments.

March 27, 2012

Screen for Child Anxiety Related Disorders (SCARED)

CHILD Version—Page 1 of 2 (to be filled out by the CHILD)

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pittsburgh *(October, 1995)*. *E-mail:* birmaherb@upmc.edu

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(10), 1230–6.

Name: _____ Date: _____

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then, for each sentence, fill in one circle that corresponds to the response that seems to describe you *for the last 3 months*.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
1. When I feel frightened, it is hard to breathe	O	O	O	**PN**
2. I get headaches when I am at school.	O	O	O	**SH**
3. I don't like to be with people I don't know well.	O	O	O	**SC**
4. I get scared if I sleep away from home.	O	O	O	**SP**
5. I worry about other people liking me.	O	O	O	**GD**
6. When I get frightened, I feel like passing out.	O	O	O	**PN**
7. I am nervous.	O	O	O	**GD**
8. I follow my mother or father wherever they go.	O	O	O	**SP**
9. People tell me that I look nervous.	O	O	O	**PN**
10. I feel nervous with people I don't know well.	O	O	O	**SC**
11. I get stomachaches at school.	O	O	O	**SH**
12. When I get frightened, I feel like I am going crazy.	O	O	O	**PN**
13. I worry about sleeping alone.	O	O	O	**SP**
14. I worry about being as good as other kids.	O	O	O	**GD**
15. When I get frightened, I feel like things are not real.	O	O	O	**PN**
16. I have nightmares about something bad happening to my parents.	O	O	O	**SP**
17. I worry about going to school.	O	O	O	**SH**
18. When I get frightened, my heart beats fast.	O	O	O	**PN**
19. I get shaky.	O	O	O	**PN**
20. I have nightmares about something bad happening to me.	O	O	O	**SP**

Screen for Child Anxiety Related Disorders (SCARED)

CHILD Version—Page 2 of 2 (to be filled out by the CHILD)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
21. I worry about things working out for me.	O	O	O	**GD**
22. When I get frightened, I sweat a lot.	O	O	O	**PN**
23. I am a worrier.	O	O	O	**GD**
24. I get really frightened for no reason at all.	O	O	O	**PN**
25. I am afraid to be alone in the house.	O	O	O	**SP**
26. It is hard for me to talk with people I don't know well.	O	O	O	**SC**
27. When I get frightened, I feel like I am choking.	O	O	O	**PN**
28. People tell me that I worry too much.	O	O	O	**GD**
29. I don't like to be away from my family.	O	O	O	**SP**
30. I am afraid of having anxiety (or panic) attacks.	O	O	O	**PN**
31. I worry that something bad might happen to my parents.	O	O	O	**SP**
32. I feel shy with people I don't know well.	O	O	O	**SC**
33. I worry about what is going to happen in the future.	O	O	O	**GD**
34. When I get frightened, I feel like throwing up.	O	O	O	**PN**
35. I worry about how well I do things.	O	O	O	**GD**
36. I am scared to go to school.	O	O	O	**SH**
37. I worry about things that have already happened.	O	O	O	**GD**
38. When I get frightened, I feel dizzy.	O	O	O	**PN**
39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport).	O	O	O	**SC**
40. I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well.	O	O	O	**SC**
41. I am shy.	O	O	O	**SC**

SCORING:

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific. **TOTAL =**

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**. **PN =**

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A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**. **SC =**

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**. **SH =**

For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.

The SCARED is available at no cost at www.wpic.pitt.edu/research under tools and assessments, or at www.pediatric bipolar.pitt.edu under instruments.

March 27, 2012

Teen Functional Assessment (TeFA)

The TeFA is a self-report tool. It is meant to be completed by the patient and should take no more than three minutes to complete for most adolescents. The health care provider can use the information obtained on the TeFA to probe for further information – especially in those areas where the young person noted worse or much worse than usual and in those domains that the teen identifies as either self or parental worry.

This form is meant to let your health provider know about how you are doing. All information you give is confidential. Please write your answers to the items on the form.

For each of the following categories, write down one of the following options in the space provided – much better than usual; better than usual; about the same as usual; worse then usual; much worse than usual.

Over the last week how have things been at:

School _____

Home _____

Work _____

Friends _____

Write down the two things in your life that either worry you the most or are causing you the most problems.

1) _____

2) _____

Write down the two things about you that cause your parents or other adults to be concerned about or that you think might concern them if they knew about these things.

1) _____

2) _____

What is trauma?

Trauma is defined as experience that overwhelms an individual's capacity to cope. Whether it is experienced early in life—for example, as a result of child abuse, neglect, witnessing violence and disrupted attachment—or later in life due to violence, accidents, natural disasters, war, sudden unexpected loss and other life events that are out of one's control, trauma can be devastating. Experiences like these can interfere with a person's sense of safety, self and self-efficacy, as well as the ability to regulate emotions and navigate relationships. Traumatized people commonly feel terror, shame, helplessness and powerlessness.

The terms "violence," "trauma," "abuse" and "post-traumatic stress disorder' (PTSD) are often used interchangeably. Trauma expert Stephanie Covington suggests that one way to clarify these terms is to think of trauma as a response to violence or some other overwhelmingly negative experience. Trauma is both an event and a particular response to an event; PTSD is one type of disorder that results from trauma.[1]

There are multiple types of trauma. The definitions used in psychiatric manuals have been built upon the groundbreaking work of Judith Herman,[2] who contributed to our understanding of levels of complexity of trauma and to our understanding of safety and connection as a necessary first stage of healing from trauma. Definitions of trauma useful to support awareness for clients of substance use services[3] and for service providers[4, 5] have been published by the Centre for Addictions and Mental Health.

Why is an understanding of trauma important for the substance abuse workforce?

Trauma is pervasive. It can be life changing, especially for those who have faced multiple traumatic events, repeated experiences of abuse or prolonged exposure to abuse. Even the experience of one traumatic event can have devastating consequences for the individual involved.

It is very common for people accessing substance use treatment and mental health services to report overwhelming experiences of trauma and violence. Often people who have experienced trauma view their use of substances as beneficial in that it helps them to cope with trauma-related stress. Unfortunately, this seemingly adaptive coping mechanism can make people more vulnerable to substance use problems.

Given that the experience of trauma is commonly associated with substance abuse,[6,7,8] to meaningfully facilitate change and healing, substance use treatment providers must help people make the connections between their experience of trauma and their problematic substance use or mental health concerns. How we make our services emotionally and physically safe, as well as how we create opportunities for learning, the building of coping skills and the experience of choice and control, can make a significant difference in client engagement, retention and outcomes.

A multi-side study funded by the Substance Abuse Mental Health Services Administration in the United States found that integrated, trauma-informed models of substance use and mental health treatment for women were more effective than treatment that was not trauma-informed—and did not

cost more.[9] This study tested specific models of integrated approaches such as Seeking Safety,[10] generated principles for trauma-informed practice,[11] effectively included consumer voice[12] and identified approaches to relational systems change.[13]

What are trauma-informed approaches?

Trauma-informed services take into account an understanding of trauma in all aspects of service delivery and place priority on trauma survivors' safety, choice and control.[8] They create a treatment culture of nonviolence, learning and collaboration.[14]

Working in a trauma-informed way does not necessarily require disclosure of trauma. Rather, services are provided in ways that recognize needs for physical and emotional safety, as well as choice and control in decisions affecting one's treatment.

In trauma-informed services, there is attention in policies, practices and staff relational approaches to safety and empowerment for the service user. Safety is created in every interaction and confrontational approaches are avoided.

Trauma-specific services more directly address the need for healing from traumatic life experiences and facilitate trauma recovery through counselling and other clinical interventions. Advocates for trauma-informed approaches in the substance use treatment field do not ask substance use treatment professionals to treat trauma, but rather to approach their work with the understanding of how common trauma is among those served, and how it is manifested in peoples' lives. It could be said that trauma-informed approaches are similar to harm-reduction-oriented approaches in that they focus on safety and engagement. In trauma-informed contexts, building trust and confidence pave the way for people to consider taking further steps toward healing and recovery while not experiencing further traumatization.

Key principles of trauma-informed approaches

Researchers and clinicians have identified key principles of trauma-informed practice, which have parallels with principles underlying evidence-based practices in the mental health and substance use field.

1. **Trauma awareness:** All services taking a trauma-informed approach begin with building awareness among staff and clients of: how common trauma is; how its impact can be central to one's development; the wide range of adaptations people make to cope and survive; and the relationship of trauma with substance use, physical health and mental health concerns. This knowledge is the foundation of an organizational culture of trauma-informed care.[15]
2. **Emphasis on safety and trustworthiness:** Physical and emotional safety for clients is key to trauma-informed practice because trauma survivors often feel unsafe, are likely to have experienced boundary violations and abuse of power, and may be in unsafe relationships. Safety and trustworthiness are established through activities such as: welcoming intake procedures; exploring and adapting the physical space; providing clear information about the programming; ensuring informed consent; creating crisis plans; demonstrating predictable expectations; and scheduling appointments consistently.[16]

   The needs of service providers are also considered within a trauma-informed service approach. Education and support related to vicarious trauma experienced by service providers themselves is a key component.
3. **Opportunity for choice, collaboration and connection:** Trauma-informed services create safe environments that foster a client's sense of efficacy, self-determination, dignity and personal control. Service providers try to communicate openly, equalize power imbalances in relationships, allow the expression of feelings without fear of judgment, provide choices as to treatment

preferences, and work collaboratively. In addition, having the opportunity to establish safe connections— with treatment providers, peers and the wider community—is reparative for those with early/ongoing experiences of trauma. This experience of choice, collaboration and connection is often extended to client involvement in evaluating the treatment services, and forming consumer representation councils that provide advice on service design, consumer rights and grievances.

4. **Strengths-based and skill building:** Clients in trauma-informed services are assisted to identify their strengths and to further develop their resiliency and coping skills. Emphasis is placed on teaching and modelling skills for recognizing triggers, calming, centering and staying present. In her Sanctuary Model of trauma-informed organizational change, Sandra Bloom described this as having an organizational culture characterized by 'emotional intelligence' and 'social learning.' Again, parallel attention to staff competencies and learning these skills and values characterizes trauma-informed services.

Implications for substance abuse services

Services that work with people with trauma, substance use and mental health problems face pressures in keeping treatment environments healthy and safe, and in not becoming reactive and hierarchical. Trauma-informed services involve clients, clinicians, managers and all personnel—from the receptionist to the funder—working in ways that demonstrate understanding of the needs of trauma survivors. Together with individual interactions, service practices and policies, they create a democratic and supportive organizational culture.

A key aspect of trauma-informed practice is understanding how trauma can be experienced differently by refugees, people with developmental disabilities, women, men, children and youth, Aboriginal peoples, and other populations.[17,18,19,20] An increasing amount of material is being published on tailoring substance use treatment approaches to take trauma—and these differing experiences of it—into account. Of particular note is the increasing understanding of the impact of historical and intergenerational trauma for Aboriginal peoples in Canada, and the implications for trauma-informed substance treatment for Aboriginal peoples as part of a broad approach to policy, treatment and community interventions.

Trauma-informed practice can be implemented at multiple levels. The Jean Tweed Centre in Toronto, for example, has braided trauma-informed practice into its treatment programs for women and children.[21] The Centre for Addiction and Mental Health in Toronto, a larger institution, is an example where organization-wide change processes have been undertaken to minimize the use of restraints in their services, and to involve consumers in consultation on services (including implementing a client bill of rights).

Evidence-based practices in the substance use field (such as motivational interviewing) are consistent with trauma-informed practice in their valuing of collaborative, empowering stances.

Trauma-informed services demonstrate awareness of vicarious trauma and staff burnout. Many providers have experienced trauma themselves and may be triggered by client responses and behaviours. Key elements of trauma-informed services include staff education, clinical supervision, and policies and activities that support staff self-care.

Summary

There are established and compelling connections between the experience of trauma and use of substances. Thus, it is important for substance use treatment providers to help people understand

common responses to trauma, and make the connections between their experience of trauma and their substance use in order to meaningfully facilitate growth and healing.

Trauma-informed services take into account an understanding of trauma in all aspects of service delivery and place priority on the trauma survivor's safety and empowerment. They attend to creating a culture of nonviolence, learning and collaboration at the level of individual interactions with clients as well as the overall organizational level, whether or not the client has disclosed current or past violence or trauma. They help people connect to trauma-specific services based on individual preferences and readiness.

Substance use treatment services that are emotionally and physically safe opportunities for learning and building coping skills and for experiencing choice and control all make a significant difference in client engagement, retention and outcomes. Implementing trauma- informed service paradigms or cultures in substance abuse treatment services also supports staff learning, safety, health and satisfaction.

Prepared by Nancy Poole, Director Research and Knowledge Translation, BC Centre of Excellence for Women's Health.

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Selected Resources

Trauma-informed Online Tool
Virtual toolkit. Provides overview of key issues, themes in practice and policy, promising practices, and tensions. Provides links to recommended readings, curricula and training resources, and web resources for working with women and for understanding connections between substance use, mental health and trauma. Also includes strategies for developing trauma-informed practices and services.
Published: March 2011
Source: BC Centre for Excellence on Women's Health
Websites: www.bccewh.bc.ca
Language: English only
Cost: n/c

Helping Children and Youth Who Have Experienced Traumatic Events [PDF]
Provides information on how systems of care and trauma-informed services can improve the lives of children and youth who have experienced traumatic events. Includes findings from a national evaluation of such programs and describes common treatment approaches.
Published: 2011
Source: Substance Abuse and Mental Health Services Administration (United States)
Websites: www.samhsa.gov
Language: English only
Cost: n/c

What do we mean by trauma-informed care?
Webcast video and PowerPoint slides about women-centred trauma-informed support in substance use and mental health services. Topics include defining trauma, key concepts, principles and practices related to trauma- and violence-informed approaches.
Published: 2011
Source: BC Centre for Excellence on Women's Health
Websites: www.bccewh.bc.ca
Language: English only
Cost: n/c

Trauma-informed Organizational Toolkit for Homeless Services
Provides practical ways for becoming trauma-informed. Includes organizational self-assessment and a manual for creating organizational change.
Published: 2009
Source: National Centre on Family Homelessness (United States)
Websites: www.familyhomelessness.org
Language: English only
Cost: n/c

Handbook on sensitive practice for health care practitioners: Lessons from adult survivors of childhood sexual abuse [PDF]
Discusses childhood sexual abuse in the context of health care encounters. Identifies principles of trauma-informed practice and provides guidelines for health care services for trauma survivors. Based on extensive interviews with survivors and practitioners. *Published: 2009*
Source: National Clearinghouse on Family Violence (Public Health Agency of Canada)
Websites: www.phac-aspc.gc.ca
Language: English and French
Cost: n/c

Trauma-informed Approaches in Addictions Treatment [PDF]
A discussion guide to gendering the *National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada*. Identifies Canadian examples of promising practices in action. Lists discussion questions on providing integrated approaches.
Published: 2009
Source: BC Centre for Excellence on Women's Health
Websites: www.bccewh.bc.ca
Language: English only
Cost: n/c

The Trauma Toolkit: A resource for service organizations and providers to deliver services that are trauma-informed [PDF]
Provides recommended practices to assist service providers/organizations to increase their capacity to deliver trauma-informed services. Describes the benefits of trauma-informed services.
Published: 2008
Source: Klinic Community Health Centre (Manitoba)
Websites: www.trauma-informed.ca
Language: English only
Cost: Free to download; 1–9 copies are $15 each, 10+ copies are $10 each plus postage and handling.

Understanding Links Between Adolescent Trauma and Substance Abuse : A Toolkit for Providers [PDF]
Designed for both service providers and consumers. Discusses trauma and substance abuse, traumatic stress in adolescents, understanding substance abuse in adolescents, and engaging adolescents in treatment.
Published: 2007
Source: National Child Traumatic Stress Network (United States)
Websites: www.nctsnet.org
Language: English only
Cost: n/c

Responding To Childhood Trauma: The Promise and Practice Of Trauma Informed Care [PDF]
Describes differential responses to trauma depending on the age of the child; risk and protective factors related to child maltreatment, magnitude of the problem; and subtle psychological effects of trauma on children. Also discusses key components of trauma-informed care, strengths-based approaches and resiliency, and programmatic approaches to trauma-informed care.
Published: 2006
Source: National Association of State Mental Health Program Directors (United States)
Websites: www.nasmhpd.org
Language: English only
Cost: n/c

Beyond trauma: A healing journey for women
Manualized curriculum for women's services. Developed by Stephanie Covington for use in substance treatment centres, criminal justice system, mental health settings and domestic violence shelters. Additional curricula have been developed for girls and men.
Published: 2006
Source: Stephanie Covington, PhD, LCSW
Websites: www.stephaniecovington.com
Language: English only
Cost: The Facilitator's Guide is $89.95 US and the Workbooks are $9.95 US.

Seeking Safety: A Treatment Manual for PTSD and Substance Abuse
Website offers the book Seeking Safety as well as a wide variety of articles about treatment and implementation (primarily photocopies of journal articles). DVDs are also available for a fee.
Published: 2002
Source: Seeking Safety (Lisa Najavits and Associates)
Websites: www.seekingsafety.org
Language: English and French
Cost: Book is $40.43 from amazon.com; some materials are available at no cost.

Bridging responses: A front-line worker's guide to supporting women who have post-traumatic stress [PDF]
Written for frontline workers working with women in a variety of service settings (e.g., police, shelters, health care). Provides information about responses women can have to trauma and how to recognize them. Includes guidelines on asking about trauma issues.
Published: 2001
Source: Centre for Addiction and Mental Health
Websites: www.camh.net
Language: English only
Cost: n/c

ISBN 978-1-77178-171-8

Canadian Centre on Substance Abuse
Centre canadien de lutte contre les toxicomanies

The Canadian Centre on Substance Abuse changes lives by bringing people and knowledge together to reduce the harm of alcohol and other drugs on society. We partner with public, private and non-governmental organizations to improve the health and safety of Canadians.

CCSA activities and products are made possible through a financial contribution from Health Canada. The views of CCSA do not necessarily represent the views of the Government of Canada.

Handbook on Sensitive Practice for Health Care Practitioners:

Lessons from Adult Survivors of Childhood Sexual Abuse

Handbook on Sensitive Practice for Health Care Practitioners: Lessons from Adult Survivors of Childhood Sexual Abuse was researched and written by **Candice L. Schachter, Carol A. Stalker, Eli Teram, Gerri C. Lasiuk and Alanna Danilkewich**

Également en français sous le titre *Manuel de pratique sensible à l'intention des professionnels de la santé – Leçons tirées des personnes qui ont été victimes de violence sexuelle durant l'enfance*

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This publication may be provided in alternate formats upon request.

For further information on family violence issues please contact:

National Clearinghouse on Family Violence
Family Violence Prevention Unit
Public Health Agency of Canada
200 Eglantine Driveway
Jeanne Mance Building, 1909D, Tunney's Pasture
Ottawa, Ontario K1A 0K9

Telephone: 1-800-267-1291 or (613) 957-2938
Fax: (613) 941-8930
TTY: 1-800-561-5643 or (613) 952-6396
Web site: www.phac-aspc.gc.ca/nc-cn
E-mail: ncfv-cnivf@phac-aspc.gc.ca

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Handbook on Sensitive Practice for Health Care Practitioners:

Lessons from Adult Survivors of Childhood Sexual Abuse

Researched and Written by...

Candice L. Schachter, DPT, PhD
Adjunct Professor, School of Physical Therapy
University of Saskatchewan, Saskatoon, SK

Carol A. Stalker, PhD, RSW
Professor, Faculty of Social Work
Wilfrid Laurier University, Waterloo, ON

Eli Teram, PhD
Professor, Faculty of Social Work
Wilfrid Laurier University, Waterloo, ON

Gerri C. Lasiuk, RN, PhD
Assistant Professor, Faculty of Nursing
University of Alberta, Edmonton AB

Alanna Danilkewich, MD, FCFP
Associate Professor, College of Medicine
University of Saskatchewan, Saskatoon, SK

Table of Contents

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> Table 6, Traumagenic Dynamics of Childhood Sexual Abuses has been adapted from Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: a conceptualization. *American Journal of Orthopsychiatry*, 55(4), 530-41, with permission of author David Finkelhor.
>
> Appendix D, Diagnostic criteria for Acute Stress Disorder and Post Traumatic Stress Disorder has been reprinted from American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Revision), pp. 471-72 and 67-68. Washington, DC: Author, with permission of the American Psychiatric Association.

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This may be a person who's gone through something very traumatic ...[who needs] some really safe technique ... Because otherwise you're going to have a certain segment of patients that are going to walk away feeling as though they've been abused all over again, quietly abused, just walking away and seeking another health care practitioner, just going through the cycle, again and again and again, and maybe not understanding why, maybe not knowing how to say it, how to voice that, just keep going through that whole cycle over and over again. There's a huge populace out there that just needs that extra gentle care. It's because of that, maybe the whole populace needs to be treated the same way.

– A male survivor of childhood sexual abuse –

1 The Handbook as a Tool for Clinical Practice

1.1 Audience and focus

This handbook presents information that will help health care practitioners practise in a manner that is sensitive to the needs of adult survivors of childhood sexual abuse and other types of interpersonal violence. It is intended for health care practitioners and students of all health disciplines who have no specialized training in mental health, psychiatry, or psychotherapy and have limited experience working with adult survivors of childhood sexual abuse. This second edition includes experiences and ideas of both women and men survivors as well as of practitioners from more than ten health disciplines. The *Handbook* is not meant to encourage health care providers to step outside their scope of practice, nor is it a substitute for the specialized training required to provide intensive psychotherapy or counselling for survivors.

All health care practitioners - whether they know it or not - encounter survivors of interpersonal violence in their practices.

The *Handbook* is based on extensive interviews, group discussions, and a national consultation process involving adult survivors, clinicians, and mental health practitioners. Direct quotes from participants are included to illustrate selected issues and to connect health care providers in a more personal way to survivors' thoughts and feelings. To our knowledge, the *Handbook* is the only work in print that has employed a process of bringing adult survivors and health care practitioners together to develop an empirically grounded account of the issues and problems that adult survivors of childhood sexual abuse encounter in health care settings. The empirical basis of the *Handbook* is found in Appendix A.

The principles and guidelines of Sensitive Practice can be adapted to all health care venues.

1.2 An issue for all heath care practitioners

As many as one third of women and 14% of men are survivors of childhood sexual abuse.[31,62,25] Childhood adversity – including sexual, physical, and emotional abuse – is associated with a greater risk of a wide variety of health problems. This means that all health care practitioners – whether they know it or not – encounter adult survivors of interpersonal violence in their practices. Survivors are health care consumers of every age who seek all types of health services, and our hope is that the principles and guidelines of Sensitive Practice will become "universal/routine procedures" in all health care encounters and that all health care consumers[136] will benefit from them.

ⓘ Section 2.5 – Childhood sexual abuse and health

Examinations and procedures that health care providers might consider innocuous or routine can be distressing for survivors, because they may be reminiscent of the original trauma. Exclusive focus on the body, lack of control, invasion of personal boundaries, exposure, vulnerability, pain, and sense of powerlessness are common experiences in the health care environment and may be extremely difficult for survivors because they can mirror aspects of past abuse. An appreciation of the dynamics and long-term effects of childhood abuse is the first step toward a better understanding of survivors' needs and responses to care. Sensitive Practice builds on core competencies to help health care practitioners be more understanding of and responsive to the

specific needs of adult survivors of violence and abuse.

ⓘ Chapter 2 – Background Information about Childhood Sexual Abuse

Chapter 3 – What Childhood Sexual Abuse Survivors Bring to Health Care Encounters

Although our research focuses primarily on Sensitive Practice in traditional health care settings, health care providers work in widely diverse areas including client homes, rural and remote areas, and school systems. We believe the principles and guidelines of Sensitive Practice can be adapted to all health care venues.

ⓘ Chapter 3 – What Childhood Sexual Abuse Survivors Bring to Health Care Encounters

1.3 Organization

The *Handbook* is divided into nine chapters. Readers are alerted (watch for a blue "i" in a blue circle) when the topic addressed in one section is clarified or expanded upon in another section.

- Chapter 1 offers an introduction to terminology and suggestions for using the Handbook.
- Chapter 2 provides basic information about the nature and scope of childhood sexual abuse and health problems associated with a history of childhood sexual abuse to assist health care practitioners to understand the significance of Sensitive Practice.
- Chapter 3 presents information about how experiences associated with a history of childhood sexual abuse may be manifested in health care settings.
- Chapter 4 describes the principles of Sensitive Practice derived from our research; we consider these principles foundational to ethical health care.
- Chapters 5, 6, 7, and 8 outline the guidelines for Sensitive Practice. These guidelines operationalize the principles of Sensitive Practice and are meant as practical suggestions that health care practitioners can incorporate into their clinical practice.
  - Chapter 5 presents those guidelines related specifically to the context of health care encounters.
  - Chapter 6 details guidelines applicable to all interactions between health practitioners and their clients.
  - Chapter 7 offers health care practitioners guidelines for coping with the problems that can occur in encounters with child sexual abuse survivors.
  - Chapter 8 highlights guidelines focused on disclosure of past abuse, especially as it is related to survivor-clinician interactions.
- Chapter 9 explores the contributions which health care practitioners can make to an adult survivor's healing and recovery, and elaborates on the relationship between Sensitive Practice and patient-centred care.
- Chapters 4, 6, and 8 conclude with questions intended to stimulate reflection about the application of the principles and guidelines to health care practices.
- Nine appendices augmenting the text and a bibliography detailing both works cited and recommended readings and resources finish off the Handbook.

1.4 Suggested uses of this Handbook

Students, practitioners, and administrators are urged to think about the information on violence and abuse and Sensitive Practice provided in this *Handbook*, and to reflect on its potential

for informing their own practice and workplace policies. Specifically, health care providers should consider:

- How the information applies to them;
- How to implement the principles and guidelines into their practices;
- How they might best respond to the various situations described in the Handbook.

We believe the information in the *Handbook* applies to everyone in health care environments. Many of the difficulties that adult survivors experience in these environments arise because practitioners who work in them are unaware of the effects of violence on health and health care or because organizational policies and attitudes have not taken this information into consideration. Before dismissing a suggestion as inapplicable to their practices, clinicians are encouraged to reflect upon the following questions:

> The information in the *Handbook* applies to everyone in health care environments.

- What aspects of this suggestion do not apply?
- If a suggestion is not completely applicable, what element(s) of it could be relevant?

The Handbook can be used to help health care practitioners:

- Learn more about the effects of interpersonal violence on health;
- Work more effectively and compassionately with affected individuals;
- Identify and respond sensitively to individuals who are triggered or dissociate in a health care encounter;
- Feel better prepared to work with patients who disclose past abuse;
- Teach administrative personnel and assistants about childhood abuse and its implications for their work;
- Disseminate ideas from the Handbook to colleagues with the intent of creating an integrated and responsive network of care;
- Influence policies and practices within public agencies to be more sensitive to survivors;
- Coach students and colleagues to critically analyze professional practices;
- Reflect on their philosophies of care and how they are expressed in day-to-day practice, with the intent of becoming more ethical, congruent, and sensitive in their work;
- Develop clear guidelines to address their concerns about best practice with a specific patient or treatment procedure.

1.5 Terminology

The following is a clarification of terms the reader will encounter in this *Handbook*. Many health care providers have various preferences for the words *patient* and *client*, *clinician*, and *practitioner*, and for the terms they use to describe their work (examination, treatment, etc.). However, all readers are encouraged to look beyond the terminology we use in the *Handbook* and to see that the information applies to all health care providers.

> All readers are encouraged to look beyond the terminology to fully consider how the information applies to their own practices.

- *Survivor* or *adult survivor* is used instead of *victim* when referring to adults who have experienced childhood sexual abuse to acknowledge the strength and resourcefulness of individuals who have lived through the experience.[23] Attitudes about the words *survivor* and *victim* vary among those who have experienced childhood abuse, as well as among those who work with these individuals.

- *Victim* is used when referring to the abused child.
- The person seeking care is referred to interchangeably as *survivor*, *patient*, *client*, or *individual*.
- When referring to violence and abuse we use the terms *child sexual abuse*, *childhood sexual abuse*, *child abuse*, *abuse*, *interpersonal violence*, *violence*, and *trauma*. In the *Handbook*, the word *trauma* is used only with this connotation.
- *Recovery* and *healing* are both used to refer to survivors' efforts to address issues related to childhood sexual abuse.
- *Clinician*, *practitioner*, *health care practitioner*, *health care provider*, and *health care professional* are used interchangeably.
- *Survivor participant* refers to survivors who participated in the interviews, working groups, and consultations that were part of this research project.
- *Health care practitioner participants* and *health care provider participants* are the health care practitioners who participated in the working groups.
- *Assessment and examination* reflect initial and ongoing collection and evaluation of subjective and objective information about an individual's health.
- *Protocol*, *procedure*, *treatment*, and *intervention* describe types of care that health care practitioners offer.
- *Appointment*, *encounter*, and *interaction* are used to reflect ways that health care providers see patients/clients in various health care settings.
- *Self care* represents the array of actions that a person can take to promote general health and/or as a component in the management of health problems. They range from eating well and exercising regularly to adhering to clinicians' specific recommendations.
- Participants' words appear in *italics*.

1.6 Limitations

The experience and long-term effects of childhood sexual abuse are affected by a complex interaction of factors including: (a) those related to the individual (e.g., genetics, stage of development at which the abuse occurred, personal coping resources); (b) the abuse itself (e.g., frequency, duration, relationship between perpetrator and victim); (c) the presence and quality of social support at the time of the abuse and into adulthood; and (d) those related to the larger environment, including culture, ethnicity, and other social determinants of health. Adult survivors who participated in our studies were recruited from agencies, groups, and individuals offering counselling and support. Thus, they are individuals who have worked or are working towards recovery with the assistance of external support.

Notwithstanding the diversity and uniqueness of these participants, the *Handbook* cannot claim to address Sensitive Practice for adult survivors with every abuse experience, of every ethnicity and culture, of every sexual orientation, or at every stage of recovery. Similarly, although we have tried to address a wide range of health practitioners working in various settings by incorporating a broad consultation in the research method, we cannot claim to address every aspect of Sensitive Practice for every type of health care practitioner.

While acknowledging these limitations, we believe that this second edition of the *Handbook* presents a framework for working with adult survivors of interpersonal violence in all types of practice that is both accessible and empirically derived. We hope that health care practitioners will adapt and refine the guidelines as they work with survivors whose unique needs and reactions were not represented by the research participants.

2 Background Information about Childhood Sexual Abuse

2.1 Definitions

While the sexual exploitation of children and adolescents is a criminal act, legal definitions of childhood sexual abuse vary across jurisdictions. There is, however, wide agreement that childhood sexual abuse involves: (a) sexual acts with children and youth who lack the maturity and emotional and cognitive development to understand or to consent; and (b) "an 'abusive condition' such as coercion or a large age gap between participants, indicating lack of consensuality."[62p.32] In general, children and younger adolescents are unable to consent to sexual acts with adults because of their lack of maturity and relative lack of power.* An abusive condition implies a difference in power between the perpetrator and the victim. Children can also be abused by other children or adolescents who have more power by virtue of age, physical strength, life experience, intelligence, authority, or social location. The Canadian Incidence Study of Reported Child Abuse and Neglect tracked eight forms of child sexual abuse: penetration (penile, digital or object penetration of vagina or anus), attempted penetration, oral sex, fondling of the genitals, adult exposure of genitals to child, sexual exploitation (e.g., involving child in prostitution or pornography), sex talk (including proposition of a sexual nature and exposing a child to pornographic material), and voyeurism.[168p.38-39]

An abusive condition implies a difference in power between the perpetrator and the victim.

An extreme and controversial type of abuse is ritual abuse, which has been defined as psychological, sexual, and/or physical assault on an unwilling human victim, committed by one or more individuals, as part of a prescribed ritual that achieves a specific goal or satisfies the perceived needs of their deity.[27,140]

2.2 Childhood sexual abuse survivors

The great paradox of childhood sexual abuse is that, while it has become more prominent in the public consciousness, it remains shrouded in secrecy. Media coverage of high-profile disclosures and investigations provide evidence that childhood sexual abuse does exist – in "good" families and "trusted" institutions, at all socioeconomic levels, and among all racial and ethnic groups. Frequently we hear and read stories about survivors who are men and women from all walks of life – students, sports figures, clergy, entertainers, educators, police officers, judges, politicians, and health care practitioners. They are our friends and neighbours, our colleagues, and sometimes even ourselves or members of our own families. Despite this prevalence, most childhood sexual abuse survivors are invisible to us, particularly given that it is estimated that fewer than half disclose their abuse to anyone.[62,105] Some are silent because they fear reprisal from their abusers; others worry they will not be believed or that they will be blamed or even punished.[56,113] Still others say nothing because they harbour the erroneous belief that they are responsible for their abuse.

* According to the Criminal Code of Canada, when sexual activity is exploitive (such as sexual activity involving prostitution, pornography, or a relationship of trust, authority or dependency) the age of consent is 18. For sexual activity which is not exploitive, the age of consent is 16 years. The exceptions are that a 12 or 13 year old can consent to engage in non-exploitive sexual activity with another person who is less than 2 years older; and a 14 or 15 year old can consent to engage in non-exploitative sexual activity with another person who is less than 5 years older. A 14 or 15 year old can also consent to engage in sexual activity with a person to whom they are married. These laws governing the age of consent for non-exploitative sexual activity came into force on May 1, 2008. Transitional provisions allow 14 and 15 years old who were in common-law relationships on May 1, 2008, to continue engaging in non-exploitative sexual activity.

ⓘ Appendix B: The Prevalence of Childhood Sexual Abuse

If you are both a health care practitioner and a survivor of childhood abuse, before reading further please refer to Section 5.9 Practitioners' self-care

The most current and reliable lifetime prevalence estimates are that as many as one third of women and 14% of men are survivors of childhood sexual abuse.[25,31,62]

Childhood sexual abuse survivors are our friends and neighbours, our colleagues, and sometimes even ourselves or members of our own families.

2.3 Perpetrators of childhood sexual abuse

Individuals who are sexually abused as children are, in adulthood, men and women of diverse ages, ethnicity, occupation, education, income level, and marital status.[16,31,48,73,114,139] Most studies of sexual offending have focused on males as perpetrators. Although the majority of perpetrators of childhood sexual abuse are male,[31,48,49,60] recent research suggests that females engage in sexually abusive behaviour with children more often than has been previously recognized.[31,48,60] Common to all perpetrators is that they have more physical strength, social power, and/or authority than their victims.

As many as one third of women and 14% of men are survivors of childhood sexual abuse.

The most recent report of the Canadian Incidence Study of Reported Child Abuse and Neglect – 2003[168p.53] found that, in contrast to physical abuse of children, non-parental relatives constituted the largest group of perpetrators (35%) of child sexual abuse. Other groups of perpetrators include the child's friend/peer (15%), stepfather (13%), biological father (9%), other acquaintances (9%), parent's boyfriend/girlfriend (5%), and biological mother (5%).

2.4 The dynamics of childhood sexual abuse

All sexual encounters with children are intended to meet the needs of the perpetrator, with little consideration for their effect on the child. Some child abusers use physical force or explicit threats of harm to coerce their young victims into compliance, while others develop long-term relationships with their victims and carefully groom them with special attention or gifts. While childhood sexual abuse does not always involve physical injury, it is a violation of body, boundaries, and trust[23] and is typically experienced as traumatic.[81]

While people who report a history of childhood sexual abuse are at increased risk for a wide range of difficulties in adulthood, studies suggest that "in the region of 20% to 40% of those describing CSA [childhood sexual abuse] do not have measurable adult dysfunction that could be plausibly be related to abuse."[60p.89,61] A number of factors affect how a particular individual may respond to childhood sexual abuse. Some of these include the gender of the perpetrator, the number of perpetrators, the nature and closeness of the relationship between victim and perpetrator, the duration and frequency of the abuse, characteristics of the abuse itself (e.g., contact vs. noncontact, penetration, etc.), the use of threats or force, and the age of the victim at the time of the abuse.[18,29,31]

ⓘ Appendix C – Traumagenic Dynamics of Childhood Sexual Abuse

2.5 Childhood sexual abuse and health

While not everyone who reports a history of childhood sexual abuse develops health problems, many live with a variety of chronic physical, behavioural, and psychological problems that bring them into frequent contact with health care practitioners. Because health care practitioners do not routinely inquire about childhood sexual abuse, its long-term effects are under recognized, its related health problems are misdiagnosed,

and it is often not met with a sensitive, integrated treatment response.

Childhood sexual abuse often co-occurs with other types of childhood adversity, including physical abuse, marital discord, separation from or loss of parents, parental psychopathology and/or substance abuse, and other types of abuse/neglect.[31,60,108] Even when these other types of adversity are controlled for, childhood sexual abuse remains a powerful predictor of health problems in adulthood.[30,33,145,183] It is suggested that the underlying mechanism for these difficulties is "that childhood sexual abuse causes disruptions in the child's sense of self, leading to difficulty in relating to others, inability to regulate reactions to stressful events, and other interpersonal and emotional challenges".[108p.753] Kathleen Kendall-Tackett[93p.716] describes behavioural, emotional, social, and cognitive pathways by which childhood abuse affects health, pointing out that "adult survivors can be affected by any or all of these, and the four types influence each other. Indeed, they form a complex matrix of inter-relationships, all of which influence health." In addition, research in the fields of immunology, endocrinology, and psychosomatic medicine has demonstrated clear physiological relationships among stress, illness, and disease (e.g.,[71,95,101,104]).

ⓘ Chapter 3 – What Childhood Sexual Abuse Survivors Bring to Health Care Encounters

Chapter 8 – Guidelines for Sensitive Practice: Disclosure

Because most health care practitioners do not routinely inquire about childhood sexual abuse, its long-term effects are under recognized, its related health problems are misdiagnosed, and it is not met with a sensitive, integrated treatment response.

Table 1 lists the findings of a number of studies that have examined the correlation between histories of childhood sexual abuse and later health and function. Considerably more studies have examined these relationships in women, and when male survivors have been studied, the relationship between past abuse and the mental health of male survivors has been the primary focus. Guy Holmes, Liz Offen, and Glenn Waller[85] argue that two pervasive myths – that males are rarely sexually abused and that childhood sexual abuse has little effect on males – deter boys and men from disclosing their abuse and, in turn, prevent society from legitimizing it as a problem. The increasing societal recognition of the prevalence and seriousness of sexual abuse of boys is likely to lead to further investigation of physical health correlates.

Two pervasive myths - that males are rarely sexually abused and that childhood sexual abuse has little effect on males - deter boys and men from disclosing their abuse and, in turn, prevent society from legitimizing it as a problem.

TABLE 1

Correlates of childhood sexual abuse and measures of health and function: A selected list of findings from research studies

In females, a history of childhood sexual abuse or a range of childhood traumas including sexual abuse is correlated with:
• poorer physical and mental health and a lower health-related quality of life than non-traumatized individuals[59,145,176]
• chronic pelvic pain[129]
• gastrointestinal disorders[53,141]
• intractable low back pain[146]
• chronic headache[58]
• greater functional disability, more physical symptoms, more physician-coded diagnoses, and more health risk behaviours, including driving while intoxicated, unsafe sex, and obesity[176]
• ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease[59]
• high levels of dental fear[177,185]
• greater use of medical services[35,87,102,116,150,178]
• drug and alcohol use, self-mutilation, suicide, and disordered eating[156]
• adult onset of 14 mood, anxiety, and substance use disorders[108]
• higher rates of childhood mental disorders, personality disorders, anxiety disorders, and major affective disorders, but not schizophrenia[154]
• diagnosis of Borderline Personality Disorder[79,82,100]
In males, a history of childhood sexual abuse is correlated with:
• anxiety, low self-esteem, guilt and shame, depression, post-traumatic stress disorder, withdrawal and isolation, flashbacks, dissociative identity disorder, emotional numbing, anger and aggressiveness, hypervigilance, passivity and an anxious need to please others[22,28,32,45,147]
• adult onset of five mood, anxiety, and substance use disorders[108]
• substance abuse, self-injury, suicide, depression, rage, strained relationships, problems with self-concept and identity, and a discomfort with sex[49,54,133,161]
• increased risk of HIV[5]
• anxiety and confusion about sexual identity and sexual orientation[85,133]
• increased risk of “acting out” aggressively[85]
• contact with criminal justice system[85,96]

3 What Childhood Sexual Abuse Survivors Bring to Health Care Encounters

3.1 Gender socialization: Women's experiences

Gender socialization affects both children's responses to sexual abuse and how the experience affects them in adulthood. Throughout the research for this handbook, survivor participants described ways in which gender socialization shaped their interactions with health care practitioners.

Although many would argue that gender socialization has changed considerably in the past century, many female children continue to be encouraged to be non-aggressive, submissive, and "nice." They receive multiple messages that to be female is to be less valued and less powerful than males, and that the appropriate role for females is to please others, especially males. Rebecca Bolen states,

> Females develop a sense of their lack of entitlement and vulnerability to the more powerful members of society. Females internalize this message ... they are socialized to be less powerful than, and to defer to, the more powerful and more entitled males.[26 p.146]

Socialization to be submissive coupled with children's normative tendency to blame themselves for negative experiences involving adults leaves many female survivors believing that they are "bad" people who are responsible for the abuse.

These aspects of normative female socialization may exacerbate girls' tendency to be submissive and to blame themselves for negative experiences involving adults, which can leave many female survivors believing that they are "bad" people who are responsible for the abuse and that their bodies, which they have come to hate, somehow caused the abuse:

> *Most survivors I know hate their body, disown their body ... become disconnected from it.* (Woman survivor)

A female abuse survivor may also be mistrustful of authority figures, which stems from having been betrayed by the trusted adult who abused her. This helps to explain the difficulty that some survivors have trusting health care practitioners and why they experience health care encounters as distressing. It also helps explain why so many female survivors report symptoms of depression and anxiety:

> *I didn't want to state what my needs were because ... [with] the abuse ... you don't get to choose what happens to you. What happens to you happens to you, you just accept it and that's the way I thought for a long time. I still probably think that way but I'm trying to change the way I think because I do have choice now.* (Woman survivor)

Girls learn that it is important for females to be objects of male sexual desire and that appearing young and innocent is sexually appealing. "We dress fashion models up to look child-like and sexually provocative and set this standard for all women," writes Calgary social worker Lois Sapsford.[138p.76] Girls may also learn that, to be valued, they must be sexually "pure"; at the same time, they receive the contradictory message that they should be not only beautiful but also "sexy." Sexual abuse objectifies a girl's body to serve the needs of her abuser and may leave her believing that her sole value is as a sexual object. The message that females should be sexually "pure" along with the stigma attached to sexual abuse contributes to some female survivors' perceptions of themselves as "damaged goods" and to the shame and guilt that many describe. This may be manifested in a survivor's ambivalence about her body and reticence to seek care for health problems:

The other thing is the big shame and the secret ... We may have an ailment that could be addressed ... [early] but let it go and let it go until ... it takes longer to mend or to heal. (Woman survivor)

The historical and current societal factors that encourage people in our society to deny or minimize the significance of child sexual abuse also affect female survivors' perceptions about the wisdom of disclosing their experience. Many women participants talked about their fear of not being believed; some gave examples of being told directly that they must be lying or imagining things. Another aspect of female gender socialization is the message that it is the female who is responsible for setting limits on sexual behaviour, which contributes to women survivors fearing that they will be blamed for what happened, even though the sexual behaviour occurred when they were children and the perpetrator was older and more powerful. One health care practitioner responded to a woman's disclosure of past abuse by asking, "How did you let it happen?" These societal messages strongly discourage women survivors from sharing their experience with health care practitioners, which in turn impedes the clinician's ability to assess all factors that may contribute to health problems.

The stigma attached to sexual abuse contributes to some female survivors' perceptions of them-selves as "damaged goods," as well as their ambivalence about their bodies and reticence to seek care for health problems.

3.2 Gender socialization: Men's experiences

The men in our studies repeatedly reported feeling invisible as survivors of childhood sexual abuse. Among the major factors contributing to the invisibility of male childhood sexual abuse survivors are: (a) the widespread lack of knowledge about the prevalence of childhood sexual abuse of boys; (b) incongruence between society's notions of masculinity and victimhood; and (c) the fact that services for childhood sexual abuse survivors, which grew out of the second wave of feminism, were historically designed for women and not for men.

For a man to acknowledge that he has been sexually abused is an admission of vulnerability in a society that has few models for the expression of masculine vulnerability. Indeed, applying the label *victim of sexual abuse* to a man juxtaposes vulnerability with masculinity, an uneasy pairing that further contributes to the under recognition and underreporting of childhood sexual abuse among boys and men.[3,43,52,86,105]

The socialization of men to be strong and independent[15,85] complicates the situation for male survivors who consider sharing their history of abuse with a health care practitioner.[165] As Michel Dorais puts it in his book *Don't Tell: The Sexual Abuse of Boys*, the "masculine conception of virility is incompatible with the factual experience of having been a victim of sexual abuse, or needing help following such a trauma"[52p.17] (see also O'Leary[117]). Men in our study spoke about their need to appear "tough" and "in control" despite feeling anxious and fearful during encounters with health care practitioners:

For a man to acknowledge that he has been sexually abused is an admission of vulnerability in a society that has few models for the expression of masculine vulnerability.

Men are tough. Men are macho. Men don't need [help]. All we have to do is to "get over it! Get over it – be a man!" You know, men don't cry. (Man survivor)[167p.509]

Some participants also spoke about their difficulty in identifying and expressing their feelings:

Women appear to me more aware of the names of things. Such as "I'm feeling depressed" or "I've been having a real struggle for the past couple of weeks and these are the

circumstances." I don't know what half of that stuff is called. (Man survivor)[167p.510]

There is a pervasive belief that boys and men are rarely victimized and that a central feature of masculinity is the ability to protect oneself (Mendel as cited in Lab, Feigenbaum, & De Silva[96]); failure to do so is seen as evidence of weakness and can be a source of great male shame. Thus, the "dissonance between the male role expectation and the experience of victimisation"[117p.83] may seriously compromise the health care of male survivors, often because their feelings of shame and unworthiness affect their ability to seek care:

One of the reasons why for a long time I didn't go [to a health care practitioner was that] ... quite frankly, I just didn't feel worthy ... Worthy of the care, the attention. I mean doctors are busy. (Man survivor)

Most of the men in our studies expressed the belief that different reactions to male and female childhood sexual abuse survivors shape their help-seeking behaviours and, in turn, influence how health care practitioners treat them. In general, the participants suggested that health care providers are sceptical about men who disclose sexual abuse and tend to take their experiences less seriously than those of their female counterparts. In addition, some regard sexual abuse by a woman as something that the "fortunate" male survivor should have enjoyed. Ramona Alaggia[3] and Guy Holmes and colleagues[85] reiterate that such perceptions are common. The media also contribute to these views by framing the sexual abuse of boys by adult women as a "sexual relationship" (e.g.,[36,149]). The fact that boys are more often sexually abused by a female than girls[31] may fuel the myth that sex between boys and women is normative rather than abusive and perpetuates the "male gender role of seeking early sexual experiences with women."[15p.225]

Notwithstanding the general progress made in addressing homophobia in our society, some of the men in our study talked about their fear that health care practitioners would think they were homosexual if they revealed their history of childhood sexual abuse. Others talked about how their abuse experiences had led them to develop strong negative feelings about individuals (including health care practitioners) whom they perceived to be homosexual:

The participants suggested that health care practitioners are sceptical about men who disclose sexual abuse and tend to take their experiences less seriously than those of their female counterparts.

I had to go into the hospital where I had a problem with some medication I had [taken] and there was a male nurse there and he was obviously very effeminate, and he had to give me an IV, I refused him because I didn't want him touching me. (Man survivor)[167p.506]

Such reactions can be seen as internalized homophobia. These fears may also reflect the pervasiveness of the myth in our society that childhood sexual abuse causes boys and girls to become gay or lesbian.[132]

ⓘ Section 3.6 – Questions about sexuality and sexual orientation

3.3 Societal myths about the cycle of violence

The emotional cost of childhood victimization is intensified especially for male survivors by the societal belief that it is only a matter of time before they become abusers themselves, if they have not already done so. The media typically give more attention to the erroneous belief that male survivors will likely become perpetrators[43] than to information that disputes this belief.[117] Despite the lack of conclusive evidence regarding this causal link (e.g.,[68,137]) and the fact that many male perpetrators do not report a history of childhood sexual abuse,[99] the public and even some male survivors themselves continue to fear that they are destined to become perpetrators.[85,117,133] Some female survivors may also fear that they will sexually abuse children or that others will see them as potential offenders.

3.4 Transference and counter-transference

The concepts of transference and counter-transference were originally identified by Freud in the context of psychoanalysis, and refer to common human experiences that are important for everyone working in human service to understand. *Transference* is said to occur when an individual displaces thoughts, feelings, and/or beliefs about past situations onto a present experience. It is widely agreed that we all engage in transference to some extent. While transference can be positive or neutral, it can also be negative and may interfere with healthy and adaptive functioning. For example, an adult who was constantly criticized by an authority figure may grow up expecting all authority figures to be critical and may hear criticism where none is intended. Similarly, survivors of childhood sexual abuse may react negatively towards a health care practitioner whose appearance, gender, or mannerisms are reminiscent of someone who abused them. The dynamics of transference help explain why a survivor may respond to an interaction with a health care practitioner in ways that are unrelated to the encounter or to the specific health care practitioner. Understanding transference may also help health care practitioners to avoid taking patients' negative responses personally.

> The media typically give more attention to the erroneous belief that male survivors will likely become perpetrators than to information that disputes this belief.

Counter-transference involves the same dynamics as transference, but occurs when a health care practitioner responds to a patient with thoughts, feelings, and/or beliefs associated with his or her own past. For example, a patient who reminds a practitioner of an angry and demanding teacher may evoke feelings of anxiety that seem out of proportion to the current situation.

Counter-transference can also refer to the health care practitioner's expectable emotional reaction to a patient's behaviour – in particular, when the patient is transferring experiences from the past. For example, a survivor may engage in transference by behaving in a hostile manner towards a practitioner whom he incorrectly believes does not care about him just as his parents did not seem to care about his wellbeing. A health care practitioner who responds with anger and defensiveness can be said to be allowing counter-transference feelings to be expressed.

While it is understandable that health care providers have negative feelings in response to a patient's negative transference, they must strive to contain these feelings and respond professionally. Inquiring about the reasons for the patient's hostility, for example, is likely to be more productive than responding with anger. Health care providers have an ethical obligation to work continuously at being self-aware and to reflect critically on their practice in order to recognize when they may be responding harmfully to a patient's transference or experiencing counter-transference. Further, health care providers need to remind themselves repeatedly of their obligation to respond to a patient professionally, even when they believe they have been judged harshly, have been provoked, experience negative feelings about the patient or are personally upset. When practitioners have difficulty meeting these ethical requirements, they need to reflect on the situation and the reasons for their responses and take appropriate steps to prevent harming their patients directly or indirectly. If a health care practitioner notices a recurring strong reaction to a particular individual or to certain behaviours, personal characteristics, or events, it may be useful to talk to a supervisor or trusted colleague about it.

3.5 Specific behaviours and feelings arising during health care encounters

Distrust of authority figures. Throughout this project, survivors told us how, as children, they experienced violation at the hands of an authority figure and how the distrust from these

past experiences affects their interactions with health care practitioners. Although this distrust originates in the past and should not be taken as a personal affront, survivors constantly scrutinize health care providers for evidence that they are taking active and ongoing steps to demonstrate their trustworthiness. It is crucial to recognize that some survivors may associate a health care practitioner's attempts to verbally assure them that they are safe with the perpetrator's empty assurance of safety during their abuse.

While it is understandable that health care practi-tioners have negative feelings in response to a patient's negative transference, they must strive to contain these feelings and respond professionally.

ⓘ Section 4.1 – Overarching consideration: Fostering feelings of safety for the survivor

Fear and anxiety. Many survivors spoke at length about their tremendous fear and anxiety during health care encounters. The experiences of waiting, being in close contact with authority figures, and not knowing what is to come all resonated with past abuse. Some survivor participants said that they were even afraid of being abused by the health care practitioner:

> *[In the clinic waiting room, I felt] nervous, apprehensive, not exactly knowing what was going to happen ... as far as clothing was concerned or ... touch, just not knowing.* (Woman survivor)[143p.252]

Discomfort with persons who are the same gender as their abuser(s). For some survivors, the gender of a person in a position of authority is a powerful "trigger" that can leave them feeling vulnerable and unsafe. This strong reaction prevents some survivors from seeking care from practitioners who are the same gender as their abuser:

For some survivors, the gender of a person in a position of authority is a powerful trigger that can leave them feeling vulnerable and unsafe.

> *[A male health care provider and assistant were] in the room with me, and I had my pants off, and this guy's putting [ultrasound] gel on my leg. And I felt really uncomfortable ... even though ... probably nothing could have happened, but I just didn't like the fact that I was in a room by myself with my pants off, with two men. That was really eerie.* (Woman survivor)

> *My abuser was my mother. I don't like to be touched by women, especially strange women.* (Man survivor)

Triggers. Examinations or treatments may "trigger" or precipitate flashbacks, a specific memory or overwhelming emotions such as fear, anxiety, terror, grief, or anger. A flashback is the experience of reliving something that happened in the past and usually involves intense emotion. Some survivors are particularly susceptible to flashbacks and some are overwhelmed by them:

> *And the goop that they put on me for the ultrasound gave me flashbacks, nightmares, insomnia; I just couldn't deal with it.* (Woman survivor)[143p.257]

ⓘ Section 7.6 – Triggers and dissociation

Dissociation. Survivor participants also spoke about dissociating during interactions with health care providers. The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (Text Revised) (DSM-IV-TR)*[11p.519] explains dissociation as "a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment" that may be sudden or gradual, transient or chronic. Some authors (e.g.,[120,155]) liken it to a state of divided consciousness in which aspects of the self that are normally integrated become fragmented. Dissociation is also understood to be a process that exists on a continuum,[120] with one end being "common experiences such as daydreaming and lapses in attention, through déjà vu phenomena ... [and the other end of the continuum involving] a pathological failure to integrate thoughts, feelings, and actions."[111p.806]

DSM-IV-TR states that "dissociative states are a common and accepted expression of cultural activities or religious experience in many societies"[11p.519] and in these cases they do not usually lead to the "significant distress, impairment, or help-seeking behaviour"[11p.519] that is required for them to be diagnosed as a disorder. A common experience of dissociation that most of us can relate to is highway hypnosis, in which an individual driving a car suddenly realizes that he or she cannot remember all or part of the trip.[121]

The International Society for the Study of Trauma and Dissociation[89] takes the position that traumatic experiences play an important role in the development of various pathological dissociative disorders. Many believe that dissociation is an effective strategy for coping (in the immediate situation) with extreme stress such as childhood sexual abuse. However, if it becomes a long-term coping mechanism, it may contribute to a variety of mental health problems and interfere with relationships, self-concept, identity development, and adaptive functioning.[4,77]

Examination or treatment may "trigger" or precipitate flashbacks or overwhelming emotions such as fear, anxiety, terror, grief, or anger.

A number of the survivor participants told us that they do not have consistent control over this mechanism through which they "escape" from a current (usually stressful) situation; some even report that for many years they were unaware of their tendency to dissociate. When they are in a dissociative state, some individuals experience themselves as being outside their bodies, watching the present situation from a distance. Others simply go silent, stare blankly into the distance, or seem unaware of their surroundings. When the dissociative episode is over, individuals may have no memory of what occurred and may have difficulty orienting themselves back to the present:

> *[In a physical therapy session] I would just get that same dread feeling inside, and I would do the same coping that I would have done when I was abused ... just trying to not feel my arms and not really be there*. (Woman survivor)[158p.182]

Physical pain. For some survivors, the experience of acute and/or chronic physical pain may be associated with past abuse. This association can manifest itself in various ways (e.g., some individual have learned to ignore or dissociate from pain, while others are hypersensitive to it):

> *I think sometimes when survivors are in pain, and coming for physical therapy, it hooks us back into…our childhood where we were in pain and ... no one responded. And if you did indicate you were in pain ... the pain was trivialized or you were threatened [so that you did not tell] anyone*. (Woman survivor)[143p.256]

ⓘ Section 2.5 – Childhood sexual abuse and health
Section 7.1 – Pain
Recommended Readings and Resources – Childhood sexual abuse and trauma (especially van der Kolk & McFarlane[172] and van der Kolk[170])

Ambivalence about the body. Many survivors feel hate, shame, and guilt about their bodies. As children, many believed that something about them or their bodies invited or caused the abuse. This belief is reinforced if the survivor enjoyed some aspects of the abuse (e.g., special attention, physiological arousal).[85,133] This shame and guilt may lead some survivors to feel ambivalent about and disconnected from their bodies:

> *And [the amount of attention that I give to my body] ebbs and flows too, depending on where I'm at and how well I'm choosing to take care of my body. Which is a very difficult thing for me physically to do, because when you don't live there, it's just sort of a vehicle to get around*. (Woman survivor)[143p.255]

The conflict between the need to seek health care for a physical problem and the ambivalence or dislike of one's body can affect treatment. For example, an individual may ignore symptoms that might contribute to an accurate diagnosis, explain an individual's response to treatment, or

interfere with the ability to self-monitor effects of an intervention or medication.

Conditioning to be passive. Abuse can teach children to avoid speaking up or questioning authority figures. In adulthood, survivors may then have difficulty expressing their needs to a health care practitioner who is perceived as an authority figure.

> *[The health care practitioner did something and] I really freaked but ... I didn't show her I was freaking, because our history is that you don't let on if things are a problem for you. You just deal with it however you can ... by dissociating or what have you*. (Woman survivor)[143p.254]

Self-harm. Self-harm (e.g., scratching, cutting, or burning the skin) is a way that some survivors attempt to cope with long-term feelings of distress. Health care practitioners may see evidence of self-harm in the form of injuries or scars on the arms, legs, or abdomen. Self-harm may take more subtle forms as well, such as ignoring health teachings or recommendations for treatment or symptom management (e.g., refusing to pace one's activity in response to pain or fatigue, or failing to adhere to a diabetic treatment regime).

Abuse can teach children to avoid speaking up or questioning authority figures. In adulthood, survivors may then have difficulty expressing their needs to a health care practitioner who is perceived as an authority figure.

There are many reasons why survivors harm themselves. It may serve to distract them from emotional pain, focus the pain to one area of the body, or interrupt an episode of dissociation or numbness. Some survivors may harm themselves to regain a sense of control or ownership of their bodies. For others, it may be a punishment or an effort to atone for wrongs they believe they have committed.[47] Dusty Miller[107] argues that self-harm is one example of a range of self-destructive behaviours that can be thought of as an unconscious effort to reenact past trauma.

3.6 Questions about sexuality and sexual orientation

Survivors of child sexual abuse, like many other people in our society, may have questions about their sexuality or sexual orientation. Some male participants who had been abused by men said they had struggled with uncertainty about their own sexual orientation:

> *I just realized in sexual abuse, it seems very, very common that the issue of homosexuality when dealing with a male [survivor] of sexual abuse comes up. It's an issue: "Am I a homosexual?"* (Man survivor)

Some women survivors report similar struggles:

> *Female survivors of female-perpetrated abuse also experience this confusion around their sexual identity and orientation*. (Woman survivor)

For participants who self-identified as gay, public assumptions about the "cause" of their sexual orientation and about their potential to be abusers were also problematic:

> *They assume that because it was your mother [who abused you] that's why you're gay. Because it was a woman doesn't make much sense. Or that then because you're gay, you were abused, you're going to be a pedophile yourself. These attitudes come out from others that I've disclosed to. Lots of layers there; biases would be one of the big problems there with health practitioners. They're going to make assumptions*. (Man survivor)

Relatively few survivor participants raised the issue of sexual orientation in the context of their interactions with health care practitioners. However, a number of health care practitioner participants who commented on drafts of the *Handbook* pointed out that the phenomena of sexual identity and sexual orientation are often overlooked or ignored by health care practitioners. Certainly, it is important to recognize that

women and men who have been sexually abused in childhood may experience challenges around sexuality and intimacy in general. This is true of a proportion of survivors in heterosexual relationships as well as for *some* in same-sex relationships and for *some* survivors who identify as gay, lesbian, bisexual or transgendered.

> The conflict between the need to seek health care for a physical problem and difficulty in caring for one's body often affects treatment.

Because of the general societal perception that being gay, lesbian, bisexual, or transgendered (GLBT) is "abnormal" or "wrong," abuse survivors (and health care practitioners) may sometimes attribute their same-sex attraction to past sexual abuse. Shoshana Pollack, professor of social work at Wilfrid Laurier University, notes that "fostering this assumption in patients misses the important point that childhood sexual abuse involves traumatic sexualization and often leaves survivors confused about how to engage sexually in general, what their sexual preferences are (not only gender, but practices), what it means if they experience same sex attraction, what it means if they don't experience it but as a child their abuser was the same sex etc." (2007, personal communication).

> No research has supported the idea that childhood sexual abuse is associated with the development of GLBT identity.

Participants who were abused as children and who are (or have been) involved in same-sex relationships often have to deal with negative thoughts about themselves based on negative societal stereotypes. For example, some may think, "I'm bad because I was abused," or "I am *really bad* because I was abused and it made me be attracted to the same sex." These thoughts should be recognized as internalized heterosexist and homophobic social attitudes that need to be challenged and worked through. (Shoshana Pollack, 2007, personal communication)

No research studies have supported the claim that childhood sexual abuse is associated with the development of GLBT identity.[132] In an online questionnaire study of lesbian and bisexual women between 18 and 23 years old, fewer than half of those who had experienced childhood sexual abuse thought that the childhood sexual abuse had affected their feelings about their sexuality or how they "came out." Among those who did identify effects on their feelings about their sexuality and coming out process, some said that the abuse had not affected their feelings about their sexual orientation, which they believed was unconnected to the childhood sexual abuse experience.

4 Principles of Sensitive Practice

4.1 Overarching consideration: Fostering feelings of safety for the survivor

> *I now am beginning to understand that my physical wellness is really very connected to my emotional state, and if I'm not comfortable, if I'm feeling unsafe, then I'm not going to progress as quickly as [the health care practitioner] would want me to*. (Woman survivor)

The primary goal of Sensitive Practice is to facilitate feelings of safety for the client. The nine themes below were identified by virtually all participants as important to facilitating their sense of safety during interactions with health care practitioners. These themes are so critical to survivors' feelings of safety that we term them the *principles of Sensitive Practice*. Through the course of our research, we have come to conceptualize safety as a protective umbrella, with the principles of Sensitive Practice being the spokes that hold the umbrella open. When the umbrella is open, *an individual feels safe*, and can participate in the examination or treatment at hand. While most of the principles are components of patient-centred care (see Stewart[163]), they take on even greater significance within the context of childhood sexual abuse and other interpersonal violence.

> The primary goal of Sensitive Practice is to facilitate feelings of safety for the client.

Child sexual abuse is a betrayal of trust and the antithesis of safety. Survivor participants frequently described to us how perpetrators, while abusing them, assured them that they were safe when just the opposite was true. For some adult survivors, the experience of being told that they are safe can trigger fear and anxiety. Thus it is clearly not enough for health care practitioners to simply assure their patients that they are safe. To facilitate survivors' feelings of safety, practitioners need to make every effort to follow the principles of Sensitive Practice. To paraphrase one of the health care practitioner participants, the principles of Sensitive Practice articulate a standard of practice and provide a concrete and specific "how to" guide for doing this.

Since all health care practitioners – knowingly and unknowingly – work with individuals with histories of sexual, physical, and emotional abuse and other forms of violence, these principles represent a basic approach to care that should be extended to all clients. The principles of Sensitive Practice are analogous to the infection control guidelines (commonly termed "routine practice" or "universal procedures") that have become part of everyday practice in all health care settings. Just as clinicians may not know an individual's history of past infection, they may not know an individual's abuse history. By adopting the principles of Sensitive Practice as the standard of care, health care practitioners make it less likely that they will inadvertently harm their patients or clients.

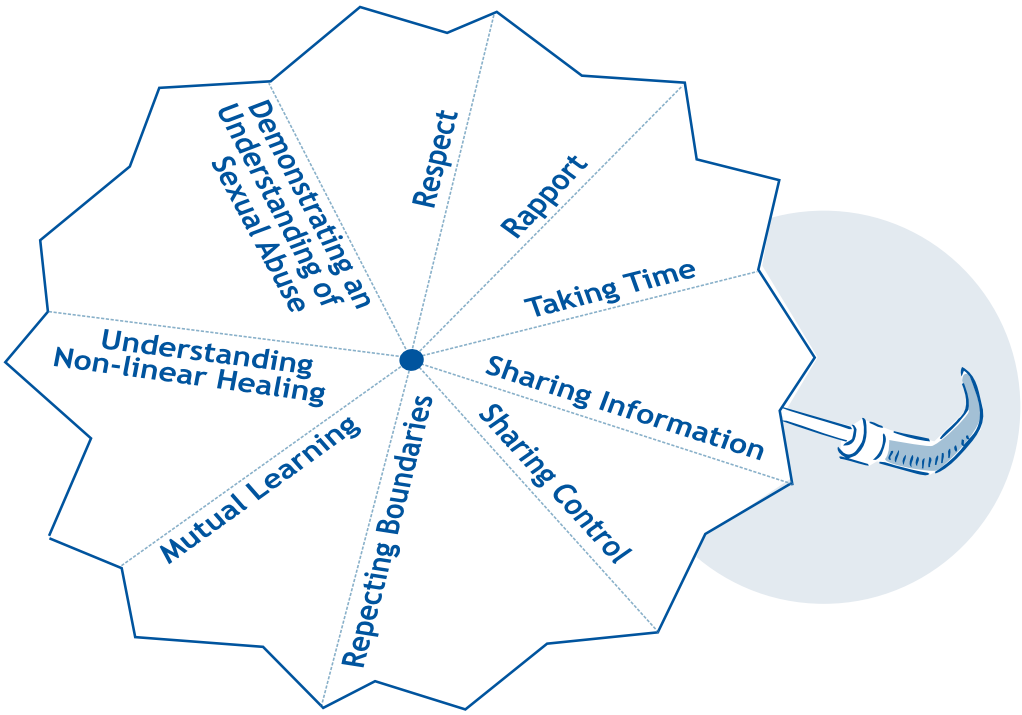
> Since all health care practitioners work with individuals with histories of violence, the principles of Sensitive Practice represent a basic approach to care that should be extended to all clients.

4.2 The nine principles of Sensitive Practice

First Principle: Respect

> *[Feeling respected], to the person who has been abused, it certainly means a great deal*. (Man survivor)

FIGURE 1
The umbrella of safety



The *Oxford English Dictionary*[118] defines respect as to give heed, attention, or consideration to something; to have regard to; to take into account. Conveying respect for another involves seeing the "other" as a particular and situated individual, with unique beliefs, values, needs, and history. It means acknowledging the inherent value of each individual, upholding basic human rights with conviction and compassion, and suspending critical judgement.[46]

> Conveying respect for another involves seeing the "other" as a particular and situated individual, with unique beliefs, values, needs, and history.

Because abuse undermines an individual's personal boundaries and autonomy, survivors often feel diminished as human beings and may be sensitive to any hint of disrespect. Many survivors said that being accepted and heard by a health care practitioner helped them to feel respected:

> *I need to have ... the ability to connect with the practitioner ... so [that] I'm not ... a number ... that I feel like I'm being respected ... [and] that I have information about myself that's valuable for them to have … [I need to know that I will] be allowed to be confused in their office, that's it okay for me to be upset and afraid in front of them. Not that I want to be ... but sometimes that happens when you're dealing with illness. And [I need] not to be put down for it or ... judged for it.* (Woman survivor)

Second Principle: Taking time

Time pressures – a reality in today's health care system – constantly challenge clinicians to balance efficiency with good care. Sadly, this often leaves individuals feeling like one of many objects in a never-ending assembly line, and compounds survivors' feelings of being depersonalized and devalued. For some, being rushed or treated like an object diminishes their sense of safety and undermines any care that follows.

Escalating patient-clinician ratios may lead many practitioners to become exclusively task-oriented, questioning whether they can afford the time to really listen to their patients. It is important to remember that feeling genuinely heard and therefore valued is healing in itself, and in some cases may be the most effective intervention a clinician has to offer:

Feeling genuinely heard and therefore valued is healing in itself, and in some cases may be the most effective intervention a clinician has to offer.

> *It's the health care practitioners that ... stop and give you a moment, and that's one of the biggest healing things right there,* ***that moment****.* (Man survivor)[159]

ⓘ Sixth Principle – Respecting boundaries
Section 6.5: Time
Section 8.4 – Responding effectively to disclosure

Third Principle: Rapport

> *Showing some empathy, some caring, some concern ... make me feel that I'm a person as opposed to another client file going through.* (Man survivor)

Developing a tone that is professional and yet conveys genuine caring promote a sense of safety and helps to establish and maintain appropriate boundaries.

While rapport is essential to every therapeutic relationship, it is an absolute necessity to facilitate safety for survivors. Practitioners who are warm and compassionate facilitate good rapport and subsequent feelings of safety:

> *[For the health care practitioner I saw, this was] just a job like any other job. She could be answering phones. And I was just another name on a [referral] ... She wasn't interested. She had no warmth ... I didn't experience being safe with her because I didn't think that this was somebody I could talk to at all, about anything! She just was* ***not*** *interested.* (Woman survivor)[143p.252]

Good rapport not only increases individuals' sense of safety, but also facilitates clear communication and engenders cooperation. Survivor and clinician participants agreed that rapport is strengthened when clinicians are fully present and patient-centred.

The balance of professionalism and friendliness that contributes to positive rapport is partly a function of interpersonal style, but it can be developed with practice. Clinicians who are distant and cold in their professionalism are unlikely to facilitate a positive connection with clients. Conversely, an overly familiar style may be perceived as invasive and even disrespectful. Developing a tone that is professional and yet conveys genuine caring promotes a sense of safety and helps to establish and maintain appropriate boundaries.

Fourth Principle: Sharing Information

> *[He always gave] a reason why he was doing something, which was great ... It wasn't just doing things and then leaving you in the dark. Or if he was asking questions, you don't have to second guess, "Why did he ask that question?" Because my favourite sport is jumping to conclusions, right? ... If the person took ten seconds to tell me, "This is why I'm going to do it," it will stop the mind from running.* (Man survivor)

While knowing what to expect decreases anxiety for most people, it is particularly important for survivors. Survivor participants emphasized that they do not know what many health care practitioners do and therefore do not know what to expect. Being told what to expect on an ongoing basis helped to allay their fear and anxiety and often prevented them from being triggered by unanticipated events:

> *I think they should spend the five minutes at the beginning saying, "This is what [I] need to do to figure out what will best work for you," so that we're prepared, you know. The element of surprise is just really, really difficult to deal with ... and if there's a preparation and there's not that fear of the unknown, and*

not the likelihood then that I will be triggered by something that is done, you know, into remembering something that is abusive for me. (Woman survivor)[143p.255]

The surprises are the worst thing. (Man survivor)

In many cases, clinicians can begin the information sharing process before seeing the new patient by providing written information about what is involved in a patient appointment. Some clinicians share information by offering a running commentary on what they are doing as they are doing it. This does not require additional time, can be a tool for patient education, and is tremendously reassuring.

ⓘ Appendix E – Sample Introduction to a Facility

As the term *sharing information* implies, it is a mutual process of information exchange in which both parties feel heard and understood. A place to begin is to ask patients what information they want or need and to invite questions:

As the term *sharing information* implies, it is a mutual process of information exchange in which both parties feel heard and understood.

[The clinician] brings definite knowledge and expertise [into treatment] ... So together with what I know and what I can tell her, I would hope that she would be able to ... assess the situation and offer alternatives ... So instead of her being the expert and me being the patient, us being co-communicators about my body. That's what I'd like to see. (Woman survivor)[144p.82]

Health care practitioners must also seek ongoing feedback about the patient's reactions to the exam, treatment, or intervention throughout every encounter and prior to the next encounter. This invitation to articulate one's reactions is particularly important for individuals who may indeed experience adverse reactions – such as flashbacks or nightmares – after an encounter (one man who had experienced oral abuse, for example, spoke about having nightmares for many successive nights after getting braces put on his teeth).

Fifth Principle: Sharing control

A central aspect of sexual victimization is the loss of control over one's body. It is understandable, then, that having a sense of personal control in interactions with health care providers who are more powerful is crucial to establishing and maintaining safety.

I'm learning that if I don't have a sense of control ... I will walk away from [the situation]. (Woman survivor)[143p.255]

Although both parties contribute to the dynamics of the helping relationship, the health care practitioner, by virtue of having greater social power and specialized training, has a greater responsibility in this area. Contracts for care, practitioner services contracts, and therapeutic contracts (either written or verbal) are all tools for articulating goals, clarifying roles and responsibilities, and defining the parameters of the helping relationship. A frank, matter-of-fact discussion of these issues should be part of the treatment plan, as it serves to minimize miscommunication and misunderstanding and contributes to increased trust on the part of patient and health care practitioner alike. To proceed without such discussion assumes that clients and clinicians are all mind readers who, without deliberate effort, can clearly understand others' words, motives, and intents.

Sharing control of what happens in the clinician-patient interaction enables individuals to be active participants in their own care, rather than passive recipients of treatment.

Sharing control of what happens in the clinician-patient interaction enables individuals to be active participants in their own care, rather than passive recipients of treatment. In this way, the clinician works *with*, rather than *on*, the client:

[A health care practitioner should say,] "If you are not comfortable with doing it that way, maybe we can make adjustments and do it

some other way that you feel more comfortable – help us, help us so that we can help you out. Let's communicate here, let's talk about things. I can't read your mind ... I care enough about you to consult with you. To make you part of the healing process rather than a recipient." You know? You need to be part of it. (Man survivor)

The process of ascertaining informed consent is a vital part of sharing control, as well as a legal responsibility. Informing, consulting, and offering choices are all part of seeking consent:

It's the approach for me. That immediate taking over, taking over for me without consulting me or giving me a choice ... For me that's the first thing that raises my anxiety level ... for instance if you lay on a table, [the health care practitioner could say], "Are you okay to lay sideways or are you okay to lay on your back?", instead of telling me, "You lay on your back." ... It goes back to education in a sense: "This is the procedure that we'll be doing and this is what is expected of you." ... So information and then choice. (Woman survivor)[159]

By demonstrating respect for and sensitivity to personal boundaries, clinicians model healthy boundaries and reinforce patients' worth and right to personal autonomy.

ⓘ Section 6.6 – Informed consent

The health care practitioner must directly address all clients – even those who are minors, speaking through an interpreter, or cognitively impaired – and negotiate care with them.

Sixth Principle: Respecting boundaries

As a survivor, I need to know that that person is not going to invade my space. Or do harm to me. Not necessarily physically, but emotionally. (Woman survivor)[164p.95]

Because respect for boundaries is crucial to a sense of safety for most survivors, it is a principle in its own right, separate from the first principle of Sensitive Practice, "respect." The provision of health care often requires clinicians to work in close physical proximity to patients and to seek information of an intimate nature. Survivors said that health care practitioners' questions and actions when initiated either without explanation or without permission left them feeling violated.

Violation of a client's personal boundaries may occur unintentionally. For example, a practitioner, when rushed for time, may neglect to ask for consent before beginning a procedure. Although this action may meet the health care practitioner's need for expedience, it does so at the expense of the client's need for control and autonomy. Similarly, asking a very personal question before establishing rapport can be perceived as a psychological breach:

[My concerns when seeing a health care practitioner] are related to the problems that I experienced as a child, and I'm still affected by them, and when somebody's going to cross my – what I call my personal boundaries, the space that's around me, that I call my own ... and if anyone else is coming into that space, I prefer that they tell me exactly what they're doing there. When it comes to doctors, more so than anybody else, because they have a tendency to approach you ... with their hands out to go to work. I just can't accept that because of the feelings and the stress and the emotions that are created in me are just too hard on me. (Man survivor)

Learning about boundaries and boundary maintenance is a lifelong process. The blatant disregard of personal boundaries during abuse teaches children that their wants and needs are of little consequence. For many survivors, healing from abuse involves establishing or reestablishing personal boundaries and learning healthy and effective boundary maintenance strategies. By demonstrating respect for and sensitivity to personal boundaries, clinicians model healthy boundaries and reinforce patients' worth and right to personal autonomy.

It is also possible that a clinician's boundaries may be violated. For example, the patient who

persistently asks for longer appointments or attempts to contact the health care practitioner outside of work hours may be testing the firmness of the clinician's professional boundaries. Talking calmly with the patient about the need to respect the health care practitioner's need for time limits and personal privacy can provide useful modelling for patients who have difficulties maintaining their own boundaries with others. Boundaries may also be violated by survivors who sexualize their relationship with a health care practitioner, having learned as children to relate to their more powerful abusers in a sexual way. This can be a difficult situation for any health care practitioner, but a calm stance that avoids blame is likely to be most helpful.

As health care practitioners learn about the health effects of interpersonal violence and about working effectively with survivors, their best teachers will be survivors themselves.

ⓘ Second Principle – Taking time

Boundary maintenance is a fiduciary responsibility clearly spelled out in professional codes of ethics, and violations carry serious sanctions. Addressing boundary problems in a direct, matter-of-fact way helps ensure patient safety and helps health care practitioners avoid potentially dangerous or compromising situations. While effective boundary maintenance may seem simple at first glance, it can be just the opposite and so requires the ongoing, lifelong attention of every health care provider. Practitioners who encounter specific difficulties are encouraged to consult with a respected peer or supervisor or seek advice from their professional body.

The degree to which a survivor is able to tolerate or participate in treatment may vary from one health care encounter to the next.

Seventh Principle: Fostering mutual learning

The principles of Sensitive Practice are intended to increase clients' sense of interpersonal safety. Because many of them have not experienced that sense of safety as children, abuse survivors may be learning about it only in adulthood. Thus, they may need encouragement to become full, active participants in their own health care. Many of the survivors in our studies talked about the importance of even small encouragements from health care practitioners and of how they carry these encouragements into other life situations:

> *That assertiveness of [saying] no takes a long time to get ... it was somebody else giving me permission that allowed me to say no until I could learn to give myself permission [to do so].* (Woman survivor)[143p.254]

> *I often need the "permission" later in the examination, when my trust has built, to be able to speak or ask about those things as well.* (Man survivor)

As health care practitioners learn about the health effects of interpersonal violence and about working effectively with survivors, their best teachers will be survivors themselves. Most survivors are interested in helping clinicians who demonstrate genuine compassion and interest to learn about the health effects of interpersonal violence and about their particular needs. In the context of a caring relationship, most survivors are even willing to tolerate missteps and the inevitable discomfort that comes with addressing a difficult topic.

Eighth Principle: Understanding non-linear healing

Survivor participants reminded us repeatedly that healing/recovery from childhood sexual abuse is not a linear process. As a result, the degree to which a survivor is able to tolerate or participate in treatment may vary from one health care encounter to the next. This variability may occur over the short term (day to day) or over longer periods of time. In recognition of this reality, health care practitioners must check in with their clients throughout each encounter and adjust

their behaviour accordingly. The practitioner who responds with under-standing and compassion in these circumstances contributes to the survivor's feeling of safety and to a stronger therapeutic alliance:

> *Parts of my body at different times might be untouchable. It's going to change, depending on what I'm dealing with. So, you're not going to be able to make a list and count on that every time … it's going to be a check-in every session*. (Woman survivor)[143p.255]

Ninth Principle: Demonstrating awareness and knowledge of interpersonal violence

> *[The health care practitioner] had a book and a pamphlet on a table nearby where I was sitting that talked about sexual abuse, and so immediately that said to me, number one, she is open to this and therefore if it comes up I know that I'm in good hands because [otherwise] this stuff would not be sitting here*. (Woman survivor)

Many survivors look for indicators of a clinician's awareness of issues of interpersonal violence. Evidence of this awareness can take a variety of forms. Posters and pamphlets from local organizations that serve those who have experienced violence may help a survivor overcome hesitancy in raising the issue with a health care practitioner. In addition to an indication that their health care practitioners have an understanding of interpersonal violence, male survivors may also be looking for an indication that they are aware that men may be survivors:

> *A poster in all the examining rooms. You know – victims of child abuse are welcome. That's easy. Male victims of child abuse validated here. We care about the victimization of children, help prevent victimization of male children. Those are messages that you can put on posters. Let's protect little boys and girls – see, inclusive. Boys and girls who have been victimized as children are welcome. Boys and girls … [and] have the picture – boy and girl*. (Man survivor)[167 p.512]

Posters and pamphlets from local organizations that serve those who have experienced violence may help a survivor overcome hesitancy in raising the issue with a health care practitioner.

Incorporating the principles of Sensitive Practice into daily practice also indicates a health care practitioner's awareness of issues related to interpersonal violence.

4.3 Using the principles to avoid retraumatization

The nature and quality of the relationship between a clinician and a survivor has implications for the safety and effectiveness of health care. A good helping relationship not only contributes to an open exchange of information, but also creates the "human-to- human" environment that is essential for the establishment of trust. Effective helping relationships are not ethereal, mystical connections that "just happen," nor are they a naturally occurring byproduct of a charismatic personality. Effective helping relationships are intentional and skill-based interactions that exist to serve the needs of the patient. Effective helpers are genuine, empathic, and warm. They are also open-minded, knowledgeable, attentive to verbal and nonverbal communication, self-aware, and reflective.

Consciously applying the principles of Sensitive Practice can not only enhance the therapeutic relationship with the survivor but also assist the practitioner to avoid retraumatizing the patient. Many survivors spoke about how interactions with health care practitioners had left them feeling violated and retraumatized:

> *It's critical that they understand that we can be retraumatized as a result of how we are treated by them … Not that they're meaning to go there, but by not treating us respectfully – giving us what we need to feel safe, and being allowed to be seen as co-partnering and not as having no power at all – [they are making it] possible for us to be retraumatized.*

And I would like them to get the information. (Woman survivor)[159]

Without attention to these principles, survivors' umbrellas of safety can collapse, interfering with their ability to benefit from or perhaps even tolerate health care interventions.

Without attention to these principles, survivors' umbrellas of safety can collapse, interfering with their ability to benefit from or perhaps even tolerate health care interventions. Survivors told us repeatedly that this applies in all health care settings, including offices (physicians, dentists, chiropractors, massage therapists, naturopathic doctors, physical and occupational therapists, etc.), acute care hospitals, community-based care, long-term care, and rehabilitation settings.

4.4 Questions for reflection

- How willing am I to share control with my clients?
- How do I ensure that patients have received what they feel is adequate information about examinations, treatment options, and treatment processes?
- What are my own personal boundaries? How do I know if they are being violated? Could any of my actions be seen as boundary violations by clients?
- How do I balance the demands of my whole practice with the need to take adequate time with each client?
- What might get in the way of communicating my respect for my patients?
- What is my own personal style of interacting with clients? Does it seem to foster rapport? Do I put effort into maintaining rapport with each patient over time?

5 Guidelines for Sensitive Practice: Context of Encounters

5.1 Administrative staff and assistants

The quality of interactions with administrative staff and assistants who work in health care environments can affect survivors' feeling of safety. Participants overwhelmingly agreed that, in an office environment, their interactions with administrative staff and assistants set the tone for the practitioner-patient relationship. For these reasons, staff need to have some understanding of the dynamics and long-term effects of interpersonal violence and require coaching in applying the principles of Sensitive Practice in ways that will work in their specific environments.

In both hospitals and community-based settings, routines and procedures have evolved to be cost-efficient and to maximize the clinician's time. They may, however, be experienced as more clinician-centred and less patient-centred. In many offices, for example, it is common practice for the receptionist to ask about the nature of the problem in order to book the appropriate type and time of visit. Many survivors said they experienced this as an invasion of privacy, especially when they are seeking assistance with psychosocial or mental health problems. The clinician participants in our working groups suggested that a preferable approach would be for receptionists to ask whether the appointment was for a discussion or an exam. Office personnel who usher individuals to examination areas and carry out preliminary procedures could also demonstrate respect for privacy by using this kind of question. Health care practitioner participants also reminded us that assistants and technicians (such as physical therapy assistants or x-ray technicians) who work directly with patient evaluation and treatment should use Sensitive Practice in the same ways that the clinician does.

One survivor emphasized the need for receptionists to learn about Sensitive Practice when she described her attempt to make an appointment with her family physician, who had previously agreed to see her if she was feeling suicidal:

> *What do I have to do, stand up on a chair and say, "Yes, I look fine but at this moment I am thinking of a thousand and one ways to kill myself"? [When the receptionist refuses to give me an appointment] the shame and guilt kick in and I blame myself and I do go home and I OD or I slash my wrists*. (Woman survivor)

5.2 Waiting and waiting areas

Survivor participants spoke at length about the extreme anxiety that they experience while waiting for health care appointments because it takes them back to past abuse experiences. Because of their naiveté, children never anticipate the first episode of abuse; it catches them unaware and defenceless. The sexual acts seem strange and may be painful; the secrecy is confusing; and the coercion or threat of harm is frightening. Children have no prior reference from which to understand why someone, especially someone they love and trust, would do these things to them. After the abuse has happened once, many children are haunted by the fear that it could happen again. They become hypervigilant and watchful, and wait in dread for the abuse to reoccur.

Although waiting for appointments is a fact of life, the experience may be particularly trying for survivors who have never completely shed the apprehension associated with waiting. Therefore, participants urged practitioners to:

- Create waiting areas that are warm and welcoming;
- Provide and clearly identify washrooms;

- Provide printed materials related to interpersonal violence;
- Provide a realistic estimate of the length of wait time.

5.3 Privacy

Privacy is another important environmental aspect of survivors' feelings of safety. The balance between safety and privacy is not the same for all survivors: some will be most comfortable in a private room; others may choose this option as long as they can be accompanied by a support person; and still others feel safer in public spaces. Many survivor participants ask that health care providers approaching a waiting client knock or announce themselves and await permission before entering.

Specifically, clinicians should consider the privacy (or lack thereof) that their practice environment affords, by reflecting upon the following questions:

- What can be heard and seen in the reception area?
- Are patients required to respond to personal questions in a public reception area where others may overhear the exchange of information?
- What can be heard and seen from the hallway?
- What can be heard between examination rooms or cubicles?

If your facility cannot provide an environment in which a particular client feels safe, discuss the option of a referral to another clinician or facility.

Practitioners are further urged to have at least one soundproof examination or interview area available for use. While privacy is even more difficult (and sometimes impossible) to achieve in hospital settings, clinicians are urged to be creative and to consider the possibility of using areas that are not soundproof when others are not present, such as during mealtimes and outside of peak hours.

5.4 Other issues related to physical environment

Having had so little control over what happened to them in childhood, many survivors seek ways to control the current physical environment in order to feel safe. They offer the following comments and suggestions:

- Designate separate washrooms for men and women;
- Take the time to familiarize the client with the physical environment (e.g., waiting area, washrooms, patient care areas, equipment, and emergency exits);
- Whenever possible, offer clients a choice of where they may sit in examination, treatment and waiting rooms (e.g., some survivors prefer to sit near or be able to see the door);
- Because some survivors are strongly affected by lighting and views of floors and ceilings, ask clients about their comfort level with the lighting. This is particularly important if treatment requires the patient to assume a position facing the floor or ceiling;
- For practitioners who use music, candles, or scent during treatment, check with the patient regarding their preference to avoid triggering negative responses.

5.5 Patient preparation

The importance of sharing information about health care procedures prior to beginning any exam, treatment, or hospital admission cannot be overstated. Since advance preparation can help significantly to reduce an individual's anxiety even before the clinician and client meet, practitioners should consider the following possibilities:

- Send printed information to clients before their first appointment or give it to them

while they wait for their first appointment. Also consider displaying it in waiting rooms or treatment areas. These materials should be written in clear, plain language that avoids jargon or medical terminology. As well as providing information about the organization and service, these materials can also cue survivors to think about what they can do to facilitate their own safety (e.g., bringing a support person or a small familiar object that symbolizes safety and security with them to appointments).

ⓘ Appendix E – Sample Introduction to a Facility

- Because not all clients are able to read written material or understand English, alternate strategies can be used to inform them about what they can expect in the health care encounter (e.g., consider using drawings, photographs, or videos that answer frequent questions and explain what will happen from the beginning to the end of the interaction).
- Helping any client prepare for hospitalization or outpatient procedures begins by assessing what they know and identifying any knowledge gaps. Responding to those gaps may involve brainstorming and negotiation as well as information sharing. For example, when working with abuse survivors it is important to discuss: (a) ways that the survivor can get through the experience in the least traumatic way; (b) ways to avoid identifiable triggers; and (c) plans to ensure sufficient ongoing support.

Collaborating with clients to develop a written plan of care ensures that everyone who works with them is aware of their particular needs.

5.6 Encouraging the presence of a support person or "chaperone"

[The presence of the assistant] would make me feel more comfortable if the door had to be closed ... it wouldn't be that one-on-one. (Man survivor)

A third party observer (either a patient-nominated support person or clinician-nominated "chaperone") is commonly used for some examinations and procedures. Survivors explained that having a support person with them often helps to decrease their fears. The support person can also serve as another set of ears to hear any information offered by the clinician:

If you're being given a lot of information and you can't necessarily hold it or get it all straight or if you're anxious ... and there's a lot of new information coming at you, it's nice to have somebody in the room that can help you remember what's being said. (Woman survivor)

The presence of a support person requires balancing competing demands for confidentiality, support, and protection of both patients and practitioners.

The presence of a support person requires balancing competing demands for confidentiality, support, and protection of both patients and practitioners. To facilitate both the patients' abilities to take advantage of the option of having a support person present and the integrity of their practices, health care providers are encouraged to:

- Inform patients verbally as well as via brochures and signs in the waiting areas about the option of having a third party observer with them;
- Remain aware that the presence of a support person may not always be in the client's best interests (e.g., a violent partner who seeks to control the client's interactions with others);
- Speak privately with the client at the beginning of the appointment to ensure that the individual actually wants to have

the support person present, to ascertain the role that the client wants the support person to play, and to discuss issues of confidentiality (keeping in mind that individuals may want to speak privately with the practitioner but may not know how to say so);

- Establish the role of the support person at the beginning of the appointment when all are present, so that the patient, support person, and clinician are in clear agreement;
- Ensure that, when a third party must be in the examining room for medical or legal reasons, patients both understand and consent to this witness, and then offer them the choice between having a personal support or staff person present.

5.7 Working with survivors from diverse cultural groups

Because Canadian society is composed of individuals from many racial, ethnic, and cultural groups, it is imperative that health care be culturally sensitive. Although much has been written about *cultural awareness*, *cultural sensitivity*, and *cultural competence* in health care, ideas about how to address the topic of culture are continuing to evolve. Early work in the area (for example,[37,38,19,20,21]) offered models of *cultural competence* as a framework for delivering responsive health care services to individuals from culturally and ethnically diverse backgrounds. More recently, proponents of the critical cultural perspective (e.g.,[34,74,75]) have encouraged practitioners to broaden their thinking about culture beyond that described in these early models and to recognize culture as a complex, dynamic, and relational process that is shaped by historical, social, economic, and political forces. As University of British Columbia nursing professors Annette Browne and Colleen Varcoe explain,

> *A critical cultural perspective, and understanding culture as relational, shifts the gaze away from cultural Others onto the self, and requires examination of how each individual is enmeshed within historical, social, economic, and political relationships and processes. This then leads to questions such as: How am I reinforcing certain norms (for example, Eurocentric norms perhaps) within the culture of health care? How am I seeing certain behaviours, beliefs, and practices as "normal" and others as "cultural"? How am I serving certain economic and political interests through my daily practices?*[34p.163]

These ideas are also reflected in Irihapeti Ramsden's work on cultural safety.[124,125] Ramsden, a Maori nurse leader in New Zealand, developed the concept of cultural safety to bring attention to the negative impact of colonization on the health of Maori people and the ways in which colonization privileged Eurocentric health/illness beliefs and many current practices perpetuated inequalities. A full discussion of this topic is beyond the scope of this handbook; however, health care practitioners and health care organizations are encouraged to examine current practice with diverse groups on an ongoing basis.

Health care practitioners and health care organizations are encouraged to examine current practice with diverse groups on an ongoing basis.

While interpersonal violence is present in all cultural and ethnic groups, we pay special attention to Aboriginal Peoples in this Handbook because they represent a significant and growing portion of the Canadian population, they continue to experience the long-term effects of widespread abuse in residential schools, and, in our view, are likely to benefit from the universal application of the principles of Sensitive Practice. It is our hope that even a basic understanding of the abuses (many of them systemic) that large numbers of Aboriginal people experience will help health care practitioners be more sensitive and therefore more effective in health care interactions with Aboriginal peoples.

ⓘ Appendix G – Working with Aboriginal Individuals

5.8 Collaborative service delivery

Survivors spoke about instances in which they did not feel comfortable or safe working with health care providers to whom they had been referred. While options may be limited, all patients have the right to referral to another clinician or facility. Clinicians may also find themselves in a position in which they cannot meet survivors' expectations or needs for care. Broaching such discussions may not be easy, but practitioners are encouraged to respond to requests for referral and to be supportive in discussing situations in which they believe they cannot meet patients' needs.

> For permanent transfer of care, the "outgoing practitioner" should ensure that the new colleague is knowledgeable about interpersonal violence and the sensitive care of survivors.

The transfer of care from one practitioner to another without prior notice can evoke feelings of abandonment and erode trust. Whenever possible, individuals should be offered a choice of alternate caregivers. Announcing planned absences well in advance provides clients with the option of making alternative arrangements. In the best possible scenario, clinicians are able to introduce their clients to the practitioner who is taking over. Discussion about what information regarding past abuse the individual consents to be given to the temporary caregiver is essential. For permanent transfer of care, the "outgoing" practitioner should ensure that the new colleague is knowledgeable about interpersonal violence and the sensitive care of survivors.

> Most survivors agreed that they did not expect any one person - including a health care practitioner - to fix all of their problems.

> Survivors urged health care providers to consider making (with permission) informal links with other practitioners with whom they were working to address health problems more fully.

Sadly, some survivors reported that their encounters with the health care system actually detracted from recovery from childhood sexual abuse:

> *As a survivor of abuse, [I feel that today's health care system] is reobjectifying ... to the point where I scarcely exist ... as a whole being because society [has] modeled a dissociative process that took my emotions to a psychiatrist, and my body to a GP, and my teeth to a dentist. They didn't show me any model that would pull me back out of dissociation.* (Man survivor)

Survivors agreed that they did not expect any one person – including a health care practitioner – to fix all of their problems. Some suggested that access to a range of practitioners from different health care disciplines would be an asset to their healing and those who had experience with primary health care teams were very positive about that experience.

Many participants were aware of the connections between mind, body, and spiritual wellbeing and wished that health services were more holistic in their approach:

> *I think that the connection between mental health and physical health can't be separated ... The [practitioner] would be able to help a client deal with their health issues significantly more if they understood what the underlying emotional stuff was as opposed to never, ever asking the question and possibly figuring this out ... I think that the role of the [practitioner] in health should [include] a larger component of emotional health ... I think that I ... could have got to the place of dealing with the emotional place and impacts of sexual abuse an awful lot sooner if there had been some help to sort of draw that out.* (Man survivor)

Survivors urged health care providers to consider making (with permission) informal links with other practitioners with whom they were working to address health problems more fully. For

example, a conversation between a counsellor and a practitioner about a treatment that a survivor experiences as triggering intense negative emotion might lead the counsellor to work with the survivor on grounding techniques and to offer the practitioner additional suggestions to minimize these reactions:

> *I was quite amazed and thrilled that I could go in to see my [psycho]therapist and ... during the week she and the medical doctor and the psychiatrist had talked about my case and, you know, they were all concerned on a certain level about a certain thing.* (Man survivor)

5.9 Practitioners' self-care

Taking care of oneself – eating well, getting enough rest, engaging in regular physical activity, taking time to relax, and so on – can be a challenge for most people. For survivors who learned as children that their needs are not important, self-care may be even more difficult:

> *This is the first time in my life for the past three years that I've given a damn about my physical well-being. I never gave a damn before. That's due to living with very poor self-esteem.* (Man survivor)

The basic tenet of self-care for practitioners is the need to extend to themselves the understanding and compassion that they demonstrate to their patients.

An important aspect of health teaching is the modelling of self-awareness and self-care. Patients who have difficulty in these areas may learn from seeing their health care practitioners modelling self-care and appropriate boundary setting.

ⓘ Section 4.2 – Sixth Principle: Respecting boundaries

The basic tenet of self-care for practitioners is the need to extend to themselves the understanding and compassion that they demonstrate to their patients. Every clinician needs to develop and use a repertoire of strategies that promote and maintain health, particularly during stressful or emotionally intense encounters with patients. It is also crucial to remember that the capacity to work through difficult situations is never constant, even for experienced practitioners.

Practitioners may need to seek the support of a colleague or counsellor to talk about their own reactions to disclosures of childhood sexual abuse or other difficult situations with patients. Obtaining this support can and must be done without breaching confidentiality. Seeking support is not a sign of weakness; rather, it is indicative of taking professional responsibilities seriously. Ignoring one's distress or discomfort increases the risk for Secondary Traumatic Stress Disorder (STSD), also known as Vicarious Traumatization (VT), or Compassion Fatigue (CF).[109] Charles Figley, director of the Traumatology Institute at Florida State University, described the symptoms of STSD as being similar to those of Post-Traumatic Stress Disorder (PTSD) "except that exposure to a traumatizing event experienced by one person becomes as traumatizing even for the second person."[66p.11] Individuals with PTSD or STSD may experience depression, anxiety, lethargy, overinvolvement with abused patients, and undue fear of personal and familial abuse. If these symptoms go unrecognized and untreated, practitioners may react by avoiding abused clients or inadvertently conveying to them that they have done something wrong.

For health care practitioners who are also survivors. It is also important to keep in mind that childhood sexual abuse survivors and health care providers are not categorically discrete groups. A proportion of clinicians are themselves survivors of childhood sexual abuse.[94] Practitioners who have personal histories of childhood sexual abuse may be especially empathic towards other survivors, particularly if they have worked through and resolved their own wounds. However, practitioners who have unresolved abuse issues may face great challenges when working with other survivors.[24,109] They may be at risk for being triggered, developing boundary problems, and counter-transferring harmful responses to patients. It is recommended that individuals work through and come to terms with their own history of childhood sexual abuse to

avoid confusing their own difficulties with those of their patients.

5.10 Community resources for survivors and health care practitioners

Survivors clearly do not expect health care practitioners to be all things to all people. At the same time, practitioners can play a vital role in helping their patients locate and access appropriate services and resources. Organizations such as sexual assault centres, women's centres, community mental health agencies, and residential addiction treatment facilities may provide information for survivors and practitioners. Organizations serving male survivors have emerged in some communities in recognition that many organizations established earlier were serving only women. Many sexual assault centres can offer specialized training or support for clinicians in their work with childhood sexual abuse survivors. Practitioners in the community who have expertise in working with survivors may be available, and they may be willing to consult or mentor other health care providers. Professional associations and regulatory/licensing bodies may be able to suggest other available resources.

Practitioners can play a vital role in helping their patients locate and access appropriate services and resources.

Prominently displaying posters and brochures for programs and agencies that serve abuse survivors offers patients the message that the practitioner is aware of the prevalence and potential long-term problems associated with sexual, physical, and emotional abuse.

Gathering information on the following questions will help practitioners determine whether an organization is appropriate for counselling referrals:

- The agency's mandate and the nature of services offered (e.g., crisis intervention, individual counselling, group therapy, support groups).
- The agency's policy on fees for service (e.g., what the fees are, whether the agency offers a sliding scale, whether it accepts payment from second parties such as employee health plans).
- How soon a prospective client can expect to receive service and whether there is a wait list.

Prominently displaying posters and brochures for programs and agencies that serve survivors of interpersonal violence offers patients the message that the practitioner is aware of the prevalence and potential long-term problems associated with sexual, physical, and emotional abuse. Materials should provide information on:

- Sexual assault centres, women's centres, community mental health agencies, and residential addiction treatment facilities;
- Telephone help lines and suicide hotlines;
- Battered women's shelters;
- Mobile crisis units.

ⓘ Recommended Reading and Resources

6 Guidelines for Sensitive Practice: Encounters with Patients

6.1 Introductions and negotiating roles

In all health care settings, steps must be taken to ensure that the first moments of an encounter set a tone consistent with Sensitive Practice. By introducing oneself, explaining the nature of the appointment, and asking patients how they wish to be addressed, practitioners convey respect for their clients and begin to build a positive relationship with them.

Steps must be taken to ensure that the first moments of an encounter set a tone consistent with Sensitive Practice.

Further, before beginning any intervention, health care providers must ask clients about their expectations for care. Doing so establishes a relationship that involves two-way sharing of information and control. It also creates an opportunity for the clinician to gain quick insight about potential apprehensions, which can help to avoid triggering negative reactions. In long-term health care relationships, the periodic revisiting of roles and responsibilities allows for renegotiation and communicates genuine compassion and concern.

Undressing for someone in a position of authority transports many survivors back to their abuse and leaves them feeling powerless, vulnerable, and filled with shame.

ⓘ Section 4.2 – Fifth Principle: Sharing control

6.2 Clothing

Few issues highlight survivors' difficulties in health care settings as much as the need for removal of clothing. While practitioners often take for granted the need to disrobe and to don an examination gown, undressing for someone in a position of authority transports many survivors back to their abuse and leaves them feeling powerless, vulnerable, and filled with shame:

> *If I had to take off clothing ... for a male [clinician] it's ... hard because there's the trust issue there and for me there was a lot of guilt and shame ... I struggle with body image and sometimes ... I feel powerless then.* (Man survivor)[159]

While the standards of care for certain examinations require removal of clothing, survivor and clinician participants alike urged all health care practitioners to consider the following:

- Discuss clothing requirements with patients and collaborate with them to find an agreeable solution (e.g., allowing clients to wear their undergarments throughout the exam or inviting clients to wear their own abbreviated clothing such as bathing suits or shorts).
- Leave the room while the patient is changing.
- Provide a variety of sizes of gowns for all body sizes and instruct the patient about whether the opening is to be at the front or back.
- Avoid paper gowns whenever possible (they were widely described by survivors as so flimsy that they escalate feelings of vulnerability).
- Do not assume that all men are comfortable baring their chests.
- Meet patients when they are fully clothed (e.g., to make contact, ascertain the reason for their visit, or perform a health history).

- If clients need to disrobe for an examination or procedure, explain what will happen next, what level of undress is required, and why. Before proceeding, ask whether the client agrees to proceed with what has been explained and ensure that the client's questions have been fully answered.
- Expose only the body area necessary for the specific intervention at any one time.
- Cover clients' bodies as soon as exams are completed to minimize the length of time that they are exposed.
- Meet with clients again once the examination or procedure is finished and they have re-dressed to offer health teaching, provide an opportunity for questions, and say goodbye. While this may take a few extra minutes, it brings closure to the interaction and allows the client to leave on equal footing.

6.3 Task-specific inquiry

A *task-specific inquiry* involves asking patients about their preferences for or potential difficulties with a specific examination, procedure, or treatment. It provides an opportunity for patients to offer health providers information that is directly pertinent to the present situation without any reference to past interpersonal violence. Task-specific inquiry should be used during an initial meeting with a patient, before any new examination or procedure, and any time body language suggests that the patient may be uncomfortable or experiencing difficulty. Regardless of other factors, it should also be done intermittently during interactions as an ongoing invitation to offer feedback or to identify problems.

Task-specific inquiries involve a combination of closed- and open-ended questions that offer patients an opportunity to share anything that they consider relevant. A closed-ended inquiry might be, "Have you ever had difficulty with examinations/procedures like this one?" If the individual answers in the affirmative, then an open-ended question – such as "What can I do to make this easier for you?" – can help to minimize the patient's discomfort. Before the examination begins, extend a broad invitation to share relevant information (e.g., "Is there anything else I should know before we begin?").

Health care providers should recognize that, while asking for this information may seem safer than talking about past abuse, survivors may still experience it as difficult. If an individual's nonverbal cues indicate tension or anxiety, the practitioner may need to ask very specific questions such as, "Do you have any discomfort having your blood pressure taken?" or "Do you have difficulty when someone touches your knees?" Survivor participants urged clinicians to:

> *Pick up on obvious things: "You seem very anxious, is there something that you are uncomfortable with or is there something I should know?"* (Man survivor)

There are many reasons that people experience specific discomforts and sensitivities during health care encounters – some of these relate to past abuse, but others do not. Therefore, while task-specific inquiry should be used for all patients, clinicians should be careful not to assume that a patient who offers a task-specific disclosure is an abuse survivor.

Task-specific inquiry should be used during an initial meeting with a patient, before any new examination or procedure, and any time body language suggests that the patient may be uncomfortable or experiencing difficulty.

> *Asking if [the individual] has any issues or any concerns or are they uncomfortable, either physically or emotionally, is a really good way to start.* (Woman survivor)

One woman suggested that clinicians:

> *Start out with, "What are your experiences with a dentist [/doctor/massage therapist etc.]? How often do you go? What are your fears?"* (Woman survivor)

Inquiries about sensitivities, discomforts, and difficulties can also be included on questionnaires that are part of an initial assessment. Some survivor participants told us that they are more comfortable with this approach. The practitioner may invite an individual who indicates having difficulty with a number of components of an examination to outline the issues in writing. Regardless of the mode used to elicit this information, it is vital to the sensitive health care of all clients.

> *[It] would be even better ... if every time you went into a [practitioner's] office, they gave you a little survey ... asking you ..., "Do you have a problem with getting undressed, or being touched?" It would be great if they did that, 'cause then they'd have an idea of what kind of person they're dealing with when that person walks in that door. They're prepared – that person's prepared, because they think, or they'll know that the doctor or the physiotherapist has an idea of what they're going to be dealing with. That if this person says, "Mm, I don't feel comfortable with that," they're going to know. They're going to understand ... And I think that would be fantastic, if they did that. So then both parties would be aware of things.* (Woman survivor)[164p.93]

Body language should be explored as cues signalling that an individual may be experiencing difficulty.

It is important to note, however, that task-specific inquiry should not be reserved exclusively for examinations involving touch. While touch can be problematic for many survivors, other health care interventions that clinicians may see as innocuous (such as standing behind a client during an examination, taking a pulse or blood pressure, or immersing a painful swollen hand in ice water) can also provoke discomfort and trigger painful reactions.

Task-specific inquiry should not be reserved exclusively for examinations involving touch.

ⓘ Section 6.7 – Touch

Practitioners also need to be aware that, although they should make task-specific inquires prior to any examination, some individuals may not be able to talk about their difficulties until they develop a rapport with their health care provider. Further, the ability or willingness to talk about task-specific difficulties may be a function of the survivor's stage of healing; certain components of an exam may be well tolerated at some times and problematic at others.

ⓘ Section 4.2 – Eighth Principle: Understanding nonlinear healing

Clinicians should not assume that an individual has disclosed all task-specific difficulties during previous interactions. Survivors who have been conditioned to be passive or to defer to authority may need ongoing permission and encouragement to talk about difficulties on a regular basis. Body language – such as trembling, flinching, tensing muscles, changing breathing patterns, flushing, crying, or dissociating (i.e., appearing spaced-out, distant, or blank) – should be explored as cues signalling that an individual may be experiencing difficulty:

> *We send out signals ... to people that we have been abused ... I was sending signals out, and I don't think the people were listening really and picking up on them ... [I would] cringe and move and I often said "What are you doing?"* (Woman survivor)[143p.252]

When these cues are evident, practitioners should explain that the exam or procedure will be easier to complete if the patient can relax, and then ask for assistance in discovering another approach to that component of the exam (e.g., "Would it help if I gave you a mirror to help you to see what I am doing?"). Addressing an individual's apparent discomfort in these ways is vital to establishing and maintaining rapport; ignoring these things can undermine feelings of safety and trust.

Documenting task-specific difficulties or preferences can be done in a way that identifies the sensitivity or difficulty without any reference to past abuse. In deciding what to include in the patient's record, practitioners should ask themselves what other clinicians need to know in order to provide the best care. When practitioners learn about task-specific sensitivities for the first time only after a patient experiences an adverse reaction to part of an exam (or treatment), they should record the unexpected response as soon as possible after the incident, including both objective (who, what, when, where, how, and how much) and subjective (what the patient and others report about the event) information.

ⓘ Section 8.7 – Legal and record-keeping issues

TABLE 2
A brief summary of task-specific inquiry

Task-specific inquiry involves asking patients about their preferences for or potential difficulties with a specific examination, procedure, or treatment. It provides an opportunity for patients to offer health providers information that is directly pertinent to the present situation without any reference to past interpersonal violence.

- Use combination of closed- and open-ended questions to offer patients an opportunity to share anything they consider relevant.
  - An initial closed-ended question such as:
    - "Have you ever had difficulty with examinations/procedures like this one?"

If the individual answers in the affirmative, follow-up using an open-ended question such as:

  - "What can I do to make it easier for you?"
  - Before beginning an exam, offer one addi-tional opportunity to disclose something the patient thinks might be relevant:
    - "Is there anything else I should know before we begin?"
  - When a clinician notes discomfort, return to task-specific inquiry. For example,
    - "Every time I go to stand behind you to take a look at your back you seem to tense up. Do you have difficulty with having someone standing behind you or touching your back?"

If the patient responds in the affirmative:

    - "What can I do to make this part of the exam easier for you?"
  - For survivors who verbally deny discomfort but whose body language suggests the opposite, task-specific inquiry is likely to facilitate feelings of safety for the survivor; explain that carrying out the exam with the patient's body more relaxed is ideal, and ask the patient's assistance to discover another approach to that component of the exam. For example,
    - "Would it help if I gave you a mirror to help you see what I am doing?"
- Documentation of task-specific disclosures can be done in a way that identifies the sensitivity or difficulty without any reference to past abuse. Focus on communicating the information that will assist other healthcare professionals to avoid the difficulties or to problem solve with the patient to minimize the difficulties.

6.4 General suggestions for examinations

In keeping with the principle of information sharing, it is important that health care providers not assume that their patients know what they are doing or understand why they are doing it. Thus, it is important that they provide a running commentary of an examination or procedure explaining what is being done and why. Further, repeated invitations for questions are crucial:

> *I found quite often when you go to a health care practitioner, they automatically assume that you have some kind of knowledge of their job outline ... And why should I know? I didn't go to school for that, so it's really frustrating. And they expect you to know something about it.* (Woman survivor)[143p.255]

Repeated invitations for questions are crucial.

While interactions with clients may be routine by clinicians, for many survivors, health care environments are strange and frightening places. Simply being in such environments can challenge an individual's ability to ask questions or to verbalize their needs. This fact cannot be emphasized strongly enough:

> *I feel very (pause) almost frightened. To some degree the fight or flight syndrome kicks in where I'm ready to hit the floor and head for the door. I know it's because of problems that I've had as a kid. But at the same time those feelings come over me and then I lose all train of thought as to what I'm there for, what I want to ask him, I forget what day it is.* (Man survivor)

While employing the following strategies for sensitively conducting an examination or treatment may require extra time, they are important for establishing rapport, trust, and safety – and they may actually save time in the long run:

- Complete the initial health history *before* asking the client to remove any clothing required for the physical examination.
- Invite patients to make a list of questions and concerns for each future appointment in order to reduce their sense of anxiety.
- Encourage questions throughout the encounter.
- Allow enough time to help individuals understand fully what is being done.
- Seek a balance between offering descriptors of symptoms ("Would you describe the pain as sharp or dull, throbbing or aching?") and encouraging survivors to find their own words. This strategy can be particularly important since many survivors have learned to ignore their bodies and may require extra time to describe their symptoms.
- Move on from topics that are making individuals seem uncomfortable or questions that they are having difficulty answering, and return to them later.
- Use a written *Informed Consent Form* that uses readily understandable language and avoids abbreviations, jargon, and technical terms.
- Inform patients that consent can be withdrawn at any time, without penalty to them.
- Pay close attention to language to ease the patients' anxiety (e.g., ask patients to *change* rather than to *get undressed*, use the term *examination table* rather than *bed*, and use the terms *underwear* or *undergarments* instead of *panties*).

ⓘ Section 6.6 – Informed consent
Appendix F – Using Plain Language in Consent Forms (including a sample)
Recommended Readings and Resources – Plain Language: Websites

Throughout the physical examination:

- Avoid using too many closed-ended yes-or-no questions. (Intellectually challenged individuals may try to answer in a way to please the clinician. Because the prevalence of childhood abuse is even higher among disabled individuals than it is among children without disability, clinicians need to be particularly attentive to nonverbal cues when working with these patients.)
- Do not approach patients from behind and, because some individuals startle easily, avoid quick, unexpected movements.
- Notify patients before shifting focus from one area of the body to another.
- Explain the rationale for examining areas of the body other than the site of the symptom.
- Encourage individuals to ask that the examination or treatment be paused, slowed down, or stopped whenever it is necessary to lessen their discomfort or anxiety.
- Inform patients when procedures/examinations are likely to be uncomfortable and collaborate with them to minimize the discomfort by soliciting and responding to feedback throughout the procedure (e.g., ask, "How are you doing? Can we continue?" and, if they say "No," take a break until they can continue).
- Avoid glib or false assurances which sound dismissive or indicate lack of understanding of their concerns (e.g., instead of saying "Trust me" or "Don't worry, you'll be fine," say "I know this is difficult for you. How can I help you to feel more comfortable?").

6.5 Time

- Most of the survivors we spoke with recognize the time pressures under which health care practitioners work and do not expect exceptional treatment. The following three suggestions are offered by survivor and health care practitioner participants as ways to use the available time more effectively:
- Inform clients at the outset of an appointment/interaction how much time you have to spend with them and negotiate how best to use it. In a clinic setting, a health care practitioner might say, "We have 15 minutes for this appointment, what do we need to focus on?" or "We have 15 minutes and I plan to ... Is there anything else that you need or want?" A health care practitioner in a hospital emergency department might say, "My name is ... I am a Registered Nurse and will be looking after you. We are very busy here today, so you may have to wait an hour or more to see a doctor." The nurse might go on to say, "I need to get some information from you and then I'll be in and out every 15 minutes or so to check on you. Please use the call button if you need me."

> Even though employing these strategies may require some extra time, they are important for establishing rapport, trust, and safety - and they may actually save time in the long run.

- Aim to keep interruptions (from assistants, colleagues, pagers, cell phones, BlackBerries, phone calls, etc.) to a minimum. Eight or ten minutes of uninterrupted time allows the health care practitioner to focus on the patient and is more likely to achieve the objectives of the interaction than 20 minutes of interrupted time.
- Use both verbal and nonverbal communication to convey interest and attention. For example, when a health care practitioner conducts office interviews while standing with his or her hands on the door knob or abruptly leaves patients

to take telephone calls without any explanation, the message to patients is that the practitioner is not focused on them.

Throughout this project, we have heard repeatedly that short-term interactions pose the greatest difficulty for integration of Sensitive Practice because of the reality of time pressures. Survivor and health care practitioner participants alike urged that while it may take some commitment and ingenuity to incorporate the principles of Sensitive Practice in short-term interactions, it is important to make the effort to do so.

6.6 Informed consent

Obtaining informed consent for examination and treatment is an important part of practitioners' responsibility to their clients and is regulated by professional/licensing bodies as well as legislation. Clinicians are urged to ensure that they are thoroughly familiar with all appropriate sources of information about informed consent. Informed consent involves: (a) explaining the health problem; and (b) making recommendations for addressing the problem (which must include: a discussion about the nature, benefits, material risks, and side-effects of treatment; alternative courses of action; and likely consequences of not having the treatment). Written consent forms are part of the process of obtaining informed consent in many health care settings and health care providers are urged to draft written consent forms in plain language.

Clinicians are urged to ensure that they are thoroughly familiar with all appropriate sources of information about informed consent.

This section highlights aspects of informed consent that are particularly pertinent to survivors. Because survivors have had early experiences of boundary violation, it is essential that practitioners be particularly attentive to obtaining consent which goes beyond the standardized forms and which is an ongoing aspect of their work with patients:

> *When I was a child ... you might say yes [consent] to [one thing] but, my God, you didn't know that you were ... going to be taken elsewhere and what was going to happen. So it's where you're going.* (Man survivor)

ⓘ Appendix F – Using Plain Language in Consent Forms (with an example written by a survivor with the goal of increasing patient understanding)

In many instances, it is necessary to seek consent for each separate component of an examination or procedure:

> *Ongoing [consent is required] – it's not a blanket consent when you're touching me.* (Man survivor)

The nature of that consent, however, can vary by circumstance. Some men indicated that inquiring about their comfort was synonymous with asking for consent once an examination had begun. For yet other survivors, once trust had been established, the need for the practitioner to repeatedly seek consent for each segment of a procedure was unnecessary:

> *As the trust builds in our relationship you would get to a point that perhaps you wouldn't need to ask me and perhaps I would get to a point where I would say, "You don't need to ask me for permission any more. We're now at a point where I trust you and I know you're not going to hurt me ... But there are some instances where health practitioners need to ask for permission to go to those places. (*Man survivor*)*

The inclusion of other individuals in any examination/procedure requires additional consent. It is important to inquire about student participation when the student is not present. In addition, even if clients have previously agreed to student involvement for other procedures, always reconfirm their willingness to have the student present, especially during sensitive examinations. Some individuals may agree to have a student present for part of the examination but not for all of it:

She just told me that ... she was bringing a student into the room with her and that she would be helping remove the packing. She didn't ask permission ... I think it's a privilege for a student to be in that situation and you still need to be respectful of how a patient feels about you being there. (Woman survivor)

In all circumstances, the onus for ensuring that the patient is fully informed and consents to what is happening is on the practitioner:

> *When [the practitioner] came back, right before she was going to [proceed with further treatment], she'd ask me again, "Are you comfortable with this? Is everything all right? And do you understand what I'm doing?" And that was so much easier, because one minute you can feel comfortable, and the next minute, you could feel uncomfortable ... so she gave me an opportunity that, if I were to change my mind and feel uncomfortable, all of a sudden, for whatever reason, she would know, and I'd be able to say something. So I felt like I was in control, and I did have the say of what was going on.* (Woman survivor)[143p.254]

In all circumstances, the onus for ensuring that the patient is fully informed and consents to what is happening is on the practitioner.

The clinician's responsibility to monitor and respond to the client's verbal and nonverbal communication cannot be overstated. Some survivors may be working to overcome the passivity towards authority figures they learned as children:

> *I don't think it's good enough to just say, "At any point if you are uncomfortable ..." because some people will say, "Okay I understand," and may never say anything because ... we're just taught to not say anything. We just don't question. I know there are a lot of people out there like me, and we would say, "Okay, yeah, I hear ya!" and then wouldn't say a word no matter what. So I think on the part of the health care practitioner they'd be doing those people a great service by checking and rechecking. It doesn't have to be every minute but perhaps as they move on to another sensitive stage of whatever they're doing, just recheck. "How are you doing? I'm going to be doing something different now, if at any point you feel uncomfortable, let me know and we'll proceed from there."* (Man survivor)

To establish a context for ongoing informed consent, practitioners must:

- Allow ample time for patients to explore concerns, ask questions, and decide whether or not they want to proceed;
- Seek consent for each component of an examination or treatment;
- Obtain consent before bringing in students to observe or work with individuals;
- Keep in mind that the onus of ensuring that the client's consent is truly ongoing is on the clinician;
- Respond to the client's verbal and nonverbal communication when discerning consent.

6.7 Touch

> *I rarely go to the doctor; I only go when I absolutely have to and also for physicals. I would just disassociate, that was my only way of coping with that ... any time they touched me.* (Woman survivor)

All forms of physical touch, from all types of practitioners, can provoke anxiety.

Most survivors we spoke with told us that all forms of physical touch can provoke anxiety. This includes touch from all types of practitioners and in a wide variety of situations, from having blood pressure taken or blood drawn to undergoing a complete physical exam:

> *Touch is difficult, but if I feel safe, then I can tolerate more.* (Man survivor)

Survivor participants agreed that having information before and while being touched is crucial to their sense of safety:

Information and knowing just before you're going to be touched that it is coming [helps], so, it isn't sort of a shock to you that you are being touched. (Man survivor)[159]

An understanding of the dynamics of abuse and some of the difficulties behind survivors' experience of touch can help health care practitioners develop strategies to use during interventions that require touch:

When people used to touch me, it took me right back to the sexual abuse and the physical abuse ... Health care practitioners, if they see their patients sort of backing off or shutting down a bit, they should investigate why. (Man survivor)

For some survivors, the use of touch by the clinician to explain a physical problem or as a component of treatment may be difficult:

[Some clinicians] have automatically assumed that it's okay for them to go, "Okay, well we're going to work ... on these muscles [as they touch me] ... because we need to strengthen this because this does this and –" ... It's not meant [to be sexual touching] ... Once I've gone home and calmed down, [and I] thought that they did [not do] anything inappropriately sexual. But at the time, when you first get triggered, it's an extremely difficult situation to deal with. It triggers a lot of memories ... and then you completely lose whatever you are there for. (Man survivor)

Other survivors spoke of continuously monitoring and reacting to the intent and quality of touch they receive.

If you're with [health care workers who are] aggressive ... in the way that they touch you, then you're instantly intimidated and then it's not safe any more. (Woman survivor)

No one approach to touch is appropriate for every client. Gentle touch, which may be appropriate for some, may be experienced by others as sexually suggestive:

As far as gentle touch goes, you would want a firm but not aggressive touch. Something that's too soft can be seen as an advance on you. (Man survivor)

Despite the fear and anxiety that many survivor participants experience with touch, some told us about its positive aspects:

I think that touch for healing ... has its place based on my own experience and it helps for rebuilding trust. (Man survivor)

Because touch is such a fundamental issue for survivors of childhood sexual abuse, health care practitioners – before and during any encounters which involve touch – must:

- Recognize that, for many survivors of childhood sexual abuse, no touch is routine;
- Provide patients with information about the reason for and nature of the touch which is involved in any examination or procedure;
- Be sensitive to the intent and nature of all touch, and discuss patient reactions to different types of touch;
- Create a context wherein responses to touch can be freely articulated and the healing nature of touch can be explored.

6.8 Pelvic, breast, genital, and rectal examinations and procedures

Understandably, pelvic and breast exams for women and genital and rectal exams for men and women were cited as being the most difficult parts of a physical exam. Some survivor participants described how these examinations triggered flashbacks for them:

It can trigger ... physical night sweats and severe rectal pain, enormous inexplicable attacks of anxiety. (Man survivor)

Others are unable to tolerate such exams at all:

> *I don't think I would allow anybody to touch me now ... nobody would get an internal on me. No. I will not allow myself to be that vulnerable again.* (Woman survivor)

Participants suggested that practitioners begin by describing the usual sequence of an examination and ask individuals whether they need to adapt it in any way:

> *And you know, they take your blood pressure and I said, "You know you'd better do the Pap smear first and then take the blood pressure because right now it will be off the charts and after it will be okay."* (Woman survivor)

> *I think being uptight about the actual procedure also made it very difficult for me to talk in general about the other parts of the examination or the other questions they had to ask about the pregnancy or about that kind of thing ... The question-and-answer thing was always before the actual physical exam and I would be really stressed out and really kind of paralyzed feeling, and so I don't think I ever gave really great information because of that. So maybe having the physical exam first would have helped, get it all over with first, get yourself all back together again ... Or have someone come with you, which I never did, but I suppose that would have [helped].* (Woman survivor)

Because there is no single approach that is appropriate in every situation, it is important to:

- Use task-specific inquiry before the exam to learn about anticipated difficulties and negotiate with the individual to minimize discomfort;
- Offer a running commentary about what you are doing;
- Pay attention to nonverbal signs of distress (e.g., tense muscles, flinching, "spacing out," facial flushing, tears, or stuttering) and ask for the client's feedback about ways to decrease difficulty;
- Minimize the time a patient must remain in a subordinate position;
- Drape parts of the body not being examined;
- Allow patients to wear clothing on parts of their body not involved in the examination (e.g., chest, arms, feet, etc.);
- Offer clients a mirror with which to watch the examination or treatment;
- In some cases, suggest to a tense patient that she insert the speculum herself, allowing her to have some control over the intrusion;
- When possible, conduct pelvic examinations with the woman's head and upper body slightly elevated, as described below:

There is no single approach that is appropriate in every situation.

> *I had been seeing [my family physician] for one and a half years. I kept postponing my physical and the MD noticed that. She kept bringing it up and reminding me until I finally told her that I was frightened of laying flat on my back in a paper gown. She told me that it would not be a problem for me to be partially sitting up throughout the whole examination including the pelvic exam. Now she tells all of her patients that that is an option. She told me that it had been an important conversation for her.* (Woman survivor)[159]

ⓘ Section 6.3 – Task-specific inquiry

6.9 Body position and proximity

Both women and men survivors spoke about the difficulty they experienced being in certain positions, partially clad, with a fully clothed clinician standing over them. Health care practitioners can approach the topic of positioning in the same manner as they do other

aspects of the examination or treatment: explain the rationale for the proposed position, obtain consent, monitor for signs of distress, and offer a running commentary:

> *[I had to lie on my stomach] and I was really uncomfortable. Finally, I told him, "I can't do this." I didn't tell him why. I said ... "I can't lay on my stomach; can I do it some other way?" [He said,] "Oh yeah, well – you can sit up." So there was an alternative.* (Man survivor)

> *I don't like somebody standing behind me, but if they [must] ... the explanation is important.* (Man survivor)

Health care practitioners can approach the topic of positioning in the same manner as they do other aspects of the examination or treatment: explain the rationale for the proposed position, obtain consent, monitor for signs of distress, and offer a running commentary.

Other participants talked about experiencing difficulty when a clinician had to be in certain positions or was in close physical proximity, as is the case when practitioners examine the eyes, ears, and oral cavity or carry out treatments such as spinal adjustment.

6.10 Pregnancy, labour and delivery, postpartum

> *[Pregnancy is] a very vulnerable [time] ... for women that have been sexually abused. Like for me it was a little bit scary because I wasn't sure how the end result would be, like during my labour, would I have flashbacks?* (Woman survivor)

There is evidence that childhood sexual abuse survivors: are more reluctant to address their health care needs, have poorer relationships with caregivers, have more anxiety and fear about labour and delivery, report disappointing birthing experiences, are (re)traumatized by the birth experience itself, have more emotional problems in the postpartum period, and experience more problems with breastfeeding and parenting.

While childbearing is a profound experience for most women, it can be particularly difficult for women with histories of childhood sexual abuse. In their book *When Survivors Give Birth*, Penny Simpkin and Phyllis Klaus[151p.33] describe pregnancy as:

> *A time of monumental change for women – a time when the past, present, and future all come together, a time of openness, a time of vulnerability. Being pregnant causes memories of one's own childhood to surface. Past events are stirred up. The present evokes the paradox of excitement over the baby on the one hand, and fears and anxiety on the other.*

According to these authors, some survivors welcome pregnancy as a sign that they are "normal" and develop a growing trust and confidence in themselves as their bodies change to support a new life. For others, however, the experience of pregnancy stirs up memories of past childhood sexual abuse. In her personal account, Christine,[42] an incest survivor, describes not having conscious memory of her abuse until sometime after her third child was born. In retrospect, that knowledge has helped her to understand the difficulties she had with each of her pregnancies: the tears she shed for no apparent reason after every prenatal visit; her severe nausea and vomiting; her long, slow, overdue labours; and the serious postpartum depression. It also explained her life-long shame and distrust of her body, her high need for control, and her life-long struggles with depression. Although she remembers the practitioners who attended her during and after her pregnancies as being caring individuals, none of them ever asked whether she had a history of abuse.

There is some evidence that, compared with women who do not have histories of childhood sexual abuse, survivors: are more reluctant to address their health care needs, have poorer

relationships with caregivers, have more anxiety and fear about labour and delivery, report disappointing birthing experiences, are (re) traumatized by the birth experience itself, have more emotional problems in the postpartum period, and experience more problems with breastfeeding and parenting.[76,84,92,130,134,148,151,180,182]

In the Western world, "good" prenatal care involves frequent contacts with health care practitioners (physicians, nurses, midwives, ultrasound technicians, lab personnel, etc.) and typically includes a number of examinations, tests/procedures, and treatments that may prove difficult for some survivors. Debra Hobbins[84] offers the following list of perinatal experiences that might trigger memories of past childhood sexual abuse:

- Disrobing;
- Genital exposure/examinations;
- Raised side rails;
- Restraint or entrapment in bed by equipment (such as fetal monitor leads, belts, blood pressure cuffs, or oxygen masks);
- Being drugged (pain medications);
- Delayed or absent response to calls for assistance.

This list underscores the importance of inquiring about violence and abuse during health history taking with all patients:

> *I was afraid of how the care would be, because they didn't know in my first pregnancy, they didn't know at all, they didn't ask and I didn't feel comfortable with telling them because of where I was at and I didn't have that voice to be able to speak out and say, you know, this is what I need and this is what happened to me and I need you to understand this and I need you to help me if I zone out.* (Woman survivor)

A practising midwife who participated in our second study told us that she may spend the first two to three prenatal visits just chatting with clients and waits for them to let her know when they are ready for a physical assessment. She tries to minimize invasive procedures and possible triggers as much as possible, performs only necessary interventions, and tries to be flexible (e.g., allowing women to perform certain procedures – such as swabs – themselves).

The principles and guidelines for Sensitive Practice presented in this *Handbook* are a useful foundation for perinatal care. We encourage health care practitioners who work closely with women through pregnancy, birthing, and the postpartum period to read Simpkin and Klaus's *When Survivors Give Birth*[151] for more specific and detailed guidance concerning the provision of safe and respectful care.

We encourage health care practitioners who work closely with women through pregnancy, birthing, and the postpartum period to read Penny Simpkin and Phyllis Klaus's *When Survivors Give Birth* for more specific and detailed guidance concerning the provision of safe and respectful care.

ⓘ Recommended Readings and Resources – Pregnancy, labour, and postpartum

6.11 Oral and facial health care

Although the guidelines for Sensitive Practice are pertinent to all types of practitioners, there are special concerns for practitioners who work with the mouth, jaw, and face. Because childhood sexual abuse may be oral in nature, many survivors have difficulty tolerating various aspects of oral or facial health care (e.g., the body position they must assume during treatment, the physical proximity of the clinician, and the smells and textures of certain materials such as latex gloves or alcohol):

> *Too many things in my mouth at once ... You're making me hold my mouth open too long because you have to do that when somebody's forcing you to do oral sex, like when you're a*

child, like, 'cause your mouth is too small. (Woman survivor)

Many survivors have great difficulty tolerating various aspects of oral or facial health care.

This means that knowledge of a patient's past history of abuse is extremely relevant to oral and facial health care:

Because I was anticipating [difficulty with] a certain procedure I said, "I think you should also know that I am a sexual abuse survivor and ... maybe that's part of my reaction here." . . . So if I happen to freak out when he's poking around in my mouth, that he would have more information there and would know more of what he's dealing with. (Man survivor)

ⓘ Section 7.6 – Triggers and dissociation

Oral health care can regenerate the feelings of powerlessness and vulnerability that survivors felt as children:

You have no control because you're in the chair, your mouth is frozen and you're pretty much at the mercy of that person. (Man survivor)

The practitioner who can help the survivor feel some sense of control during treatment will be addressing the patient's abuse-related fears and laying the groundwork for greater compliance during treatment.

The practitioner who helps the survivor to feel some sense of control during treatment can allay abuse-related fears and increase the likelihood of greater cooperation during treatment. As noted earlier, sharing information and asking permission before performing a procedure can reduce the patient's feelings of anxiety and powerlessness.

[The dentist] would talk his way through what he was doing. He would say, "Now I'm going to clean your teeth" or "Now I'm going to spray a little water on that tooth, it may be a bit sensitive." He doesn't overdo it but he explains everything he does, so that I have a very clear sense of where he's going and what he's doing next. And that has been extremely helpful. (Woman survivor)[159]

Although practitioners may perceive these frequent explanations and step-by-step consent as repetitious, they are valuable to the apprehensive patient. Intermittently inquiring about a patient's comfort and following up on negative body language are also helpful, as are establishing hand signals to indicate the need to stop.

Most of the time [the dentist says] "You know the signals, right?" And I go, "Yeah." And he'd always review the signals ... "This is what you can do for yes, this is no, this is stop." (Man survivor)[157p.1280]

Allowing breaks during an appointment or, when possible, breaking a long appointment into two shorter ones can be helpful options for many patients.

[When I told my dentist that I was having problems that day, he responded,] "Well, what do I need to do? Are you comfortable in the chair? Are we going to need more breaks today?" ... There's just an unbelievable level of respect with this man. He's fabulous. (Woman survivor)

ⓘ Section 6.3 – Task-specific inquiry

Childhood sexual abuse survivors also can feel uncomfortable being in a reclining position in a dental chair with practitioner in close proximity:

I feel really trapped in the chair, in a very vulnerable position – you know, where you have your mouth open, you're laid back. For me a lot of my trauma occurred, like, when I was in a laid back position ... and [so having a health care provider] ... over the top of me, I find that very threatening. (Man survivor)

While supine positioning cannot be avoided, the initial exchange of information and obtaining of

consent should be done while the patient is still sitting upright. Furthermore, reclining may be accepted more readily if patients are given an ongoing explanation of what is being done and are offered the opportunity to watch part of the treatment using a mirror.

Survivors also talked about difficulties with materials that were reminiscent of condoms and other objects used during abuse:

> *Dentists, for me, even on a good day, [are] a total, absolute nightmare. I'll tell you why. Number one, the gloves smell like condoms ... I can't ground myself, so ... I am back there [being abused] . . . it's not the dentist any more.* (Woman survivor)[157p.1280]

While gloves are a necessity, opting for gloves made of vinyl or other materials may be an alternative that helps patients who seem particularly anxious about the smell or sensation of latex.

A further issue that arises in oral care is evidence of neglect. In many instances, neglect of oral health may indicate fear of treatment or that a patient does not consistently value or care for his or herself or his or her body. In such cases, fears can compound: the fear of treatment that keeps a patient from treatment can be a source of shame and can lead to a fear of being reprimanded for the neglect:

> *When they do my teeth they are going to say, "Oh you haven't been taking care of them, you should have come in before."* (Man survivor)[157p.1280]

While patients deserve and expect a realistic evaluation of their oral health, they may find it difficult to hear a poor prognosis for a condition that may have been preventable if it had been treated in a timely fashion. Because many survivors believe that they are bad or undeserving, they expect to be judged harshly. This makes it critical that oral health practitioners use a supportive, nonjudgmental tone when presenting treatment options. Instead of reprimanding their patients, oral health practitioners can engender trust by asking how they can best help patients take better care of their teeth.

Because many survivors believe that they are bad or undeserving, they expect to be judged harshly. This makes it critical that oral health practitioners use a supportive, nonjudgmental tone when presenting treatment options in instances of dental neglect.

Survivors indicated that, while oral health care was difficult for many of them, working with practitioners to address the difficulties together often resulted in a positive experience:

> *He ... doesn't ignore what I tell him. He has compassion ... He listened to me. He addressed my situation ... When it's over ... I feel really great. I really do. Like he's so gentle, he's so kind, soft-spoken, yeah, he's amazing.* (Woman survivor)

To minimize the strain which many childhood sexual abuse survivors experience with oral and facial care, practitioners are encouraged to:

- Undertake the initial exchange of information and obtaining of consent while patients are still sitting upright;
- Opt for gloves made of vinyl or other materials for patients who are anxious about the smell or sensation of latex;
- Establish and use hand signals for "stop" and always respond promptly to them;
- Share information with patients on an ongoing basis;
- Address patient comfort on an ongoing basis by frequently checking in with patients and using task-specific inquiry;
- Follow up on negative body language;
- Allow breaks during an appointment or divide long appointments into two shorter ones;
- Offer patients the opportunity to watch part of the treatment using a mirror;

- Address issues of oral health care neglect in a supportive, nonjudgmental tone and offer to collaborate with patients in finding a way to take better care of their teeth.

ⓘ Section 6.3 – Task-specific inquiry

6.12 Care within the correctional system

The proportion of childhood sexual abuse survivors is higher within the correctional system than in the general population. Prevalence rates of childhood sexual abuse among incarcerated women range from 47% to 90%;97,152,162 among men, these rates are 40% to 59% (for sexual and/or physical abuse).[91,131]

The strict health care protocols which are standard procedures within the prison health care system dramatically decrease the likelihood that childhood sexual abuse survivors will seek health care.

Two of the men who participated in our studies were incarcerated in federal institutions at the time of their interviews. They spoke about feeling unsafe when seeking health care not only because of the lack of privacy and confidentiality but also because of standard procedures used within the prison health care system. While the need for strict health care protocols is understandable, it is likely that such protocols dramatically decrease the likelihood that childhood sexual abuse survivors will seek health care:

> *[When I went to the clinician for a topical nonprescription medication for haemorrhoids, she] wanted to physically check ... I was thinking, "No, no that's not necessary" ... So she refused me treatment ... [and told me,] "If you're refusing [to let me examine you] then I can't give you anything, so I'll just assume that there's nothing wrong with you."* (Man survivor)

It is likely that similar difficulties exist for women survivors as well, as has been documented by Pamela Dole,[51] a physician who worked in the US correctional system. Although further study is warranted, we urge clinicians who work in the correctional system to examine current practices and seek ways to introduce the principles and guidelines of Sensitive Practice.

6.13 After any physical examination

When ending any interaction, it is essential that practitioners establish a sense of equality with their patients. This will need to be handled differently in different settings:

- In clinic or office settings, see patients *when they* are *fully dressed* for health teaching and before they leave an appointment.
- In hospital settings, allow patients who are remaining in hospital garb to regain composure and experience themselves being recognized as a whole person (e.g., shake hands and say good-bye).
- In all settings, invite final questions and, when appropriate, provide a briefly stated plan for future meetings.

6.14 Questions for reflection

- Might any of my current practices be interpreted as insensitive by survivors? What needs to change?
- In what ways might I adapt my own practice to incorporate specific guidelines?
- Do any of these guidelines seem unrealistic or unworkable in my practice? What are some alternate ways of following such guidelines?
- How committed am I to incorporating these guidelines into my routine practice and into the routine practice of those who assist me in my work? What does this level of commitment mean to my clients?

- How aware am I of nonverbal communication of discomfort? Do I follow up on these indicators with my clients?
- Am I aware of resources in my community to which I can refer survivors for care outside my scope of practice? Is this information readily available?

7 Guidelines for Sensitive Practice: Problems in Encounters

7.1 Pain

Pain is a complex issue involving the dynamic interaction of biological, psychological, and social factors that is only partially understood. Research has repeatedly found an association between childhood sexual and physical abuse and increased risk of chronic pain syndromes. An individual may experience pain associated with body (somatic) memories of past abuse in addition to the pain of the disease, illness, or injury for which they seek treatment.

Research has repeatedly found an association between childhood sexual and physical abuse and increased risk of chronic pain syndromes.

ⓘ Section 2.5 – Childhood sexual abuse and health

In keeping with the responses learned in childhood, some survivors cope with their memories by ignoring pain, dismissing its significance, or dissociating from it:

> *The experience as a child is to discount the pain, [the abuser will] threaten [the child], say "Don't tell anyone about this," [and so the child will] hide the pain, to begin to dissociate from the pain.* (Woman survivor)

These responses may make it more difficult for health care practitioners to assess patients' level of pain, factors that may aggravate the pain or change their experience of pain during the course of treatment.

To complicate matters further, some survivors come to health care encounters having had negative experiences with other practitioners who have either discredited the patient's pain because it was inconsistent with objective evidence or questioned the client's rating of pain severity:

> *While I was lying there I did hear some of the [clinicians] saying things like "Why doesn't she suck it up" and "What's she doing back here again? She was here all day" ... I thought they were derogatory things because they didn't know my history ... My history was all there but obviously they hadn't looked at it.* (Woman survivor)

Because an individual's experience of pain is real, whether or not the pain is consistent with objective findings, it is the clinician's responsibility to assess the client's pain in a systematic, thorough, and nonjudgmental manner. The clinician can also:

- Include other practitioners on the treatment team (e.g., mental health practitioners, pain specialists, or pharmacists) to ensure a comprehensive treatment regime;
- Initiate a discussion of other options, including referral to other practitioners who specialize in the management of chronic pain (considering both traditional and complementary practitioners) if an individual's experience of pain does not remit despite the practitioner's best efforts;
- Offer a referral, where appropriate, for psychotherapy, clearly explaining the reasons for the suggestion and carefully documenting the details of the discussion;
- Follow up on any referral in future interactions with the client.

7.2 Disconnection from the body

Judith Herman[81] emphasizes the importance of reconnecting with the body in healing from trauma. Being out of touch with one's body can

make looking after one's body difficult for a survivor. Indeed, for many survivors, the body becomes nothing more than "a vehicle to get around [in]" (Woman survivor). Such individuals often remain unaware of the messages that their bodies are sending and fail to recognize or attend to signs and symptoms of things such as stress, anxiety, fatigue, or overexertion. These individuals may require specific guidance about activities of daily living and leisure time, physical activity (from doing laundry to gardening), or exercise (either therapeutic or physical fitness training).

Feeling out of touch with their bodies can make self-care difficult for childhood sexual abuse survivors.

For many survivors, assistance from a health care provider to help them become more aware of their bodies may be a critical step in their process of recovery:

> *[One part of treatment] has been for me to start to get in touch with my body ... I think that a physiotherapist can really affect that [by giving] that supportive invitation to ... come back into [one's] own body.* (Woman survivor)[143p.256]

> *I needed ... my [massage therapist to] introduce me to my body ... [to] talk to me about my body because I'm not in touch with it.* (Man survivor)

The inability or apparent unwillingness of clients to adhere to treatment may be related to childhood sexual abuse.

Accordingly, health care providers who encounter patients who seem out of touch with their bodies should:

- Repeatedly invite those individuals to focus on their bodies.
- Offer ongoing health teaching about the importance of paying attention to somatic signs and symptoms.
- Provide detailed verbal and written specific instructions for activities of daily living that are problematic as well as for leisure time physical activity. These instructions should include a description of what the activity should feel like and give upper and lower limits for the performance of the activity (e.g., "If your pain increases after making one bed, rest before continuing" or "If you are out of breath, you are doing it too vigorously").
- Monitor performance and progress.
- Help clients set small, achievable goals to develop neuromuscular skills and understand how to perform the activities correctly.
- Provide careful instructions to facilitate adherence to the treatment program.
- Teach the signs and symptoms of overuse so that survivors can learn how to monitor activity both during treatment and, later, independently of the clinician.
- Suggest a range of strategies to aid self-awareness and connection to the body including: (a) physical activity; (b) somatic-based re-education strategies (e.g., guided visualizations, relaxation exercises, breathing exercises, or yoga); or (c) referrals to other health care providers including complementary health care practitioners.

7.3 Non-adherence to treatment

As stated previously, the inability or apparent unwillingness of clients to adhere to treatment may be related to childhood sexual abuse. Factors such as depression and negative self-perception can lead to unsuccessful courses of treatment for patients and frustration for practitioners. In some instances, the difficulties which survivors experience are directly related to the specifics of past abuse:

> *There [were] some of the exercises ... that they wanted me to do [after a total hip replacement] ... and one of them that I still*

today cannot do ... You lie on your side ... it's a scissor ... [Even when the practitioner] had the sling ... around my ankle and it had a handle and I could pull it and my leg would go up, I couldn't even do that. I'd get it so far, but I wouldn't go any further because I had to keep [my legs] so tight ... [and the practitioner] got frustrated, she really did ... she thought I wasn't trying, and that wasn't true at all because I was doing the other [exercises] very well. (Woman survivor)[143p.257]

Section 2.4 – The dynamics of childhood sexual abuse

Chapter 3 – What Survivors Bring to Health Care Encounters

Appendix C – Traumagenic Dynamics of Childhood Sexual Abuse

In other instances, fear and anxiety decrease survivors' ability to hear and retain information. If they are in a dissociative state while information or instructions are given, they may be unable to recall them or to decipher cryptic written instructions.

The following suggestions may help practitioners elicit survivors' participation in their health care:

- Always explain the rationale for the recommendations being offered.
- Avoid using words such as *must* and *should*.
- Provide detailed written as well as verbal instructions.
- Ask clients whether they feel able and willing to follow the recommendations.
- Explore barriers to treatment adherence (e.g., values, social factors, finances, or past abuse) and make adaptations where possible.
- Adapt at-home treatment to fit the client's lifestyle and abilities, particularly for individuals whose low self-esteem undermines their motivation and sense of agency.
- Where adherence to treatment is particularly important (e.g., for postoperative mobilization), work with individuals to achieve small and reasonable goals (e.g., by ensuring adequate analgesia, teaching splinting techniques, etc.), and acknowledge all successes.
- Remember that blame and guilt are more likely to lead to withdrawal than adherence.
- At the beginning of the meeting, check with clients about reactions during or after the previous meetings, address any problems that have occurred, and answer questions.
- Encourage the view that actively taking care of oneself fosters autonomy and independence.

7.4 Appointment cancellations

For many survivors, "walking through the door [for a health care appointment] is a big deal," (Man survivor) and they cancel appointments as a means of avoidance:

> *My wife had been bugging me for a while now, "The dentist has been calling you. You've got to go." "Okay I'll call her back," and I don't call her back. But then eventually ... the adult part of me says, okay you need to go to the dentist ... but the emotional side of me [says] no way I'm going there at all.* (Man survivor)

It is helpful for service providers to understand why survivors may cancel appointments and, wherever possible, to make changes in their practice environment to facilitate feelings of safety.

Certainly, cancellations are problematic in that they waste valuable health care resources and are a liability to fee-for-service practitioners and organizations. Nonetheless, it is helpful for service providers to understand why survivors may cancel appointments and, wherever possible, to make

changes in their practice environment to facilitate feelings of safety.

To help minimize cancellations, practitioners could:

- Offer "same-day" appointments that would allow survivors to book appointments on days when they feel able to cope. (This can be particularly helpful for oral health practitioners.)
- Work with clients who have identified their apprehension and tendency to cancel appointments to develop a strategy that will assist them.

7.5 "SAVE the Situation": A general approach for responding to difficult interactions with patients

All health care practitioners encounter difficult situations in the course of their day-to-day practice (e.g., informing a family of the death of a loved one, diagnosing a life-threatening disease or condition, or encountering someone who is angry, anxious, or extremely distressed). These emotionally charged situations may leave practitioners feeling unsure about how to respond. In such instances, reference to the "SAVE the Situation" model may be helpful. The model uses "SAVE" as an acronym for the following four steps: **S**top, **A**ppreciate, **V**alidate and **E**xplore. A particular benefit of the "SAVE the Situation" approach is that it can be effective in any difficult situation and is not reserved exclusively for work with survivors.

ⓘ Section 7.6 – Triggers and dissociation

Recommended Reading and Resources – The therapeutic relationship, boundaries, and managing challenging situations

TABLE 3
S A V E the situation

The acronym ***SAVE*** is a guide for responding effectively and compassionately in a variety of emotionally charged situations.
STOP
Stop what you are doing and focus your full attention to the present situation.
APPRECIATE
Try to appreciate and understand the person's situation by using the helping skills of empathy and immediacy. Empathy involves imagining the other person's experience (thoughts, feelings, body sensations) and communicating an understanding of that experience. Immediacy is verbalizing one's observations and responses in the moment, using present tense language. For example, 'Your fists are clenched and you look angry. What is happening for you?' or 'You seem upset' or 'I doubt there is anything that I can say that will make this easier. Is it okay with you if I sit here with you for a few minutes? If the patient is unable or unwilling to answer, the practitioner can shift the focus to determining possible ways to be helpful (e.g., "How can I help you?").
VALIDATE
Validate the other person's experience. For example, "Given what you have just told me, it makes sense that you feel angry."
EXPLORE
Explore the next step. For example, "Who can I call to come and stay with you?" or 'This has been difficult for both of us. I am not sure where to go from here. Can I call you tomorrow to see how you are doing?"

7.6 Triggers and dissociation

A trigger is anything (e.g., a sight, sound, smell, touch, taste or thought) associated with a past negative event that activates a memory, flashback or strong emotion. While the focus of this section is on triggers related to abuse, it is not the only cause of this type of adverse reaction to examination and treatment. The suggestions in this section can be used regardless of the origin of the trigger.

> Different stimuli will trigger different people and a practitioner can never remove or avoid every potential trigger in a practice setting.

[After] surgery on my arm ... the [clinician] would put my arm in water ... [That was something] that my perpetrators had done, had victimized me ... [in] bathrooms. Being in the tub area ... had quite an effect. (Man survivor)

Because triggers are directly associated with a particular event or events, they are unique to each individual. This explains why different stimuli will trigger different people and why a practitioner can never remove or avoid every potential trigger in a practice setting. At the same time, common themes in triggers (see Table 4) are apparent and practitioners are encouraged to consider whether some of these potentially triggering situations can be anticipated. If a patient is able to identify a trigger, the clinician

TABLE 4
Common triggers

Sense	Trigger
Sight	• An individual who resembles the abuser or who has similar traits or objects (e.g., clothing, colouring, mannerisms). • A situation where someone else is being threatened or abused (e.g., a scowl, a raised hand, actual physical abuse). • The sight of an object that was part of the abuse or similar to such an object (e.g., a belt, rope, sex toys) or that is associated with the site where the abuse took place (e.g., a dark room, a locked door).
Sound	• Sounds associated with anger (e.g., raised voices, arguments, loud noises, objects breaking). • Sounds associated with pain or fear (e.g., sobbing, whimpering, screaming). • A situation in which the survivor is being reprimanded. • Sounds associated with the place or situation before, during, or after the abuse occurred (e.g., footsteps, a door being locked, a certain piece of music, sirens, birds chirping, a car door closing). • Anything that resembles sounds that the abuser made (e.g., particular words, phrases or tone of voice, whistling, cursing, groaning).
Smell	• Odours associated with the abuser(s) (e.g., cologne or after-shave, tobacco, alcohol, drugs). • Odours associated with the place or situation where the abuse occurred (e.g., mildew, petroleum products, food odours, outdoor smells).
Touch	• Any type of physical contact or proximity that resembles the abuse (e.g., touch on certain parts of the body, touch that comes without warning, standing too close, the sensation of breath on the skin, the manner in which someone approaches). • The sensation of any type of object that was used during abuse (e.g., ice, gel similar to lubricant or semen, the sensation of equipment that is reminiscent of restraints used during abuse).
Taste	• Any taste related to the abuse (e.g., certain foods, alcohol, tobacco).

and patient can problem-solve together to either avoid or minimize that trigger during future interactions.

Clinical practice incorporates many experiences in addition to touch that may trigger a negative response in a survivor even though they seem innocuous to the clinician. Survivors described triggers such as the use of water, ice, traction, or ultrasound gel. They also spoke about medical procedures and treatments during which they had to remain immobile or silent or heard others crying out with pain or anxiety, reminding them of abuse experiences. Other participants told us that a practitioner's body language or reprimands for behaviours interpreted as deliberate non-adherence to recommendations could also trigger intensely negative experiences.

Survivors may or may not be aware of their triggers and may realize that they have been triggered only after they have had this experience. Individuals may also be triggered whether or not they have conscious memory of past abuse or have disclosed to anyone:

> *[During] my first experience [with this type of practitioner], they didn't have any Kleenex, and the minute [the clinicians started] touching me I just started sobbing, without having any idea of ... why.* (Woman survivor)[143p.258]

> *When he did the physical examination I just basically dissociated myself from my body and I never had any idea why ... or how I did it. But looking back now, I used to do that quite a bit. After the examination was over I had no idea what he said to me. The only thing I wanted to do was get out of there. I felt extremely violated.* (Man survivor)

Survivors stressed that it is important that all clinicians have a general understanding about triggers and how to respond to an individual who is triggered:

> *The flashbacks that could happen while you're having an exam. The not being present in the moment ... It would be helpful for a [clinician] to be able to help bring a patient back into the present moment and give them the time to sort through what's going on in their head.* (Woman survivor)[159]

> *If you have a guy crying in front of you and especially if he's a victim, [if you understand triggers], at least you can have some type of understanding of where this person's coming from.* (Man survivor)

Health care practitioners should be attuned to the following behaviours, which may be nonverbal indicators of discomfort, distress, or dissociation:

- Rapid heart rate and breathing (breath holding or sudden change in breathing pattern may also be seen);
- Sudden flooding of strong emotions (e.g., anger, sadness, fear, etc.);
- Pallor or flushing;
- Sweating;
- Muscle stiffness, muscle tension, and inability to relax;
- Cringing, flinching, or pulling away;
- Trembling or shaking;
- Startle response.

These behaviours are probably best understood as "freeze-fight-or-flight" responses to the perception of a threat (i.e., sympathetic nervous system arousal).

The following responses may be clearer indications of dissociation:

- Staring vacantly into the distance;
- Spacing out or being uninvolved in the present;
- Being unable to focus, concentrate, or respond to instructions;
- Being unable to speak.

After being triggered into a dissociative state, an individual may seem confused or vague and ask questions such as "Where was I?", "What did I just say?", or "What just happened?" However,

it is possible that the clinician and even the clients themselves may not know that they have dissociated. Indeed, some survivors only discover as adults that they dissociate under stressful circumstances:

> *The health care practitioner would come into my personal space and.... I would just dissociate. She'd touch me and then I'd just be gone. She worked with a lot of women who were survivors and she knew it. She'd just stop and say, "Where did you go?" And I didn't have a clue what she was talking about. But over the years I started getting a clue.* (Man survivor)

> *Now, [clinicians] don't have to handle the [whole] crisis, but they do need to know how to recognize [it]. And how to make a referral in a nice way [by saying, for example,] "Do you see your counsellor tomorrow?" or "Is there someone you can talk to?" . . . They wouldn't need to go beyond [their scope of practice], but [it is helpful] if they can recognize what can happen when a woman is going through a flashback ... [and know] how to ground a person. It's not hard; ... [it's] just basic humanity and reassurance. You know, "You're okay, it's safe here," or [validating] the energy and the courage that it takes to go through [the specific intervention] ... And [they can say,] "Yes, [this treatment] can trigger memories, and it can be really disturbing and distressful, and what you're feeling is normal."* (Woman survivor)[143p.258]

To support clients who have been triggered and ensure that they do not leave the encounter feeling disoriented or embarrassed about their reactions to treatment, practitioners should:

- Follow the SAVE protocol;
- Orient clients to the present by reminding them where they are and what was happening when they began to have trouble staying present;
- Encourage slow, rhythmic "4-6 breathing" (inhale to the count of four and exhale to the count of six) and (if possible) sitting up and placing their feet on the floor;
- Remind individuals to keep their eyes open and to look around the room;
- Encourage patients to notice physical sensations (e.g., the feeling of their back on the chair and their feet touching the floor, or the sensation of the air on their face).

As clients become more oriented and responsive:

- Do not touch them;
- Offer verbal reassurance in a calm voice;
- Avoid asking complicated questions or giving complex instructions; instead, ask simple questions to try to connect with the person (e.g., "Are you with me?", "Are you following me?", "Do you have ways of staying present?");
- Offer them a glass of water;
- Allow them the necessary time and space to regain their equilibrium (a quiet room may be helpful);
- Normalize the experience. If the patient has disclosed abuse prior to this incident, let her or him know that health care interventions commonly trigger flashbacks or emotional responses, but do not ask for details of past abuse that may have contributed to being triggered. If the patient has not disclosed abuse, frame the normalizing comments in terms of anxiety that many people feel when seeing health care practitioners;
- Ask what the clients need right now (e.g., do they want your company, or would they rather be left alone);
- Offer continuity of care (i.e., if time constraints prevent you from staying with upset clients as long as you would like, explain this and ask if someone else can help, such as another staff member or a friend whom you could call).

Being triggered can be a frightening or bewildering experience. Some clients may benefit from talking about the experience with someone. Thus clinicians should:

- Inquire about whether the patient has someone to offer support and whether they would like to contact that person now (e.g., "A new exam like the one we were doing today can be scary for many people and can bring about very strong emotions, as you just experienced. Sometimes it helps to talk about what happened. Do you have anyone you can process this with? Would you like to call this person to be with you now?").

Being triggered can be a frightening or bewil-dering experience.

- Find out whether patients would like to explore what has happened; if they have no one to talk with, ask them whether they want a referral to a counsellor or other community resource and whether they know about telephone help lines that exist in your community.
- Ask whether the client feels able to continue the examination or treatment.

A person who has been triggered or has dissociated may not retain or recall important information.

A person who has been triggered or has dissociated may not retain or recall important information shared by the clinician. Thus, it is helpful for practitioners to:

- Repeat all instructions;
- Write down instructions and recommendations in clear language.

For individuals who have repeated experiences of dissociation during their interactions with clinicians:

- Suggest that they use a notebook to write information, instructions, and suggestions;
- Share with clients the responsibility for ensuring that essential information is recorded before the end of the interaction.

The next time the practitioner sees the client who has been triggered or dissociated:

- Discuss the experience with clients to ensure that they are feeling better and to reaffirm the message that the event does not alter the esteem in which they are held;
- Problem-solve with clients to identify what to avoid or modify in the future to prevent further triggering, keeping in mind that they may or may not be able to identify the trigger of a particular incident;
- Learn from the individuals what techniques they use to stay present and grounded, including any reminders or instructions that you can give them;
- Suggest – if the severity of the client's reactions and subsequent difficulty so indicates – a consultation with a mental health practitioner to develop additional strategies for coping with triggers.

Some survivor participants suggested that practitioners offer general cautionary messages to clients about adverse reactions to procedures or treatment that are invasive or uncomfortable (e.g., pelvic and rectal exams and dental work):

> *Something that my orthodontist may have never realized, for me with that history of abuse, [is that] when I got the braces on, for three nights in a row I just had horrible nightmares. I was phoning my counsellor and saying, "Can I book an appointment, get in right away?" Because I didn't have a clue what was going on ... All of a sudden I'm having nightmares being that little kid again because of all this prodding and pulling going on in my mouth. I would want an orthodontist handing out a leaflet going, if you've had sexual abuse, keep in mind this could give you nightmares or this could trigger you.* (Man survivor)

If health care providers are shaken or upset by the triggering or dissociation of a client, they should talk with a colleague, a supervisor, or someone within their support system. This can be done without breaching confidentiality.

ⓘ Section 3.5 – Specific behaviours and feelings arising during health care encounters

Section 5.9 – Practitioners' self care

7.7 Anger or agitation

[Anger is] my initial response to almost everything ... I try to hold on to myself, which I do much better than before I was 40. But initially my reaction is to get angry. (Man survivor)

Many men survivors and a few women survivors talked about responding with anger when they are anxious or fearful or have been triggered:

Anger shows up often when you are triggered – like [when] somebody touches you in the wrong place. (Man survivor)

Anger often elicits responses of defensiveness, irritation, or withdrawal.

While it is generally easy to respond compassionately to someone who is sad or afraid, anger often elicits the opposite response – defensiveness, irritation, or withdrawal. This type of response, however, can leave survivors in an even more difficult situation:

You are frightened and everybody is frightened of you. (Man survivor)

Health care providers will benefit from recognizing the connection between anger and past abuse for some survivors as well as from realizing that anger (an emotion) and violence (a behaviour) are distinct entities, not to be confused or seen as one response. Participants recommended that practitioners use the SAVE guidelines to understand the cause of the anger. They advised against trying to control agitated patients' behaviours; rather, they suggested that the clinician: (a) allow clients time to cool down; (b) reflect their observations back to the clients; and (c) work with them in seeking a solution to the problem (i.e., "Don't dictate, negotiate!" (Man survivor)).

A situation can quickly escalate if a practitioner responds to an angry or agitated client with defensiveness or anger. Managing one's own anger is critical to interpersonal effectiveness. Although many institutions and organizations have established policies to deal with angry and violent patients, it remains crucial that health care providers:

- Manage their own feelings of anger;
- Pay attention to personal safety (e.g., do not stand too close, do not make quick or sudden movements, identify an escape route);
- Adopt non threatening body language (e.g., stand with arms uncrossed, at a slight angle to the person to avoid the experience of face-to-face confrontation);
- Speak slowly in a low voice, breathe slowly and rhythmically.
- Encourage agitated individuals to relax and assure them that you are interested both in listening to their concerns and in helping them find solutions to their problems.

8 Guidelines for Sensitive Practice: Disclosure

8.1 The challenge of disclosure for survivors

[Choosing whether to disclose] depends on where you are in your journey. Because sometimes in your journey you don't want them [health care providers] to know [you're a survivor]. (Woman survivor)

Although this discussion speaks of survivors collectively, survivors are not a homogenous group; each survivor is a unique individual with a unique history and point of view. While survivors may or may not disclose their histories, their abilities to recall the abuse and their places in the journey towards recovery consistently play significant roles in disclosure. For example, most of the study participants have always had clear memories of the abuse they experienced, while a smaller number only began to remember the abuse in adulthood. Some attempted to deny to both themselves and others that the abuse occurred:

I just buried it and pretended that it didn't happen ... and sort of just [said to myself], "No, no-how could that affect my life?" And it wasn't until last year I really started to realize that it did affect my life. I knew it wasn't right at the time, way back, but I didn't know that it could potentially have the effect that it had. (Man survivor)

Some survivors also told us that they had always remembered their childhood abuse, but did not identify it as abusive (believing that what happened to them happens to all children) until some new learning prompted them to reconsider their experience:

My awareness of my childhood sexual abuse only dates from about nine or ten years [ago].

[I'm] not saying that I didn't remember things that happened to me. I did, but I didn't appreciate the dynamic that was there and I just sort of thought of them as early sexual experiences and said [to myself], "Well, doesn't that happen to everyone?" Then you suddenly discover that no, it doesn't happen to everyone. The real dynamic just really clicked one day and it really hit me hard. (Man survivor)

Participants described a number of factors that influenced their decisions about whether to disclose to practitioners, and also how much and what information they shared. Some did so spontaneously early in the relationships, while others held back until they felt more comfortable with the clinicians. Still others chose not to disclose at all.

Survivors who disclosed their abuse spon-taneously did so in the hope that the information would help the practitioners to understand them better.

Survivors who disclosed their abuse spontaneously (i.e., not in response to questioning by a practitioner) did so in the hope that the information would help the practitioners to understand them better:

[I disclosed so that the clinician would] have some of the understandings of the feelings that are associated with that part of the physical exam ... – the shame and the guilt and the things that you have going on inside your head, the flashbacks that could happen while you're having an exam, the not being present in the moment. (Woman survivor)

For many survivors, disclosure is a process. Unlike survivors who want to "get it over all at once," others prefer to reveal their history gradually over time, often so that they can take control of the timing and pace of disclosure:

[My doctor's response] helped me, little by little, disclose more of my deep dark secrets

and helped me to ask more questions. (Man survivor)[159]

Finally, some survivors want to avoid having to disclose repeatedly and take a proactive approach to the issue:

At this point in my life I think differently [than I used to about disclosing]. I want "survivor" written on the front of my chart so that [clinicians] know and recognize that I want to be treated sensitively. Then, if a new [person] in the practice sees me it would be a reminder to them. Other survivors may not want that, but I think it would be great if I did not have to disclose every time I see a new [practitioner]. (Woman survivor)

A reluctance to disclose may relate to: (a) survivors' feelings about themselves; (b) pressure from families, friends, or abusers to remain silent; (c) their fear of negative responses; and/or (d) the sense that their practitioners do not have the time to listen or seem unaware of the potential long-term health implications of violence.

Many individuals spoke about how their own feelings of shame and guilt affected their attitudes towards disclosure:

There's a whole lot of shame [about having been victimized] … and disclosing that. (Man survivor).

Others told us of the vulnerability they feel when disclosing:

Every time you disclose, you expose yourself. (Woman survivor)[159]

Previous experiences with disclosure play a major role in survivors' decisions about disclosure. Many were reluctant to say anything because they feared a negative reaction, particularly rejection:

I'm really hesitant on mentioning it to people, especially ... [to health practitioners] – I don't want to start talking about it or mention it and get that rejection. 'Cause that's the worst. 'Cause then I clam up and I – my headaches will probably get worse and everything will just get worse. (Woman survivor)[143p.258,164p.94]

Others fear being blamed for the abuse or being judged:

One [practitioner] that I saw ... reacted with insensitivity, by asking me, "How did you let it happen?" In the moment I felt revictimized and took all of the blame for what happened. That really had an impact on me. (Woman survivor)

Many male survivors, in particular, are fearful that if they disclose past abuse a clinician will assume that they are also perpetrators:

I called the hospital to talk about sexual abuse and they thought that I was the abuser and referred me to domestic sexual abuse centre. (Man survivor)

Both men and women whose abuser(s) were women were reluctant to disclose for fear of not being believed:

Female survivors of female-perpetrated abuse ... experience disbelief as to the likelihood of having been abused by a woman. (Woman survivor)

If it was with a woman it's, "Well aren't you mistaking it for nurturing?" (Man survivor)

Finally, both survivor participants and health care practitioner participants identified practitioners' apparent lack of time as a huge barrier to disclosure:

I was almost 60 when I started [to deal with issues of sexual abuse] and it came to light after a lot of very significant [psychotherapeutic] work of mine ... So these are deep things. In other words, this is a deep question and to think of it in terms of a 15-minute segment [with a clinician] is hard. (Man survivor)

8.2 Possible indicators of past abuse

While there is no single indicator or cluster of symptoms and/or behaviours that provides evidence of past abuse, there is a growing body of research that documents a relationship between

adverse childhood experiences and certain behaviours and/or experiences in later life. Some of these include:

- Avoidance of all health care practitioners and/or health serving agencies;
- Repeated cancellations of appointments;
- Repeated postponement of a physical exam;
- Poor adherence to medical recommendations;
- Chronic unexplained pain (e.g., headache, pelvic, back, muscular);
- Unexplained gastrointestinal symptoms/distress;
- Disordered eating, obesity, or wide fluctuations in weight;
- Sleep disturbances (insomnia, hypersomnia);
- Sexual problems (e.g., avoidance, many sexual partners, unsafe sex practices);
- Alcohol or drug misuse;
- Depression;
- Pattern of difficulty in interpersonal relationships;
- Self-harm behaviours and/or suicide ideations/attempts;
- Posttraumatic Stress Disorder or other anxiety problems;
- Dissociative states (blanking out, long silences).

ⓘ Section 2.5 – Childhood sexual abuse and health

Recognizing clusters or patterns of these behaviours and symptoms along with inconsistencies or gaps in information provided by the patient should alert a clinician to consider the possibility of abuse or violence:

> *But I would ask [practitioners] to go a step further, to [talk] ... to men, particularly males who have addiction problems, who have eating disorders, sleep disorders, depression, anything that has to do with emotion, emotional things or mental health issues. I think it's important that these [clinicians] ... get trained to be able ... to identify [behaviours that may be related to past abuse] and to be up on what the actual symptoms are.* (Man survivor)[159]

Recognizing clusters or patterns of these behaviours and symptoms along with inconsistencies or gaps in information provided by the patient should alert a clinician to consider the possibility of abuse or violence.

It is crucial that health care providers be aware that these indicators, although clearly suggestive of abuse or psychological trauma, may actually stem from other causes. Abuse is not always the source of these behaviours; nonetheless, inquiry about a history of childhood sexual abuse is essential.

8.3 Inquiring about past abuse

A growing body of evidence indicates a relationship between abuse or violence and health problems. Our studies further demonstrate a range of ways in which past abuse can negatively affect survivor-practitioner interactions. Accordingly, inquiring about violence and abuse should be an integral part of collecting a health history:

> *I think it's important that [health care practitioners] ask questions about abuse as part of a medical history, particularly of women, and I think that anyone dealing with women's pain who doesn't ask questions about violence in a woman's life is not doing their job. I feel that very, very strongly.* (Woman survivor)[164p.93]

ⓘ Section 2.5 – Childhood sexual abuse and health

By routinely asking about past violence and abuse, practitioners open the door for individuals

to disclose if they choose to do so. In asking the question, practitioners: (a) demonstrate that they have an understanding of the relationship between interpersonal violence and health; (b) break the harmful silence surrounding abuse and violence; (c) signal that they recognize interpersonal violence as a health issue; and (d) validate their patients' experiences. Asking about a history of abuse can also lead to improvements in health care and may help avoid or reduce retraumatization, which often occurs in health care settings.

Some survivors who want to disclose find the topic too difficult to initiate on their own and are relieved when a practitioner broaches the topic:

> *It was a huge relief to have my doctor ask, "Were you ever abused?"* (Man survivor)

Inquiring about past abuse may also be a first step towards helping a survivor develop a network of support. Because some survivors deal with chronic health problems related to childhood abuse, they may experience ups and downs in their health – that is, periods of time during which they are relatively healthy interspersed with exacerbations of symptoms (e.g., pain, anxiety, or depression). Assessing this pattern as part of the routine health history allows the practitioner to work with the individual proactively to ensure that adequate supports are in place in times of relative health. On the other hand, if a clinician learns about the past abuse for the first time during a crisis, it can be more difficult to respond effectively:

> *If we don't talk about it for years and suddenly open up the can [of worms], it becomes difficult to deal with the outburst of reactions.* (Man survivor)

Inquiring about violence and abuse should be an integral part of a health history.

As one practitioner participant reported:

> *Most patients present for chiropractic care for pain (lower back pain, neck pain, headaches). During history taking I ask if they can identify aggravating factors. Sometimes patients will relate stress as an aggravating factor. At other times I will ask if stress or being emotionally upset causes their symptoms to worsen. If they respond "Yes," then I will ask what the greatest causes of stress are for them ("Is the source of your stress: home life, relationships, work, school, finances, family issues etc.?"). Once the patient confirms that stress is a factor and that they can identify what their main stress reaction triggers are, then I will ask if they have a good support system ("Do you confide in friends, significant others, other family members?"). I next will ask if they actually use their support system. Many patients will respond with comments such as "Not as much as I should" or "Yes, and I think that they are tired of listening to me." At this point I am able to intervene by explaining to the patient that I have a good referral network, and that perhaps they should consider seeing a counsellor. I reassure the patient that I do not necessarily require any details regarding their stress, but many patients will spontaneously divulge ... In short, history taking allows me to develop a relationship with the patient. During history taking, when the patient feels heard and cared for, then the patient will often disclose childhood sexual abuse. Patients are always reassured that they are in control of everything that takes place during their visit. Communication is established during history taking and is reinforced during examination and treatments.*

While our own research and that of others makes it clear that health care practitioners have a professional and ethical responsibility to inquire about abuse or violence, it is important to understand this statement in relation to the debate regarding the evidence pertaining to inquiry about/screening for interpersonal violence. It is also important to acknowledge that not all survivors want to be asked about past abuse and may choose not to disclose:

> *If I wanted to tell him, I'd tell him. It's not his business.* (Man survivor)[159]

As long as health care providers respect the wishes of survivors who prefer not to disclose a

history of abuse to them, there is no harm caused by inquiring about abuse. The Family Violence Prevention Fund's Research Committee made this point when it stated, "We know of no research to suggest that assessment and/or interventions [of family violence or intimate partner violence] in health care settings are harmful to patients."[57p.5] As one survivor participant explained:

> *I don't know that there's any harm in asking. My guess is that if you are denying it or you aren't sure that you want to reveal any secrets, you probably won't say anything. But at least it would give an opportunity to either ask, "What are you talking about?" or to say a little bit about that ... If I'm not ready to talk about it, I'll just skip over that and say I don't know anything.* (Man survivor)

> History taking allows me to develop a relationship with the patient. During history taking, when the patient feels heard and cared for, then the patient will often disclose childhood sexual abuse.
>
> *- Health care practitioner -*

ⓘ Appendix I – The Evidence Debate Pertaining to Inquiry about Interpersonal Violence

For many practitioners, the first step towards routine inquiry about interpersonal violence is an attitudinal one. Studies have shown that barriers to inquiring about interpersonal violence include: (a) a lack of knowledge and training about the topic and how to ask relevant questions;[44,80] (b) lack of privacy and time limitations;[55] (c) the belief that abuse is not a problem for their patients; and (d) frustration with being unable to help the victim.[119] A clinician's own experience with violence might also factor into an unwillingness to address the topic with patients.[110] Nonetheless, routine inquiries about interpersonal violence are fundamental to Sensitive Practice:

> *Surely [practitioners] realize that it's a part of who I am and it needs to be acknowledged, and it does have an impact in terms of how I need to be treated.* (Woman survivor)

> For many practitioners, the first step towards routine inquiry about interpersonal violence is an attitudinal one.

Both women and men described a number of factors that might encourage disclosure. They look for signals that the clinician has an understanding of the effects of interpersonal violence, including posters and pamphlets (directed at both women and men) prominently displayed in waiting rooms, washrooms, and examination rooms. Survivors also stressed the importance of feeling safe, and trusting their practitioners:

> *My doctor made me comfortable from the beginning so I felt I had someone to talk to. I've been married for 28 years and I wasn't even able to tell my wife, but I was able to tell him. If I wasn't able to tell him I don't know if I would have been able to move in the direction of recovery.* (Man survivor)

> *There was this one specific [practitioner who] was just so, so kind ... that person would definitely be someone that I would not have a problem sharing, you know, what had happened to me, what I had experienced.* (Woman survivor)

Survivors emphasized the importance of confidentiality in their decision to disclose:

> *I guess the primary issue is ... confidentiality. [I need to know,] are you going to tell anybody? Are you going to do anything with the information?* (Man survivor)

Although a number of professional and regulatory/licensing bodies have guidelines and recommendations in place for inquiring about past violence or abuse (e.g.,[6,7,12]), most are not specific about how to approach the task. As gastroenterologists Alexandra Ilnyckyj and Charles Bernstein[88] observe, this lack of specificity contributes to the fact that, in practice, inquiries about past violence or abuse are not part of routine care, even when health care providers may suspect that it is relevant for an individual.

Recommended Reading and Resources – Screening tools

The therapeutic relationship and the health care environment are crucial factors in the inquiry about past abuse. The Society of Obstetricians and Gynaecologists of Canada[153p.366] clinical practice guidelines offer a valuable reminder to clinicians about the therapeutic relationship: "Several validated questionnaires exist for enquiring about [interpersonal violence]; however, the nature of the clinician-patient relationship and how questions are asked seem more important than the screening tool." Regarding the environment, survivor participants emphasized that privacy and clearly visible and available information (e.g., posters or brochures) convey the impression that a practitioner acknowledges the relationship between interpersonal violence and health.

Verbal inquiry. There is no one correct way to ask about a history of childhood abuse. Direct approaches are a relief to some survivors, but may be too intrusive for others. Introducing questions in a way that relates past abuse to health and health care provides context and rationale. Practitioners could draw on the following statements as possible lead-ins to an inquiry of childhood sexual abuse history:

There is no one correct way to ask about a history of childhood abuse. Direct approaches are a relief to some survivors, but may be too intrusive for others.

- "Research tells us that child sexual abuse among both girls and boys is much more common than was once believed. We also know that it can have long-term health effects."
- "Is there anything in your history that makes seeing a practitioner or having a physical examination difficult? If there is, I would like to hear about it so that we can work together more easily."
- "Some women (or men) want to talk with their health care providers about very personal or difficult topics. If you do, I am open to hearing about them."

Statements and questions such as these may open the door to disclosure, either in the moment or at some later time. If an individual hesitates or seems very reluctant to respond, another effective response from a clinician would be something such as:

- "I know these things can be hard to talk about. I think it is important to ask because there is growing evidence that violence and abuse can affect a person's health and create difficulties when they see health care practitioners. You don't have to discuss this with me if you don't want to. If you do, I can work with you to ensure you are comfortable when you see me and to get whatever support or assistance you need."

Regardless of how the questions are framed, participants told us that trust in their healthcare provider influenced their decision to disclose:

> *I had one [practitioner] ask me, "Was there any trauma in your childhood or lately that could cause these symptoms?" And right then, I thought, "Oh, okay. I can talk about it. And I'm not going to get rejection."* (Woman survivor)

Some men survivors told us that they were unclear whether clinicians were asking if they were victims or perpetrators of sexual abuse when asked questions such as, "Have you encountered sexual abuse?" Therefore, they urged health care practitioners to clearly ask if the man is a *victim* of past abuse.

Most of the survivors in our research, both women and men, indicated that they did not want to discuss the *details* of their abuse with their practitioners:

> *Some people press for more info upon disclosure and that is invasive and unacceptable.* (Woman survivor)

Written inquiry. Survivors in our studies varied in their views about the merits of written and oral

inquiries. Proponents of written questionnaires believe that they are less intimidating than verbal inquiries. Others prefer verbal inquiries, because they open the door for an ongoing conversation. Given what survivors told us about their preference for a written or verbal approach to assessment, it seems that the most prudent strategy is for health care providers to use both written and verbal forms to collect every health history and to keep in mind that survivors may or may not choose to disclose.

8.4 Responding effectively to disclosure

Well, for one thing, it's really important [to tell survivors] ... that you believe them, because this might be the first person they've told. And also, it's really important to accept them as a person. You can say whatever your real feelings are. [For example,] "I'm really sad to hear that." (Woman survivor)[143p.258,164p.95]

> The most prudent strategy is for health care providers to use both written and verbal forms as part of every health history.

Communicating to survivors that they have been heard and believed is crucial whenever survivors disclose. While follow-up is also important (as the next section indicates), the practitioner's immediate verbal and nonverbal responses to disclosure can have a tremendous impact on the survivor.

Accept the information. Individuals need to know that their health care providers have heard them, have accepted the information, and believe that children are never responsible for abuse:

His response was first one of acknowledging what I said and, you know, genuinely looking like he cared and kind of going with that and not really pushing anything, not giving me advice or telling me what to do but, you know, just kind of going slowly with me through that. And I found that was excellent. (Woman survivor)

When survivors disclose their history of abuse, it is usually because they hope that something positive will come from it. If practitioners do not respond, survivors may interpret the silence as an indication of lack of interest, which may deter them from mentioning it again. Moreover, they may stop seeing that particular clinician or, in the extreme, avoid all health services:

I told the [health care provider] about my history of abuse. She didn't acknowledge [it] ... She just kept right on going with what she was doing ... Oh boy! If somebody says it, then you've got to acknowledge it. Because then what that says to me is that it's not valid, it's not important, it doesn't have anything to do with us. (Woman survivor)[164p.95]

Express empathy and caring. Survivors also want to know that their practitioners care about them. Simple statements of empathy and concern can convey both compassion and interest:

He just looked at me and he said, you know, I'm really sorry this happened to you. And that was the best thing he could have said. (Woman survivor)[159]

I remember feeling comforted by her, probably by her words. She probably said, "It's okay to cry" or she might have even rubbed my arm. I remember her telling me that she was going to give me a phone number where I could call so I could talk to somebody about it, which she did. She handled it very professionally. (Woman survivor)

Clarify confidentiality. Confidentiality is a vital concern for many survivors. Although a clinician may have already discussed it previously, following a disclosure of abuse, health care practitioners need to repeat information about the level of confidentiality that they can extend. For example, the clinician might say, "Because you are an adult now, I am under no legal obligation to report this to police or a child welfare agency" and "I think it is important to write something about your

childhood history in the chart. What would you like me to put down?"

ⓘ Section 8.7 – Legal and record-keeping issues

The most important thing is, "Whatever you say is confidential with me." Because confidentiality is so huge. (Man survivor)

Acknowledge the prevalence of abuse. Understandably, many survivors feel very isolated and alone in their experience. Having health care providers demonstrate awareness about the prevalence and long term effects of childhood sexual abuse normalizes the experience for survivors and may reduce their sense of shame. For example, a clinician might say, "We know that as many as one in three women and one in seven men are survivors of childhood sexual abuse. It is sad to realize that so many children have suffered in this way."

Validate the disclosure. Health care practitioners must validate the courage it took to disclose and communicate that they believe what they have been told. Visible distress needs to be acknowledged (e.g., "I see that this is painful [distressing, disturbing] for you right now. What can I do to help?" or "It is okay if it takes more than one visit to do a complete examination"). Failure to validate the individual's experience, silence, or judgemental comments can be shaming and contribute to a reticence to disclose in the future:

Health care practitioners must validate the courage it took to disclose and communicate that they believe what they have been told.

[It is important] to validate that experience because ... [it is hard] to keep that buried for 20 years and then bring it out and start talking about it and then look across and see a look of what you might perceive to be disbelief in somebody's eyes and you're wondering inside yourself, you know, . . maybe I am crazy and it didn't really happen or it wasn't like that or, you're supposed to be a man and it wasn't that bad and just shake it off and carry on right? (Man survivor)[167p.510]

Address time limitations. Time pressures are one of the biggest impediments to disclosure. If individuals disclose a history of abuse and the health care provider can spend only a few minutes with them afterward, it is important that the time constraints are communicated in a way that will not leave survivors feeling dismissed or that they have done something wrong by disclosing (e.g., "Thank you for telling me about being abused. I can only imagine how difficult things have been for you. I have another patient waiting – do you want to book a longer appointment later this week?").

ⓘ Section 4.2 – Second Principle: Taking time
Section 6.5 – Time
Section 8.5 – Additional actions required at the time of disclosure or over time
Section 8.6 – Responses to avoid immediately following a disclosure

Offer reassurance. Because individuals who have disclosed have shared some very personal information, they may feel vulnerable and exposed – both at the time of the disclosure and during future encounters with the practitioner to whom they have disclosed. To minimize this sense of vulnerability, practitioners can reassure survivors that they applaud the courage it takes to talk about past abuse and that the information that has been shared will be useful in providing appropriate health care.

Collaborate to develop an immediate plan for self-care. Some survivor participants identified unsettled feelings or flashbacks of their abuse as an immediate after-effect of disclosure:

I was triggered more, and I was getting more flashbacks after [disclosing the abuse]. (Man survivor)

Accordingly, health care providers should caution individuals who have just disclosed to be prepared for these feelings. They should then work with survivors to make a specific plan for self-care

(e.g., "Sometimes talking about past abuse stirs up upsetting memories. Tell me what you can do to look after yourself if this happens to you."). In working out this plan, clinicians should encourage individuals to:

- Include activities and coping strategies that have been successful (i.e., are supportive, comforting, or help the individual to manage distressing emotions).
- Be specific and realistic, and include things that are easy to implement in a moment of distress. An unspecific plan (e.g., to take it easy for the next few days) may be too ambiguous to translate into meaningful activity, whereas a more specific plan (e.g., to call a specific support person or engage in a specific activity, such as going to the gym, meditating or praying, writing in a personal journal, or attending a self-help group meeting) gives survivors clear direction.
- Include ideas about what to do if the usual coping strategies do not work. This step is particularly important if the individual has a history of depression or self-harm. It might involve calling a health information line or crisis line or going to the emergency department of the local hospital.

Recognize that action is not always required. Health care practitioners tend to be problem-oriented and may respond to disclosure as a problem that requires immediate action or resolution; however, survivors may simply want the clinician to have the information. Survivors who have just disclosed may not necessarily expect clinicians to do anything except to be present with them in the moment. While it is important to ask survivors if there is anything they want done related to their disclosure, it may be preferable to identify a later time for discussion about what actions (if any) the survivors want from the practitioner.

Survivors who have just disclosed may not necessarily expect clinicians to do anything except to be present with them in the moment.

ⓘ Section 8.5 – Additional actions required at the time of disclosure or over time

Ask whether this is the patient's first disclosure. As well as responding to a disclosure as outlined above, health care providers can inquire whether the patient is disclosing for the first time. By asking "Have you talked with anyone else about this?" practitioners can get a sense of whether the survivor has previously taken any steps to address the abuse. An answer of "No, I have never told anyone before today," as compared to "Well, my counsellor knows and suggested that I tell you," can help clinicians to shape their next response. It may also help them learn what supports the clients have in place and what they may need.

8.5 Additional actions required at the time of disclosure or over time

Either immediately following the disclosure or during the next interaction, health care providers should seek to understand the survivors' reasons for disclosing and determine what (if anything) they want from the practitioners. It is also important to clarify the survivors' general expectations of the clinician and to explore any implications that the disclosure has for the survivors' health care. Such questions need to be asked in a manner that indicates clear support for the individuals' choice to disclose and may provide a bridge to discuss ways to maximize their feelings of safety and comfort. While such discussions may take some time (and be spread over a few interactions), the information which comes from them will provide a basis for future interactions:

> *When I came in, [the clinician] said, "I did some reading up on your condition," and he said, "This is what we're going to do." He says, "We're going to work out a system, okay, so that I know if you're having trouble and you need to stop."* (Woman survivor)

Practitioners might say, for example, "Knowing this will help me care for you better. Can we talk about things that might make you more comfortable during your appointments?" or "Is there anything I can do differently?" The ensuing discussions may lead to disclosures of task-specific issues as survivors gradually feel freer to express their needs or preferences. As difficulties are identified, clinicians can integrate changes into the individual's ongoing care. Regardless of what is accomplished, health care practitioners should not assume that all issues have been dealt with in one or two discussions; rather, they should check in with their clients throughout each interaction and make repeated invitations for feedback:

> Health care providers should not assume that all issues have been dealt with in one or two discussions; rather, they should check in with their clients throughout each appointment and make repeated invitations for feedback.

[The practitioner could say,] "Just let me know [what you need]; the lines are open. I know this [abuse] happened and if you need to talk about it or have any questions [you can talk about them with me]." (Man survivor)

[After] I told him I was a survivor ... he always questioned if I was comfortable doing anything ... Communication was more [important]. (Woman survivor)

Some survivors hope for a response that is beyond the clinician's ability or scope of practice. It is therefore important for practitioners to be clear about what they can and cannot do to help. If clinicians feel that individuals require assistance beyond that which they can offer, then a referral to someone more able or qualified may be suggested.

Most survivors recognized that disclosing their history of abuse was important to both their health and their health care. Nevertheless, many were concerned that, once they had disclosed their history of childhood sexual abuse, their health care practitioners would tend to attribute their health problems to the abuse before thoroughly investigating other possible reasons for the problems:

[Practitioners] should never assume. Just because I was abused, that doesn't or shouldn't rule out the possibility that there could be something physical and serious that is wrong. That's one of the reasons I don't like to tell ... health practitioners about my abuse. They tend to write everything off as nerves and don't even check to see if the problem is something else. (Woman survivor)

While an abuse history may contribute to some illnesses, it is the clinician's responsibility to ensure that health problems are investigated thoroughly for all patients.

Because of the vulnerability that they felt after disclosing their abuse histories, some survivors were wary about being referred to other health care practitioners. Although clinicians typically see referrals as a normal and reasonable action to ensure accurate diagnosis and treatment, survivors may think that the referral implies that their practitioners cannot take care of them because they are "too complicated." As well, survivors may feel uncomfortable or anxious about having to meet one more clinician, whom they do not yet know or trust.

All patients have the right to make an informed choice about the health care practitioners with whom they will work. Thus, before making referrals, practitioners are encouraged to discuss the issue with their clients in order to come to an agreement on a new practitioner. These discussions may be very significant for survivors who, for example, are uncomfortable working with clinicians who are the same gender as their abuser(s). Whenever possible, practitioners should refer to health care providers who are knowledgeable about and sensitive to issues of interpersonal violence. Local resource registries may maintain a list of service providers (including health care practitioners) who specialize in working with survivors.

While some survivors may disclose past abuse as a lead-up to asking for a referral to specialized

counselling or support services, it is a mistake to assume that all survivors who disclose need or want to be referred to a mental health practitioner. By offering a referral before exploring the survivors' intentions, practitioners may give the impression that they think they know what is best for the individual or do not want to deal with the disclosure. An immediate referral to a mental health practitioner, regardless of whether the client is having difficulties related to past abuse, can feel like a clear statement that the clinician has judged the survivor to be "not okay." Under many circumstances, raising the issue of referral to a mental health practitioner may best be postponed to a later interaction so that practitioners can reinforce their acceptance of the survivor after the disclosure.

ⓘ Section 5.10 – Community resources for survivors and health practitioners

A preferable response to disclosure is for practitioners to ask about the presence and effectiveness of supports (e.g., friends, family, counsellor, spiritual advisor, or self-help group) available to the survivor. Such questioning gives the practitioner information about the survivor's current resources and helps identify gaps. Questions such as "To whom do you turn for support?" or "Do you have enough support in your life?" can help assess the individual's situation. Further questions can help the practitioner make survivors aware of the organizations in the community that offer information, support, and other services to survivors:

> *I needed to be reminded of resources and also that it was okay for me to call and use the resources. I needed permission to get the support I need.* (Man survivor)

8.6 Responses to avoid following a disclosure

There are, unfortunately, instances when health care practitioners fail to respond sensitively to a disclosure. This failure often leaves the survivor who has risked sharing deeply personal information feeling more distressed.

TABLE 5
Components of an effective response to disclosure

After hearing a disclosure of past abuse, the clinician should:
• Accept the information • Express empathy and caring • Clarify confidentiality • Normalize the experience by acknowledging the prevalence of abuse • Validate the disclosure • Address time limitations • Offer reassurance to counter feelings of vulnerability • Collaborate with the survivor to develop an immediate plan for self care • Recognize that action is not always required • Ask whether it is a first disclosure
At the time of disclosure or soon after:
• Discuss the implications of the abuse history for future health care and interactions with clinician • Inquire about social support around abuse issues

[Sometimes] someone [will start] to disclose [and the practitioner will say,] "You don't have to tell me this if you don't want to." People who are really nervous about hearing [a disclosure] keep saying that, and it gives the message, "I don't want to hear this." (Woman survivor)

Negative responses (such as ignoring the disclosure, disbelief, denial of the negative impact of the abuse, or telling a survivor to "just get over it") are both painful and silencing:

He told me that I should just get over this and move on. (Woman survivor)

Don't push the person and be really aware not to use the "shoulds," like "You should call the crisis line." (Woman survivor)[143p.259]

Men survivors also cautioned against minimizing the effects of female-perpetrated abuse. Viewing the survivor as lucky to have had such an early introduction to sex or perceiving the abuse as merely a sowing of wild oats was very damaging.

8.7 Legal and record-keeping issues

Legal obligations. In our studies, we use the term *disclosure* to refer to survivors telling health care practitioners that they have a history of childhood abuse, as distinct from *task-specific disclosure*, which occurs when individuals identify discomfort or difficulty with all or part of a specific examination or treatment. With the exception of this section, when we speak about disclosure in this handbook, we are referring strictly to *adults* revealing a history of *past abuse*.

Health care practitioners do not have a legal obligation to report *past* child abuse disclosed by an *adult*, unless, in disclosing his or her own experience, an individual identifies a child who may be currently in need of protection (e.g., if a male patient who was abused by a family member tells the practitioner that he has reason to believe that the same perpetrator is continuing to abuse children).

In contrast, all Canadian jurisdictions, except Yukon, have laws that mandate a duty to report cases of suspected abuse or neglect of children to child welfare agencies or to police.[103,127] Although the definitions of a child and the definitions of a child at risk vary somewhat among individual provinces,[127] these same laws require that all cases of suspected abuse of children (under the age of majority) be investigated by the appropriate child welfare service to determine whether the children are in need of protection. When the suspicions are substantiated, child welfare authorities are mandated to intervene.

Responses to avoid after a disclosure

Survivors identified the following responses as clearly not helpful:

- Conveying pity (e.g., "Oh, you poor thing").
- Offering simplistic advice (e.g., "Look on the bright side," "Put it behind you," "Get over it," or "Don't dwell on the past.").
- Overstating or dwelling on the negative ("A thing like that can ruin your whole life").
- Smiling (while you may hope that your smile conveys compassion, a neutral or concerned expression is more appropriate).
- Touching the person without permission even if you intend it as a soothing gesture.
- Interrupting (let the individual finish speaking).
- Minimizing or ignoring the individual's experience of abuse, the potential impact of past abuse, or the decision to disclose (e.g., "How bad could it be?", "I know a woman that this happened to and she became an Olympic gold medalist," "Let's just concentrate on your back pain," or "What's that got to do with your sprained ankle?").
- Asking intrusive questions that are not pertinent to the examination, procedure, or treatment.
- Disclosing your own history of abuse.
- Giving the impression that you know everything there is to know on the subject.

If clinicians think that they have inadvertently responded to the disclosure in an inappropriate way, or if the patient's nonverbal feedback suggests a negative reaction to their initial responses, they should immediately clarify the intended message and check with the survivor for further reaction.

It is the responsibility of all health care practitioners to know the legal requirements for reporting child abuse and neglect in their jurisdiction. Information and guidance about this obligation is available from regulatory/licensing bodies and local child welfare authorities (Children's Aid Societies or Child and Family Services).

Health care records. Health care records are both a means of communication among health care practitioners and legal documents. The type of information collected and how it is documented and shared must comply with national, provincial, and territorial legislation. The onus is on all practitioners to understand and comply with the privacy and confidentiality requirements within their jurisdiction.

It is the responsibility of all health care pra-ctitioners to know the legal requirements for reporting child abuse and neglect in their jurisdiction.

In the interests of safeguarding the privacy of Canadians, the federal, provincial, and territorial deputy ministers of health have undertaken the development of the *Pan-Canadian Health Information Privacy and Confidentiality Framework*.[78] The aim of the *Framework* is to address Canadians' privacy and confidentiality needs and to articulate "a harmonized set of core provisions for the collection, use, and disclosure of personal health information in both the publicly and privately funded sectors." The *Pan-Canadian Health Information Privacy and Confidentiality Framework* outlines a set of core provisions aimed at protecting the privacy and confidentiality of individuals' health information, while at the same time enabling the appropriate sharing of information to facilitate effective health care. These core provisions are consistent with the *Canadian Charter of Rights and Freedoms* and with *The Personal Information Protection and Electronic Documents Act (PIPEDA)*[40] and endeavour to reflect the realities of the current health system.

A guiding principle underlying the *Framework*[78] is that the collection, use, and disclosure of health information are to be done on a need-to-know basis and with the highest degree of anonymity possible under the circumstances. Furthermore, the *Framework* understands privacy as a consent-based right and, unless otherwise stated in legislation, an individual's consent must be obtained for any collection, use, and disclosure of personal health information. As well, Alberta, Saskatchewan, Manitoba, and Ontario have enacted provincial legislation that addresses the collection, use, and disclosure of personal health information by health care providers and health care organizations.

Documenting a history of abuse. Some of the survivors in our studies specifically asked their health care providers not to document past abuse. In responding to this request, a practitioner needs to balance the patient's right to privacy and legal reporting requirements. While not reporting suspected abuse of a child clearly contravenes the intent of the law, the same is not true of past abuse of a person who is currently an adult. Both practitioner and survivor participants concluded that it is important for clinicians to discuss with their patients how documentation of past abuse might be done while still protecting their privacy. Survivors, for example, might agree to a chart note that states they have a history of abuse but provides no further details. Privacy may, however, be an issue when working with patients whose care is being paid for by a third party (e.g., insurance companies, employee assistance programs, or workers' compensation). Clinicians involved in fee-for-service practices are urged to pay particular attention to the reporting that is required of them.

In responding to survivors' requests not to document their abuse histories, a practitioner needs to balance the patient's right to privacy and legal reporting requirements.

Health care practitioners are further urged to consider the possible ramifications of sharing information about patients' histories of abuse

when referring them to other health care practitioners:

> *On many occasions when I've been referred to a specialist, it has been noted in the referring letter/form that I have a history of abuse. Too often the referring [practitioner] assumes it is sexual abuse although I have never specified. I have learned the hard way that this information is not seen only by the [receiving health care practitioner] ... but is also read by some of the staff at the clinic I am going to. I don't want my history of abuse broadcast to the world so I now ask the referring clinician to state that a sensitive approach to any physical examination is required rather than disclose my abuse history. If the referring doctor needs to know, I am in a position to disclose or not and to only that person.* (Woman survivor)

Documentation about past abuse may have legal implications for clients who are (or may in the future be) involved in a court case. If, for example, a client chooses to press criminal charges or launches a civil action against an abuser, or if civil litigation follows a motor vehicle crash, relevant health records may be subpoenaed. Sometimes the records will be sought to support the client's case; however, in other instances, they might be used to challenge the client's credibility or account of events. Regarding consent for the provision of medical records to insurance companies, survivors should be advised that they have the option of sharing all or only specific portions of their record. Health care practitioners are strongly encouraged to seek legal advice in situations where a client's health record is requested by a third party before taking any action.

ⓘ Section 5.8 – Collaborative service delivery

8.8 Questions for reflection

- Does my environment foster a sense of safety for potential disclosure?
- Do my clients trust me enough to disclose? Are there any steps I could take to increase their feelings of trust and safety?
- How do I want to integrate routine inquiry about child sexual abuse? Do I have a "script" that feels natural to me?
- How would I feel if a client disclosed a history of child sexual abuse? Are my reactions different for males and females? How would I know whether my reactions are helpful for my clients?

9 Summary and Concluding Comments

9.1 Clinicians' contributions to survivor's healing from childhood sexual abuse

> *I think that we're talking about really long-term partnerships with a number of medical people ... maybe a physiotherapist, a psychotherapist, a family doctor. We need these nuclei of support, and they need to be in touch with each other, and I have that, so I feel like I have a network of support.* (Woman survivor)[143p.259]

All forms of violence and abuse can leave an individual feeling disempowered and disconnected from others. Healing from abuse involves re-empowerment and reconnection with self and others.[81] Because the harm of abuse occurs in the context of relationships and because it affects individuals' ability to relate with others, healing can only occur in relationships. Relationships with caring others provide the substrate – the nutrient medium – for healing the parts of the self that were damaged by past trauma. The absence of trusting relationships leaves survivors isolated in their shame. Through engagement with others, survivors can learn to rebuild their basic capacities for autonomy, trust, and intimacy.[81] Health care practitioners can be allies in that process by offering effective and sensitive health care in the context of genuine human connection. They can also facilitate reconnection by helping survivors learn about their bodies and how they function in health and illness.

9.2 Sensitive Practice and patient-centred care

Some would argue that the Sensitive Practice paradigm is redundant – that client-centred care, by definition, incorporates all that this *Handbook* describes. However, we have a different perspective. While the *Handbook* includes neither all possible ways that practitioners can be sensitive to survivors nor all of the ways that interpersonal violence can affect an individual's health or health care experiences, we have come to see Sensitive Practice as a refinement or "fine tuning" of patient-centred care. If all practitioners were knowledgeable about the association between abuse and health, then Sensitive Practice might not be necessary. Unfortunately, many curricula devote little attention to violence and abuse and their implications for health and health care,[169] and some practitioners remain convinced that our health care system cannot afford the few extra minutes it takes to enact Sensitive Practice. We suggest that, especially in light of the pressures on the health care system, failure to practice sensitively is tantamount to abdicating our ethical responsibility to do no harm.

Thus, we encourage all health care providers to become more aware of the effects of violence and abuse and to ensure that their words and behaviour communicate this understanding in a sensitive way. By fine-tuning our patient-centred approach, we will make greater strides in helping patients become healthier and better functioning members of society. Although a practitioner's contributions to an individual's healing are not always measurable, survivors have reminded us that the trust and safety that allow (re)connection within a strong therapeutic relationship can be hugely helpful to them. And the possibility that the survivor will be further empowered to make gains, however slow, holds bright promise:

> *So, what we have is a relationship of ... mutual give and take ... [The clinician] gives me a lot of responsibility; I give her a lot of information; we negotiate how best to work [together] to help me to fulfil my needs and to let me have power over my own life.* (Woman survivor)[143p.260]

APPENDIX A: Empirical Basis of the Handbook

This *Handbook* is informed by two multi-disciplinary, multisite research studies that employed grounded theory[67] and action research[126] methods. The overall intent of the project has been to facilitate a process by which childhood sexual abuse survivors and health care practitioners collaborate to develop practice knowledge that influences health care.[166] In the first study, we explored women survivors' experiences of physical therapy, consulted with survivors, physical therapists and physical therapy students to develop guidelines for Sensitive Practice, and summarized the results of the study in a handbook. In the second study, we addressed gaps and questions from the first project, by asking men and women survivors about their experiences with and ideas about Sensitive Practice for a wide range of health care practitioners (including but not limited to physicians, nurses, nurse practitioners, oral health practitioners, massage therapists, complementary therapy practitioners, and other health care practitioners without special training in mental health/psychiatry or psychotherapy). We then engaged health care practitioners and survivors in a dialogue about Sensitive Practice and the creation of this second edition of the *Handbook*.

The first research project was conducted in three phases. In the first phase, 27 adult female childhood sexual abuse survivors in Saskatchewan and Ontario were interviewed. The women were between 19 and 62 years of age and from a broad range of educational backgrounds, professions, and income levels; 26 identified themselves as Caucasian and one woman self-identified as Métis. All had been referred for physical therapy in either inpatient or outpatient clinics; four had declined to see physical therapists. Transcripts of the interviews were analyzed and the central themes identified.[142,143,158,164]

In the second phase of the project, working groups of four survivors and four physical therapists in each group met in Saskatoon, Saskatchewan, and Waterloo, Ontario, four to six times over six months to refine the themes into principles and guidelines for Sensitive Practice. In the final phase of the project, the information from the interviews and working groups was used to draft the first edition of the *Handbook*. Approximately 200 survivor participants, other survivors, physical therapists, physical therapy students, and counsellors across Canada commented on successive drafts in writing or during focus groups. This lengthy and broad consultative process was intended to ensure the clinical relevance of the first edition of the *Handbook*.

In our second study, we focused on survivors' experiences with *all* types of health care providers. We conducted individual interviews with 49 men survivors and talked with one group of nine men. Interviews were conducted in six provinces (British Columbia, Alberta, Saskatchewan, Ontario, Nova Scotia, and New Brunswick). We also conducted interviews with 19 women survivors in Saskatchewan and Ontario. Repeated efforts to recruit Aboriginal survivors and survivors of colour were not overwhelmingly successful. Eight men and one woman self-identified as Aboriginal (Métis or First Nations). Participants ranged in age from 24 to 62 years. Participants were from a broad range of educational backgrounds, professions, and income levels.[157,159,167]

As in the first study, themes from these interviews served as the starting point for two working groups in each of two cities. In Winnipeg, one working group was made up of four male survivors and three nurses and nurse practitioners and the other working group consisted of four male survivors and four physicians. In Saskatoon, one working group included four female survivors and three nurses and the other was made up

of three female survivors and four physicians. The groups met three or four times over four months. Interview findings and recommendations from the working groups in both studies were incorporated into a draft of the second edition of the *Handbook* that was sent to all participants. Feedback was incorporated into draft 2 and was sent to 110 health care practitioners representing a wide range of health disciplines and perspectives (including those from academic training programs, professional associations, regulatory/licensing bodies and various practice settings). Feedback was received from 56 consultants, including aroma therapists, chiropractors, dentists, dental hygienists, dental assistants, individuals teaching and researching in the area of kinesiology and sport, massage therapists, mental health practitioners, midwives, naturopathic doctors, nurses, nurse practitioners, physicians, physical therapists, occupational therapists, and reiki practitioners. Draft 3 was developed from this consultation and was used for further consultations with six focus groups of health care practitioners and students. In total, approximately 200 survivors and health care practitioners from across Canada participated in this consultation process.

APPENDIX B: Prevalence of Childhood Sexual Abuse

Because childhood sexual abuse is often unreported in childhood or adolescence, adult retrospective studies are the most common source of prevalence estimates. The most current and reliable lifetime prevalence estimates are that as many as one third of women and 14% of men are survivors of childhood sexual abuse.[25,31,62] Accurate accounting of the occurrence of childhood sexual abuse is hampered by methodological issues related to reporting barriers (e.g., shame, guilt, self-blame, fear, etc.), definitional controversies, population sampled (community vs. clinical), method of data collection (e.g., self-report questionnaire vs. interview), response rates, and the number of questions researchers ask about childhood sexual abuse.[62,122,135,184] This helps to explain the wide range in reported results and suggests caution when interpreting results and making cross-study comparisons.

Large community-based studies of the incidence and prevalence of childhood sexual abuse among children and youth are rare, with the most comprehensive one being a telephone survey of 2,000 U.S. residents (aged 10-16 years) done by David Finkelhor and Jennifer Dziuba-Leatherman.[65] These authors report that in the year preceding the interview, 3.2% of girls and 0.6% of boys had experienced contact childhood sexual abuse, which was defined as "a perpetrator touching the sexual parts of a child under or over the clothing, penetrating the child, or engaging in any oral-genital contact with the child."[65p.419] In the overall sample, the combined prevalence of attempted and completed childhood sexual abuse categories was 10.5%.

Community-based probability samples typically find that 12%-35% of women and 4%-9% of men have had an unwanted sexual experience before the age of 18 years.[122] After adjusting for sample-related variation, response rates, and differences in definitions across 16 cross-sectional community sample surveys, Kevin M. Gorey and Donald R. Leslie[70] determined that the prevalence of childhood sexual abuse was 16.8% for women and 7.9% for men. In his review of large community-based studies in 19 countries around the globe, Finkelhor[63] found that the prevalence of childhood sexual abuse was 7%-36% for females and 3%-29% for males, indicating that childhood sexual abuse is an international problem and has been found in every region where it has been studied. More recent studies in non-Western countries confirm this (e.g.,[41,98]). David Murray Fergusson and Paul E. Mullen,[60] after examining community-based prevalence from several countries, concluded that between 15% and 30% of females and between 3% and 15% of males report exposure to some form of unwanted sexual attention in childhood. This is consistent with John Briere and Diana Elliot's recent study,[31] which found 32.3% of women and 14.2% of men reported sexual abuse in childhood. In the latter work, 21% of adults who reported histories of childhood sexual abuse also experienced physical maltreatment.

The prevalence of childhood sexual abuse is even higher among individuals with disabilities. A review of literature regarding children with disabilities,[83] defined as "the full spectrum of physical, mental, and emotional impairment,"[83p.1018] cited research that reported children with disabilities are almost twice as likely to be neglected, 1.6 times more likely to be physically abused, and 2.2 times more likely to be sexually abused than are children without disabilities.[83] Other studies report even higher rates of sexual abuse for children with disabilities.

APPENDIX C: Traumagenic Dynamics of Childhood Sexual Abuse

Some of the common problems experienced by childhood sexual abuse survivors are summarized in Table 6 using David Finkelhor and Angela Browne's conceptualization of the traumagenic dynamics of childhood sexual abuse.[64] These dynamics describe the impact that abuse-related behaviours, events, and experiences can have on their victims.

TABLE 6

Traumagenic dynamics of childhood sexual abuse

Characteristic	Dynamics	Possible Manifestations
Traumatic Sexualization	• Rewarding a child for sexual behaviour may heighten the salience of sexual issues for him or her • Receiving attention and affection for sex can affect a survivor's ability to achieve a healthy sense of love and belonging • Sexual parts of the child may be fetishized • Abuse may impart misconceptions about sexuality (e.g., sexual identity, sexual orientation, sexual behaviour, and sexual morality) • Sexual activities may become conditioned to negative emotions and memories, creating an aversion to sex or intimacy	• Avoidance of all things sexual • Preoccupation with sexual matters or compulsive sexual behaviours • Precocious sexual activity • Aggressive sexual behaviours • Promiscuity • Prostitution (making use of or working in the sex trade) • Sexual dysfunctions (e.g., lack of desire, difficulty with sexual arousal, inability to experience orgasm, and avoidance of sexual intimacy)
Betrayal	• Childhood sexual abuse manipulates a child's vulnerability, violates the expectation that others will provide care and protection, and may interfere with the ability to trust • The child's autonomy and wellbeing are disregarded, which may affect the sense of self • Deep-seated guilt and shame develop because children believe something bad about them caused the abuse • Profound sense of grief over lost innocence or the "perfect" or "normal" family; depression • Extreme anxiety or fear, which engenders a sense of dependency	• Overdependence or clinginess • Vulnerability to subsequent abuse and exploitation • Failure to accurately judge the trustworthiness or motives of others, leading to subsequent abuse and exploitation and/or inability to protect one's own children from abuse • Social withdrawal, isolation, and/or avoidance of intimate relationships • Chronic relationship difficulties • "Acting out" behaviours (e.g., aggression, delinquency, risk-taking, etc.)

Characteristic	Dynamics	Possible Manifestations
Stigmatization	• Abuser(s) and others blame or denigrate the victim engendering a sense of shame or guilt • The abuser and others pressure child for secrecy • The victim feels "damaged," "abnormal," "bad," which may contribute to a distorted sense of self and lowered self-esteem	• Dysphoria or chronic depression • Stigmatization, isolation, and marginalization may contribute to substance abuse • Criminal behaviour • Failure to care for oneself (e.g., risk-taking behaviours, poor hygiene, poor health practices) • Self-harm or self-mutilation
Powerlessness	• Unwanted invasion of one's body or personal space can interfere with the establishment and maintenance of healthy boundaries and increase risk of repeated victimization • Abuser(s) may use violence, threats, trickery, or bribery to involve their victim • If others do not believe and respond appropriately to disclosure of abuse, an individual may develop a lowered sense of efficacy • Some victims develop a high need for personal control and may even identify with the abuser	• Hyper-arousal (i.e., chronic anxiety, phobias, tendency to startle easily, irritability, poor sleep) • Intrusion (e.g., flashbacks during waking states, traumatic nightmares during sleep) • Constriction (dissociation to endure danger that one is unable to fight off or escape) -alters perception, sensation, and time sense and may result in avoidance of reminders of the trauma, emotional numbing/blunting, detachment, and an inability to experience joy • Stress-related disease and illness; chronic and/or vague somatic problems

Adapted from Finklehor and Browne[64] with permission of D. Finkelhor.

APPENDIX D: Diagnostic Criteria for Stress Disorders

Acute Stress Disorder (ASD)

Reprinted from *The Diagnostic and Statistical Manual of Mental Disorders* (4th ed., Text Revision)[11p.471-472] with permission of the American Psychiatric Association.

A. The person has been exposed to a traumatic event in which both of the following were present:

- the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
- the person's response involved intense fear, helplessness, or horror

B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:

- a subjective sense of numbing, detachment, or absence of emotional responsiveness
- a reduction in awareness of his or her surroundings (e.g., "being in a daze")
- derealization
- depersonalization
- dissociative amnesia (i.e., inability to recall an important aspect of the trauma)

C. The traumatic event is persistently re-experienced in at least one of the following ways:

- recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience
- distress on exposure to reminders of the traumatic event

D. Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people).

E. Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.

G. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.

H. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition, is not better accounted for by Brief Psychotic Disorder, and is not merely an exacerbation of a pre-existing Axis I or Axis II disorder.

Posttraumatic Stress Disorder (PTSD)

Reprinted from *The Diagnostic and Statistical Manual of Mental Disorders* (4th ed., Text Revision)[11p.467-468] with permission of the American Psychiatric Association.

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

(2) the person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behaviour.

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

(2) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.

(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma

(2) efforts to avoid activities, places, or people that arouse recollections of the trauma

(3) inability to recall an important aspect of the trauma

(4) markedly diminished interest or participation in significant activities

(5) feeling of detachment or estrangement from others

(6) restricted range of affect (e.g., unable to have loving feelings)

(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep

(2) irritability or outbursts of anger

(3) difficulty concentrating

(4) hypervigilance

(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if: Acute: if duration of symptoms is less than 3 months
Chronic: if duration of symptoms is 3 months or more

Specify if: With Delayed Onset: if onset of symptoms is at least 6 months after the stressor

Disorders of Extreme Stress not Otherwise Specified (DESNOS)

Judith Herman[81] has challenged the ability of the diagnosis of posttraumatic stress disorder (PTSD)[9,10,11] to capture the full range of human response to trauma. She and others (e.g.,[173]) suggest that it is more accurate to think about human responses to trauma as a spectrum anchored at one end by an acute stress reaction that resolves on its own without treatment, and on the other by what Herman calls "complex posttraumatic stress disorder," with "classic or simple" PTSD residing somewhere between the two.[81p.119]

When the *DSM IV*[10] was being developed, a field trial was completed to explore whether the construct of complex PTSD, also termed *disorders of extreme stress, not otherwise specified* (DESNOS) should be included as a diagnosis separate from

PTSD. Although many argue that the field trial and other more recent studies support the legitimacy of the DESNOS diagnosis,[174] DESNOS was not included in the *DSM IV*. However, the categories of symptoms included in the conceptualization of DESNOS were listed under the "Associated and Descriptive Features of PTSD."[171]

In the most recent version of *DSM-IV-TR*, the authors state that the following constellation of symptoms may be associated with PTSD, and are generally seen when the stressor involves interpersonal trauma such as childhood sexual or physical abuse or domestic battering:

- impaired affect modulation;
- self-destructive and impulsive behaviour;
- dissociative symptoms;
- somatic complaints;
- feelings of ineffectiveness;
- shame, despair, or hopelessness;
- feeling permanently damaged;
- a loss of previously sustained beliefs;
- hostility;
- social withdrawal;
- feeling constantly threatened;
- impaired relationships with others;
- a change from the individual's previous personality characteristics.[11p.465]

APPENDIX E: Sample Introduction to a Facility

Survivors pointed out that they are unfamiliar with the scope of practice for many health care practitioners and much of what is involved in examination and treatment. The following is an information sheet for new patients developed by survivors and clinicians to provide an understandable introduction to an out-patient physical therapy facility. Health care providers are encouraged to work with patients to develop introductions to their practice and facilities similar to this physical therapy example.

Suggestions for clients at out-patient physical therapy facilities

Welcome to physical therapy! We are glad to work with you. Physical therapy will include an assessment and treatment by the physical therapist. Direct and open communication between the client and the therapist is important. Below is a list of suggestions that may help you at physical therapy.

You have the right to choose a male or female physical therapist.

- If you know this is important for you, please tell us when you book your first appointment.
- If you decide later in treatment that you would rather work with a therapist of a different gender, you may tell us then too.
- If we are unable to book you with your choice of a male or female therapist, we may refer you to a facility that can.

You can choose to have someone accompany you during your physical therapy appointments.

This person can be:

- a family member or friend.
- a staff member from the clinic.

Physical therapy works best when you and your therapist work as a team.

For example, your physical therapist will explain your treatment to you. Please tell your physical therapist if:

- you are not comfortable with the treatment.
- you do not understand the treatment or language your therapist is using.
- you do not agree with the treatment.

Also, physical therapy works best when you talk to your physical therapist about how the treatment is working (or not working!) for you. The more you are able to tell your physical therapist, the better he or she will be able to help you.

We will do our best to ensure your privacy.

- Your physical therapist may need you to wear a gown for some treatments. If you would prefer to bring loose fitting clothing from home, please tell your physical therapist.
- In some cases it is necessary to change your clothing for your treatment: you will have privacy to change your clothing.
- Please tell us if you would like the curtains drawn around your treatment table during any part of treatment.

Physical therapy involves touch and movement of your body.

Tell your physical therapist if:

- certain parts of your body are sensitive to touch or movement.
- you are nervous about touch.
- there is something your physical therapist can do to make you more comfortable.

You have the right to stop treatment at any time, during or after a session.

Reasons people might stop treatment may include:

- discomfort during treatment.
- deciding to try a different type of medical care.

If you decide to try a different type of care, your physical therapist may be able to give you the name of someone she or he thinks can help you.

Above all, we want you to notice an improvement in your health.

APPENDIX F: Using Plain Language in Consent Forms

The following form was created by a survivor who revised a "standard" consent form used in a physical therapy clinic to illustrate how Plain Language can be used to create forms that are easier to understand. Clinicians are urged to work with both legal advisors and clients to develop forms that include all legal requirements but are written in Plain Language.

Consent Form for Examination and Treatment by a Physical Therapist

I am about to be examined and treated by a physical therapist and her/his assistants.

In order for me to be properly examined or treated, I will need to wear shorts and a T-shirt. The physical therapist will need to observe my body while it is still and while it is moving. It will be necessary for the therapist to touch and move my body in assessment and treatment. Should I feel uncomfortable about the assessment and treatment process at any time, I can inform the physical therapist and request that assessment and/or treatment be stopped. I can have someone else in the room with me; either a friend or relative, or someone else from the clinic, if available. In the latter case, I can choose the gender of this person.

I will need to tell the physical therapist about my health problems, both past and present. The therapist will ask my permission to contact my doctor if he or she finds any new problems. I am aware that all information I disclose and all information that will be charted is confidential.

Physical therapy treatment may involve: _____(plain language, be specific). Soreness after treatment is common because joints and muscles are stretched. If I have any other symptoms, I will tell my physical therapist.

My signature below indicates that I understand all of the above information.

APPENDIX G: Working with Aboriginal Individuals, *by Dr. Rose Roberts, RN, PhD*

A brief history of Aboriginal Peoples

Abundant literature describes the history of the First Nations, Métis and Inuit in Canada. An abbreviated list of recommended readings is found in the bibliography. The purpose here is to provide an overview as a starting point for health care practitioners working with First Nations, Métis, and Inuit peoples in the area of Sensitive Practice.

Aboriginal Peoples constitute a diverse population in Canada. There are several terms that have been introduced in the literature in an attempt to categorize these populations into one group, such as aboriginal, native, Indian, and indigenous. The Constitution of Canada uses the term *Aboriginal* to include Status and Non-Status Indians, Métis and Inuit. Status Indians are those whose ancestors signed treaties; Non-Status Indians are those whose ancestors refused to sign treaties or were absent at the time of the signing. A subpopulation of Non-Status Indians was also created through loss of treaty rights for various reasons such as serving in the armed forces, voting, obtaining a postsecondary degree, and, for Status Indian women, marrying non-Aboriginal men. For the most part, members of this subpopulation have regained their treaty rights through a revision in the Indian Act in 1984 (Bill C-31).

Our knowledge of the history of indigenous people in Canada prior to the arrival of the Europeans is very limited. The majority of information has been gleaned through the sciences of archaeology and anthropology. The most commonly held theory in the Western world is that the ancestors of the First Nations came from Asia over the Bering Strait. *Time immemorial*, a phrase often used by First Nations to describe how long they have been here, has been roughly translated to mean between 50,000 and 15,000 BC.[50] There have been three separate times when the Bering Strait could have been used as a land bridge, and there are theories arguing that there were three distinct migrations.[50] On the basis of archaeological findings, it appears that, through multiple generations, the first wave of people travelled down the Pacific coast into South America. As the glaciers retreated, some headed back up north. The second wave, the Athapascans (Dene), stayed in the north, but began to move south following a volcanic eruption. The third wave, the Inuit, spread eastward through the north.[50]

There have been several attempts to categorize the First Nations people of Canada. Linguistics is one common method, and there are 11 different language families: Algonquian, Athapaskan, Eskimo-Aleut, Haida, Tlingit, Siouan, Tsimshian, Wakashan, Salishan, Kutenai, and Iroquoian.[175] It has been hypothesized that around the time of European contact there were between 50 and 60 languages, but the most commonly spoken languages today are Cree, Ojibway, and Inuktitut. Many First Nations are diligently working to save their languages.[175] Another method of categorization is culture areas, and these areas are based on geography and a group of people sharing similar cultures. These *culture areas* are: Arctic, Western Subarctic, Eastern Subarctic, Northeastern Woodlands, Plains, Plateau, and Northwest Coast.[175] It is interesting that these geographical culture areas closely resemble the geographical separation according to linguistics. Today there are more than 610 First Nations communities in Canada, and the total population, living both on and off reserve, is more than 733,000.[13]

The time following contact with Europeans brought many changes to First Nations peoples in Canada, including the creation of an entirely different people: the Métis. The Métis were primarily the offspring of First Nations women and French men. The term *half-breed* was more

often used to describe children of First Nations women and Scottish or English men. The Métis of today define themselves according to the following definition adopted by the Métis National Council, the national governmental organization representing the Métis: "Métis means a person who self identifies as Métis, is of Historic Métis Nation ancestry, is distinct from other Aboriginal peoples and is accepted by the Métis Nation."[106] The "Historic Métis Nation" means the Aboriginal people then known as Métis or Half-Breeds who resided in the Historic Métis Nation Homeland, the area of land in west central North America used and occupied as the traditional territory of the Métis or Half-Breeds. The Métis National Council estimates that there are between 350,000 and 400,000 Métis in Canada.[106]

The Inuit are peoples who live in the Arctic regions of Canada, Alaska, and Greenland. They have very similar cultural and physical characteristics despite the wide geographical area in which they live. The Inuit have survived in one of the world's harshest environments for more than 5,000 years.[90] The areas are mostly coastal, consisting of shallow basins with rivers flowing through and many islands covered with permanent ice and mountain glaciers. The treeless shores provide no wind protection, temperatures are below freezing for eight or nine months of the year, and total precipitation is so slight that the area nearly qualifies as desert. According to the 2001 census, there are more than 45,000 Inuit in Canada, representing about 5% of the Aboriginal population.[160] They are represented nationally by the Inuit Tapiriit Kanatami.

The residential school legacy

Between 1892 and 1969, approximately 135 residential schools were established to meet the treaty right to education.[1] Although First Nations leaders wanted schools built on the reserves, the federal government decided that residential schools would be cheaper and entered agreements with the Roman Catholic Church, the Church of England, the Methodist Church, and the Presbyterian Church to operate the schools. The vast majority of these schools were in the western provinces and it is estimated that more than 150,000 students attended them. The Assembly of First Nations estimates that more than 105,000 survivors of residential schools are still alive today.[14]

The premise of the residential schools was assimilation through education, religious indoctrination, and cultural degradation (teaching the children to be ashamed of their heritage). Physical, emotional, and sexual abuses were rampant and living conditions were often substandard. Former residents say that they were often hungry and that their parents brought them food on their weekend visits;[72] others report being forced to steal food from the kitchens. The education the children received was also substandard. As late as the 1950s, more than 40% of the teaching staff at the schools had no professional training.[1] Cultural degradation practices included physical and emotional abuse for speaking a traditional language, cutting students' hair (hair has strong cultural and spiritual implications), imposing foreign religious practices, and intentionally separating students from visiting parents.

The residential school experiences continue to have a detrimental impact on Aboriginal communities today. These "intergenerational impacts refer to the effects of physical and sexual abuse that were passed on to the children, grandchildren, and great-grandchildren of Aboriginal people who attended the residential school system."[2] Some of these effects include:

- Alcohol and drug abuse;
- Past and ongoing physical, emotional, and sexual abuse;
- Low self-esteem;
- Dysfunctional families and interpersonal relationships;
- Parenting issues;
- Suicide;
- Teen pregnancy.

The Aboriginal Healing Foundation (AHF) was established in 1998 in response to the Royal

Commission on Aboriginal Peoples. The AHF's mandate is to fund and support Aboriginal healing initiatives. As of November 2005, the federal government had committed $378 million to 1,346 community-based grants and has pledged another $125 million over the next five years. The AHF has received more than $1.3 billion in funding proposals and estimates that $600 million is required over the next 30 years to fully address the residential school legacy. For more information, interested readers are encouraged to visit the AHF website (www.ahf.ca). The Indian Residential School Survivors' Society is another organization that offers resources to survivors as well as those that work within the healing field (www.irsss.ca). Among other services, it provides a national 24-hour toll-free crisis line (1-866-925-4419).

With respect to Sensitive Practice, health care practitioners working with Aboriginal clients should be aware of the following personality characteristics that may indicate past residential school trauma: (a) unconscious internalization of residential school behaviours (e.g., false politeness, not speaking out, passive compliance, excessive neatness, or obedience without thought); (b) flashbacks and associative trauma (e.g., certain smells, foods, sounds, sights, and people trigger flashbacks and memories, anxiety attacks, physical symptoms, or fear); (c) internalized sense of inferiority or aversion in relation to white people and especially white people in power.[2]

Health care practitioners are strongly encouraged to approach individuals of Aboriginal heritage with respect and openness, allowing more time than usual for introductions and the development of a trusting relationship. The Sensitive Practice protocols presented in this *Handbook* are appropriate to use when working with Aboriginal clients, especially when they are accompanied by concerted efforts to increase one's awareness and understanding of Aboriginal cultures.

ⓘ Recommended Readings and Resources – Aboriginal Peoples: Readings (especially the policy statements by Dr. Janet Smylie)

Health care systems

Health care is not a provision specifically addressed in the treaties between Canada and First Nations and Inuit. The only direct mention of health care can be found in Treaty 6 which was signed in the mid-prairies of Saskatchewan and Alberta in 1876 and reads, "That a medicine chest shall be kept at the house of each Indian Agent for the use and benefit of the Indians at the direction of such agent."[39] Subsequent court proceedings involving Treaty 6 have ruled that at the time the treaties were signed, the Chiefs were looking for the best possible agreement for their members, and within that understanding, the clause could mean the provision of any and all services necessary for continued health for First Nations.[112] The intent of the medicine chest clause has been applied to all First Nations and Inuit peoples.

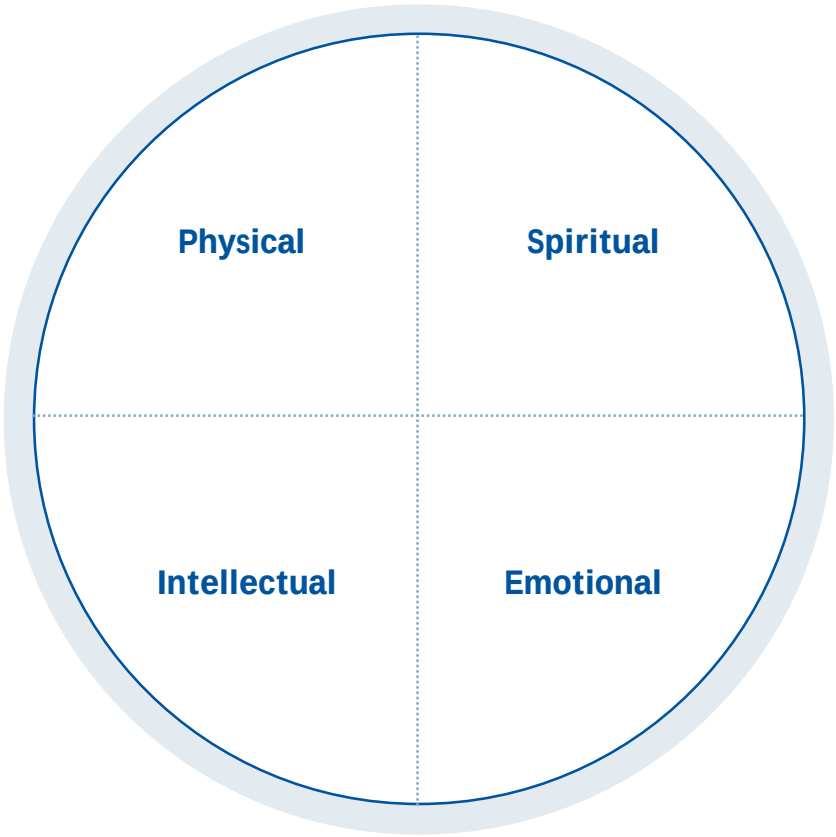
The federal government provides comprehensive health care services to First Nations and the Inuit through the First Nations and Inuit Health Branch (FNIHB). FNIHB provides direct care to on-reserve populations and reimburses the provincial and other health care agencies for services provided to off-reserve populations. There has been a recent shift in responsibility as First Nations are reclaiming some aspects of self-government. Health transfer payments to individual First Nations or Tribal Councils has allowed First Nations to administer the funding and given them the freedom to determine their own health needs and plan their programs accordingly. Non-Status and Métis people are left out of these arrangements and receive their health care within the provincial or territorial health system.

Aboriginal health beliefs

The most common health model found in the literature and the oral tradition of Aboriginal peoples is the medicine wheel model (see Figure 2). Actual medicine wheels are circular stone formations found in all parts of North America. The term *medicine wheel* has been borrowed from these stone structures and applied to the theory of health and other areas of Aboriginal traditions. The medicine wheel is a circle, which means there

is no end and no beginning. The same could be said for one's health status. The four areas of the wheel are intellectual, emotional, spiritual, and physical. Some Aboriginal people believe that all four areas have to be in balance if one is to be in an optimum state of health; in other words, if any of the four areas are out of balance, then the individual becomes ill. All four areas are also connected and interrelated, so that there is no distinction such as the separation between mind and body that is often found in Western health paradigms. Specific programs have been developed in many Aboriginal communities and organizations using the medicine wheel as the framework. An Internet search of the term *medicine wheel* reveals the diverse situations and disease entities to which this framework has been applied.

FIGURE 2
Medicine Wheel



APPENDIX H: A Note about Dissociative Idenity Disorder

Dissociative Identity Disorder (DID) – which was previously called Multiple Personality Disorder – is a psychiatric condition which requires specialized training to diagnose correctly. The *DSM-IV-TR* criteria for DID include "the presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self)."[11p.529]

Researchers believe that DID is almost always associated with a history of severe child abuse[69] and requires very specialized treatment by a multidisciplinary team. If a health care practitioner encounters a person who has been diagnosed with DID and is not already receiving treatment from a mental health team, a referral to and collaboration with such a specialized service is essential.

APPENDIX I: The Evidence Debate Pertaining to Inquiry about Interpersonal Violence

While the empirical evidence is clear about the high prevalence of childhood sexual abuse and links between childhood adversity and adult health problems, it is less clear about whether health care practitioners should routinely assess for current and past abuse/violence (usually including intimate partner (or domestic) violence and childhood abuse). Three recent systematic reviews from the United States,[115] Britain,[123] and Canada[179] concluded that there is insufficient evidence to recommend routine screening for family and/or intimate partner violence. In contrast, the Intimate Partner Violence Working Group of the Society of Obstetricians and Gynaecologists of Canada (SOGC)[153] and the Registered Nurses of Ontario[128] both issued clinical practice guidelines endorsing routine assessment for intimate partner violence/woman abuse as standard practice. Furthermore, existing practice guidelines and recommendations for management of a number of conditions also call for an assessment of abuse history (e.g.,[6,7, 8,12]).

ⓘ Section 2.5 – Childhood sexual abuse and health

This debate is pertinent to any discussion of making inquiries about a history of child sexual abuse. Exposure to childhood violence or abuse increases an individual's risk for intimate partner violence in adulthood (e.g.,[17]). Because the two co-occur with some frequency, childhood abuse/violence and intimate partner violence may not be categorically discrete entities. This means that if an individual discloses intimate partner violence, there is also the possibility of past childhood abuse/violence.

Considerable expert opinion (including[57,153,181]) disagrees with the findings of the systematic reviews cited above. Much of this disagreement centres around the distinction between *inquiring about violence* and *screening* (which by definition must meet strict requirements related to lack of symptoms, specificity, sensitivity, positive predictive value, negative predictive value, etc.). Those who oppose universal screening point to the "absence of any high quality evidence of the benefit and a similar lack of evidence that screening does not harm."[181p.163] Those who support routinely inquiring about violence point out that such inquiry does not equate to screening but rather, represents "asking questions about domestic violence during a health care contact."[181p.163] The SOGC reiterates this in its consensus statement on intimate partner violence screening:

> *Asking women about violence is not a screening intervention* [emphasis added]: victims are not asymptomatic; disclosure is not a test result, it is a voluntary act, and the presence or absence of violence is not under the victims' control; and most interventions required to protect and support survivors are societal, not medical.[153p.366]

Because the three systematic reviews looked only at those studies that met the criteria for "screening," they considered only a small portion of the existing intimate partner violence research. For example, of the 806 abstracts that related to screening for intimate partner violence, only 14 met the inclusion criteria that Nelson and colleagues[115] used; similarly, only two of the 667 abstracts on intimate partner violence intervention studies were considered.[57] This led the Family Violence Prevention Fund's Research Committee to conclude:

> As a consequence of this overly narrow approach to what the most relevant research questions are, an important body of studies related to IPV [intimate partner violence] was not considered. The outcomes most closely focused on are harm, death, and disability. In contrast, most researchers in the field would expect that measurable benefits (desirable

outcomes) would include improved health and safety of the patient and their children, enhanced protective factors, and decreased frequency and severity of physical and/or emotional abuse.[57p.2-3]

We believe that the research on which this Handbook is based further supports the argument that routinely inquiring about a history of past abuse is not harmful to individuals and, if done in a sensitive and informed manner, is likely to lead to improved health for all patients.

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Childhood sexual abuse and trauma: Websites

National Clearinghouse on Family Violence has many resources available free of charge. Toll free telephone 1-800 267-1291; (613) 957-2938; Fax (613) 941-8930; http://www.phac-aspc.gc.ca/nc-cn

Canadian Association of Sexual Assault Centres is a pan Canadian organization of sexual assault centres in Canada. Their website has contact information and links for sexual assault centres across Canada. http://www.casac.ca/english/home.htm

Tamara's House, a residential treatment centre for women survivors of childhood sexual abuse (Saskatoon, Saskatchewan) http://www.tamarashouse.sk.ca/

British Columbia Society for Male Survivors of Sexual Abuse (Vancouver, BC) http://www.bc-malesurvivors.com/html/mission_purpose.htm

Men's Resource Centre (Winnipeg, Manitoba) http://www.elizabethhill.ca/mrc.html

The Men's Project (Ottawa/Cornwall Ontario) http://themensproject.ca

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Critical cultural perspective: Readings

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Aboriginal Peoples: Websites

Assembly of First Nations: http://www.afn.ca/
First Nations & Inuit Health Branch website: http://www.hc-sc.gc.ca/fnih-spni/index_e.html
Métis National Council: http://www.metisnation.ca/
Aboriginal Healing Foundation: http://www.ahf.ca/

Plain Language: Readings

Human Resources and Social Development Canada. http://www.hrsdc.gc.ca/en/hip/lld/nls/Resources/plainws.shtml

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Sensitive Practice At-a-Glance

The goal of Sensitive Practice is to foster a sense of safety for patients. Although the principles and guidelines articulated in this *Handbook* and outlined in Tables 7 and 8 are based on studies with Canadian men and women with histories of childhood sexual abuse, they represent a basic approach to care that should be extended to all patients. By adopting the principles of Sensitive Practice as the standard of care, health care providers convey respect, support clients' autonomy and right to participate in healthcare, and decrease the likelihood of inadvertently retraumatizing the survivors of abuse with whom they work knowingly or unknowingly.

TABLE 7

Summary of principles of Sensitive Practice

Respect	Acknowledging the inherent value of clients as individuals with unique beliefs, values, needs, and histories means upholding and defending their basic human rights and suspending judgment of them.
Taking time	Taking adequate time with patients ensures that they do not feel depersonalized or objectified.
Rapport	Developing and maintaining an interpersonal style that is professional, yet conveys genuine caring, promotes trust and a sense of safety.
Sharing information	Informing patients of what to expect on an going basis and inviting them to ask questions and offer information and feedback helps reduce anxiety and promotes active engagement in their health care.
Sharing control	Seeking consent and offering choices enables the clinician to work *with* rather than *on* patients, and ensures that patients become full active participants in their own health care.
Respecting boundaries	Paying ongoing attention to boundaries and addressing difficulties that arise reinforces patients' right to personal autonomy.
Fostering mutual learning	Fostering an environment in which information sharing is a two-way process encourages survivors to learn about their health and how to become active participants in their own health care. It also assists clinicians to learn how best to work with individuals who have experienced interpersonal violence.
Understanding nonlinear healing	Checking in with patients throughout each encounter and over time, and being willing to adjust their actions accordingly, enables caregivers to meet the needs of individuals whose ability to tolerate health care examinations and procedures vary over time.
Demonstrating awareness and knowledge	Showing that they are aware of interpersonal violence helps professionals foster a sense of trustworthiness and promotes an atmosphere in which patients are willing to work alongside their health care providers.

TABLE 8

Summary of guidelines of Sensitive Practice

Context of encounters	
Administrative staff and assistants	• Train all personnel about Sensitive Practice • Work with staff and assistants to establish a few "routine responses" that are survivor-friendly
Waiting areas	• Keep patient informed of length of wait *or* invite patient to check intermittently • Provide printed materials related to interpersonal trauma • Provide and clearly identify washrooms
Privacy	• Knock and wait for acknowledgement before entering • Have at least one soundproof examination or interview room • Problem-solve with patients to meet their needs for privacy and safety
Preparation of clients	• Provide introductory information in plain language, both written and verbal • Negotiate with patient to identify needs and workable solutions • Encourage presence of support person or chaperone; agree upon roles for all parties
Encounters with patients	
Introductions	• Discuss and negotiate roles for patient and clinician prior to all examinations or treatments • Allow enough time to help individuals understand fully what you are doing • Do not assume the patient knows what is involved in an exam, treatment, or procedure • Seek consent in an ongoing way throughout the encounter
Clothing	• Meet patient fully clothed before and after • Explain why removal of clothing is necessary • Discuss clothing requirements with patients and collaborate with them to find an agreeable solution • Minimize amount of clothing being removed and length of time patient must be disrobed • Provide gowns in a wide variety of sizes for all body types • Leave the room while the patient is changing
Task-specific inquiry	• Inquire about patient's past experiences, preferences, difficulties with the exam/procedure • Inquire about how to increase the person's comfort • Inquire about whether the patient thinks there is anything else that the clinician should know about • Repeat inquiry intermittently over time, and if body language suggests discomfort
General approach	• Use task-specific inquiry to identify difficulties; problem-solve together to increase comfort • Monitor body language and follow up on signs of distress • Explain why positions for patient and clinician are necessary
Touch	• Describe what is involved before and during the exam or treatment • Seek consent before beginning and when shifting from one part of the body to another • Encourage individuals to ask you to pause, slow down, or stop the examination or treatment at any time to lessen their discomfort or anxiety • When a presenting problem necessitates examination of areas of the body other than the site of the symptoms, explain the rationale
Genital, rectal exams and procedures	• Acknowledge discomfort • Offer a running commentary about what you are doing • Minimize time the patient must remain in a subordinate position • Drape parts of the body not being examined

Oral and facial health care	• Agree on hand signals so that the patient can give instant feedback when verbal communication is not possible • Problem-solve with the patient around difficulties with smell/feel of gloves, dental dam, body position, other task-specific difficulties • Ensure that your comments to the patients about their oral health and behaviour during the appointment are offered in a nonjudgmental way • Keep the length of appointments as short as possible; consider doing longer procedures over two or more appointments
Challenges in encounters	
Pain & disconnection from body	• Assess pain in systematic, nonjudgmental manner • Work with client to set realistic goals and determine appropriate referrals • Repeatedly invite individuals to focus on their bodies • Provide clear verbal and written instructions that the patient understands • Suggest a range of strategies to increase self-awareness
Non-adherence to treatment	• Explore all types of barriers with the patient and problem solve to identify workable solutions • Adapt treatment to fit patient • Create a "same-day" appointment for patients who frequently cancel appointments whenever possible
SAVE the situation	• **S**top what you are doing and focus fully on the present situation • **A**ppreciate and understand the person's situation • **V**alidate the person's experience • **E**xplore the next steps with the patient
Triggers and dissociation	• Examine list of common triggers and consider what can be avoided/accommodated • Become familiar with signs of a 'fight or flight' response • Work with patients who have been triggered to ground and reorient them • Normalize the experience • Ensure adequate follow-up
Anger and agitation	• Pay attention to personal safety • Adopt non-threatening body language • Negotiate and assure patients of your interest and concern
Disclosure	
Responding effectively	*Upon hearing a disclosure of past abuse:* • Accept the information • Express empathy and caring • Clarify confidentiality • Normalize the experience by acknowledging the prevalence of abuse • Validate the disclosure and offer reassurance to counter feelings of vulnerability • Address time limitations • Collaborate with the survivor to develop an immediate plan for self care • Recognize that action is not always required • Ask whether it is a first disclosure *At the time of disclosure or in a future interaction:* • Discuss the implications of the abuse history for future health care and interactions with clinician • Inquire about social support around abuse issues