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Abused Women's Concerns about Safety and the Therapeutic Environment during Psychiatric Hospitalization

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Cette étude vise à identifier chez des femmes victimes de violence les inquiétudes relativement à la sécurité et à l'environnement de soins au cours d'une hospitalisation en psychiatrie, et à cerner les changements que celles-ci aimeraient voir dans cet environnement. Les inquiétudes ressenties par les femmes ont été explorées au moyen d'entrevues semi-structurées dans le cadre d'une étude qualitative. Des instruments de mesure des agressions sexuelles et physiques ont été utilisés. Parmi les 20 femmes recrutées dans 3 hôpitaux, 18 ont rapporté avoir été victimes d'agressions sexuelles ou physiques. Un chercheur menait les entrevues auprès des participantes tandis qu'un autre prenait des notes. Après chaque entrevue, une liste des inquiétudes identifiées était produite; ces inquiétudes étaient soulevées au cours de l'entrevue suivante si la participante n'en faisait pas mention spontanément. Dix-sept femmes ont déclaré ne pas se sentir en sécurité dans les unités de soin mixtes (hommes et femmes) et ont dit qu'elles préféreraient l'affectation de locaux séparés pour les activités thérapeutiques et les repas; 16 ont exprimé des inquiétudes concernant l'organisation des soins pendant la nuit, les pratiques traditionnelles de restriction des médicaments et les contacts avec le personnel de nuit; 15 considèrent que les soins infirmiers de base sont des éléments extrêmement importants qui ont une influence sur le fait qu'elles se sentent comprises et en sécurité. Les participantes ont dit vouloir être écoutées et participer à la prise de décision.

The purposes of this study were to identify the concerns of women who have a history of abuse regarding safety and the inpatient environment during psychiatric hospitalization, and to identify environmental changes they would like to see. A qualitative design was used to explore the women's concerns through semi-structured interviews. Instruments

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measuring sexual and physical abuse were administered. Of the 20 women recruited from 3 hospitals, 18 reported a history of sexual and/or physical abuse. One investigator interviewed the participants and one acted as recorder. After each interview, a list of identified concerns was generated; these concerns were raised in the next interview if not spontaneously brought up by the participant. Seventeen women reported feeling unsafe in mixed-gender units and said they would prefer segregated areas for programming and meals; 16 expressed concerns about nighttime routines and the traditional practices of restricting medications and contact with staff at night; 15 considered primary nursing extremely important to feeling understood and safe. The participants said they wanted to be heard and to be included in decision-making.

Despite clinicians' increasing awareness of the psychological and pathophysiological sequelae of child abuse, women with a history of abuse present an enormous challenge for clinical management in ensuring that hospitalization does not reinforce their sense of powerlessness and of being silenced. There is limited literature examining the experience of hospitalization for women with a history of abuse. What little literature does exist highlights hospitalization as a significant risk for evoking feelings of powerlessness and of being silenced (Doob, 1992; Firsten, 1991; Urbancic, 1992). The present study was an attempt to identify ways in which the clinical environment can be modified to increase women's sense of safety and of maintaining control.

Clinical reports and research studies of the past few years have reported that approximately two thirds of female psychiatric patients have a history of childhood physical and/or sexual abuse (Beck & van der Kolk, 1987; Briere & Zaidi, 1989; Bryer, Nelson, Miller, & Krol, 1987; Chu & Dill, 1990; Firsten, 1991). Firsten reports that 83% of a sample of Canadian women hospitalized in a large urban psychiatric hospital reported either physical or sexual abuse in childhood and/or adulthood. The broad psychological sequelae of abuse can include feelings of betrayal or powerlessness, lack of trust, need to avoid close/intimate relationships, and lowered self-esteem (Briere, 1992; Herman, 1992). These feelings can lead to a view of the world as a hostile environment (Briere).

Background

A history of abuse can influence expression of psychopathology, length of hospitalization, and clinical outcomes (Carmen, Rieker, & Mills, 1984; Goff, Brotman, Kindlon, Waites, & Amico, 1991). Strong association has been observed between a history of abuse and specific psychiatric disorders such as dissociative identity disorder, post-traumatic stress disorder, and borderline personality disorder (Herman, Perry, & van der Kolk, 1989; Sansonnet-Hayden, Haley, Marriage, & Fine, 1987; Westen,

Ludolph, Misle, Ruffins, & Block, 1990). Greater frequency and severity of depression and psychotic symptoms have been reported for hospitalized women with a history of abuse than for those without a history of abuse (Hall, Sachs, Rayens, & Lutenbacher, 1993; Muenzenmaier, Meyer, Struening, & Ferber, 1993). Increased alcohol and drug abuse have been reported among sexual-abuse victims (Beck & van der Kolk, 1987; Briere & Zaidi, 1989; Herman, 1986; Margo & McLees, 1991; Pribor & Dinwiddie, 1992). Suicidal ideation, suicide attempts, and self-mutilation have also been found to be associated with sexual abuse (Briere & Zaidi; Romans, Martin, Anderson, Herbinson, & Mullen, 1995). A positive relationship has been demonstrated between the severity of abuse (in terms of form, duration, and closeness of relationship) and self-harm behaviours (Briere, 1992).

Some authors have drawn parallels between the experience of psychiatric hospitalization, designed to help the client during a state of acute crisis, and the experience of trauma. As early as 1984, Mills, Rieker, and Carmen found that abuse victims, particularly women, experienced longer hospital stays than other clients and that abuse victims were more likely to use self-harm as a means of coping with anger. Authors such as Fromuth and Burkhart (1992) question whether there can be a "benign" psychiatric hospitalization for women with a history of abuse. They argue that the experience of psychiatric hospitalization shares with abuse the themes of stigmatization, betrayal, and powerlessness. Harris (1994) speaks to the need, among women with a history of sexual abuse, for hospitalization that is carefully planned, voluntary (when possible), and under the control of the client. She suggests that alternatives to traditional hospitalization be explored and that efforts be made to reframe the hospital as a place where one goes when in need of safety rather than where one goes when out of control. Cohen (1994) uses Herman's (1992) model of captivity, in which fear is produced by the unpredictable violence and "capricious" application of rules, to argue that psychiatric hospitalization with its locked units, isolation from familiar people, use of restraint, and violence can produce a form of captivity trauma. A moving article by Jennings (1994) uses the 17 years of mental health records of her sexually abused daughter to document the system's failure to help. Not only was the abuse ignored during her daughter's hospitalization, but, according to Jennings, many common hospital practices can lead to a form of institutional retraumatization for the client.

Recent surveys with psychiatric nurses indicate that nurses fear they lack the skills to assess a history of abuse in an appropriate and sensitive manner and to respond or counsel appropriately when

women disclose a history of abuse (Gallop, McCay, Austin, Bayer, & Peternelj-Taylor, 1998; Gallop, McKeever, Toner, Lancee, & Lueck, 1995). It would seem that what is required is a therapeutic environment that attends to the abuse without fostering the silencing of women concerning their experiences or inviting potentially harmful abreaction or regression. Unfortunately, the inpatient setting with its acutely ill patient population and structure can actually increase feelings of powerlessness and anxiety in abused women. This may lead, in turn, to a loss of behavioural control with increased suicide attempts and self-harm behaviours.

Often the response to self-harm behaviours and loss of behavioural control is increased use of such interventions as chemical and physical restraints, which can be experienced as a re-enactment of the abuse, perpetuating the sense of betrayal, insecurity, and powerlessness so central to the experience of women with a history of abuse (Gallop, McCay, Guha, & Khan, in press). The therapeutic milieu should be sensitive to the needs of women who have been abused, with inpatient programs that negotiate proactive interventions with the women, enabling them to attend to their need for safety and containment. Kirby, Chu, and Dill (1993) consider acknowledgement, security, and containment as essential features of the first phase of dealing with trauma and with ongoing issues in the treatment of trauma.

Purpose

This paper addresses two research questions: *What are the concerns of abused women regarding their safety and their experience of hospitalization? How would these women like to see these concerns addressed?* The ultimate objective of the study was to develop clinical guidelines to ensure that, from the beginning of psychiatric hospitalization, key issues and identified concerns of abused women regarding safety and control are used in shaping the therapeutic environment and the responses of clinicians.

Methods and Procedures

The study was conducted in two phases. In phase one, women admitted to acute-care inpatient units were interviewed to identify their safety concerns. These findings are described in this paper. In phase two, the concerns identified by the women were discussed in focus groups of nurses and other clinicians in the study units to determine how this information might be used to modify unit policy and practice. Phase two is not covered in this paper.

Overview

The study relied on qualitative methodology. In phase one, women's perceptions of safety during hospitalization were explored through semi-structured face-to-face interviews. One of the investigators conducted the interviews while another took detailed verbatim notes.

Participants

Data were collected at three inpatient sites, selected to represent the variation in acute-care psychiatric facilities available to clients: an acute-care unit of a large urban teaching hospital, an acute-care unit of an urban psychiatric teaching hospital, and an acute-care unit of a community hospital. Every woman admitted to either of the three sites was eligible to participate if she could understand and communicate clearly in English and provide informed consent.

Twenty-one women agreed to participate. At two sites, no woman was excluded by the nurses from eligibility and no woman declined to be approached. At the third site, approximately six women were considered too ill to participate. All women who heard the study description agreed to participate; however, one woman was always too tired or unwell at scheduled times and therefore did not participate in data collection. Data were collected over a 5-month period.

Originally, the researchers had planned to interview women until there were at least 20 with a history of childhood physical and/or sexual abuse and 20 without a history of abuse, in order to see if safety concerns differed for abused and non-abused women. However, of the first 20 women interviewed, only two did not report a history of childhood abuse. The researchers believed it would be very difficult to obtain a sample of 20 non-abused women and were reluctant to invite women to hear about a study, then reject them because they had a history of abuse. When 20 interviews had been conducted, the research team agreed that no new information was being obtained and the topic was saturated. In the interests of consistency, the interview data for the two women who did not have a history of abuse are not reported, even though their concerns were similar to those of the abused women.

Interviews

Semi-structured interviews were used to gather information. The interview commenced with an open-ended question / comment such as: *We are interested in knowing what you think we can do to help you feel safe in this setting.* If a woman did not spontaneously bring up concerns

identified during previous interviews, she was asked if she had any thoughts about specific concerns identified by others: male clients; room location; nighttime issues; participation in decision-making; nature of contacts she found helpful. For each concern identified, the interviewer sought clarification as to how the client would like staff to respond to that concern.

History of sexual abuse. The investigators made the decision to inquire about a history of physical and/or sexual abuse, given the increasing evidence that many hospitalized women do have such a history. If during the semi-structured interview the woman disclosed a history of abuse, the researcher asked her permission to inquire in more detail about it. A brief questionnaire was developed by the authors for this purpose. The women were given the option of refusing to answer any question, and it was made clear that such refusal did not imply a history of abuse. No woman refused to answer these questions.

History of physical abuse. The Physical Abuse Research Schedule (a sub-schedule of the Child Maltreatment Interview Schedule [Briere, 1992]) includes three basic questions about physical abuse occurring before the age of 17 (during the years when the typical shared parent-child living arrangement is most prevalent). Measures of physical abuse are usually defined as punishment that results in marks, bruises, breaks in skin, or injury warranting medical attention (Weaver & Clum, 1996). The Briere schedule captures these requirements and has been used extensively.

Data Analysis

Data analysis used the following process for identifying issues of concern consistent with the techniques for inductive analysis described by Huberman and Miles (1994). After each interview, the data were analyzed for emergent concerns. After the participant had listed her concerns and possible solutions, the interviewer asked about areas not mentioned but identified by other participants. Following completion of all interviews, the members of the research team individually examined the concerns identified (e.g., concerns about male patients). The researchers counted the number of times a concern was expressed. They then met and discussed each area in order to reach consensus on the nature of the concerns. All the researchers were psychiatric nurses, and one senior student had also been involved in research in this area for 2 years; therefore, care was taken to ensure that personal biases were not inserted into the data and that the reported concerns reflected the actual content of the data.

Results

Participants

Twenty women participated in the study. Interviews ranged in length from 15 to 60 minutes. Women ranged in age from 20 to 61 years, with a mean age of 36.8 years. Eighteen women had completed high school; 12 women reported being educated beyond high school. For six women this was the first admission; 10 women reported at least four previous admissions. Twelve women had a primary diagnosis of depression, five bipolar disorder, two dissociate identity disorder, and one schizophrenia.

Sixteen women reported a history of childhood sexual abuse; of these, nine also reported a history of childhood physical abuse. One woman reported a history of childhood physical abuse without childhood sexual abuse. No women reported being in an abusive relationship currently, although one woman did state that she had just left an abusive relationship. Four women reported both adult sexual abuse and adult physical abuse, four reported adult sexual abuse, and four reported adult physical abuse. Only two women did not report some form of abuse as a child or as an adult.

Concerns

The abused women reported many concerns about safety and other elements of hospitalization, and they made many suggestions. Collectively the comments reveal, from the women's perspective, how the therapeutic milieu should be shaped.

Three major areas of concern are discussed: male patients, night issues, and nursing issues. The quotes offered below are taken verbatim from the record of each interview. The numbers in brackets are participant code numbers.

Male patients. Seventeen women raised concerns about male patients. The women spoke of their fear of men, and most stated that they would have preferred an all-female unit or at least a unit with segregated spaces and programming.

> *Having an all female floor would be better, or at least have men on one side of the floor and women on the other.* [07]

> *Having a floor with only ladies on it would be better.* [03]

Concerns reflected a preference for not only separate bedrooms but also separate dining and other communal areas.

When you are in with men — I am not thinking about myself as a sexual object, I would wander for breakfast in my bathrobe — I questioned what message am I giving? [19]

Eating lunch alone versus with male patients is an important choice. [02]

The women gave a number of reasons for feeling unsafe or wanting segregated areas. For many, the wish for segregation was related to the threat of violence and sexual assault.

Having male patient screaming next room [is] scary. [02]

Older male patients — it was adults who abused me, so it feels unsafe when the males walk by my room and say something — it scares me — I can't sit in same room with them. [20]

Being in same room with these men, like dining area, meeting area etc. is scary better to be able to eat in room if afraid. [04]

Just because of my history I don't trust males. [16]

They described feeling unsafe with men wearing pyjamas or underclothing in public areas of the unit (dining room, corridors).

Making male patient wear clothes or gown or something that covers them. [03]

Guys walking around in their underwear, they should be covered up. [05]

Profane language caused particular concern for several of the women.

It frightens me when men use bad language. [04]

Night issues. Nighttime clearly presented difficulties for many of the women. Sixteen participants discussed specific concerns, which can be clustered into four subcategories: lights; doors; routine checks and interventions; and staff availability.

Most of the women felt safer and more secure knowing that there were routine night checks, but they found the use of a flashlight intrusive, frightening, and disruptive to their sleep. They expressed a preference for softer lights that could be left on all night, affording visibility within their bedrooms. This issue was related to fear of both nighttime and having a man next door or nearby. The women found it especially distressing to have a flashlight shone in their faces during night rounds, although in general these routine night checks promoted their sense of safety.

Afraid in hospital when light is off in room, helpful to have a choice to have light on/off. [03]

Light on at night so you can see whole room. [02]

The night rounds are good, although the flashlight startles me. [07]

A number of women spoke about bedroom doors being open or closed at night. Some preferred the doors kept open, while others preferred them shut. In general, their concerns reflected a fear of someone wandering into their room at night while they slept.

At night it is good to have door closed, safer so people don't wander in. [05]

Prefer to have the door closed so that I wake up if someone comes in. [09]

Feel safer with door open with a little light, helps nurses not to wake you up and if someone comes in I can see them, but if they open and close the door I can't see them. [04]

Routine night checks made many women feel more secure, both because it ensured their safety and because it indicated the availability of staff.

Short frequent contact at night to make sure I was OK at night, really made me feel safe. [18]

Night checks make me feel safe. [16]

Need to have staff around who know what you are up to — how you are doing — put pins in my wrist one night but the staff did not know because they did not come around. [14]

Many of the women felt that there was a need for more therapeutic interventions at night and that staff was inaccessible during the night shift.

Having staff available to talk to is important to help me feel safe [at night]. [05]

Helped me feel safe when nurse asked if she could sit with me because I couldn't sleep, the nurse was very empathic and sat with me, I really appreciated talking with her. [04]

Night is the hardest time, the staff is usually unknown to me, and they do not seem to care, they do not introduce themselves to you at night, they don't even look at you, they seem very unapproachable. [07]

They spoke of the need to have a place to go, such as a lounge, when they couldn't sleep and having medication available if they needed it.

Have panic attacks only at night. [01]

Having to stay in your room 11–7 when you can't sleep is unsafe. [05]

Having a place to go at night is good and having medication available when I need it is also good, watching TV helps me at night. [07]

Smoking privileges at night nearby are important — hard because you need to have a cigarette because you are upset and it is late at night and now you are going out on your own — it is dangerous for me. [14]

Not having meds after one o'clock to sleep intimidated me and I felt bad, one night I woke up around 3 and asked for meds to help me sleep but nurse said she could not give them to me after 1 am — this was terrible, the nurse intimidated me. [15]

Nursing issues. All of the women described the qualities and skills that nurses should possess. Fifteen participants spoke about the importance of a primary nursing relationship in ensuring consistency of care, caregiver, and coordination of care, and thus their own sense of safety, comfort, and empowerment. Central to their sense of safety was the ability to develop a trusting relationship with their primary nurse.

Closely related to primary nursing was staff skill perceived as important in this milieu. Sixteen women spoke about staff skill. Their sense of safety and comfort was influenced by the skill of the staff, primarily because it was manifested in superior coordination and interventions. Skill covered experience, knowledge, treatments, and medications; knowledge of the individual patient — including keeping up to date with any changes; spending time getting to know the patients; initiating contact; and professionalism.

The following comments illustrate the importance they attached to primary nursing.

When you feel connected with someone you don't feel so alone and vulnerable, you know you will not lose control, therefore important to have primary nurse. [05]

The bond created with a primary nurse makes you feel safer — they are working with you, they know you and understand what is wrong. [14]

Primary nursing is important because you have someone to turn to that you have gotten to know and who knows you — you can divulge more, you don't have to start from the beginning all over again, it is like climbing stairs. [11]

A problem identified by the women was the feeling of being ignored by and unconnected to nursing personnel other than their own nurse. They found this especially difficult when the primary nurse was not there, such as at night.

Having primary nurse is good but if a nurse is not your primary they don't even smile at you, I know they are understaffed but that does not mean they cannot be friendly when they walk past you. It would be nice if they came to talk to you if they had time even if they are not your nurse. [07]

Many of the women found that experienced staff made them feel safe. However, they believed that experience was not as important as caring, empathy, and compassion.

> *Having experienced staff is one of the most important things, they have confidence in their skills, it is reassuring when they say "I have seen this before."* [06]

> *Not being task oriented — more important to have a nurse who actually cares rather than one who has been there for 25 years — she has seen it so many times but couldn't care less about you.* [14]

Participants said it was important that staff be knowledgeable and informed about their problems, treatments, and medication; otherwise, they felt unsafe and afraid. The women also spoke about the importance of staff sharing this knowledge with them.

> *Expert nurses tell you each time what medication they are giving you and why; they are informed and educated, putting time and effort into the moment of giving you medication is almost like bonding.* [08]

> *The nurses, they are the ones who are really with the patients; they see the progress of the patient; it is important they know what is happening with you.* [07]

Many women said it was important for staff to initiate contact, because it showed that staff both cared about them and understood their condition well enough to know when an intervention was needed.

> *I would like the caregivers to interact with me at times, I cannot always articulate it.* [19]

> *Important to not feel like you are imposing, better for the nurse to initiate the contact.* [11]

The women said it was important that staff remain professional — leaving their personal issues at home, maintaining confidentiality, and making and keeping appointments.

> *When the nurses are here they don't bring their personal lives in here, they do not bring their personal problems in here, they are professional — I know they have their own problems but when they are here they concentrate on mine.* [06]

> *Confidentiality — I'm worried professionals may go home and tell their families about some of my horror stories.* [20]

The participants also felt it was important to their sense of safety to have staff available to help them cope with their symptoms.

> *Knowing that people are around because I'm suicidal, so that people are here to stop me from harming myself.* [16]

I panic sometimes, it was good when I panicked once and they stepped in and sat with me and ensured I did not harm myself. [14]

For nine participants, the gender of staff was an issue. For three of these women, the concern centred on bodily touching.

[I] like female nurses as opposed to men, do not trust male nurses. [02]

People should have a choice in not having a male nurse — I am disabled and having a male nurse is hard to preserve my dignity. [09]

They [the staff] were searching me, but I am Muslim and should not be touched or looked at naked by men — but they did not seem to care. [12]

All the participants spoke about the wish to be more informed about unit policy and practices and to be consulted about treatment decisions. There was an overall sense in the interviews that the women wanted to be considered integral to planning care, although some women recognized that at the time of admission they may not have been well enough to participate.

Nursing care plan drawn up and being involved in that is important — could not do it when came in because I was too depressed but it was good that when I was feeling better my primary nurse went over it with me again; important that nurses step in when I cannot. [10]

I am supposed to tell them if I want to hurt myself — but this is hard to do, I would feel safer if there was another plan in place also; for example, they should assess the contract frequently so that it changes as I change and to be on guard for when I may not able to control myself. [14]

Not surprisingly, many women cited knowing what to expect as contributing to their feeling in control and empowered. Given the centrality of a sense of powerlessness, betrayal, and insecurity in the experience of abused women, anything that helps them feel in control and secure is important.

Getting some preparation and being involved with treatment helps me feel safe — shows they are listening. [17]

People should ask you what helps you feel safe prior to admission or tell you conditions on the floor prior to admission so you can prepare yourself. [02]

Information giving — telling me how they will treat me and how my treatment will treat me — what the treatment plans are or including me in treatment plans makes me feel safe because I know I'm listened to. [16]

The women wished to have choices and to have input concerning their medications. Choices included being free to come to the hospital to feel safe. Harris (1994) cites this as an important issue — rather than

coming to hospital because one is out of control — for women with a history of trauma. For 16 of the participants, being consulted meant being believed and taken seriously; otherwise, they felt unsafe, not listened to/validated, humiliated, and treated inhumanly. These themes are similar to concerns expressed by participants in a recent study by Gallop et al. (in press).

> *Being treated as a person, having choices in care as important.* [02]
>
> *Having a choice to come into hospital — that they will let me in when I need it — helps me feel safe.* [17]
>
> *One night a nurse told me just to forget my family because I have problems with them, I was so insulted, I got angry for the first time — so his unempathic response made me feel unsafe for the first time — "don't tell me how to feel."* [17]

On the other hand, when the participants sensed that the nurses took their job seriously and cared for the patients they felt more secure and comfortable. They felt safer when the staff respected them, took them seriously, believed them, listened to them, and showed genuine concern.

> *A listening and compassionate air cannot be replaced by medication.* [08]
>
> *I just feel safe when I have nice people around me — professionals who know how to respect and talk to me, act like they care then I feel safe in the environment.* [20]

Additional Observations

Twelve of the participants reported that having women's groups on the floors would contribute to their feeling of safety in hospital. Women's groups were seen as an opportunity to share experiences, as helping to promote feelings of safety, and as private places where women could comfortably and openly discuss distressing and personal issues.

> *Being told I have to go to group therapy makes me feel unsafe because there are males there, I don't even have male visitors.* [20]

Discussion

The participants in this study suggested environmental changes to limit their exposure to male patients, to provide them with more options in managing nighttime difficulties, and to facilitate their active participation in all aspects of treatment planning and the therapeutic relationship. Concerns about male patients may be related to the state of hyperarousal and chronic fear evident in trauma survivors (van der Kolk et

al., 1996). In addition, women who have experienced childhood sexual and/or physical abuse are at significantly greater risk of adult victimization, and concerns about males may be a reflection of this reality in the lives of the participants (Briere, 1992).

The participants wanted a fuller range of treatment options made available to them at night, to alleviate their fears and enhance their sense of safety and containment. Some of the suggested modifications were: having staff available to speak with or simply to be present during difficult times in the night; access to the television lounge or other communal space; smoking privileges; and medications regardless of the hour. These recommendations are not surprising given that trauma survivors frequently experience a chronic state of hyper-vigilance and a related inability to rest (van der Kolk, 1994). In addition, sleep disturbance, such as difficulty falling asleep, frequent waking in the night, and early waking, are common. Nightmares and flashbacks may be experienced, and panic may be greater at night.

The participants wished to be involved in the planning of their care and in decision-making. They discussed characteristics of the nursing staff essential to establishing this type of collaborative relationship. Their need to be involved may be related to the chronic feelings of powerlessness engendered in women who have experienced abuse. The need to exert control in the outside world is paramount to a woman's sense of safety given that the world may have been internalized as a hostile place (Herman, 1992). The repeated call by these women for qualities in nurses that foster a sense of safety reflects the traumatic experiences that leave women feeling socially vulnerable and make it exceedingly difficult to establish trust.

The participants identified the important role of nursing. When the characteristics of primary nursing, willingness to make contact, professionalism, and knowledgeability were lacking they felt insecure and anxious. All of the participants acknowledged concerns about their lack of involvement in treatment planning and described aspects of their care that seemed to fall short of what are essential elements of nursing.

For decades, the nursing profession has espoused a participatory decision-making framework and advocated for client-centred care focused on the needs of each individual patient. In addition, there is an extensive nursing literature on the centrality of empathy and interpersonal process in mental-health nursing (Gallop, 1997). Despite these espoused and documented nursing values and the literature on trauma,

these participants cited many examples of nurses forsaking these values and failing to apply their trauma knowledge. The study sites still practised what might be ingrained and traditional night routines. The premise that nighttime is reserved for sleeping and daytime for programming seems to be the basis for these practices. The nighttime practices of "lights out," unavailability of sedation after 1:00 am, restriction of lounges, and minimal nursing contact all support the assumption that patients must sleep at night so that they can participate fully in treatment during the day. The historically rooted night routines and traditional restrictions continue to be applied even though nurses should know that an estimated two thirds of women admitted to their unit have experienced trauma and may suffer from distressing symptoms such as flashbacks and panic, which are often heightened at night. It may be that what nurses have come to know experientially over years of practice takes precedence over newly acquired theoretical and empirically based knowledge.

Another factor contributing to an apparent lack of integration of trauma knowledge into unit practices may be a weariness on the part of nurses resulting from failed attempts to effect change. Nursing, a predominately female profession, functions in a system that has historically provided its practitioners with little control over intervention and change. Nurses may feel much as the women in this study did — silenced and powerless to change the system. Changing unit practices and policies requires the support of colleagues and administrators. Silencing can occur in many ways. Mohr (1995) describes the team meeting in psychiatric units as a pleasing myth of egalitarianism and democratic principles. Mohr claims that in reality it is strictly hierarchical and led by the psychiatric expert; nursing input is valued only to the extent that it reinforces the scientific model. Because nurses and physicians may speak different languages at the meetings, the nurse may feel both unheard and silenced (Gallop, 1997). Frequently, medical staff speak the language of science — positivist; signs, symptoms, diagnoses — nurses, the language of feelings, context, and process. Lack of response to nurses' language conveys the message that their input is of no consequence. Senior nursing administrators may also contribute to the silencing of nurses. Roberts (1983) describes nurses as an oppressed group and nurse administrators as identifying with the oppressor (i.e., physicians) in order to exercise power over the front-line clinicians. Hence the struggle to bring about changes that may be valued as important by both nurses and clients, but not by the power groups, can become a fruitless and frustrating experience.

Conclusion

The concerns of women with a history of abuse can be addressed by modifications in unit and nursing practices. If nurses acquire the ability to comfort clients who have experienced abuse, recognize the high rate of abuse in the lives of psychiatric clients, and believe they have the authority and support to proceed with change, they will be able to provide safe and empowering environments.

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