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# Research Participants Telling the Truth About Their Lives

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## *The Ethics of Asking and Not Asking About Abuse*

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*Most discussions of the ethics of self-report research on abuse and interpersonal violence focus on the risks of asking participants about their experiences. An important element of the cost–benefit analysis—the costs of not asking about child abuse—has largely been ignored. Furthermore, little research has been conducted on the costs and benefits of child abuse research, leaving researchers to make decisions based on individual beliefs about such issues as the prevalence of abuse, the likelihood of disclosure, the effects of child abuse, and the ability of abuse survivors to give informed consent. The authors suggest that these beliefs tend to overemphasize survivors’ vulnerability and ignore the costs of avoiding asking about abuse. In fact, these beliefs may reinforce societal avoidance of abuse and ultimately harm abuse survivors.*

**Keywords:** experimental ethics, institutional review boards, trauma, abuse, human participants

What would happen if one woman told the truth about her life?  
The world would split open.

—Muriel Rukeyser

**P** psychological researchers should gather information about child abuse, family violence, and other interpersonal violence. Abuse is associated with so many important social problems: poverty, divorce, HIV risk, school performance, criminality, learning disorders, and mental and physical health (e.g., Brush, 2000; Fagan, 2001; Green et al., 2001; Jaffe, Poisson, & Cunningham, 2001; Jenkins, 2002; Kendall-Tackett, 2003; Resnick, Monnier, & Seals, 2002). When researchers do not measure abuse history, they obscure the role of abuse and overestimate the strength of other factors (Putnam, Liss, & Landsverk, 1996).

Measuring abuse history is especially important for clinical research. Read and colleagues (Read, Perry, Moskowitz, & Connolly, 2001) have pointed out that when researchers carefully gather abuse information, its role in the development of schizophrenia appears much stronger than genetic and biological studies suggest. Maltz (2001) described how ignoring abuse led to inappropriate sex therapy treatments that retraumatized survivors. In a study of depression, those who had experienced early trauma, unlike those who were not trauma survivors, responded

better to psychotherapy alone than to antidepressant medication alone (Nemeroff et al., 2003).

Participants themselves provide information that both adds to the overall accuracy of information on abuse and is unavailable in any other way. Finkelhor and Hashima (2001) found that caretaker reports of physical abuse resulted in twice the incidence reported by child protective agencies. Hardt and Rutter (2004) reviewed studies that included both retrospective and corroborative reports of abuse. They concluded that adult retrospective reports underrepresent the true prevalence of maltreatment and do not inflate estimates.

Although most researchers recognize the need to gather information about child abuse and interpersonal violence, many ethical and practical questions remain about how to do so. Several years ago, Newman, Kaloupek, Keane, and Folstein (1997) listed some of these ethical issues and called on scientists to make use of empirical evidence to answer these questions rather than “strong emotions [that] may interfere with an ability to evaluate scientifically the ethical dilemmas” (p. 272). In this article, we lay out 10 concerns that researchers often have about asking participants about abuse, including some described by Newman and colleagues. Since 1997, more empirical research has become available to address these concerns (Newman & Kaloupek, 2004). We review research relevant to addressing these concerns, provide context, and suggest solutions. In the end, we conclude that carefully asking about abuse is not only ethically defensible, but required.

In this article we are referring to research that asks adults about abusive events, whether conducted via telephone, computer, written surveys, or in person, and whether the questions are very brief or very detailed. We include here neither intervention studies nor challenge

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This work was completed while Kathryn A. Becker-Blease was a postdoctoral fellow with the Family Research Laboratory (National Institute of Mental Health Grant 5-T32-MH15161-25). Manuscript preparation was also supported by the University of Oregon’s Foundation’s Fund for Research on Trauma and Oppression. We thank Anne DePrince, Theo Johnson-Freyd, Juliana Kyrk, Alice Rothschild, and members of the Family Research Laboratory seminar for valuable suggestions.



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studies (that induce trauma reactions), both of which carry additional ethical considerations. Although asking children directly about abuse can be done ethically, the ethical issues are too complicated to address adequately here. We do discuss studies that include child participants when parents or guardians are the reporters. For clarity, we use the term *adults* for people reporting on their own experiences and *parents* for those reporting on children's experiences.

## **Concerns of Researchers Who Ask About Abuse**

### **Concern 1: The Institutional Review Board Won't Let Me Ask Participants About Abuse**

Although we know of no case in which an Institutional Review Board (IRB) has prevented researchers from asking anyone about abuse, this has presumably occurred on some occasions, and certainly researchers have expressed to us the fear that this might happen to them. Because IRBs operate independently and can vary widely in their assessment of risk, researchers studying controversial topics cannot predict particular boards' judgments. In fact, IRBs have approved studies in which researchers have asked parents and children directly about current abuse (e.g., Becker-Blease, Freyd, & Pears, 2004; Finkelhor, Ormrod, Turner, & Hamby, 2005).

We suggest that many IRB members, like the rest of society, are reluctant to confront abuse. Researchers can remind reviewers of the obligation to adhere to the principle of justice (Penslar, 1993), which may be violated when studies exclude certain groups (e.g., when abused children are excluded from research on conditions that affect a significant proportion of abused children). Researchers can

also explain why the results need to generalize to abuse survivors.

Researchers can also help IRB members determine risks and benefits by reviewing evidence that indicates that participants themselves see the value in asking about abuse, as long as debriefing is handled appropriately. For example, DePrince and Freyd (2006) asked undergraduates the following:

Please consider both your experience answering the questions [about child abuse and other trauma], and your feelings about how important it is that we ask the questions, and then rate how good of an idea it is to include such a measure in psychology research.

Of the 481 participants, 410 (85%) answered "somewhat good" or "very good." Only 3 participants responded "very bad" or "somewhat bad." By comparison, Fisher and Fyrborg (1994) asked undergraduates to read about three different published studies that involved deception. Between 70% and 85% of the 90 participating undergraduates approved of deception research, depending on the study. Thus, undergraduates are at least as likely to support child abuse research as research involving deception.

Other researchers are concerned about inflammatory language imposed by IRBs. These notices may suggest that a seriously upsetting reaction is likely and convey the unintended message that the research is riskier than participants would otherwise judge it to be. Overly alarming language may create anxiety for participants and/or set up the context for a self-fulfilling prophecy. For projects that are judged to present more than minimal risk, legal counsel has advised some IRBs to require statements, similar to the following, on all consent forms:

If you experience harm because of the project, you can ask the State of Oregon to pay you. If you have been harmed, there are two University representatives you need to contact. [Names and contact information are given.] A law called the Oregon Tort Claims Act limits the amount of money you can receive from the State of Oregon if you are harmed. The most you could receive would be \$100,000, no matter how badly you are harmed. If other people are also harmed by the project, all of you together could only receive \$500,000. (University of Oregon CPHS/IRB [Committee for the Protection of Human Subjects/IRB], 2002)

In other cases, IRBs require telling participants that a survey may cause distress:

The risks involved are limited to the possible stress of completing a questionnaire. As some of the questions might be personal and sensitive for some people, it is possible that you might feel some distress as a result of participation. If you should become distressed while completing the questionnaire, Dr. Walker will be available to talk with you (telephone xxx-xxx-xxxx 24 hours a day). In addition, treatment for any distress can be made available through your family doctor or Group Health's mental health services within the limits of your coverage plan. (Newman, Walker, & Gefland, 1999, p. 195)

Researchers can reference the American Psychological Association's (APA) "Ethical Principles of Psychologists and Code of Conduct" (hereinafter referred to as the Ethics Code; APA, 2002) that requires informing partici-



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pants of risks in research (Standard 8.02) but also requires that doing so avoids harm (Standard 3.04). As an alternative to the potentially problematic consent form language shown previously, IRBs have approved statements like the following:

There are no known risks to you associated with completing the packet. However, if you become upset and would like to talk to someone, please call the Counseling Center at xxx-xxxx. There are no known benefits to participation but some participants may get satisfaction from contributing to research on family experiences.

It is also crucial that consent forms clearly describe under what circumstances, if any, researchers will release the information to an outside agency.

### **Concern 2: I Don't Know How to Ask and I'm Not Prepared to Work With Survivors**

We refer readers to *Trauma Assessments* (Carlson, 1997) for detailed information on various kinds of self- and parent-report measures related to abuse. The National Center for PTSD [posttraumatic stress disorder] also maintains a list on their Web site. Many of these are self-administered surveys that do not require special clinical skills. The Brief Betrayal Trauma Survey is a short trauma measure that is easy to administer (Goldberg & Freyd, in press).

Adult abuse survivors participate in research whether or not researchers inquire about abuse history. Many research studies, on topics such as dating, parenting, and emotions, could elicit abuse disclosure. Adding contact information for community resources specific to abuse survivors in debriefing materials would be inexpensive and appropriate for many studies.

Researchers and assistants who conduct research that may lead to disclosure need additional information and

experience to respond appropriately when someone discloses abuse or when abuse of a child is suspected. A local sexual assault, court-appointed special advocate, or domestic violence program may be able to educate staff about reactions to abuse, community resources, and helpful responses to disclosure. Some psychology students will already have this training as part of volunteer work at an agency.

Staff will also need extra training and debriefing opportunities to cope with their own possible emotional distress resulting from hearing about participants' experiences. Debriefing during regular lab meetings usually works well. It is also helpful for research assistants to write about their thoughts and feelings after a participant leaves. The book chapter "Emotional Issues and Ethical Aspects of Trauma Research" (Armstrong, 1996) is an accessible introduction to these issues. In order for staff to receive more training, it is worth seeing if a clinician on faculty, in the counseling center, or in the community would be willing to discuss self-care with staff.

In the case of children, we make an even stronger case for training all research staff to deal with suspected abuse. Researchers who study children are also virtually guaranteed to encounter abused children as research participants, and mandated reporting laws present additional risks to children and parents. Without a clear protocol and an informed-consent statement regarding abuse reporting, researchers who suspect abuse are left to make a quick decision about breaking confidentiality to make a report. Your local child protective services can help you decide if you are a mandated reporter, when you must report, and what you must report. *A Family's Guide to the Child Welfare System* (Child Welfare League of America, 1996–2005) can help explain child protective services to parents.

### **Concern 3: Asking About Abuse Necessarily Requires Reporting Abuse**

Many researchers consider reporting abuse to be onerous, as it can break confidentiality promises, put families at social, psychological, and legal risk, and scare away participants. The issue is complicated because reporting laws differ from state to state. In many states, researchers are not mandated reporters, and reporting abuse is optional (e.g., Liss, 1994; Putnam et al., 1996). Exactly what constitutes "reportable" abuse differs. For example, if an adult reports past abuse, does the researcher have a duty to find out if the perpetrator still has access to children? If a parent tells the researcher that the abuse has been previously reported, must the researcher still report? If the researcher does not believe a child's or a parent's claim, should the researcher report? The lack of clarity about researchers' mandate to report is one argument for requiring all researchers who work with children—not just those who study child abuse—to include their policy in the informed-consent statement. We refer readers to Fisher, Higgins-D'Allesandro, Rau, Kuther, and Belanger (1996), Liss (1994), and Urquiza (1991) for more thorough analyses of the ethical and legal issues involved in reporting suspected abuse.



We argue that it is ethical to not report suspected abuse when (a) this is legally allowable; (b) doing so has the potential to yield benefits to society and participants; (c) the risks to participants do not outweigh the benefits to society and participants; (d) participants are clearly informed about the conditions under which abuse will or will not be reported so that they do not mistakenly think that their disclosure is a report to an outside agency; and (e) participants are told how they can report abuse in such a way that information reaches an appropriate outside agency.

This fifth requirement is quite important and speaks to the increased responsibility researchers face when they choose to assist participants in ways other than reporting to child protective services (see also APA [2002] Ethics Code Standards 3.04 and 8.08). Researchers can design studies that help participants report the abuse themselves and make positive changes in their lives that result in direct benefits. For example, parents can be asked to complete questions about their children's experiences privately and anonymously. At the end, all participants can be given information about resources available to families experiencing abuse. This allows participants to ask for and receive assistance while maintaining confidentiality and answering survey questions honestly (Becker-Blease et al., 2004). Participants may be more willing to accept the number to a generic helpline (e.g., the Girls and Boys Club national hotline) than to a domestic violence shelter.

Another strategy is to tell participants that it may be necessary to follow up with them after the initial participation and to ask for their preferred contact method. Researchers can explicitly ask, for example, "Will you have privacy if I contact you by email?" When researchers contact participants by phone, it is helpful for them to ask periodically "Is this still a good time to talk?" to give participants a way to get off the phone if necessary. Researchers might consider having a clinician make follow-up contact to allow adolescent and adult participants to receive additional referrals, including assistance with telling a trusted adult or the authorities about abuse.

#### **Concern 4: Asking About Abuse Means Losing Participants**

Researchers who ask parents to report on abuse their children have experienced may choose or be required to report this abuse to authorities. Researchers who involve parents in the process of reporting abuse tell us that researchers' fears about attrition are greatly exaggerated (e.g., Putnam et al., 1996). For a variety of reasons, such as current involvement with child protective services, parents may not react as negatively as researchers fear. We simply do not know how many participants would withdraw because a researcher reported suspected abuse. Research on participants' beliefs and feelings related to mandated reporting and child protective services would be a helpful first step.

Researchers who study adults sometimes avoid asking about abuse because they believe participants will decline to participate or will drop out. In one relevant study of

adults, participants were randomly assigned to write either about a trauma or about a mundane topic not related to a trauma (Park & Blumberg, 2002, p. 605). Those in the trauma-writing group were instructed to write about "the most traumatic and upsetting experience of your life" in each daily session for four days. At the end of the study, participants in the trauma-writing group were no more likely than those in the control group to drop out.

#### **Concern 5: Asking About Abuse Exposes Participants to Unusual, Upsetting Stimuli**

The evidence available suggests it is not direct questions about abuse that usually trigger traumatic memories. Instead, survivors often report that memories of trauma surface when survivors are in environments or experience emotions similar to those in the original traumatic event (van der Kolk, McFarlane, & Weisaeth, 1996). Elliott (1997) surveyed a national random sample of adults about their experiences recalling traumatic memories after a period of time when the memories were inaccessible. Of the 115 respondents who reported recovering traumatic memories, the highest percentage indicated that the media (e.g., a TV show or movie) precipitated the recall. Elliott (1997) reported a significant percentage of respondents whose traumatic memories were triggered by sensory or, for sexual abuse survivors, sexual experiences. Research questions are not the kind of stimuli usually reported to elicit memories; the daily exposure to media is relatively more likely to precipitate recall.

Even if questions remind participants of upsetting events, the feelings that come up are not necessarily overwhelming or even completely undesirable. Brabin and Berah (1995) interviewed 417 parents of stillborn children, concluding with two questions: "Did you find that talking about your baby now was distressing?" and "Do you think that talking about your baby now has been helpful or unhelpful in some way?" Most participants (81.3%) reported that the interviews were not distressing, and only 1.2% of the sample found the interviews to be both distressing and unhelpful. It is interesting to note that the remaining 17.5% of the participants found the interviews to be distressing but helpful. Those who have experienced deeply upsetting events may continue to experience negative emotions about the event and at the same time find discussing the events to be manageable and even helpful.

It is rare that a research participant becomes distressed after answering questions about abuse (DePrince & Frey, 2006). In the study by Park and Blumberg (2002) involving writing about trauma, no participants reported adverse reactions (C. L. Park, personal communication, September 2, 2003). Similarly, researchers who conducted a study of 9,508 HMO members on abuse and other trauma reported no calls to their 24-hour crisis line (Edwards, Anda, Felitti, & Dube, 2003). In sum, these data support the claim that research is not more stressful, and may be less stressful, than other experiences in everyday life.

### **Concern 6: It Is Unethical to Ask Participants to Disclose Stigmatizing Information**

It could be argued that asking participants about abuse represents an invasion of privacy, requiring participants to choose among disclosing potentially stigmatizing information, lying, or refusing to answer a question. Nevertheless, researchers routinely ask participants about one kind of potentially stigmatizing personal information: income. In a study of young women who had sought abortions, participants were asked to rate how willing they were to disclose various pieces of personal information (Smith, Adler, & Tschann, 1999). Respondents were more willing to report having sought an abortion than to report income. In fact, the means were in the direction of greater willingness to report both parent and dating abuse when compared with income (no statistics on this comparison were presented). Thus, participants may be just as willing to report past abuse as to report other personal information.

Private written or computerized surveys more easily allow participants to avoid providing potentially stigmatizing information. Consistent with the APA (2002) Ethics Code (Standard 8.02), concerns about upsetting participants and stigmatization can be addressed with informed consent that allows participants to refuse or to end participation in the research.

Is the magnitude of risk, due either to uncovering upsetting feelings (Concern 5) or to stigmatizing information (Concern 6), at a level greater than participants encounter in everyday life? We suggest it is not, in part because of the policies of health care providers who now routinely ask about abuse history. According to an epidemiology publication circulated to doctors and nurses, “many advisory bodies have determined that inquiring about IPV [intimate partner violence] is justified because of the severity and prevalence of IPV, the potential for helping victims, and the low cost and low risk associated with asking about abuse” (Oregon Department of Human Services, 2003, p. 1). The publication highlights the potential benefits to patients, concluding with the statement, “Asking the question is an important intervention” (p. 2). Although there are some important differences between health care providers and researchers, many of the same arguments for asking about abuse apply to both groups. In fact, because researchers are ethically required to debrief participants and minimize any harm done by the research (APA [2002] Ethics Code, Principle 8.08), the risk–benefit ratio may be even better for researchers than for health care providers.

### **Concern 7: Questions About Abuse Directly Cause Harm**

Participants—abuse survivors or not—feel a variety of negative reactions to child abuse. Not all negative feelings are dangers from which participants need protection. For example, some people feel embarrassed or offended when confronted with a taboo topic. Some IRBs have sought to limit researchers’ ability to collect data on racism because participants might feel embarrassed about times when they demonstrated racist thoughts or actions (Begley, 2002).

Some participants feel the same way about sexual violence. To limit research in these areas would be to spare the sensibilities of some at great cost to the well-being of others.

Even when the negative feelings evoked by research are more closely associated with the experience of trauma or abuse (e.g., feelings of betrayal or grief), this is not necessarily an indication of psychological harm. Feelings like grief, anger, and fear in response to remembering a trauma may be a transitory negative state that is understandable and not harmful.

We should be more concerned about longer term reactions. Feelings that are so intense that they cannot be resolved before the end of the participation in the research may be indication of possible harm. Even then, the follow-up may produce a beneficial outcome. For instance, the participant may seek help and may subsequently heal from a traumatic experience. Feelings that are so intense that they lead to behaviors that are harmful to the self or others are obviously of great concern. Although such strong reactions to being asked about abuse are rare, researchers do need to be prepared to help participants access mental health services in these cases.

It is important to differentiate survey studies from studies that are designed to induce symptoms or distress. Unlike trauma survey research, some studies intentionally *cause* participants to feel sadness, shame, anger, or frustration, and such studies sometimes use deception (e.g., Ainsworth, Blehar, Waters, & Wall, 1978; Goldsmith & Rothbart, 1991; Herral & Tomaka, 2002). Trauma surveys, by comparison, risk *reminding* participants of distressing events caused by people or circumstances other than the research itself. Other studies—known as challenge studies—present participants with stimuli known to elicit a particular symptom (such as a flashback in a participant who has been diagnosed with PTSD). It is noteworthy that in both distress-causing studies and in challenge studies, eliciting distress is not confused with causing psychological harm.

### **Concern 8: Survivors Are Not Emotionally Stable Enough to Assess Risk or Seek Help**

Newman and colleagues (1999; Walker, Newman, Koss, & Bernstein, 1997) directly asked how well women anticipated their level of distress related to participation in research on child abuse and PTSD. Approximately 1,100 women completed questionnaires, and approximately 250 completed two follow-up interviews. After each phase, participants reported their level of agreement with two statements: “Completing this survey upset me more than I expected” and “Had I known in advance what completing this survey would be like for me, I still would have agreed” (Newman et al., 1999, p. 190). As results were similar for both interviews, only results for the first are mentioned here. Most participants (72% following both the questionnaire and interview) disagreed that the survey upset them more than expected and agreed that they would still have participated had they known what the experience would be like (77% following the questionnaire and 97% following

the interview). It is interesting to note that of the 123 women who reported unexpected upset, only 14 indicated they would not have participated had they known what the experience was going to be like. Most women ( $n = 44$ ) who indicated they would not have participated had they known what it was going to be like did not report unexpected upset.

In Brabin and Berah's (1995) study of parents of stillborn infants, 66% of those recruited through phone calls and 76% of those recruited through the mail who refused to participate indicated that they did not want to bring up painful memories. These rates, coupled with the low rate of participants who found the interviews to be distressing and unhelpful, suggest that participants can and do decline to participate when they are concerned about upsetting memories.

Many abuse survivors have developed adaptive ways to cope with reminders of abuse and seek support when those coping mechanisms fail. Researchers must be careful that their efforts to protect survivors do not send the message that the survivors are incompetent. Treating survivors as overly vulnerable risks repeating abuse dynamics that cause further harm (Violanti, 2000).

Sadly, some abuse survivors do have serious mental health or substance abuse problems that may affect their ability to assess the risks of research and to seek help. Researchers recruiting participants with mental health or substance abuse problems will have additional ethical considerations, but those issues are specific to those problems, not simply to abuse.

### **Concern 9: Asking Participants About Abuse Has No Direct Benefits to Participants**

Too often discussions of asking participants about abuse begin and end with the potential for harm. In the study by Newman and colleagues (1999; Walker et al., 1997) discussed earlier (see the section on Concern 8), when participants were asked after finishing the questionnaire whether they had gained something positive from the experience, the highest percentage of participants were neutral about having received any benefit. Following the first interview, 86% agreed or strongly agreed that they had gained something positive, and no participants disagreed or strongly disagreed that they had benefited. In a separate study of undergraduates, Lutgendorf and Antoni (1999) found that participants who disclosed trauma to an experimenter had a decrease in intrusive thoughts over time, whereas participants in the control group had constant levels of intrusive thoughts. Reich and Kaplan (1994) interviewed children about mental illness, family conflict, and their parents' alcohol use. Later, when asked about their experiences as participants, 90% of parents and 94% of children said they enjoyed the interview, whereas 90% of parents and 93% of children said they learned more about themselves. After completing a lengthy survey on the details of both victimization and perpetration as part of one of our studies, one convicted sex offender wrote the following:

This was a helpful survey. It shows me where I've been, versus where and what I am today. . . . This survey also shows me how

careful today I need to be as not to fall back into those old behaviors anymore. Thank you for this survey.

Another suggested constructing a similar survey to help respondents realize that they should seek help (Becker-Blease & Freyd, 2003).

Meanwhile, professionals may underestimate the benefits that participants themselves experience. Marshall and colleagues (2001) asked psychotherapy clients to complete questionnaires, participate in interviews, and have their therapy sessions taped as part of a study on psychotherapy effectiveness. The clients and therapists rated positive and negative impacts of the questionnaires and taping for the client. Marshall and colleagues (2001, p. 321) summarized their results as follows: "Clinicians underestimated the positive benefits of research participation to patients and overestimated the intrusive and disruptive aspects of the research, compared to patients' ratings." Researchers and IRB members should be aware of this potential bias.

It is helpful to compare the perceived benefits of trauma research with other kinds of research. Brody, Gluck, and Aragon (2000) interviewed participants who had participated in a variety of studies in a university human subjects pool. Fully 41% characterized the experience as negative, citing invasive questions, boring activities, unpleasant stimuli, anger at being deceived, or "worthless" research.

Binder, Cromer, and Freyd (2004) directly compared participants' responses to questions about abuse and other personal topics. Using the same items that DePrince and Freyd (2006) used, Binder et al. (2004) asked 274 participants to rate their experience answering questions about child sexual abuse, emotional abuse, the participant's grade point average and Scholastic Aptitude Test scores, and the participant's body image. There were no significant differences in the amount of distress reported among the four question types. However, participants rated the abuse questions as being the most important and as having the most favorable cost-benefit ratio.

### **Concern 10: Not Asking Is Safest, Because There Are No Costs to Not Asking About Abuse**

Just as researchers underestimate the benefits of asking about abuse, they underestimate the risks of *not* asking. When we do not ask, science and humanity lose important information (Freyd et al., 2005). Further, we withhold child protective services responses that prevent future harm. We deprive participants of the opportunity to learn about normal reactions to abuse and about community resources that could help. Studies that ask about child abuse help break the taboo against speaking about abuse, helping survivors to know that talking about their experiences is important. As an analogy, consider suicide. Some people worry that asking a depressed person about suicide will make it more likely that they will attempt suicide, but experienced clinicians note that clients very often appreciate the concern, and interventions can help (Soreff, 2005).

As psychologists, we must avoid harm (APA [2002] Ethics Code Standard 3.04), even if we do harm by *not*



asking at all. If we do not ask, we will not be as able to prevent victimization and help survivors. The threat to study validity is high, particularly in clinical studies. For example, Measelle and Stice (J. Measelle, personal communication, November 15, 2005; see also Measelle, Stice, & Hogansen, in press) have examined predictors of adolescent girls' depression, problematic eating, substance abuse, and antisocial behavior. Latent growth models indicate that a family history of psychopathology and trait levels of negative affect predict growth in problems during adolescence. However, once entered into the model, childhood trauma appears to be the strongest unique predictor of growth in symptomatology.

Participants lose, particularly in long-term studies that ask about many aspects of their personal lives. Therefore researchers ought to worry about a study likely to include a substantial proportion of abuse victims (drug addicts or delinquent adolescents, for example) that does *not* ask about abuse. When research is set up with a "don't ask, don't tell" policy in which researchers ask about many aspects of participants' lives (sexual behavior, illegal behavior, etc.) but not about abuse, they may convey to participants that abuse is unimportant or makes researchers uncomfortable.

In fact, research indicates that not disclosing abuse is harmful (e.g., Pennebaker & Hoover, 1985). Sinclair and Gold (1997) asked 204 adult survivors of child sexual abuse to rate the extent to which they have wanted to disclose abuse to someone on a scale from 1 (*I have not wanted to tell anyone*) to 5 (*I have very much wanted to tell others but did not*). This question pertained to any time participants had wanted to disclose, not just to the first time, and regardless of whether they actually had ever disclosed to anyone. Results indicated that wanting to tell but not telling was a better predictor of mental health symptoms than whether a person told someone else about the abuse or severity of abuse. We have yet to hear a discussion on the effects of this kind of selective silencing of abuse survivors, who often believe that they are alone in their experiences and that other people do not understand their point of view. Additional research, perhaps building upon the work of Herman (1992), Suarez-Orozco (1990), and Lykes (1996) on the silencing of trauma survivors, is needed.

In fact, it is possible that researchers and others who have never had to confront abuse in their personal lives benefit from a "don't ask, don't tell" policy while survivors bear the costs. There is some evidence to suggest that nonabused people are more likely to raise objections to questions about abuse than are abuse survivors. In at least one study, abused women were more likely than nonabused women to agree that health care providers should routinely screen all women for domestic violence (Gielen et al., 2000). Similarly, in our own experience running a study of undergraduate men's experiences with abuse perpetration and victimization, the few participants who have objected to the questions have done so not on the grounds that the questions are incriminating or upsetting but that they simply do not think research should be conducted that asks

these questions. Why should nonabused people be more likely to object to asking questions about abuse than survivors? Nonabused people may underestimate the prevalence of abuse or feel the questions are not applicable to them, but this is not a strong argument for not asking. We suggest that some participants are unhappy about having to confront the fact that abuse occurs. Asking research participants about abuse requires researchers and participants to break through their denial that someone they know may have hurt another person or been hurt by somebody else. Breaking through denial may be uncomfortable for nonabused people, but it may be a welcome change for survivors who otherwise hide their abuse histories from others. When evaluating risks and benefits, then, researchers and IRBs must keep separate the feelings of participants who may be offended by questions about abuse and those who may be at risk of becoming overwhelmed by reminders of trauma or by interviewers' insensitive reactions to disclosure.

## Response to Disclosure: Opportunity and Risk

Although there may be harm in not asking participants about abuse, the way in which survivors are treated when they do disclose is crucially important. In addition to the evidence on the risks of not asking (see the section on Concern 10), Ahrens (2002) described the silencing effects of insensitive comments in a group of women who initially disclosed sexual assault but later stopped disclosing after receiving unsupportive comments. In this study, the average number of years of silence following unhelpful reactions was seven years.

In contrast, carefully selected and trained interviewers may have been the key to Brabin and Berah's (1995) successful interviews with bereaved parents. These researchers selected female interviewers who had experienced perinatal loss, had undergone training offered by a self-help group, and had participated in research training to provide empathetic feedback and referrals to participants. Abuse survivors who have received some counseling and research training may similarly make excellent interviewers for research on abuse.

Participants' well-being, and whether they tell anyone else about the abuse, depends on how researchers respond when they disclose. Researchers must not ask about abuse without planning, ideally with clinicians, trauma survivors, and advocates, ways in which to respond that are empowering and compassionate (we outlined some of the necessary steps in the section on Concern 2).

## To Ask or Not to Ask?

How do researchers decide when a variable is important enough to measure? Who has not struggled to decide which measures to cut when the survey or interview goes too long? We point to two factors to consider when deciding whether abuse history makes the cut.

First, grant reviewers and journal editors require researchers to measure predictors, moderators, mediators,

and confounds that have been strongly implicated in the existing literature. Beware of the catch-22 here. As mentioned previously, if researchers who previously published research on interpersonal violence and maltreatment failed to measure abuse when it was in fact important to do so, not only would the link with abuse be obscured but the role of other variables would be inflated. It may be necessary to draw on clinical experience and preliminary studies for clues to the role of abuse in one's work.

Second, we must all acknowledge our feelings and beliefs about this difficult subject. We once began a collaboration with a colleague who was studying an aspect of child development that theory and empirical evidence suggested could be related to abuse. The colleague did not disagree with the possible connection but objected to survey questions asking adolescents about abuse. When we tried to find out what the concerns were so that we could address them, we heard, "I'm just not comfortable asking those kinds of questions." To us, that sentiment seems accurate and valid, and a very good starting place. The next question to ask is why these particular questions make us feel uncomfortable. In fact, further reflection could be required by the principle of justice (APA, 2002, Principle D), which states that "psychologists . . . take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices" (pp. 1062–1063).

What assumptions are we making when we think it is a risk to ask versus not to ask? And who is bearing that risk? Are we protecting researchers and institutions at the expense of participants? After all, it is presumably so much more comfortable to not know about child abuse. Whether we ask or we don't ask, some of those participants have been abused. Whether we ask or don't ask, those participants are getting a message about whether their abuse matters and whether researchers want to hear about it.

We have identified a few areas that could benefit the most from a greater focus on abuse. Because the rate of abuse and abuse-related problems among clinical clients is high, clinical research on virtually all disorders would benefit the participant population if consideration of abuse were included in the study. The role of abuse in personality and temperament research bears further investigation. Abuse disadvantages people in social, economic, and other ways, so researchers studying disadvantaged people would certainly benefit from taking abuse histories.

In some cases, taking abuse history is not necessary or appropriate. Arguably, some research topics are sufficiently removed from the influence of abusive experiences. We do not call on all researchers to include a measure of abuse in their next projects. Instead, we ask all researchers to carefully consider whether abuse might play a role and, if so, to examine ways of asking about abuse for the benefit of science and participants.

In sum, we suggest that to date decisions on the risks and benefits of child abuse research have been made largely on the basis of individuals' beliefs about the prevalence, importance, and effects of child abuse on individuals and society. In particular, psychologists have largely ignored

the costs of not asking about abuse. As a result, there is the possibility that the social forces that keep so many people silent about abuse play out in the institution, research labs, and IRBs. To the extent that silence is part of the problem—silence impedes scientific discovery, helps abusers, and hurts victims—then this is no trivial matter.

## REFERENCES

- Ahrens, C. E. (2002). Silent and silenced: The disclosure and non-disclosure of sexual assault. *Dissertation Abstracts International*, 63 (3), 1553B. (UMI No. AAT 3047842)
- Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Erlbaum.
- American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, 57, 1060–1073.
- Armstrong, J. G. (1996). Emotional issues and ethical aspects of trauma research. In E. B. Carlson (Ed.), *Trauma research methodology* (pp. 174–187). Lutherville, MD: Sidran Press.
- Becker-Blease, K. A., & Freyd, J. J. (2003, July 14). *Sex offending: The role of previous victimization and cognitive processing*. Paper presented at the 8th International Family Violence Research Conference, Portsmouth, NH.
- Becker-Blease, K. A., Freyd, J. J., & Pears, K. C. (2004). Preschoolers' memory for threatening information depends on trauma history and attentional context: Implications for the development of dissociation. *Journal of Trauma and Dissociation*, 5, 113–131.
- Begley, S. (2002, November 11). Review boards pose threat to tough work by social scientists. *The Wall Street Journal*, p. B1.
- Binder, A., Cromer, L. D., & Freyd, J. (2004, November 15). *What's the harm in asking? Participant reaction to trauma history questions compared with other personal questions*. Poster session presented at the 20th Annual Meeting of the International Society for Traumatic Stress Studies, New Orleans, LA.
- Brabin, P. J., & Berah, E. F. (1995). Dredging up past traumas: Harmful or helpful? *Psychiatry, Psychology and Law*, 2, 165–171.
- Brody, J. L., Gluck, J. P., & Aragon, A. S. (2000). Participants' understanding of the process of psychological research: Debriefing. *Ethics & Behavior*, 10, 13–25.
- Brush, L. D. (2000). Battering, traumatic stress, and welfare-to-work transition. *Violence Against Women*, 6, 1039–1065.
- Carlson, E. B. (1997). *Trauma assessments: A clinician's guide*. New York: Guilford Press.
- Child Welfare League of America. (1996–2005). *A family's guide to the child welfare system*. Retrieved October 1, 2005, from [www.cwla.org/childwelfare/familyguide.htm](http://www.cwla.org/childwelfare/familyguide.htm)
- DePrince, A. P., & Freyd, J. J. (2006). Costs and benefits of being asked about trauma history. *Journal of Trauma Practice*, 3, 23–35.
- Edwards, V. J., Anda, R. F., Felitti, V. J., & Dube, S. R. (2003). Adverse childhood experiences and health-related quality of life as an adult. In K. Kendall-Tackett (Ed.), *Health consequences of abuse in the family: A clinical guide for evidence-based practice* (pp. 81–94). Washington, DC: American Psychological Association.
- Elliott, D. M. (1997). Traumatic events: Prevalence and delayed recall in the general population. *Journal of Consulting and Clinical Psychology*, 65, 811–820.
- Fagan, A. A. (2001). The gender cycle of violence: Comparing the effects of child abuse and neglect on criminal offending for males and females. *Violence and Victims*, 16, 457–474.
- Finkelhor, D., & Hashima, P. Y. (2001). The victimization of children and youth: A comprehensive overview. In S. O. White (Ed.), *Handbook of youth and justice* (pp. 49–78). New York: Kluwer Academic/Plenum Press.
- Finkelhor, D., Ormrod, R., Turner, H., & Hamby, S. L. (2005). The Victimization of Children and Youth: A comprehensive, national survey. *Child Maltreatment: Journal of the American Professional Society on the Abuse of Children*, 10, 5–15.
- Fisher, C. B., & Fyrberg, D. (1994). Participant partners: College students



- weigh the costs and benefits of deceptive research. *American Psychologist*, 49, 417–427.
- Fisher, C. B., Higgins-D'Allesandro, A., Rau, J. M. B., Kuther, T., & Belanger, S. (1996). Reporting and referring research participants: The view from urban adolescents. *Child Development*, 67, 2086–2099.
- Freyd, J. J., Putnam, F. W., Lyon, T. D., Becker-Blease, K. A., Cheit, R. E., Siegel, N. B., et al. (2005, April 22). The science of child sexual abuse. *Science*, 308, 501.
- Gielen, A. C., O'Campo, P. J., Campbell, J. C., Schollenberger, J., Woods, A. B., Jones, A. S., et al. (2000). Women's opinions about domestic violence screening and mandatory reporting. *American Journal of Preventive Medicine*, 19, 279–285.
- Goldberg, L. R., & Freyd, J. J. (in press). Self-reports of potentially disturbing experiences in an adult community sample: Gender differences and test–retest stabilities of the items in a Brief Betrayal-Trauma Survey. *Journal of Trauma & Dissociation*.
- Goldsmith, H. H., & Rothbart, M. K. (1991). Contemporary instruments for assessing early temperament by questionnaire and in the laboratory. In A. Angleitner (Ed.), *Explorations in temperament: International perspectives on theory and measurement* (pp. 249–272). New York: Plenum Press.
- Green, B. L., Krupnick, J. L., Stockton, P., Goodman, L., Corcoran, C., & Petty, R. (2001). Psychological outcomes associated with traumatic loss in a sample of young women. *American Behavioral Scientist*, 44, 817–837.
- Hardt, J., & Rutter, M. (2004). Validity of adult retrospective reports of adverse childhood experiences: Review of the evidence. *Journal of Child Psychology and Psychiatry*, 45, 260–273.
- Herman, J. (1992). *Trauma and recovery*. New York: Basic Books.
- Herrald, M. M., & Tomaka, J. (2002). Patterns of emotion-specific appraisal, coping, and cardiovascular reactivity during an ongoing emotional episode. *Journal of Personality and Social Psychology*, 83, 434–450.
- Jaffe, P. G., Poisson, S. E., & Cunningham, A. (2001). Domestic violence and high-conflict divorce: Developing a new generation of research for children. In J. L. Edleson (Ed.), *Domestic violence in the lives of children: The future of research, intervention, and social policy* (pp. 189–202). Washington, DC: American Psychological Association.
- Jenkins, E. J. (2002). Black women and community violence: Trauma, grief and coping. *Women and Therapy*, 25(3–4):29–44.
- Kendall-Tackett, K. (2003). *Treating the lifetime health effects of childhood victimization*. Kingston, NJ: Civic Research Institute.
- Liss, M. (1994). Child abuse: Is there a mandate for researchers to report? *Ethics & Behavior*, 4, 133–146.
- Lutgendorf, S. K., & Antoni, M. H. (1999). Emotional and cognitive processing in a trauma disclosure paradigm. *Cognitive Therapy and Research*, 23(4), 423–440.
- Lykes, M. B. (1996). Meaning making in a context of genocide and silencing. In M. Morris (Ed.), *Myths about the powerless: Contesting social inequalities* (pp. 159–178). Philadelphia: Temple University Press.
- Maltz, W. (2001). *The sexual healing journey* (2nd ed.). New York: HarperCollins.
- Marshall, R. D., Spitzer, R. L., Vaughan, R., Mellman, L. A., MacKinnon, R. A., & Roose, S. P. (2001). Assessing the subjective experience of being a participant in psychiatric research. *American Journal of Psychiatry*, 158, 319–321.
- Measelle, J. R., Stice, E., & Hogansen, J. (in press). Developmental trajectories of co-occurring depressive, eating, antisocial, and substance abuse problems in adolescent girls. *Journal of Abnormal Psychology*.
- Nemeroff, C. B., Heim, C. M., Thase, M. E., Klein, D. N., Rush, A. J., Schatzberg, A. F., et al. (2003). Differential response to psychotherapy versus pharmacotherapy in patients with chronic forms of major depression and childhood trauma. *Proceedings of the National Academy of Sciences, USA*, 100, 14293–14296.
- Newman, E., & Kaloupek, D. G. (2004). The risks and benefits of participating in trauma-focused research studies. *Journal of Traumatic Stress*, 17, 383–394.
- Newman, E., Kaloupek, D. G., Keane, T. M., & Folstein, S. F. (1997). Ethical issues in trauma research. In G. Kaufman Kantor & J. L. Jasinski (Eds.), *Out of the darkness* (pp. 271–281). Thousand Oaks, CA: Sage.
- Newman, E., Walker, E. A., & Gefland, A. (1999). Assessing the ethical costs and benefits of trauma-focused research. *General Hospital Psychiatry*, 21, 187–196.
- Oregon Department of Human Services. (2003). IPV: Do ask, Do tell. *CD Summary*, 52(20), 1–2.
- Park, C. L., & Blumberg, C. J. (2002). Disclosing trauma through writing: Testing the meaning-making hypothesis. *Cognitive Therapy and Research*, 26, 597–616.
- Pennebaker, J. W., & Hoover, C. W. (1985). Inhibition and cognition: Toward an understanding of trauma and disease. In D. Shapiro (Ed.), *Consciousness and self-regulation* (Vol. 4, pp. 107–136). New York: Plenum Press.
- Penlar, R. L. (1993). *Institutional Review Board Guidebook*. Retrieved July 18, 2003, from [http://ohrp.osophs.dhhs.gov/irb/irb\\_guidebook.htm](http://ohrp.osophs.dhhs.gov/irb/irb_guidebook.htm)
- Putnam, F. W., Liss, M. B., & Landsverk, J. (1996). Ethical issues in maltreatment research with children and adolescents. In K. J. P. S. Hoagwood (Ed.), *Ethical issues in mental health research with children and adolescents* (pp. 113–132). Mahwah, NJ: Erlbaum.
- Read, J., Perry, B. D., Moskowitz, A., & Connolly, J. (2001). The contribution of early traumatic events to schizophrenia in some patients: A traumagenic neurodevelopmental model. *Psychiatry*, 64, 319–345.
- Reich, W., & Kaplan, L. (1994). The effects of psychiatric and psychosocial interviews on children. *Comprehensive Psychiatry*, 35, 50–53.
- Resnick, H., Monnier, J., & Seals, B. (2002). Rape-related HIV risk concerns among recent rape victims. *Journal of Interpersonal Violence*, 17, 746–759.
- Sinclair, B. B., & Gold, S. R. (1997). The psychological impact of withholding disclosure of child sexual abuse. *Violence and Victims*, 12, 137–145.
- Smith, L. B., Adler, N. E., & Tschann, J. M. (1999). Underreporting sensitive behaviors: The case of young women's willingness to report abortion. *Health Psychology*, 18, 37–43.
- Soreff, S. (2005). *Suicide*. Retrieved November 14, 2005, from [www.emedicine.com/med/topic3004.htm](http://www.emedicine.com/med/topic3004.htm)
- Suarez-Orozco, M. M. (1990). Speaking of the unspeakable: Toward a psychosocial understanding of responses to terror. *Ethos*, 18, 353–383.
- University of Oregon, CPHS/IRB. (2002). *Investigator's manual on research with human subjects*. Retrieved August, 29, 2003, from <http://darkwing.uoregon.edu/~humansub/manual.html>
- Urquiza, A. J. (1991). Retrospective methodology in family violence research: Our duty to report past abuse. *Journal of Interpersonal Violence*, 6, 119–126.
- van der Kolk, B. A., McFarlane, A. C., & Weisaeth, L. (Eds.). (1996). *Traumatic stress: The effects of overwhelming experience on mind, body, and society*. New York: Guilford Press.
- Violanti, J. M. (2000). Scripting trauma: The impact of pathogenic intervention. In C. Dunning (Ed.), *Posttraumatic stress intervention: Challenges, issues, and perspectives* (pp. 153–165). Springfield, IL: Charles C Thomas.
- Walker, E. A., Newman, E., Koss, M., & Bernstein, D. (1997). Does the study of victimization revictimize the victims? *General Hospital Psychiatry*, 19, 403–410.