
Women Survivors of Childhood Sexual Abuse: Knowledge and Preparation of Health Care Providers to Meet Client Needs

Final Report

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Introduction

The prevalence of childhood sexual abuse (CSA) has been described as “shockingly frequent” in both Canada and the United States, with estimates ranging from 15-38% in the female population. Increasingly, research is uncovering the emotional, psychological and physical sequelae of this tragic statistic. The implications of these findings have not been considered in the development of health policies particularly in the field of health promotion activities. Neither have the needs of these women been considered in the delivery of women’s health care. The result is that many women avoid routine and preventive services or suffer in silence when they do receive care.

In a previous study by several members of this research group, women survivors of CSA in Manitoba made specific recommendations about improvements they would like to see in the organization and quality of care provided by a wide range of health practitioners (Heinonen, Merrett-Hiley, McClure, Tudiver and Kreklewetz, 1997). In consultation with health care providers and CSA survivors this qualitative study undertook to interview 25 health care providers including physicians, nurses, mammographers and sonographers, dentists and dental hygienists in Winnipeg and neighbouring areas. Their views on, education, preparation for, and experiences with CSA survivors were documented. As well, the providers were asked to recommend ways to address these women’s concerns both within policy development and health care delivery. Through this process, our aim is to encourage appropriate professional bodies and individuals to consider developing new structures (e.g., referral networks), appropriate curriculum, and formulate policies and practice guidelines that would meet the needs of women survivors of childhood sexual abuse. Educational tools will be developed for both providers and CSA survivors to support these endeavors.

Review of the Literature

Prevalence rates of women with a history of CSA are estimated at between 12-38% (Finkelhor, Hotaling, Lewis & Smith, 1990; Holz, 1994; Lechner, Vogel, Garcia-Shelton, Leichter & Steibel, 1993; Paxton, 1991, Roberts, 1996; Seng & Hassinger, 1998). Women consistently show a higher prevalence of CSA rates than their male counterparts, with one in three to four females, versus one in six to eight males having been sexually abused by age 18 (Finkelhor et. al., 1990; Holz, 1994). The focus of this literature review will be health care professionals and the culture of their practice in interactions with female survivors of childhood sexual abuse (CSA). While the focus on interactions between women and health care professionals is a reflection of the higher prevalence rate of CSA among women, it is not to diminish CSA’s traumatic effect on men.

For the purpose of this study, a definition of CSA should be considered. Holz (1994) has broadly defined childhood sexual abuse as, “any sexual activity between a child less than age 18 and a person of power, usually two or more years older, and who has authority over the child” (p. 13). CSA has been further differentiated into incest and extra-familial abuse. The abuse is incestual if it is perpetrated by a consanguineous (“blood”) relative, a relative by marriage, or a person who functions in the role of a family member (Courtois, 1993; Flournoy, 1996; Holz, 1994). Extra-familial abuse is usually perpetrated by parental or family friends who are often trusted people holding power over the child (Courtois, 1993; Holz, 1994).

There is a wide range of incestuous behaviours from sexual comments, gestures, exhibitionism, fondling, and intercourse (Chalfen, 1993; Paxton, 1991). Although the specific behaviours involved in CSA may vary, abuse situations commonly elicit fear in the victim by the perpetrator, whether psychologically through verbal threats, or less often, by physical force, to coerce the vulnerable victim into sexual acts (Bala, 1994; Courtois, 1993; Paxton, 1991).

This literature review examines current written work relevant to the health practitioner’s knowledge, preparation, and skill to meet the needs of women survivors of CSA. Four areas will be addressed: 1) the sequelae of CSA

pertaining to the medical encounter, 2) issues of routine screening by the practitioner, and the management of disclosure, 3) recommendations for appropriate care for women survivors, 4) health care services, education and public policy, and 5) knowledge and preparation of practitioners in meeting the needs of survivors of CSA. Finally,

an informal telephone survey of the post-secondary educational curriculum in Manitoba was conducted in order to understand the preparation of Manitoba health care practitioners in meeting the needs of women with an abuse history. The results of this survey will be discussed.

Sequelae of childhood sexual abuse pertaining to the medical encounter

The literature suggests that profound, long-term effects may result from CSA. Effects from previous sexual abuse may influence current encounters with health care providers without the awareness of one or both parties. Sequelae of CSA include post-traumatic stress disorder (PTSD) symptoms, psychological problems, interpersonal problems, self-abuse, pain, and other somatic complaints without organic cause (Bala, 1994; Roy, 1998). Awareness of these symptoms as possible sequelae of CSA and the identification of their presence in a patient may evoke the suspicion of CSA, and serve as a “red flag.”

Several authors link the effects of childhood sexual abuse and symptoms of PTSD (Bala, 1994; Chalfen, 1993; Doob, 1992; Hays & Stanley, 1996). Symptoms presenting as PTSD include: hyper-arousal, flashbacks, insomnia, nightmares, and anger control problems (Bala, 1994). Survivors may describe intricate sleeping rituals with unusual sleep patterns (Bala, 1994). In an effort to gain control and shield themselves from painful feelings, sometimes survivors have been described as over-achievers, and workaholics, paying constant attention to details (Chalfen, 1993). Although limited by sampling methodology and questionnaire reliability, Hays and Stanley (1996) found symptoms associated with PTSD in their study of dental experiences of female survivors. The symptoms identified included fear, anxiety, dissociation, flashbacks, nausea, and shame.

While the symptoms presented in this section are described as PTSD symptoms, the other problems, i.e., psychological or interpersonal problems, may be viewed as “chronic effects” of PTSD, the source of traumatic stress being, of course, the abuse itself (Chalfen, 1993; Doob, 1992; Farley & Keaney, 1987; Hays & Stanley, 1996; Hendricks-Mathews, 1993; McKegney, 1993). Framing the effects in this manner brings attention to the source of the behaviours and may help to refocus interventions in such a way as to address underlying issues (Doob, 1992).

Women with a history of CSA frequently present with symptoms that are psychological in nature. Lechner, Vogel, Garcia-Shelton, Leichter and Steibel (1993) found a statistically significant increase in previous mental health treatment in a group of women with a history of CSA versus a control group. Problems may include but are not limited to: depression, anxiety, low self-esteem, suicidal gestures, or attempts, sleep disturbances, personality disorders, dissociative disorders and panic attacks (Bala, 1994; Courtois, 1993; Doob, 1992; Farley & Keaney, 1997; Hendricks-Mathews, 1993; McKegney, 1993; Paxton, 1991). It is important to recognize the origin of many of the symptoms associated with these problems. Often they developed as coping strategies used during the abusive situation that once helped the patient to survive, but may have become maladaptive (Bala, 1994; Courtois, 1993; Paxton, 1991).

Relationship or interpersonal problems may present as marital or sexual dysfunction, difficulty with intimacy, parenting problems, or social isolation (Bala, 1994; Courtois, 1993; Hendricks-Mathews, 1993; Holz, 1994). Problems with boundary confusion (Bala, 1994; McKegney, 1993; Roberts, 1996; Seng & Hassinger, 1998), trust (Simkin, 1992; Varallo, Ray & Ellis, 1998), and safety (Roberts, 1996; Schachter, Stalker & Teram, 1999; Teram, Schachter & Stalker, 1999) are frequently cited in reference to abuse survivors. Boundary confusion may manifest as inappropriate closeness and familiarity, or as perpetual avoidance of any closeness (Bala, 1994). These problems can easily extend into the health care provider-survivor relationship, creating a strained therapeutic relationship (McKegney, 1993).

Alcohol or drug abuse, eating disorders, and self-injuries are manifestations of self-abuse, which may be present in a survivor of CSA (Bala, 1994; Hendricks-Mathews 1993; Holz, 1994; McKinney, 1998; Read, Stern, Wolfe & Ouimette, 1997; Roberts, 1996). Survivors also have a higher rate of re-victimization than the general population (Hendricks-Mathews, 1993; McKegney, 1993), which may be a result of inadequate responses to uncomfortable stimuli or self-preservation skills (McKegney, 1993).

Roy's excellent study of the complex relationship between childhood abuse (including CSA) and chronic pain examines the literature on short term and long term health consequences of childhood abuse and the limitations of the research. He cogently argues the need for practitioners to recognize the relevance of childhood abuse to pain complaints, such as chronic pelvic pain, gastrointestinal disorders (Roy, 1998). Somatic complaints without organic cause are frequently cited in women with a history of CSA (Holz, 1994). Common complaints include chronic pelvic pain, chronic headache, abdominal pain, and gastro-intestinal complaints. Chest pain, throat pain, respiratory symptoms, musculoskeletal, and neurological symptoms are less frequently cited complaints of CSA survivors (Bala, 1994; Hendricks-Mathews, 1993; Lechner et. al., 1993; Roberts, 1996; Read et. al., 1997; Schachter et. al., 1999; Teram et. al., 1999). In addition, several studies have revealed the association between a history of CSA and multiple somatic complaints (Farley & Keaney, 1997; Kendall-Tackett & Marshall, 1999; Lechner et. al., 1993; Read et. al., 1997).

An exploratory study by Farley and Keaney (1997) revealed that dissociation and chronic physical symptoms was highly correlated in subjects with a history of CSA. They also found that the greater the number of perpetrators the greater the number and severity of symptoms. Generalizability of this study was limited because these subjects were psychiatric patients who were asked to volunteer for this project at their treatment facility.

The relationship between women with CSA history and self-reported medical complaints was also explored by Lechner and colleagues (1993). They used a consecutive sample study of 523 primary care patients and determined that the 26% of patients with CSA history reported more problems in respiratory, gastro-intestinal, musculoskeletal, neurological and gynecological functions. The women studied were all seeking treatment for self-identified medical problems limiting the study's generalizability to the public. In addition, findings were based entirely on self-report.

Kendall-Tackett and Marshall (1999) studied the association between diabetes and abuse history after noting higher rates of health problems in adult survivor of abuse than in the general population. The link between diabetes and CSA survivors was chosen because chronic stress, which is a component of abuse, can lead to an elevation in blood levels of triglycerides, free fatty acids, cholesterol, glucose and insulin (Kendall-Tackett & Marshall, 1999). Their study revealed that patients with abuse history were significantly more likely to have diabetes than their non-abused counterparts, with a higher percentage of the abused group reporting three or more symptoms (39%) than the control group (10%). The researchers cited several limitations including a lack of distinction between physical and sexual abuse among participants, and the possibility of diabetes symptoms being caused by other illnesses.

In an effort to provide appropriate care for survivors, it is essential for health care providers to understand the origin of somatic symptoms, and to consider CSA in patients with multiple complaints without an organic cause. With prevalence rates as high as one third of women, it is important to retain a high level of awareness regarding the possibility of a CSA history with all patients.

Survivors and the nature of the medical encounter

Studies have found that health examinations requiring touch by a person in a position of power can present difficulties for women with a history of CSA and in some cases may even trigger PTSD symptoms (Hays & Stanely, 1996; Heinonen et. al., 1997; Kitzinger, 1990; Stalker, Schachter & Teram, 1999). Personal accounts of health care experiences confirm this data (Rose, 1992; Grossman, Cook, Kepke & Koenen, 1999). A survivor who is a health care professional described difficulties with exams, or procedures which restrict movement, occur in a darkened or confined room, involve previously traumatized body parts, or being strapped to a table (Courtois, 1993).

For obvious reasons the gynecological exam can be particularly difficult for survivors of CSA (Chalfen, 1993; Kitzinger, 1990; Roberts, 1996). Chalfen (1993) astutely comments that in any other context the pelvic exam would represent severe boundary violations. Kitzinger (1990) studied survivors' feelings regarding obstetrical and gynecological care and found that gynecological exams were potential triggers for flashbacks, and evoked feelings of powerlessness, and depersonalization reminiscent of previous abuse.

Many behaviours and feelings such as regression under stress, suicidal gestures, self harm, distrust, boundary confusion and multiple somatization complaints, although important behavioural responses that at times served as coping strategies for these individuals during their abusive past, can have a negative impact on their relationships with their health care providers (McKegney, 1993). An understanding of the origin of these behaviours may improve relations and can be an initial step in determining the appropriate care and treatment of individuals with a history of CSA (Bala, 1994; McKegney, 1993).

Although physicians commonly treat medical consequences of CSA, they are often unaware of the CSA itself and the link between CSA and medical complaints (Courtois, 1993; Friedman, Samet, Roberts, Hudlin & Hans, 1992). In fact, the sequelae of CSA frequently influence encounters with health professionals (Stalker et. al., 1999). It is the responsibility of the clinician to be aware of these long-term effects and to be alert to any signs of distress or "red flags" exhibited by their patients.

Issues of disclosure: Are we opening up a can of worms?

A great deal of controversy exists regarding whether practitioners should routinely screen women for a history of CSA. Response to disclosures that may result from routine screening are critical to the woman's sense of trust and safety, and require some knowledge and preparation on behalf of the practitioner. These areas will be considered in the following section.

A number of studies have attempted to determine the appropriateness of routine screening for CSA (Friedman, et. al., 1992; Gallop, McKeever, Toner, Lancee & Lueck, 1995; Heinonen et. al., 1997; Jacobson & Richardson, 1987; Read et. al., 1997; Teram et. al., 1999). The general consensus among researchers and practitioners is that some form of routine screening for CSA is appropriate and necessary. Friedman and colleagues (1992) studied 164 patients in private and publicly funded primary care settings to determine attitudes, expectations, and practices relating to inquiries about victimization experiences. Of those patients with a sexual abuse history, 85% favored routine inquiries and 64% of the non-abused group favored routine inquiry. This study excluded non-English speaking patients, limiting its generalizability to different cultural groups.

Opinions regarding routine screening were also sought from 323 nurses in a study conducted by Gallop and colleagues (1995). Forty-two nurses with abuse histories and 206 nurses without abuse histories participated in the study. The majority of nurses were supportive of routine inquiry with 62% of the abused and 63% of the non-abused group in favor. Reasons cited against routine screening included concern of increasing patient distress and being intrusive, unwillingness to listen to accounts of abuse due to personal histories, discomfort in talking about sex, fears about sexual violence, feeling unqualified to deal with the topic if abuse did occur, and lack of awareness of resources (Gallop et. al., 1995). Results of this study emphasize the inadequacy of nursing education in teaching students how to question clients regarding CSA, and how to listen and support clients when a history of CSA is confirmed. The study also outlined the importance of adequate resources to support nurses and patients should patients reveal a history of CSA (Gallop et. al., 1995). The present study is consistent with these findings.

Heinonen and colleagues (1997) conducted a qualitative study of eleven women with histories of CSA to explore their experiences in seeking and using health care resources. Based on the opinions of the study participants recommendations for routine screening were made. One participant of this study commented regarding routine screening, "[It's] better to ask than for the majority of them who never [do]" (p. 26). All of the survivors studied were, or had been, in a therapeutic process and had received information about the study from a counselling

facility. While the small number of women interviewed limits the generalizability of the findings, this pilot study provided a number of fruitful suggestions for further research.

Concerns regarding increasing a patient's distress with inquiry about past CSA are common, yet unfounded according to the literature. There is evidence, in fact, that failing to ask empowers the abuse situation, contributes to feelings of isolation and conveys the impression that it is irrelevant to current issues or symptoms (Bala, 1994; Courtois, 1993; Doob, 1992; Varallo et. al., 1998). As one woman commented, "If your doctor is afraid to talk about it [sexual abuse] then what are you going to feel?" (Heinonen et. al., 1997, p. 27).

Methods of screening

Several authors have reviewed methods of screening for CSA (Bala, 1994; Holz, 1994; Hendricks-Mathews, 1993; Paxton, 1991; Seng & Petersen, 1995; Teram et. al., 1999). Most applicable to the majority of health care providers are the methods discussed by Teram and colleagues (1999) and Seng and Peterson (1995) who favor a task-centered method of screening.

Task-centered disclosure is a form of screening relevant to the examination to be performed, whereas use of open-ended questions regarding abuse history is called relationship-based disclosure (Schachter et. al., 1999). Teram and colleagues (1999) found in their interviews with 27 women survivors that in treatment with a physiotherapist, perhaps an abridged form of screening is indicated. Survivors felt that physical therapists don't necessarily have the responsibility to specifically inquire about abuse, but as it is important to understand the impact of previous abuse on treatment, it would be appropriate for physical therapists to inquire regarding any sensitivities they may anticipate during an examination (Schachter, Stalker & Teram 1999). The use of task-centered disclosure may be appropriate for any practitioner who has yet to build a trustful, therapeutic relationship with a patient or may never have such an opportunity, as with mammographers, sonographers, dentists, dental hygienists, or specialists (Seng & Petersen, 1995; Teram et. al., 1999).

Researchers suggest that sensitive questions be asked when the patient is fully dressed and sitting, and recommend a question such as, "Is there anything about your past experiences that makes this exam particularly difficult for you?" With a follow-up question such as, "What can I do to make it easier for you?" (Seng & Petersen, 1995, p. 29). Open-ended questions may be reserved for ongoing relationships where it is necessary to explore the impact of the abuse in more depth (Seng & Petersen, 1995).

Responding to disclosure

Responding to disclosures that may result from routine screening is an important skill for all health care practitioners. The implications of disclosing abuse to a person ill-equipped in managing the intense feelings, emotions and images can have negative and even devastating effects on a survivor (McKinney & Frank, 1998; Teram et. al., 1999; Schachter et. al., 1999).

Schachter, Stalker and Teram (1999) provide an insightful description of appropriate responses to disclosure, based upon recommendations from the 27 female survivors they studied. They concluded that the least appropriate response was to ignore or act negatively to the disclosure, or to overwhelm the survivor with things they "should do". The basic elements of appropriate response involved acceptance and acknowledgement of the abuse and its consequences to the survivor. Applying the information to increase the patient's sense of trust and safety was also deemed important. Research by Heinonen and colleagues (1997), Hendricks-Mathews (1993) and Teram and colleagues (1999) concur with this data. At the conclusion of a visit that revealed an abuse history the practitioner should attempt to bring a sense of normalcy to the feelings the survivor may have and offer a link to the future by encouraging the survivor to check back in a few days (Hendricks-Mathews, 1993; Paxton, 1991). Paxton (1991) also offers an excellent resource on appropriate response to disclosure of CSA based on a review of the literature.

Issues around disclosure of CSA can be very intimidating for health care providers who may feel ill equipped to manage the outcomes of disclosure. There is a belief that assessment of CSA is a job for specialists (Gallop et. al.,

1995). The literature overwhelmingly supports inquiry regarding CSA, but depending on the relationship between the care provider and the survivor, one may favor a task-centered approach versus an open-ended question that may bring more vulnerability than comfort to a survivor.

Recommendations for appropriate care for women survivors

Many authors suggest strategies for improving interactions between survivors and health care practitioners (Chalfen, 1993; Courtois & Riley, 1992; Creedy et. al., 1998; Flournoy, 1996; Grant, 1992; Holz, 1994; Jacobson & Richardson, 1987; McKegney, 1993; Roberts, 1996; Seng & Hassinger, 1998). Recommendations for practitioners based on accounts from survivors themselves will be explored. These recommendations are based on the emotional needs of survivors and some of their common interpersonal characteristics and may be applied to various health care practitioners. Literature examining the effect that cultural factors may have on these recommendations and an examination of changes the health care system can adopt to facilitate survivors' experiences will be considered.

Safety and trust

The long-term sequelae of CSA are well documented. It is important that the clinician acknowledges the contributions of childhood sexual abuse to the survivor's sense of safety and trust (Grant, 1992; Kendell-Tackett & Marshall, 1999; Schachter et. al., 1999; Seng & Hassinger, 1998). Schachter and colleagues' (1999) study exploring survivor's experiences with physical therapy highlights the importance of attending to the client's sense of safety. This can be done by increasing the patient's sense of control during all exams where touch is required, but particularly with sensitive exams, (i.e., pelvic, rectal or oral examinations), where patients may feel particularly vulnerable. Clinicians are asked to have a respectful, calm, accepting approach, to listen carefully to their patients, being sensitive to individual needs, offer choices wherever possible, and always examine gently, asking permission before touching (Grant, 1992; Hays & Stanley, 1996; Heinonen et. al., 1997; Kitzinger, 1992; Schachter et. al., 1999; Varallo, et. al., 1998).

Many studies stress the importance of offering the presence of a support person of the gender the patient feels most comfortable (Heinonen et. al., 1997; Kitzinger, 1992; Schachter et. al., 1999). The importance also of giving careful and thorough explanations of procedures, warnings about pain, encouraging questions, and confirming with the patient her ability to stop the procedure at any time has not only been shown to improve experiences of survivors with the health care system (Hays & Stanley, 1996; Kitzinger, 1990; Schachter et. al., 1999), but may help to empower women to assert themselves in other areas of their life and regain some sense of control about what happens to their bodies (Kendell-Tackett & Marshall, 1999; Kitzinger, 1990; Seng & Hassinger, 1998).

Several researchers provide suggestions for specific practitioners. Specific recommendations for dentists (Hays & Stanley, 1996) and physical therapists (Schachter et. al., 1999) may prove useful to practitioners in these areas. Other suggestions have been made to all health care providers. These are based on literature reviews and offer an excellent resource for practitioners (Chalfen, 1993; Courtois & Riley, 1992; Holz, 1994; Roberts, 1996).

Boundary confusion

Issues surrounding boundary confusion are frequently cited as problems when caring for survivors of CSA (Creedy et. al., 1998; Seng & Hassinger, 1998; McKegney, 1993). Although there are no specific studies examining this phenomenon, a review of the literature suggests it can be an integral component of interactions with survivors of CSA. Survivors have had repeated violations of their physical and emotional boundaries, therefore any violation of boundaries by the practitioner can elicit distrust and lack of safety for the patient (Seng & Hassinger, 1998). A practitioner would be violating a patient's boundaries of body integrity and control, for example, by performing a vaginal exam during labor without permission or urgent need to do so (Seng & Hassinger, 1998). At the same time, repeated violations of boundaries by the patient can contribute to practitioner frustration (McKegney, 1993). Examples of boundary violations by the patient may include repeated evening calls to a midwife without an emergent problem (Seng & Hassinger, 1998). In this case there is a violation of the midwife's boundaries related to

time, privacy, and rest. There may also be confusion between gentleness and sexuality or professional caring and friendship (McKegney, 1993).

Suggestions include an increased awareness of the potential for boundary confusion, and an examination of one's own responses and feelings surrounding interactions with survivors. It is important to help the patient establish boundaries within the therapeutic relationship by setting very clear limits within the relationship (Creedy et. al., 1998; McKegney, 1993).

Culturally sensitive care

A vast literature in medical anthropology and sociology documents the rich complexities of how experiences of illness and health - physical, mental and spiritual - are embedded in, and articulated through, cultural contexts. Culture and ethnicity are determinants of health, and provide the meanings within which health and illness are experienced and interpreted. Practitioners find that knowing more about a patient's beliefs and health practices helps build rapport, can ease patient anxiety and enhances the quality of care.

While we know that childhood sexual abuse exists throughout the world, issues of ethnicity and culture have not been given much attention in research specifically related to CSA. Exposing childhood sexual abuse threatens communities with divisions and public shame and sometimes precipitates legal actions against individuals or organizations. Immigrant or racially diverse communities, already marginalized in a dominant society, may be particularly cautious to air internal social problems. Anyone researching these concerns must have the trust and respect of a community. Health care providers serving diverse communities are often confronted with difficult situations when there is evidence of CSA.

Austin, Gallop, McCay, Peternelj-Taylor and Bayer (1999) studied 1701 Canadian psychiatric nurses and their self-perceived ability to nurse clients with a history of CSA when cultural differences are present. They found that only 4.6% of these nurses felt they delivered competent care to culturally diverse groups, the First Nations population being the most predominant. The authors suggested that nurses rating themselves in the middle levels of self-perceived competency (40% of the nurses studied) were, in fact, the most competent. They rationalize that nurses rating themselves with lower competency were aware of the impact of culture, but required further knowledge and experience, while the 4.6% of nurses rating themselves as highly competent may have been unaware of the impact of culture in the care of patients with a history of CSA (Austin et. al., 1999). Measurement of self-perceived ability tends to be affected by individual and subjective factors. Some recommendations made by the authors to improve culturally competent care include an examination of oneself within one's own culture, increased understanding of different cultural beliefs and customs, and the acquisition of good communication skills, warmth and empathy (Austin et. al., 1999).

Heinonen and colleagues' (1997) qualitative study of eleven women with histories of CSA also underscores the importance of culturally sensitive care to CSA clients. One of the participants of this study was of Aboriginal ancestry. This woman identified a need for, and recommended the development of culturally sensitive treatment approaches and services for aboriginal women with a history of CSA. As well, informal interviews which the researchers conducted with Aboriginal nurses underscore the need for culturally sensitive approaches to invasive tests and examinations, including Paps and breast examinations. For example, positive health promotion messages, such as encouraging a mother to breast feed, may be ignored by a woman with a history of abuse who may feel uncomfortable touching /or having her breasts touched. The deeper issues pertaining to CSA must be healed before the health promotion practices can be addressed.

Relevant research studies related to CSA in diverse ethnic communities were not readily identified in a literature search for this study.

Health care services, education and public policy

The culture of western medicine

The term “culture” can also be applied to the norms, values, beliefs, practices, and social settings of Western/North American medicine, to which practitioners are socialized through formal and informal education and training, mentoring and peer relationships. For example, Austin and colleagues (1999) suggest that three cultures are present in all nursing situations: the personal and professional culture of the nurse; that of the patient and family; and the culture of the health care system. While we would suggest that a more nuanced approach considers the multiplicity of perceptions, assumptions and practices that each of the participants bring to the situation, the authors point to the important fact that the “culture” of the health care system can have an enormous impact on the care of women who have survived childhood sexual abuse. In a system based on specialization, fragmented care, and short appointments, most women, including those with a history of CSA, often feel less than the sum of their body parts and experience considerable anxiety in encounters with various practitioners and health care settings. The health care system has traditionally been structured to disempower women by medicalizing/pathologizing normal female processes (i.e., childbirth and menopause), and discounting or misinterpreting many women’s physical and mental health problems (Malterud, 1993; Dyehouse, 1992; Ward, 1995). As well, hospital or clinic environments can be intimidating.

Within this “culture of medicine” women who have been sexually abused have sometimes been labelled “difficult” or “over-users” of the system (Bala, 1994; Lechner et. al., 1993). Some survivors may have acquired this label because of repeated visits for perceived problems, not keeping appointments or arriving late, being overly controlling, or being demanding (Bala, 1994; Lechner et. al., 1993; McKegney, 1993). These behaviors can elicit feelings of anger or frustration on the part of health providers, but often abate with the understanding of their relation to the abuse (Bala, 1994). Without this type of understanding, survivors may be punished or re-abused by the system and will not likely get the care they need (Bala, 1994; Lechner et. al., 1993; McKegney, 1993). This area deserves further study and was an impetus behind the present research.

Patient education and public awareness

Several authors make recommendations for the care of survivors of CSA that apply to health care delivery and the health care system. These areas include patient education and prevention programs, coordination of services, and attitudinal changes. All patients may benefit from increased awareness about the implications of CSA (Hays & Stanley, 1996). To increase awareness and comfort during health care encounters, survivors studied by Heinonen and colleagues (1997) suggested leaving pamphlets or articles in the patient waiting areas regarding what can be expected from medical exams, and the health implications of CSA. Public education measures in various community programs and facilities may also be helpful in preventing childhood sexual abuse. Flournoy (1996) suggests education in parenting classes regarding the prevention of CSA. Nurses can also contribute to the prevention of CSA by ensuring the appropriateness of school and community-based childhood sexual abuse prevention programs.

Several researchers offer suggestions to effect broader changes in health care delivery, including influencing public policy to address social inequities that marginalize women, better coordination of health care services and continuity of care (Creedy et. al., 1998; Heinonen et. al., 1997). These authors concur that increased coordination of mental health and general practitioner services will benefit survivors of CSA, as would the availability of a directory of practitioners specializing in care of abuse survivors, including practitioners offering alternative and complementary therapies. A need is identified for systemic changes in the medical culture and in hospital environments to ensure more patient-centred care. However, the current tensions in Canadian health care, such as practitioner shortages and cost containment measures, present obstacles to patient-oriented, systemic changes.

Knowledge and preparation of practitioners in meeting the needs of survivors of CSA

The importance of practitioner knowledge and skill in meeting the needs of survivors of CSA is underscored throughout the literature. Curriculum addressing the long-term sequelae of CSA and its implications to clinical

practice of various disciplines, self-perceived skill in meeting the needs of survivors, and workplace support for practitioners faced with managing a survivor's care are briefly examined here.

Research has shown the necessity of further training for practitioners in virtually every study examining practitioner interactions with CSA survivors (Austin et. al., 1999; Friedman et. al., 1992; Gallop et. al., 1995; Hays & Stanley, 1996; Heinonen et. al., 1997). These studies examined the expertise of nurses, physicians, physical therapists and dentists. The problem is best exemplified by one woman's account in a study by Heinonen and colleagues (1997), "I think [my doctor] tried to be compassionate but she didn't have the training she needed to understand" (p. 27).

Greater skill in inquiring about CSA, increased knowledge of resources available and proper identification of abuse survivors are cited as gaps in practitioner knowledge by several studies (Austin et. al., 1999; Friedman et. al., 1992; Gallop et. al., 1995; Hays & Stanley, 1996). Several methods of increasing this knowledge base have been suggested including journal groups, chart reviews, networking with therapists, and team approaches (McKegney, 1993; Seng & Petersen, 1995). Many practitioners are aware of this knowledge gap. As one physical therapist put it, "I wish they could have told me about the profound impact that some early experiences have on people's lives and all of their further experience" (Clark, McComas & Potter, 1999, p. 268). No formal studies were found through this literature review identifying necessary curricula that would improve this state of practice, or examining this lack of educational preparation within curricula.

Workplace support may exist for mental health workers and therapists but is lacking for professionals who do not normally manage the care of survivors directly. Several authors discuss workplace support in general terms and recommend interdisciplinary support and teamwork (McKegney, 1993; Seng & Hassinger, 1998) as well as an understanding of one's limitations and the necessity of self-care when addressing these issues (McKegney, 1993). This area is also not well researched.

Considering the number of survivors in contact with health care providers and the difficulty survivors may have with health examinations, the findings regarding health practitioner knowledge and experience is troubling and a call to action. There are tremendous implications here for educational systems. The curricula of all health care providers should be re-evaluated to ensure the care of survivors is addressed at a discipline-appropriate level.

Surveying the post-secondary educational curriculum in Manitoba about CSA

In order to gain an understanding of the preparation of Manitoba health care practitioners in meeting the needs of women with an abuse history, an informal telephone survey was conducted. The survey included faculties/schools of medicine, medical rehabilitation, nursing, dentistry, dental hygiene and mammography program training. The aim of this survey was to determine formal curriculum content addressing the long-term effects of childhood sexual abuse in adult patients /clients. The curricula in mammography, dentistry, dental hygiene, and nursing do not formally teach about the long-term effects of CSA. However, with the exception of mammographers, all stated they do address the acute effects of abuse through lectures and readings. The School of Dental Hygiene also covers this content with the EVOLVE program from Klinik Community Health Centre, Inc. a program aimed at meeting the needs of women and men currently in abusive relationships. Other faculties use experts in the field of mental health within their faculties to teach this subject.

The Faculty of Occupational Therapy felt that their client-centered approach gives their students the skills necessary to identify and deal sensitively with women with a CSA history. There is minimal formal content, however, regarding sexual abuse history and its possible impact on the relationship with an occupational therapist. The Physiotherapy department felt that their students were prepared to pick up the signs of CSA through courses in Psychosocial Issues, Professional Issues, and Physical Therapy Treatment Modalities. At a national level, physical therapy has identified the importance of practitioner knowledge regarding the long-term effects of CSA and regarding immigrants who were victims of torture.

Due to the multidimensional nature of the medical curriculum, it was difficult to elucidate the formal curriculum content regarding the long-term effects of CSA. Consultation with the Curriculum Database failed to reveal it as a separate topic. The survey suggested CSA is covered briefly, or mentioned in smaller topics, through some or all of the following: the communication skills stream, problem solving stream, sexuality and sexual dysfunction, psychiatry, developmental medicine, behavioral medicine, and obstetrics and gynecology.

While most schools preparing health care practitioners in Manitoba do not formally teach about the needs of women with a history of childhood sexual abuse and long-term sequelae of CSA, they do address the identification of acute symptoms and signs of sexual and physical abuse. Simply raising the question of curriculum content regarding the long-term effects of CSA was informative, as most schools or faculties were unaware that the long-term effects could have different implications for diagnosis, treatment and patient care from acute effects of abuse.

Conclusion

Childhood sexual abuse impacts many women. Almost all practitioners will interact with a woman with such a history, whether the practitioner is aware of it or not. For many providers, this is a relatively new and emerging issue and an understanding of the implications of CSA is just beginning to be recognized. The literature clearly documents the lack of knowledge, preparation, experience, and support for providers in meeting the needs of women survivors of CSA. In order to adequately address the needs of these women, practitioners must begin to see the importance of education regarding the long-term effects and issues faced by women with a CSA history. As one participant of a study commented, “Family doctors, or physiotherapists, have to be aware that we do have all this pain that relates to our past, that it’s serious pain and it has to be treated” (Teram et. al., 1999, p. 90).

Methods

A collaborative feminist approach

A feminist orientation guided the process of the study in which the unique contribution and experience of each research team member were recognized as resources. The diverse perspectives from our backgrounds in anthropology, medicine, nursing, and social work enhanced our learning and added richness to the data analysis process and research findings. Some researchers on the team had worked together on related research several years ago and this was an advantage in establishing good work relations and a comfortable team process. The previous study, “Perception and Utilization of Health Care Services by Women Survivors of Childhood Sexual Abuse” (Heinonen et. al., 1997), formed the foundation for this research project. The study’s results pointed to a need to work with practitioners to promote quality health care for women who have survived childhood sexual abuse.

Through this study (as in the 1997 research), we have committed ourselves to dissemination of the findings to respond to the broader mandate improving health care for women. Thus, the importance of acknowledging and responding to the concerns of women who have survived abuse and of exploring how health care practitioners can prepare to meet these women’s needs, is an overarching goal in this research initiative. In this way, women’s well being is promoted (Jayaratne & Stewart, 1991). The study advances this goal by raising awareness of women survivors’ needs and the concerns of the practitioners who provide health care to them.

The research process can be enriched by a collaborative team’s unique perspectives and experiences, which promote the integrity and quality of analysis and findings (Barry, Britten, Barber, Bradley & Stevenson, 1999). We were interested in the opportunities for reflexivity that team analysis could offer to us as participants in the research. As practitioners and researchers from diverse backgrounds ourselves (anthropology and consumer rights, nursing, social work and education, medicine, and psychology), we could understand how each researcher’s individual approach and views enhanced the texture in the team’s analytical process and the interpretation of data. Team meetings, in which the interview data from the different professional groups interviewed was discussed, were rich with a range of ideas, perspectives and experience. Everyone had an opportunity to contribute to and refine the findings as a team member. This qualitative study required such a team process for thematic analysis. Schwandt

(1997) asserts, researchers are part of the research setting and material due to their intense involvement in the topic studied and through self-reflection of individual viewpoints, orientations and experiences which pertain to the research material and process.

In this study, the research team collaboratively developed a semi-structured questionnaire guide that included questions that were asked of all groups of health professionals, and some that were specific to certain groups (Appendix 1). Professional groups included in the study (i.e., physicians, nurses, dentists, dental hygienists, sonographers, and mammographers) were selected for certain reasons. First, the practitioners had to be providing care which involved invasive procedures, those which meant observing, touching, probing, or otherwise manipulating parts of a woman's body in the course of examination or treatment of them. Second, the health care providers had to be providing health care services to women, either proportionate to the population or in greater numbers than men. Third, the providers had to have undergone a professional education in their field program to practice in their specialty. It was felt that the practitioner groups selected would fill these three criteria.

Letters were sent to professional associations informing them of the study. Snowball sampling was used to generate the sample. Each researcher selected a professional group to interview. Team members, each with established contacts in the health care system, provided names of potential participants in each of the professional groups. Letters were sent to each informing them of the study and requesting them to contact the researcher if they were willing to be interviewed. A small honorarium was provided to the participants to cover their time and expenses.

The sample consisted of 20 women and 5 men. All of the seven nurses and five mammographers were female; two out of four physicians, two of the four dental health providers and four out of five sonographers were also female. All worked in urban settings, many of them in community-based clinics or private practice. Some had international or rural practice experience. There was a range of experience and education among the research participants; some had studied beyond basic training, taking workshops, specialized courses or educational programs to advance their professional knowledge. None of the participants represented visible minorities; all were white.

Procedures

The research proposal was reviewed by two independent Research Ethics Committees, one at the University of Winnipeg and the other at the University of Manitoba (Faculty of Social Work). Invitational letters to potential respondents were mailed out and consent forms were drawn up. Snowball sampling was also used in order to increase and diversify the pool of study participants. Before each interview, the consent forms were reviewed and signed (Appendix 2).

Each researcher independently conducted face-to-face interviews with health professionals. The interviews were audiotaped and later transcribed. The transcripts for each group of health professions were reviewed by the interviewer, who coded the material and established themes and sub-themes based on the content in the transcripts (Padgett, 1998). This involved a process of identifying initial themes in the transcripts, refining the themes based on further re-reading of the texts, and matching sections of text with themes that correspond. Constant comparison (Strauss & Corbin, 1990) in which portions of data were compared with other portions of data, was used to aid in thematic analysis.

The transcripts were shared among team members in order to facilitate discussion, comparison, and analysis across professional groups. In this way, we were able to compare responses of nurses and doctors with those of dentists, sonographers and mammographers, to determine differences in understanding, experience, and knowledge which shaped health care provided to women survivors of childhood sexual abuse. Internal consistency and reliability of each interview was assessed during these discussions.

Key Themes in the Data

While the semi-structured questionnaire provided the framework for the issues raised in all the interviews, each respondent was able to elaborate on issues of particular relevance to them. Important themes and sub-themes emerged as the researchers reviewed each transcript and the interview material was organized under these themes. As we shared our data and became aware of the breadth of information in the interview material within and across all the professional groups, we further refined the themes. Major themes identified were:

1. Practitioner education and training
2. Work history and types of practice
3. Practitioner preparation and education about childhood sexual abuse
4. Practitioner experiences with CSA (clues or disclosures)
5. CSA as part of medical history taking
6. Possible effects of CSA (physical, emotional sequelae)
7. How women survivors' needs are currently met in the medical setting (patient control, etc)
8. Barriers in responding to needs of women survivors
9. Potential adaptations and improvements in care
10. Practitioners' access to support re CSA survivor issues
11. Relevance of gender issues
12. Suggestions for additional education and training about CSA
13. Impact of the study
14. Other recommendations

Limitations in the Study

One of the limitations of the research is that its sample is not inclusive of diverse groups of practitioners in Manitoba. Nor does the study sample represent all or even a representative sample of health care practitioners in Manitoba. However, while all the practitioners were white and urban they do reflect the dominant pattern of health care delivery.

Although some of the data reflect rural and northern experiences some practitioners had, it was not possible to include practitioners currently practicing in rural or northern areas. Initially we had hoped to involve physicians and nurses from rural areas, but our resources did not allow us to do so. Seeking rural study participants would, nevertheless, have added another dimension to the research findings. We recommend that this research study be extended to include practitioners from diverse backgrounds and those from rural and northern areas of Manitoba, where health care and health issues differ from southern and urban areas. Such research would also reflect the experiences of professionals in serving the needs of Aboriginal people many of whom reside in isolated, northern areas of the province. It might also capture the views of some practitioners who are themselves Aboriginal and provide health care to their own communities.

Another limitation of the study is that not all health care professions, allied health care or alternative health care professions could be included. Having research participants who were chiropractors, physiotherapists, optometrists, acupuncturists, and massage, touch, relaxation, and body movement therapists, for example, would have greatly enriched the study and made the sample more comprehensive. Further research could add these and other practitioners to the research, thereby enhancing understanding and approaches of diverse groups of professionals providing health care. It might also indicate whether sexual abuse survivors seek out allied or alternative health care practitioners for certain kinds of care, and whether these practitioners have treated women survivors of childhood sexual abuse.

Finally, the research was focused on care for female, not male, survivors of childhood sexual abuse. Although there may be differences and similarities, it is not possible in this study to speculate on what they might be and whether different responses from health care practitioners are generated or needed.

Findings

Health care providers often find it both stressful and challenging to care for women with backgrounds of CSA. The disclosure of an individual's story is often upsetting and may provoke in the provider a response of anger and/or distress. Clients may often have difficulties separating the emotional reactions and sequelae of abuse from true organic problems. Decision making regarding further investigations can be difficult especially when these may be intrusive and upsetting for the client. The issues are often complex requiring considerable time for discussion between the client and her health care provider. This can be problematic in a health care system geared to short appointments and specialization, rather than an integrated holistic approach to health care.

Each professional group in health care functions within particular context, which includes workplace conditions and policies, professional mandate, and standards of care, and a changing health care policy environment. These features offer both constraints and opportunities in providing health care services to women with a history of childhood sexual abuse. The interviews with various health care professionals pointed not only to gaps in education and training, but to challenges in providing health care services when time and space was limited, referral resources were few, and when staff complement provided few supports in dealing with psychosocial issues that arose.

The following sections outline some of the essential issues which were addressed by each professional group, and suggest ways in which health care providers could provide quality care to women survivors of CSA.

I. Physicians

Interviews with four medical physicians revealed a range of experiences with, and exposure to CSA. The physicians' experiences practicing medicine ranged from 6 months to 34 years. Three were family practitioners and one was an obstetrician. The family practitioners were employed in primary health care in community health clinics. This included having Aboriginal clientele and seniors' populations. All of the physicians dealt almost exclusively with women's health issues, with 90-100% of their practice being with adult women.

Practitioner preparation and education about CSA

None of the physicians recalled receiving information about CSA during their medical training. One recently graduated physician recalled briefly exploring the issue of CSA in a course on Human Development, "Although I don't remember it being a real focus." Another physician said, "I've never been educated any more than a clinical clerk would have been on [CSA]. Is there a proper way of dealing with sexual abuse?"

Several physicians felt that they attained a significant part of their exposure and training in CSA through residency training, and practice in the community (e.g., child abuse units, volunteer work on a crisis line, community medicine, and primary health care). For two physicians, exposure to CSA came in their psychiatric and pediatric rotating internships with clinical cases. One commented,

In my extended internship in psychiatry there was some [information that] touched on that. It was mostly through case histories, particularly dealing with some anorexics that were on the ward. When looking at family histories, was this a factor or not. But it was more in the context of 'How...did this contribute to this diagnosis?' rather than 'What is this person's life like?'

The issue of CSA seemed to be "touched upon" most in obstetrics training than in other disciplines, however, as one physician noted. "I still don't think it's a very comfortable level for either the residents or the teachers - it's like sexual counselling."

Even in post-graduate training, the physicians received limited information about CSA including how it affects women's health care in general, and its treatment. One physician stated: "I have to say there was, I think, maybe five minutes in my six months of extended internship that we talked about needle phobias, might be from sexual trauma." In another case, the information a physician gained was strictly related to how it pertained to gynecological examinations. One physician stated that the discussions that occurred about treating CSA survivors "...had more to do with protecting yourself as a physician as opposed to approaching the exam in a sensitive manner."

The physicians agreed that more training in CSA would have been useful for increasing their physician's sense of competence in dealing with this population. Two physicians commented:

I think it would have added to your understanding so that you would have been even more tolerant of certain acting out behaviour and abuse on the patient's side. ... I had a lot of abuse from patients. I got no respect. I think I probably would have been a little bit more tolerant I think if I understood more of the dynamics of sexual abuse and what they go through.

When I was first in practice and this sort of thing was revealed to me and the angst that goes with it I really felt kind of lost as to what do I do now with this person. Because you are trained that you are supposed to do something. That's a big part of what made me feel uncomfortable with it because I didn't know what I was supposed to do.

Experience with CSA and cues to sexual abuse histories

Most of the physicians were unsure about the prevalence of CSA in their practice as well as in the general population. One physician estimated that close to 100 percent of her First Nations female population had experienced CSA. Another felt that about 10 percent of her practice were sexual abuse survivors. One physician, who recognized that sexual abuse occurred, felt that clients often overplayed its significance.

Like the few cases I've seen, I think the tendency on the part of the patient who has had sexual abuse to kind of - and I'm not saying this is wrong - but it seems to be that everything is due to the sexual abuse. Like every problem in the world that they've had is blamed on that one issue so that it kind of becomes almost a crutch and whatever the problem is, it always says, 'It's because I was abused as a child' and can be sometimes you know, kind of diverts from the main problem why they're there for which is not necessarily a sexual issue related.

When asked, many of the physicians had wondered about the connection of presenting symptoms to a history of CSA.

The wiser gynecologists and the older more experienced ones would recognize that these experiences influenced how people reacted to examinations but it fell in the category of psychiatric illness - [a patient has] chronic pelvic pain but you couldn't figure out what it was. Well, maybe it was psychiatric.

All of the physicians felt that having a history of CSA would influence one's ability to access health care. This might entail a client avoiding general health care, being afraid of or having difficulties with private exams such as: pap tests, breast exams, pelvic exams. One insightful physician said that for some survivors of CSA, "To actually schedule a time to come in and see a doctor or even a nurse might be too much." Another stated,

It influences so much of their perspective on life. If you've never learned to trust then the whole world looks different. You may not go to doctors, you don't trust people in authority... you do not do well in an authoritative medical society.

For two physicians, certain medical conditions prompted them to wonder about a history of CSA. These included: emotional or personality disorders, depression, eating disorders or weight preoccupation, pelvic pain or difficulties with pelvic exams, sexual problems, Irritable Bowel Syndrome, Crohn's disease, difficulties coping, isolation from

the family, multiple dysfunctions or medical complaints without a cause and suicide attempts. One physician stated, "Sometimes things that just don't make a lot of sense. You wonder if there is some other things going on that account for it." While one physician was not aware of specific behavioural clues that CSA survivors might exhibit, the others felt that self-destructive behaviour, drug abuse, alcohol abuse, panic attacks, guardedness, anxiety during labor and delivery, and difficulty trusting authority might be behavioural signs of a history of CSA.

Asking about and responding to disclosures about CSA

While all of the physicians felt that having a history of CSA would affect one's ability to access health care, none of the physicians routinely inquired about CSA of their patients. Three of the physicians had patients who had voluntarily disclosed that they were survivors of childhood sexual abuse.

Two physicians felt that asking their patients about a history of CSA would be like "opening up a can of worms." Several of the physicians were ambivalent about asking patients about a history of CSA, as the following physician's comment reveals:

I would definitely not want to feel like I'm pushing somebody into something that they're really not ready for. On the other hand, I would also not want to feel that I haven't sort of encouraged... who just needs a little bit.

Several of the practitioners described asking more general questions that "leaves the door open" for survivors to disclose past CSA. One physician said,

I like the 'Is there any way we can make this easier for you?' I like that and I think that's something that could be asked by everybody to everybody and it should be. That's not opening any cans of worms.

From her experience working in the North, one physician found that "yes" or "no" answers or direct questions do not work well with certain cultural populations. A more comfortable approach for most physicians was to ask questions that are more general.

I gradually lead into it: 'Any problem in your childhood, any depression, did you ever get any medical attention, was there anything that happened that upset you as a child?' - gradually. I don't necessarily blurt out and say did your father sexually...

For two physicians, their own comfort level played an important role as to *if* and *when* they would ask patients about a history of CSA. "My own comfort level I guess is my own best judge of when is an appropriate time or a good time to ask that sort of question." One admitted that a barrier to asking about CSA was her own discomfort with the issue and the fact that it would disrupt the typical physician/client medical encounter.

It's a socially taboo kind of topic it's not something you just ask... Somehow I feel like it might throw off the flow of my interview and create a moment of awkwardness maybe, which I think that the only downside would be that it might sort of interfere with my rapport building.

Two physicians mentioned how timing was important to consider when asking about CSA. Both felt that second, or subsequent visits would be most appropriate since some rapport would have been established. Another added, "I also think that there are some women who are not ready to look at that and it would really scare them away." One insightful physician underscored the importance of not making assumptions about the effects of CSA:

I also think when you do ask it's important to leave it fairly open because some women haven't necessarily been raped but still have been traumatized a lot by lesser forms of abuse. I think the reaction doesn't always match with what we would consider the extent of the abuse.

Similarly, a second physician stated,

It certainly is not true that everybody [who] has painful Pap smears, has been sexually abused and I don't think that we should insist that they tell us they have because as I say some people have repressed it so successfully, they're not even aware until someone brings it up.

Barriers in responding to the needs of survivors

The physicians mentioned the lack of time, less than optimal office environment, attitudes, and lack of knowledge about CSA as potential barriers to asking about and responding to the needs of CSA survivors. Three physicians mentioned the issue of time. "Time is always a barrier. You're trying really hard not to act rushed but you're thinking about the time." Another said, "Quite often sometimes time [is a barrier], and if there is a whole bunch of other problems, 'I have enough for today thanks, maybe we'll look at that another time.' That would be part of it - to be honest." One physician pointedly remarked,

For a physician who is fee-for-service and for whom every second counts which is what we're trained to actually - that's one from MD management committee - 'Every second that you're doing something that you don't have to be doing is a waste of your money making time and someone else should be doing it, you shove a nurse there, everything that you don't necessarily have to do.'

The same physician later stated, "We talk about being patient-centered but it's still not patient-centered, it's system-centered."

Two physicians felt either unsure about approaching the issue of CSA or did not understand the dynamics of CSA. One respondent with limited experience with survivors wanted a structured way of approaching the issue. He said, "It would be good to know how to speak to a person, how to approach the subject and maybe not be so afraid of embarrassing them or kind of treading on forbidden ground or causing some trauma to be brought up." A second physician expressed feeling frustrated when an abused patient who successfully underwent a pelvic exam, began to have trouble around it at a similar later examination. "For me that's hard to figure out - well how come ... not then, but now?...that's a barrier for me."

Improvements in preventive health care for CSA survivors

Specific strategies that physicians felt might improve health care for survivors of CSA included using relaxation techniques, and providing patients with a greater sense of control and comfort over procedures. Gender of the practitioner was also seen as important, especially for more "intimate" procedures. Providing a safe, open-minded office environment along with positive physician characteristics were also mentioned as ways to encourage patients to discuss any past CSA.

One physician, who used visualization and various relaxation techniques, felt that these could be very beneficial to women patients with a history of CSA, however, the physician stressed that these techniques need to be used carefully. One physician mentioned ways she dealt with dissociating patients: "Use their name. 'Are you able to hear me? Is this okay?' Trying to connect with the right voice, touching them probably isn't the best. Sometimes I stop what I'm doing, move away and sit down and talk with them."

All of the physicians agreed that providing a sense of control to women with a background of childhood sexual abuse was both important and feasible in their practice. This might take the form of encouraging women to have a friend, partner, or other trusted person with them during the exam, and providing as much information to the patient about examinations and procedures as possible. Allowing patients more control also meant giving women choices in their treatment. Specifically, this included asking women what would make the examination easier for them, allowing women to say "stop", and giving them the right to refuse the procedure. One physician commented, "I always say to them, 'If you're uncomfortable with anything during the examination I'll stop at any time' and I've had them say 'Take it out and stop'."

One physician felt that CSA survivors should be somewhat responsible for enhancing their health care experience. According to this physician, this may involve the survivor telling the physician what she needs so it will be easier for joint treatment planning. While it is not always possible to know of a client's history of CSA ahead of time, or discuss CSA before the appointment, this knowledge can be beneficial for both the client and physician especially in respect to short appointments. This physician stated,

If you do have a practice where you can't spend even 15 minutes or half an hour explaining things or doing things, then you need to develop a plan together...If it takes four appointments then fine...In some ways the person who is having difficulty also has to make some compromises in that we might not be able to do it all in one hour... You sort of go along and do the whole pelvic exam, which is usually the more time consuming piece. Then you start getting frustrated because it's taking so much time and the point where you're starting to get frustrated is the point that's the most difficult.

Two physicians highlighted allowing ample time and flexibility in examinations. One remarked,

You don't always have to have a Pap smear the first time you come in to meet a new doctor or maybe the digital examination is not as offensive as the speculum examination. We can do it at different times.

For another physician, an internal examination may take a whole appointment just to explain the procedure to a woman with a history of CSA. "Let them hold the speculum, let them see for themselves, if they want. That's what I do, that's what I choose to do, that's what I always will do." Another respondent summed up an effective and sensitive doctor-patient relationship as,

I think you have to be patient with the patients, you have to really explain to them exactly what you're going to do, what they're going to feel and why it's important that you do it and I think you have to do it in a non-threatening way that it's not - for example, I have a feeling that a lot of patients can understand a speculum exam but when you do it by manual exam it kind of has a different connotation, it's almost more invasive because you're using your hands more.

One physician pointed out, "I think that anything that makes the exam easier for them is going to make it easier for me so I'm going to get over with faster, everybody is going to be happy."

Most of the physicians had not considered how changing the office environment might enhance the CSA survivor's health care experience. Three of the physicians for instance had not considered how changing the lighting in the examining room (e.g., making it brighter or less bright) might affect their sexually abused clients. One said, "Basically if you're doing a Pap smear you need to see but you can use the light at the foot of the bed, haven't thought about it...I guess I'm not perceiving it in their way." Similarly, another added, "I've never thought of the lights on before but I mean it's not a big deal, right?...I just can't think of what things couldn't be accommodated." All of the physicians were open to meeting their patients' requests for increased comfort and control in the examinations. One physician, however, mentioned that her clinic's structure posed problems to meeting these needs (i.e., no dimmer switches, unmovable examining tables). Having books on CSA available in waiting rooms, and posters on walls were mentioned as other ways of encouraging disclosures of CSA. One physician said, "[This] kind of thing opens up the idea that you're a little more open to some of these other issues that are not at the centre of most medical histories."

Gender of the examiner as well as language used in examinations was perceived by all the physicians as requiring special consideration. This was the case particularly for personal examinations such as pap smears, internal exams, STD checks, routine breast exams, and pelvic ultrasounds. One physician provided the following example:

A good many ultrasound techs [sic] are male and to have a male ram something into your vagina is pretty offensive for somebody who's been abused. They use a condom for covering the probe and that also has connotations for some people. The words used in describing the procedure might make a difference

too....I guess you have to say something like insert a probe into the vagina, it's not stick this thing in your vagina sort of thing. It has to be a technical, maybe not a big long word but a professional term.

Most physicians felt that the caregiver's personality could make it easier for a client with a history of CSA. One physician stated, "Someone who doesn't appear rushed. Someone who seems to give space to think about your answer before you say it, doesn't put words in your mouth and appears interested, to listen." One respondent summed it up as,

I think a lot of that just boils down to respectful practice, that if you explain what you're doing routinely then the person who really needs it the most is going to get it even if you don't know they need it the most.

A need for continued education

All of the physicians felt that more access to literature about CSA was needed. Most assumed that this information was available through the medical colleges but were not sure. Two physicians had educated themselves further about CSA through reviewing academic literature. One was disappointed with the apparent biases and said,

I was really very disappointed in the psychiatric literature on incest ... I didn't think it was good at all...It was usually one or two patients only and broad generalizations were made which I don't think was apropos... The ones that get written up are the extreme ones, the ones that make the TV talk show - Oprah kind of things.

Three physicians felt that a telephone line or physician network would be useful. One suggested that having individual mentors in place for physicians who have a history of CSA themselves might help them feel that their needs were addressed so that they could deal with patients with a similar history. All the physicians felt that more education about CSA was critical for medical students and residents. Medical students need to know about the prevalence of CSA and what abuse means, "It doesn't just mean intercourse." One physician said,

That [CSA] exists, that it's for real, the kind of impact it has on women and how it shapes their contacts with the medical community...I think they need to learn a language for dealing with patients that is not offensive, it doesn't turn them off, that allows women to bring forth issues if they're ready to. We need to develop a whole attitude of respect for our patients, for women.

All of the physicians felt that case reviews and personal life stories from survivors of CSA would be most powerful and beneficial in delivering information about CSA. One said, "I think it's useful to listen to the survivors themselves - those are the ones you remember. Another added that survivors should speak to students about their experiences with physicians: "This is what I would like to see...I think it would be more of a lasting impression than just lectures." One physician added the caveat that, "I also think that in medicine it's helpful to have useful data to base your information on. Personal experience is great but..."

It was suggested that this information could be communicated at continuing medical education (CME) and Society of Obstetrics and Gynecology (SOGC) meetings, conferences, and workshops. Journal articles were seen as a more limited way of imparting this knowledge by one physician since, "If they don't like the title they won't read it." Two physicians felt that the best way to present the information would be within a larger scope of violence against women or within other topics, as opposed to a specific workshop on CSA. One physician explained,

To always sort of be offering it in amongst - I mean and it doesn't have to be just this topic, I mean it can be introduced in a lot of places as part of whatever...If it's a family practice conference and you're talking about new treatments for vaginal yeast. I mean you can have it in as part of when you examine

someone. That way it's always part of things ... If it's too much a separate topic you forget how it's in someone's day-to-day life, not just today the topic is...

Conclusions

The interviews with physicians revealed a strong need for increased awareness about how CSA might affect women in the health care system. The physicians interviewed had limited experience with women who had disclosed a history of CSA. For practicing physicians, post-secondary and continuing education about CSA was very limited. Most were unfamiliar with the prevalence and symptoms of this social problem. Some were unsure about specific strategies they could use in their practice in making these women's experience in the health care system easier.

Interestingly, while all of the physicians felt that having a history of CSA would influence one's ability to access health care, none of the physicians routinely inquired about CSA with their patients. Many were cautious and ambivalent about asking women directly about having a history of CSA. This was partly because once the disclosure was made, physicians felt ill equipped for dealing with the disclosure. For some, this was due to a lack of personal comfort, lack of knowledge about CSA, or a lack of time to appropriately address the issue. Most of the physicians felt comfortable asking more general questions that would "leave the door open" for disclosure of past CSA.

All of the respondents felt that physicians could benefit from more information on CSA and its impact on women patients in the healthcare system and that awareness be integrated into various aspects of care. It is critical to prepare family physicians for the reality of treating women patients with a history of CSA.

II. Nurses in Primary Health Care

The seven nurses interviewed were employed in community-based clinics serving diverse populations of women, including those who were young, Aboriginal, immigrant, and street workers. Some also saw a small number of men in their practice. Most of the nurses had worked in the north, where they had gone unprepared for the complexities involved in caring across cultures and conditions. Their experiences in the north had provided much valuable, but sometimes difficult, experience for the nurses. Among the nurses interviewed, basic training (undergraduate level) was completed from six to fifteen years ago. All of the nurses wanted additional training on CSA and its effect on women's health and on use of health care.

Some workplaces had introduced policies or practices to identify women who had histories of trauma or violence, including childhood sexual abuse. In other workplaces, the nurse who took the patient's history or provided services had worked out her own system of assessing whether CSA was a factor in health care experiences.

The highlights from interviews centred on the following: responding to disclosures of CSA, cues to CSA histories in clients, barriers to good health care for survivors, practitioner preparation and education about CSA, and recommendations for enhanced health care for women survivors of CSA.

Responding to disclosures about childhood sexual abuse

According to one of the nurses interviewed, "If we knew better how to deal with [CSA], and how to point a person in whatever direction they needed to be able to heal from that, then I think you would take away or help heal some of the physical complaints that people are coming in with." In her view, if help is not provided to women who have survived childhood sexual abuse, they seek it through health care for problems that manifest in physical illness.

Many nurses interviewed felt uncertain about appropriate responses and available resources for clients who disclose that they have been sexually abused as children. "[Do] I just come right out and say, "Do you have any history of physical, sexual abuse? If it is somebody who has, how do you respond to that?" Another said, "I'm not a counselor."

Nurses who had northern work experience, however, had some experience in working with women survivors of CSA. “Actually, up north, people are more open about sexual abuse.” One nurse, comparing attitudes to abuse in the north and south of Canada, said, “They’re still the same feelings, anger and all of that but they’re not alone with it in the same way.”

Most of the nurses were inclined to help clients become more comfortable so that the examination could be carried out. Sometimes, clients wanted physical examinations that caused distress or discomfort to be done quickly without time spent talking.

There wasn't really anything to handle....They were people who had obviously dealt with it. It wasn't an emotional thing. It was, 'I've talked about this.' They were very up front....You leave open-ended questions, 'Is there anything you want to talk about?' And you talk a little about what you're doing....They both came for a Pap smear and a pelvic exam and commented that they didn't like the procedure because of past sexual abuse. It really bothered them. For them, it was, 'Do it as quickly as possible.'

Talking by the nurse during an examination distracted clients from “zoning out”, which helped them to mentally escape the situation.

Nurses spoke about the anxiety created by the prospect of an examinations. “I’ve had people who are so tense that you just can’t get a speculum in and just won’t relax for the procedure which would indicate some sort of trauma.” In an effort to reduce fear and nervousness in teenage girls, a nurse explained, “I tend to do a lot of educating and talking, telling them exactly [what will occur].” This kind of attention to the client was seen as helpful to any woman who was nervous about medical procedures, such as Pap tests.

If a history of abuse is asked about as part of routine history taking, it usually occurs after a trusting relationship has been established between the provider and client. One of the nurses stressed how important it was to respond appropriately to disclosures:

You're just sort of exploring that. I guess for some, it's an issue with reliving it, they're talking about it again, it seems to be very painful for them. For some people, they say it's like having to relive it all again. So I think coming from a very understanding and supportive role [is helpful].

Another nurse feared the potential torrent of feeling that questioning someone about a CSA history might have: “If somebody discloses for the first time...to me, it’s like a Pandora’s box and I just wouldn’t know what to do. I wouldn’t know what to do with this stuff coming out.”

Cues to childhood sexual abuse histories

Women who have a CSA history tended to react to certain invasive examinations. “In breast exams, I have seen some distress. Definitely in the pelvic exam, though.” A few nurses referred to the coping methods, such as dissociation, which some women used. They recognized it as a time, “when women go off to another world, don’t look at you, close their eyes.” Sometimes, women avoided Pap tests and other examinations altogether. One nurse related how some women needed three sessions to have a pelvic exam. “First they need to be made comfortable, and hear what will happen and then follow-up sessions to actually get to the exam. Some don’t come for appointments when it’s time for a pelvic.” A nurse recounted the situations of two girls in her care: “It took over a year for one girl to actually get comfortable enough to have a pelvic [exam]. The other didn’t actually get a pelvic until she got pregnant and then it was sort of taken out of her hands.” Having only one part of the examination done and putting off the most uncomfortable procedures was mentioned as a means of coping.

Unusual behaviour in the examining room suggested to one nurse that the patient might have experienced some trauma in the past. “Anytime I touched a sensitive part of her body, like doing the breast exam, she burst into hysterical laughter. It was like...and she was trying to make the excuse that it was really ticklish but I don’t think anybody is that ticklish.” For some women, breast examinations were more distressing than pelvic examinations.

Another situation was related where a woman came in for a Pap test and said that she was a “nervous wreck”, and said to the nurse that in order to have the test she needed a sedative. Aggressive, nervous behaviour was also observed among clients who had survived CSA. “They’re so anxious, but you can see they’re really quite scared at the whole system.”

Nurses’ own observations of physical signs on the body also cued them about possible physical and sexual abuse currently: “The colour of bruises....but inner thigh bruises and definite...on her arm, looks so much like someone pulling her and actually genital scratch marks, and every time I approached the issue....You know she was very...distant. Yes, very, very talkative but never looking at you in the eye.”

Recurrent health problems that seemed to have no physiological cause were also cues that other issues were at the root, “like nothing is ever found. The tests are done and nothing is ever found and I know that can happen and there are things that we don’t test for that can cause problems and things we can’t see that can cause problems.” In one situation, numerous explorative surgeries and examinations for pelvic pain in a woman were carried out, without any cause ever found. “Sometimes, I wonder what else is going on”, said one of the nurses. Another nurse remarked that she had observed that abdominal pain was prevalent in women with a CSA history.

I just found that there were a lot of correlations between there never being a diagnosis for abdominal pain and the patient insisting that there was something wrong and having all sorts of tests. I felt like it was going in circles and circles.

One of the respondents remarked that a few women frequently came to her clinic requesting “swabs” in different areas of the body to determine whether they were “clean.” This behaviour, she felt, was driven by the women’s past abuse experiences.

Barriers to good health care for survivors

Many nurses did not ask about childhood sexual abuse as part of history taking. Often, working conditions did not make it easy to do so. “I don’t usually ask people...those phones are ringing constantly and people are walking up to the desk constantly.” A lack of privacy in clinic settings (e.g., waiting or reception areas) also made it difficult to speak to women about any concerns they might have about their health or health care.

Nurses who had worked in the north found that the limited counselling resources, isolation and time constraints on the job posed formidable barriers to caring for women who have experienced CSA. “The resources are so strapped up there...isolated. It’s not like you can just pick up and go and send somebody off somewhere. It’s a plane ride, lots of barriers. There’s just two of you [up] there and you’re busy, busy, busy....No time. You deal with triage.” Regarding taking the time to offer some supportive counselling to clients, another respondent related, “I would have to...go to a room and expect to spend time and when I do that I’m leaving other people holding the load.” As one nurse summarized, “the [health care] system doesn’t allow for a lot of flexibility.”

A nurse in a clinic emphasized that “In traditional medical settings, you’re not given much time and it’s very clinical, like it sticks to one level. You’re going to find the physical is where it’s going to stay and so I think for a person who has that [kind of CSA history], they’re not willing to disclose that particular history.” This comment was echoed by another respondent who felt that it was impossible to get to the root of women’s health problems if psychological issues, such as the effects of abuse were ignored. She stressed, “We’re not helping anyone by just...concentrating only on the [physical] problems and not offering any opportunity...to deal with this [CSA]. There should be a place that you can go and deal with this.” In the city too, affordable counselling and other support for women with a history of childhood sexual abuse is a problem. “There are not enough therapists. The waiting lists are really long. And there are not enough available, good therapists.”

Another nurse offered a different view in stressing that she would deal with the physical complaint first. If there was an opportunity later, then she would turn her attention to the clients’ social and psychological situation.

So if a client comes in to me and they...have a tummy pain, they may have been raped, they may have been beaten up, they may have sexual issues, they may be pregnant, they may be sniffing—I'm not going to deal with those issues at the time, I'm going to deal with the tummy ache and hopefully they will come back to me and we can work towards the other issues....But I think I leave the doors open.

In the clinic setting, there may be room for improvements too. “Just the way the clinic is set up—I mean the cubicles—it’s not a very warm environment....Four white walls, white curtains.” The respondent added that a friendlier environment would help to put clients at ease. Another nurse suggested that a white ceiling to look at is not helpful when a client is lying down and feeling vulnerable and in need of some control. Some women clients requested to have a partner or friend come into the examining room, even if only for part of the time. One of the nurses pointed out that there could be more accommodation for a supportive companion to be with the client.

Only one nurse spoke about environmental and social obstacles that stood in the way of access to health care services. “Barriers to health care for women that come here are things like no child care, poverty, transportation, and costs.”

Preference for female health care providers was particularly important for many women, including those who did not have a CSA history. A shortage of female doctors often meant no choice for clients.

Practitioner preparation and education about CSA

Some nurses had completed specialized courses, such as nurse practitioner education and crisis intervention training. Most recalled little or no exposure to childhood sexual abuse and its effects in adulthood, as a health issue in their basic training. Rather, they learned about it through practice experience, reading, or presentations for health care professionals.

Nearly all the respondents suggested that inclusion of CSA as a topic area in their nursing training would have been useful. One said,

Generally just some information, I think, in nursing school would be good—that it’s out there. Perhaps some common ways that women react and men....What the signs are, what might be a trigger when you’re talking to somebody, how to keep yourself open to those thoughts when you’re talking with somebody.

Experience in the north raised the awareness of a number of nurses to the problem of abuse, but they often felt at a loss to respond appropriately. Few counsellors were available to take referrals from nurses or to offer advice in dealing with client situations where sexual abuse was a factor. “So I felt what training I had had was completely inadequate and I feel that the whole medical system isn’t trained. Like physicians—I mean no one has really got much training in how to deal with it and it shows.”

Some nurses sought out books and other literature on their own so they could inform themselves and be more prepared. Conferences and informal discussions also added to the nurses’ training on the subject of CSA.

Recommendations for enhanced health care

Most of the nurses said that their workplaces were open to accommodating particular women’s needs if it made them comfortable.

Yes, women can control the health care encounter. They can ask for things. We can do them....We even have special examining tables where the woman’s face is not flat on the table, but comes up to meet the face of the practitioner so they can see one another as they speak.

As this nurse pointed out, “That kind of care is good for all women, not just those who have a history of CSA.” Being able to choose whether to use clinic-issue drapes or some of one’s own clothing to keep on during the examination would also give women more choice and control. One of the nurses related how she told a client,

You don't have to take off your shirt if you don't want to. Leave your socks on, just because it can feel very cold in a gown and then you just feel a little less naked. It doesn't matter if you're...listening to their heart or lungs or whatever. You can still pull their shirt up or whatever...they can keep their shirt on and be happier, if they wanted to.

For some clients, this approach was less helpful as illustrated by one nurse's comments:

Some people don't like that, don't like it taking longer, feeling part of it. It makes it more personal and for some people—and I think even if those people that have a history of sexual abuse being part of that is not something they're ready or emotionally able to deal with, but for others it is.

This created too many decisions for some clients and this was not what they wanted. Cultural attitudes may also have been a factor in these situations. The physical environment of clinics and health facilities could be enhanced by having, "Pictures on the ceiling, I would have music playing....I think the whole environment—you lay on this bed and you look at the ceiling. Even at a dentist you often get a TV or something."

An explanation of what would happen in the examination was important to many of the nurses as good care provision.

We make sure that before we do anything with them, that they're aware of what exactly [will happen] and how long it's going to take. Is this going to hurt? It can be something as simple as listening to a fetal heartbeat and just explaining where this is going to be placed and what this is. This is how I will hear it. This is the gel we're going to place—it's cold.

Taking the time needed to build a relationship is a prerequisite for the completion of a "complete current health history done, outside of the physical [health status], just sitting, talking, and allowing that relationship to build." Communicating that women would be respected and listened to was also seen as necessary in the clinical setting.

The majority of the nurses felt that it was helpful to have counselling resources available to help women who had experienced childhood sexual abuse, especially if it had been disclosed to a nurse during an examination. In one of the workplaces, a nurse related, "We are already trying to address concerns. Our social worker runs support groups for women who have experienced abuse. No one knows the reason why the women come."

Half the nurses suggested that in-service workshops or presentations on the topic of childhood sexual abuse and its effects would be welcome at their workplaces. "Someone who has really researched it [CSA] and kind of keeping us current or informing us. What I like about the person-to-person contact is we can debrief about a situation and learn from each other...how...maybe handle it differently."

Conclusions

The nurses all referred to serious gaps in their educational experiences, especially in basic training, on childhood sexual abuse. Many learned on their own either through attending seminars, specific training courses, conferences, and on-the-job experience. All were interested in being more helpful and responsive to women survivors of childhood sexual abuse, and in most cases their interests stemmed from the desire to be sensitive and caring to women who had experienced CSA. Often, they felt inadequate in broaching the subject themselves unless there was a counselor in the facility to whom they could refer the client. Some feared opening up a "Pandora's box" which would be overwhelming for them. Privacy, and time to provide appropriate and sensitive health care in busy clinics was limited as was the knowledge of how to respond to disclosures. Several other nurses felt that some of their clients were more direct and expressed wanting examinations over with as quickly as possible.

During certain procedures, the nurses had observed distress or physical signs in some of their clients, for example, having to take a sedative before a pelvic examination or recurring pain in the abdomen where no cause could be found.

All of the nurses were open to adapting their practice so they could enhance comfort for women. This sometimes meant allowing for return visits that helped women prepare for an invasive procedure such as a Pap test, or talking clients through the examination.

III. Dental Providers

Three dentists (two males and one female) and one female dental hygienist were interviewed for the study. Two of the dentists had completed their training in the early to mid-1970s; the other in 1983. One had trained in Canada and the U.K. Two had worked in northern Canada for several years; one in Africa. One dentist had taught part-time in a University School of Dentistry. Another was active in continuing education in dentistry.

All three did general restorative dentistry, treating men, women and children. This involved fillings, restorations, root canals, and for two of the dentists, crowns and bridges. They each estimated that women clients made up about 60% of their practices. Two of the dentists currently worked in private practice, while one worked in a community clinic in Winnipeg's core area. While all three of the dentists had clients from diverse social and economic backgrounds, the dentist working in the community clinic setting described that practice most specifically:

Basically people who are low income working or on employment insurance, a lot of seniors, new immigrants, refugees. There's no typical patient; there's really a wide range of people. ...Quite a number (don't speak English as first language or at all). We certainly have quite a number of people who are recovering alcoholics ... and for whatever reason certain people with very badly neglected mouths ...and neglect, poor oralogy, it's a cycle that goes together.

This dentist estimated that about 10% or more of his patients might have a history of CSA. Another dentist had several clients who had disclosed histories of CSA. The third dentist had not thought about the issue in relation to his practice until this interview, but readily acknowledged that some of his clients may well have experienced these past traumas.

The dental hygienist had completed her basic education program in 1969 and had worked on a part-time and full-time basis in urban dental offices. Employed in her present position for several years, she described her clientele as approximately 50% women, 50% men.

Training and familiarity with CSA

None of the dentists or the hygienist received any formal training about childhood sexual abuse. They noted that with mandatory reporting, there was now greater awareness of physical abuse. They had varying degrees of awareness about childhood sexual abuse and how clients might be affected by such a history. One dentist said he was more aware of such issues because a close family member worked as a counsellor. Another acknowledged that this was "new territory" for him, although he knew that physical abuse and sexual abuse of women were prevalent. The dentist working in the community clinic said that issues of sexual abuse were "constantly swirling around us." That practitioner had encountered situations of abuse working in northern communities and had clients who had experienced torture in their country of origin. The hygienist also knew of the prevalence of CSA among women.

None of the dentists nor the hygienist specifically screened for CSA when they took a medical history. However, one dentist in private practice said he sometimes asked if the patient has experienced problems related to emotional stress.

The dentists offered several reasons why their profession had little formal recognition of CSA issues in relation to client care. Until recently, dentistry was predominantly a male occupation and less attention would be given to concerns of female abuse. Two of the dentists noted that there is a heavy focus on skills and techniques in dentistry, and less on psychosocial issues. And as one dentist put it,

The nature of dentistry is such that people may not be willing to disclose such personal issues to a dentist. I'm not sure that in the field of dentistry that people will be as open as they might be with a physician. They might talk about abuse, sexual abuse with your physician or psychiatrist, might seem more natural as a health care giver than the awkwardness of discussing oral sex or something with a dentist. It's something that's just never really been tackled, so it will take time. But it may be a key to helping very anxious patients to be able to accept dentistry better, if they could see that's one of the reasons why they are inhibited.

In addition, physical sequelae of childhood sexual abuse are not evident years later in a dental examination. One dentist described what she had seen in sexually abused children, but noted that the mouth heals, leaving no later trace:

I suppose the most clearly defined thing is lacerations in the mouth through forced oral sex. Lacerations to the hard palette and soft palette, lacerations to the tongue where it's trapped or forcibly jammed between the teeth, lacerations around the lips and in the mouth, again, broken teeth. There are also problems with sometimes - we pick up bruises on the neck where there's been some kind of strangulation. Broken teeth, which could again be accidental. It's unusual to see some of these things in very young children -- that's the things that tip you off. ... Most of the injuries - a lot of them are soft tissue injuries which heal. Actually injuries to the bones of the teeth, the bones will heal to a certain extent if everything is treated. Injuries to the teeth are reparable if help is sought. If the teeth are knocked out then they're often gone and not replaced. It's difficult in retrospect to look at somebody and say, 'I suspect that there has been abuse.' It's much easier to see it at the time.

Cues and clues to childhood sexual abuse histories

Overall, the dentists reported that very few clients disclosed a history of CSA. In cases where disclosure occurred, either the history had been noted by a referring practitioner, or the woman herself had made the decision to disclose. As one dentist recounted:

This one individual had been working through all her problems and sort of the last thing to do was to get these teeth fixed up and she related this to me. I kind of noticed it a couple other times. The history would come up sort of incidental. It wasn't any cleverness on my part to realize that maybe this is the common factor.

Two of the dentists felt that some clients implied they had such a history. All the dentists had clients who showed signs of fear, possibly indicating past traumas. These included clients who pulled away from the slightest touch, had clenched cheeks that would not release, who used alcohol in order to cope with the dental appointment, and who seriously neglected their teeth. As one dentist commented, "While there are other reasons why a person might neglect their teeth (lack of money as a child, a bad experience with a previous dentist), sexual abuse is also a likely reason."

With histories of sexual abuse, I think there is definitely a tendency towards neglect and really avoiding treatment at all costs. Even to the point of suffering quite a bit.... A lot of people have, do come with years of neglect, who have never sought treatment except in emergency situations.

Another dentist described clients that panicked:

I've had patients that have panicked. ... they may shake and they're afraid to have a rubber dam on their mouth because they're very claustrophobic... sometimes that person felt they couldn't return, they couldn't

carry on with the procedure that day.... It's often earlier in treatment that people will be panicky and yet there are some patients that are just absolutely - still no matter what I do - they're petrified. We get through the experience but they are out of the norm and there must be some reasons for that and I haven't found the link... Some are people who won't [seek treatment] and you hardly ever see them and they come in when it's just the absolute worst situation possible and then there are others who will chip a tooth and they'll come in and they're trembling for me to even touch and look and blow air on the tooth or whatever I have to do. They are in all walks of life.

Now that you mention it, I do sometimes wonder... everybody has a gag reflex but there are some people that you can put your mirror in the opening of their mouth and they will almost gag. These are at the far end of the spectrum, this isn't normal behaviour and people tell me that they have trouble brushing their teeth because they gag or they can't get their fingers back to floss their back teeth because it causes a gag reaction. Who knows what it is but when it's that extreme maybe there is a real aversion to having anything in their mouth or in the back of their mouth.

One dentist summarized the signs of fear:

Short respirations, nervous perspiration, dilated pupils, it's the "fight or flight" reflex caused by the nervous system, their hands on clenching on the arms of the chair. So even before they get to the office people will make appointments and cancel them at the last minute. So that and changing appointments those are tip offs.

In the case of one woman who had disclosed a history of CSA, she specifically identified the constricted feeling of the rubber dam as a difficult part of the dental setting. The dentist noted: "She didn't give me a lot of details on what exactly happened but it was her uncle and he used gloves or something else was involved like that so I think the latex might be part of it too."

Two of the dentists described the stress and discomfort they felt in these situations, especially while trying to work on someone. "My whole body is just in tension itself." One of the dentists said, "Some people you can just tell, they have bad auras and it's very tiring to work on them."

While the dental hygienist had no clients who volunteered information about a history of CSA, she was aware of signs of anxiety. "Some patients schedule the appointment first thing in the morning and are so worked up they can't sleep the night before." From her experience it seemed that women, more than men, exhibited anxiety, "Certain women that come in and they've mentioned each time that it is an ordeal for them, they force themselves to do it and I wonder why that would be." For women clients there seemed to be anxiety when the chair would be tipped back; for men fear of gagging seemed more of a concern.

Finding the best approach: Helping women exercise control

Each of the dentists expressed a deep understanding of the boundaries a client might have and the discomfort many people feel having work done in their mouth. As one dentist put it, "It's a real assault for some people to have this done in their mouths and maybe people have sort of a heightened sense of private areas and that's their zone that people shouldn't cross." Another noted that she is careful about "inadvertent touching."

The dentists described the various ways they tried to address the needs of clients with severe fears and anxiety. "I'll step back, talk to them and try and help them understand the procedure a little better" was a common first approach. When a fearful client requires a great deal of restorative work, the dentists might only do a straightforward procedure to provide a more positive experience. In some cases, they have stopped and suggested the client come back another day.

The dentists tried to create a comfortable environment, but this was somewhat limited by the particular physical layout. There was music and a pleasant decor, but dental chairs had partitions separating them and were not in private rooms (areas for the dental hygienist were private in one of the practices). The roles of the hygienist and

dental assistant were acknowledged as especially important in establishing rapport and helping a client feel more at ease. One dentist noted that patients often asked questions or confided in the assistant, hygienist or receptionist, all of whom had been long term employees. All the dentists mentioned the value of holding someone's hand. As one dentist put it,

I used to have a dental assistant who worked with me once who used to hold their hand and that was something that I didn't ask her to do but she just did it and it was quite - it worked very well for some people. I think some people were surprised but most people really appreciated that little extra caring touch. It was again not invasive, someone holding your hand is not - is quite a safe comfortable thing to do, it isn't distant from what we were doing.

Bringing a support person was encouraged by these dentists when they felt the client needed someone present. However, one dentist stated that in some cases they felt that male partners were there less at the request of their spouse than to assert their authority.

Each of the dentists discussed specific ways clients could exercise a degree of control during dental procedures. They felt this helped ease anxiety in all patients, and would be particularly helpful for women with traumatic histories. In the case of a woman with a history of CSA, she and the dentist discussed a specific treatment plan,

This person was quite self-aware so she knew that these were things that were triggers before we even started so we just worked out the treatment plan around her needs - ways of avoiding them. We had headphones going, she brought her own music, had a walkman here so she could avoid the sounds, that's another trigger, just some relaxing music of her own choice. Being able to signal to me to stop if she needed to.

Mutually agreed upon plans were seen as an important way for clients to know what procedures would be done, when and why. One dentist said she wrote down any specific requests of clients and their goal of the restorative work. Some of the ways the dentists tried to “demystify” what they were doing and help patients feel less anxious included having specific signals for time out, allowing clients to hold the suction so they could remove additional saliva, and offering clients a mirror, if they wanted to see what is going on. The position of the chair could also be adjusted to make a patient feel less vulnerable.

I suppose the very position that you're lying in when you're having treatment is vulnerable. We often do give people blankets to put on them. Often because if they feel cold and exposed they sometimes like having a feeling of just a blanket over them. ...Maybe that's not such a bad idea for a lot of people to sort of make them feel relaxed... So I think a lot of people are quite okay. It's not unusual for people to fall asleep when they're having work done. Maybe they're in the chair a long time, we don't kick them out too quickly!

The dentists were aware that there were limitations to what they could offer in terms of control. One said, “I don't know whether that gives the patient total control but it gives them perhaps adequate control or enough control for what they - to meet their concerns.”

For the hygienist, gaining client's trust was an essential factor in helping them gain a sense of control.

It's a matter of just winning their trust over very slowly and letting them be in control. If they say that's enough or don't put me back any further, I don't want this, I think that's how we would deal with it rather than say 'No, you should get this.' I mean, that's the wrong thing to do.

Barriers to responding to women's needs

The dentists recognized that there were barriers in dentistry in general, and in their own practices, to responding to the needs of women with histories of childhood sexual abuse. First, appointments were not long enough, nor are dentists reimbursed for taking extra time to address any psychosocial needs.

Part of it is that it takes a lot of time. It takes at least twice as much time and ... we're paid for the procedure. So if it's taking twice as long, even if the patient has insurance, we can't charge twice as much to the insurance company. So if you're doing counselling... it just ends up being a cost. I just felt this is sort of a triumph to do it but if it was done regularly, you'd have to have some sort of counselling thing as either a separate charge. So it's cost in time.

A second barrier identified was that dentistry tends to focus on procedures.

I actually never really thought of discussing this issue with other dentists. This is not a dentist sort of thing. That's why I was thinking about doing some research on it maybe even presenting something like a paper at one of the conventions. I've never seen any dental information on this....It's more of a sociologist kind of thing. Dentists like little procedures, there's got to be tools involved.

Limited time, the structure of payment and the focus on “tools” often makes the encounter between client and dentist rather one-sided in terms of communication. As one dentist put it,

Because one of the problems when you're doing dentistry is that most of the time you've got things in people's mouth and they can't talk to you as freely as if you're in some other situation. We can talk to them but they can't.

A third barrier was that the physical setting was not structured to encourage disclosure of a sensitive past history,

The physical layout in our clinic - it certainly is not very comfortable because we don't have rooms with doors, we have an open clinic and you certainly can hear conversations in the other rooms. ... If you can talk quietly and not have your voice carry but you're never really sure if anyone can hear. From that point of view, it's not really conducive to people disclosing...we are limited in our building as to how much we can do about this but it is a barrier.

I certainly feel the lack of privacy I think that would be the greatest [barrier]. We don't have any formal avenue for people to talk about this in terms of taking medical history. ... I suppose there's a possibility it might come up because we check medical histories in detail when they first come and have written a full sort of medical history... we don't have a room to discuss that. We do have a room that we can use; it's basically our office that we can use if there's somebody who has to talk about something privately. So we do have the opportunity of doing it but it's not - you have to take them out of the chair into a separate place.

While offering important support services such as language translation, the community clinic also had a drawback in terms of continuity of care. Since dentists worked on a part-time basis and clients might not come for regular check-ups, clients might not necessarily see the same dentist each time, making it harder to build rapport.

The dentist working in the community clinic also saw limited program funding as a barrier to providing dental services to prostitutes, many of whom have histories of sexual abuse. The prostitutes had told staff that they would be more comfortable coming at a separate clinic time, but it proved impossible to secure the needed funding. The dentist indicated that clinic staff tried to make the women feel welcome at the regular clinic, but few prostitutes attended. “It’s sort of once-only relief of pain and then we don’t see them again.”

Perhaps most significantly, the dentists identified their lack of skill to address issues pertaining to CSA should they arise. “I spent 20 years developing technical skills. Some management skills but these require extra management

skills. It's just something that I don't have, the average person doesn't have." Another dentist noted that they would not have enough training to pursue or deal with the disclosure, but could refer the client on for counselling and provide support,

Without some form of education on the part of, within myself even, that I'd be kind of flying by the seat of my pants if I tried to go into it more...There should be a way of getting some help for the dentists to be able to deal with the problem in the right way or to be able to talk about it comfortably enough to make the referral to the right person...I don't think the dentist is really going to, unless we're talking somewhere way down the road that there will be somebody who has enough information and the ability to deal with it.

The dental hygienist, while alert for signs of anxiety, felt that clients might be embarrassed to talk about the cause, so she usually did not inquire further. "I would hate to say anything to make them...decide they don't want to come back."

Suggestions for improving care

The dentists offered a few suggestions about better meeting the needs of clients who were or might be survivors of childhood sexual abuse. One of the dentists was planning to have a quiet room as part of his practice, a space where private discussions could take place and clients could feel less anxious. He was considering employing a counsellor on a part-time basis to provide support, as needed. Another suggested an expanded role for the dental assistant, to whom women in particular might feel more comfortable speaking than to a male dentist.

That might be the kind of person in a dental office ... that if you have somebody really anxious and if she sort of took the cue and when I step out said 'We have a lot of people that are anxious and do you want to talk about anything with me, I can help you.' And my guess is that might be another way...We have the ability to have support people in dentistry. It's another way - I don't have to be the guy that asks the questions and maybe I'm not the person that necessarily would be right to ask those questions all the time... I think the more mature and stable the staff are in your office, the better the chances that maybe people will open up to you. You're not a stranger to them as much. I've always felt long term staff are terrific to have.

Comments made by the dental hygienist support this premise. She suggested that her long-term employment was an essential factor in developing trust with regular dental practice clients. She described some female clients who only see her: "Often, they don't even want to see the dentist, they just want to come and get their teeth cleaned, they are very apprehensive about the dentist." In this practice, the two dentists are male. Perhaps gender and perceived power differential are considerations in how comfortable clients feel to discuss sensitive issues.

The dentists acknowledged the need for patience and sensitivity to work with any anxiety and tension a patient was feeling. It was important, as one dentist put it, "to enter that zone very carefully." Another noted,

Maybe there is some way that we could just alert people that we're concerned about this and if there is something that they would like to disclose. Maybe it could be a question. 'Do they have a particular fear of dental treatment?' Something that is quite an innocuous question but could open the doors for them if they want to let us know... So it's a question of finding appropriate language and a language that everyone can understand but we're dealing with many people whose language isn't English.... But the most innocuous thing too does offend people. It's a real mine field...

One dentist cited the need for a more integrated approach and understanding of the complexities of oral health and disease. He felt that the training of dentistry is too mechanistic. He cited his own interest in the relationship between gum disease and overall health the immune system. "Everything is more interrelated than we think." His comments suggested that a broader view within the profession would begin to recognize the effects of past traumas on dental health.

Continuing education and dissemination of findings

All the dentists were very interested in having issues identified in this study disseminated to others in the profession. They suggested presentations at the annual dental convention, and articles in dental journals and professional bulletins. They advised that such articles needed to show dentists how to deal with issues in their practice so the information would be useful. Two of the dentists noted the importance of integrating these issues into the dental school curriculum, specifically of discussing how anxiety may be related to childhood sexual abuse.

I've always advocated and I've talked with deans that the place to start in terms of having better communication and opening up for dentists is in the school. If they would graduate sensitive dentists then it's half the battle. ... So that's a good place to start.

As one dentist noted, once dentists are practicing, it is harder to have them attend lectures about communication:

You can't make people attend lectures either and if they say, 'Next month's lecture is on sexually abused patients, I want to do crowns and bridges - I'll miss this lecture.' That's what happens often. The communication lectures get attended to on a lesser basis than the technical lectures and the real breadwinner lectures. The ones that are going to make you more money! But I think you make more money being a good communicator, you have a more successful practice and if I tell patients they need a crown, I think they don't think I'm selling them a crown, they say 'Well if HE says a new crown then I need a crown, I've chosen him and I've had faith in him over the years.' It doesn't hurt my practice to have good relationships with my patients either.

The hygienist was interested in further education on these issues through in-services and group discussion of a CSA history and implications. She felt there was little available for staff in terms of support when dealing with their own or client's issues of CSA and commented. "I think as we (become) more aware and think about it, maybe realize that someone has been a victim, we would be more caring, compassionate."

Other suggestions from these practitioners included developing useful and more sensitive screening tools when taking a medical history and having information about appropriate referrals. For clients, pamphlets in a waiting room must be discreet for someone to pick it up. These should be clearly written and accessible in a variety of formats and languages.

Conclusions

The potential effects of childhood sexual abuse on dental/oral health and wellbeing are barely recognized within the profession of dentistry and dental hygiene. Yet, survivors of CSA commonly report experiences of forced oral sex/oral abuse and many report subsequent difficulties related to dental care/oral hygiene. These interviews suggest some key issues for educators and practitioners to address in dentistry.

1. Dentistry is invasive in its practice, targeting a private area of the body through procedures that allow the client very limited means of control. Dentistry maintains a heavy focus on restorative and other techniques, and the encounter between client and dentist and hygienist is structured to limit personal sharing of information or disclosure, even less so than physician visits. (One dentist noted that speaking time is "down time" in dentistry.) As the care providers suggest, these are barriers to addressing client fears, specifically for those whose fears arise from childhood sexual abuse.
2. All the dentists and the hygienist acknowledged that communication and rapport are important to helping individuals with severe anxiety related to dental work. They suggested a number of ways such communication might be improved including a client-centred approach that requires more sensitivity, time, support and greater control for the client and appropriate mechanisms for screening for past traumas.
3. An expanded role for hygienists and dental assistants and the possible input of a counsellor as part of the practice to provide support, screening, etc. were raised. Providing support and resources to clients who self-disclose or who are identified as possible survivors is an important task and may require additional training and financial

resources. Certainly, none of the dentists felt qualified to address issues of CSA that might be raised by a client, but wanted enough information for themselves or other staff to be able to help the client through support and referral.

4. There is a need for research and practical information on issues related to CSA within dental school and dental hygiene curricula, in continuing education and for development of appropriate consumer resources.

5. Greater awareness about the sequelae of physical abuse provides more opportunity to discuss the implications of childhood sexual abuse. As one dentist said, "Maybe it's just the right time, the right place to do it."

IV. Breast Screening: Mammographers and Nurse Examiners

This group of health care providers presently work or have been employed at the Manitoba Breast Screening Clinic (MBSC). While they have general educational backgrounds in nursing or radiology, they are included in the study due to their specialized experience with breast screening for women. It should be noted that attendance for breast cancer screening is a voluntary choice that all asymptomatic Manitoba women, aged 50-69 years, are encouraged to make.

Practitioner education/training/workplace background

Three respondents were mammographers and two were Registered Nurses designated as nurse examiners. The mammographers had completed their basic educational programs between 1976 and 1994; all had experience in general radiology before doing mammography. A special post basic course is required for all mammographers by the MBSC and is supplemented with correspondence education and on the job training. The role of the mammographer in rural MB is different as they assume responsibility for breast examination as well as mammography. One of the three mammographers interviewed worked mainly in rural MB with a mobile unit.

The two registered nurses interviewed had graduated in the early 1970's; both have a wide variety of hospital experiences; one was prepared at the baccalaureate level, and the second individual had a Masters degree and teaching experience. Both nurses had recent past experience as nurse examiners in breast screening. The clientele seen at the MBSC is entirely female although a woman's partner may accompany her in some cases.

Education and understanding about CSA

The three mammographers interviewed did not recall receiving any education about childhood sexual abuse. All felt that some information on this topic would have been useful. One of the mammographers described an early career experience when a psychiatric client expressed anger towards the mammographer accusing her of treating the client, "like a hunk of meat." This mammographer described her feelings,

I was frightened at that point but I never let her know; she [the patient] definitely had a problem but that was probably one of the best things that could have happened to me...because I treated everyone after that, like they might have had real problems.

In another instance a client was described as saying directly, "I've been abused and I don't like what you are doing." The mammographer said, "You sort of step back simply because...I haven't had any formal training on how to talk people through it." This mammographer indicated that she is now, with more experience, better able to cope with situations such as these but still finds it difficult. The possibility of physical or domestic abuse was better appreciated than CSA by one of the mammographers who stated that she had not encountered instances of any type of abuse often. "Conversations never really get that deep...and with limited time available, have to be careful how much we get into it...but a good way to handle it would be definitely helpful."

One of the Registered nurses recalled a component of her basic educational program where,

We addressed people with emotional problems who were going to be coming through the system. Not specifically as abuse but generally looking at people who were not going to be open to any kind of health

care procedures especially in the gynecology area. ...During more recent BN program as a mature student ...with many life skills already, I had been there, I had dealt with some of these issues....we did discuss it; can't say now whether this originated from myself or as a topic that came up.

She recalled a case where a client who had been a psychiatric patient with a history of sexual abuse, had come in for delivery, and this seemed to have accelerated her psychiatric problems.

The second RN did not recall any education about CSA at the undergraduate level. She became aware of physical abuse situations early in her career working on a burn unit; the emergency department at a children's hospital was her first real exposure to CSA. Later during her teaching experience she worked on an adolescent ward where, "One particular girl was 14 and I can remember she was in with gastro intestinal problems and a long history of sexual abuse by her father and brothers." As a result of her increased awareness of the prevalence of abuse she took a course on the subject given by the Attorney General's Department. More recently this respondent had done a presentation on CSA and felt it was a topic that should be integrated into the BN curriculum under "Issues of Today."

There seemed to have been a gradual awareness developing on the part of the nurses and some of the mammographers regarding the prevalence and implications of CSA for their target population. At a basic education level, none of the respondents could recall specifically addressing this topic. The nurses had some experience and education in other health care settings and certainly a general interest in patients' anxiety or emotional problems when dealing with the health care system. The mammographers appeared to have less preparation, and in one instance, lacked awareness that early abuse might cause a woman to have difficulties with the screening process.

Practitioner experiences with CSA

The mammographers were confused and sometimes frustrated when encountering women having difficulties with the screening mammography. While they did not always know what the problem was, they had suspicions that the difficulties might be due to some type of unresolved anxiety. One mammographer responded,

I can't figure out what is going on here, how come I can't proceed....'Why have you come to us if you don't want the help?' ... sat down and talked for a while...tried to get her to relax, explained the procedure, try to get to know each other, build rapport, trust...not there to hurt her; [We] can do the mammogram by exposing very little and can be done discreetly; some women are very withdrawn and this is more difficult.

Another mammographer had never considered that childhood abuse might be a factor.... "I just never thought that events, far back in their past would have affected them now." Earlier in her career an experienced mammographer described her reaction to a difficult client, "I was defensive with her, thought 'What's your problem? Let me just do my job.'"

Several of the breast screening staff mentioned the voluntary nature of the visit to the Breast Screening Clinic and suggested that women who had severe repercussions from CSA would not be likely to attend. One RN felt that women, who came for screening and had no counselling related to their abuse, were there because they had a sister or mother who was diagnosed, which scared them into coming. "They got to us and recognized it wasn't going to be as easy as they anticipated."

The question of disclosure and questioning clients in any routine way regarding a history of CSA stimulated considerable discussion. While it was generally felt that prior knowledge might be useful in terms of time allocation, approach and use of sensitive staff, several respondents felt that personal questions related to CSA on a questionnaire for all clients or routinely asked by a receptionist, would not be answered or be regarded as intrusive and/or irrelevant. One respondent stated,

If I was coming for a procedure and they asked me that question, I probably wouldn't answer it if it was in the past, because I would think this has nothing to do [with the procedure]. If it bothered me that much then I probably wouldn't be there having it done.

Another respondent worried that women would not answer honestly, or that someone who wanted to talk might expect more than staff could provide terms of both time and skills. Presently an inquiry regarding CSA is not routinely done at MBSC; there would need to be some indication of distress.

Sensing and appreciating anxiety was an aspect of screening that all staff were alert to. Often this fear was of finding cancer, but in some cases, an open and empathetic response would lead women to speak about a background of abuse. The approach used by one registered nurse was to "Try to establish where clients were at" (e.g., if they had access to resources in order to help them through the exam), and to let them know that they don't have to proceed if they did not feel comfortable. According to this nurse, "It is a form of abuse if the person doesn't want to (have the exam) and isn't comfortable with it. "To increase the client's comfort level the same nurse had clients proceed directly to mammography as opposed to back to the communal waiting area, and introduced clients to the mammographer giving some background like, "Things were a little raggy to start out but she has managed well," or "I told her you would understand what's happening." She felt that this helped clients gain some sense of control over the examination process where they did not have to tell their whole story again. A second RN observed that shy or inappropriate behaviour was sometimes an indication of anxiety, and used it as an opening to address the woman's apparent anxiety and ask her if she wanted to talk about it.

Women's Reactions to Triggers

The mammographers described various indicators of anxiety that some women demonstrated during the screening process. They included:

...holding onto the gown with knuckles as white as can be, really not wanting to let go; no eye contact, sometimes rudeness; when I come to using the machine, they feel like they are bread or cows with something attached to them, feel degraded, there's usually never much of a complaint until the machine comes into play.

For one client, her sister in law's experience had created fear even before she arrived. She told the mammographer, "They hurt her, she was bruised for three weeks." The age of the technologist may be a trigger for some women. "A lot of women don't like young technologists." One mammographer stated that the reason why one woman needed to have somebody older was because she had been abused by a young female baby-sitter. For two respondents, being confined was a trigger. One mammographer recalled, "I once had a lady that couldn't have the change door shut because she was locked in a closet when she was little." Removal of the gown may also sometimes be difficult for clients. One mammographer commented, "[I] thought it was a modesty type thing but maybe it does stem from further back." The application of the mammography equipment was considered by one mammographer as more problematic for some women than was the clinical breast exam since, "We're just the ones that cause pain...no time to chit chat...take the pictures, cause the pain, then out the door."

The nurses both felt that the voluntary nature of this screening may be a deterrent for many women with backgrounds of CSA. Pressure from their primary caregiver or family may result in women making the appointment but canceling, or being unable to proceed with the screening exam and mammography when they arrived. The nurses recognized that having many questions before the clinical exam and a reluctance to undress were signs of anxiety and tension surrounding the screening process. One of the nurses noted that she could sense tension in the client by the way her other hand would lie, or the how the breast felt when palpated,

We can examine the outer areas of the breast without too much difficulty but anytime you get into the fuller part of the breast, the nipple area, I'm sure with abusive situations the nipple has been the one area that has been manipulated, squeezed pulled, hurt. So when you come into those area which are more sensitive ...sometimes they'll push your hand away, strike out at you.

Mammographers also had indications from clients that certain parts of their breasts were more sensitive and might be triggers for distress. One described the approach she used to address this,

For the exam I always try to avoid the nipple area, it's most sensitive; I use a medium grip and try to use positioning of the woman's body rather than manual touching to get the breast in position for the Xray.

Both nurses felt conflicted when women, although obviously distressed and anxious, insisted they go ahead with the exam. This was especially the case when clients would say: "Just do it", or where clients "want to get it over with as quickly as possible."

Efforts at increasing clients' control and comfort levels

There were generally positive responses to the notion of women needing a sense of control during the screening examination and x-rays. The mammographers' responses varied in terms of their creativity to support women in this regard. One remarked,

If they can kind of control what you are doing in terms of telling us not to compress as hard, not to handle them roughly, not to hurt them, we can give them that kind of control in terms of thinking we are doing what they are asking us to do.

This mammographer, however, indicated the difficulties of easing compression and still being able to make the exam effective. Talking the woman through the procedure was also suggested, and encouraging her to say "If you are not comfortable with what I'm doing or if it's hurting, let me know, tell me when you've had enough and I'll stop." One mammographer cited a study that allowed women to apply their own compression. With this approach women ended up applying "way more than I would do to them." This mammographer relayed,

In fact a few times I've had women, where if they are OK with it [applying their own pressure] – 'Okay here's the pedal, you control it and you let the compression come down....for those women that would have a really really tough time with it... it gives them something else to think about while they're doing it.

This mammographer described encouraging some women to place their own breast on the "bucky" or platform before the mammogram, but she acknowledged that not all mammographers are comfortable with this degree of client involvement.

One mammographer did not feel that there were many opportunities for client control.

I don't know how we would incorporate that aspect into it... we try to put people at ease and reassure them it shouldn't be painful, it is fast; but can see it looking like a scary machine and because of what we are doing there is really no way around how the machine can make them feel.

In terms of the physical environment, the use of very ample cloth gowns, appropriate for all sized women, recorded background music, and flexibility around having a support person present, were used at the MBSC to create a positive, relaxed environment.

When encountering anxious women, the nurse examiners spent a lot of time before the examination and mammogram talking about the procedure and exploring how the client felt it was best to proceed. One nurse explained,

They need the sense of control, so at points we kind of would talk at the front, 'Okay, yes you want to go ahead with this, fine then let's establish how we are going to go about it' It's a form of abuse if a person doesn't want it and isn't comfortable with it. If I'm examining you and you're really uncomfortable you can push my hand away or say stop this... Give them parameters and a level of confidence that if they

say, 'I've had enough.' I'm going to stop. The same with the mammogram, this is your choice and if you choose not to go further nobody is going to push you and say, 'Well you're here you have to do it.'

One nurse described the importance of always introducing herself and using clear and reassuring explanations before the examination.

'I'm going to examine you using my hand only and then you'll go for the mammogram'.....Just to say I'm going to examine you, can be very threatening. I've always been very respectful of people's privacy and when anything exposes a patient I try to cover them up as much as possible and take away the drape or clothing just for that the time when the procedure has to be done... make sure the door is closed...

Barriers to effective service delivery

The participants mentioned several barriers to effective service delivery for women with a history of CSA. These included the following: lack of time for procedures, gender of the examiner, lack of education about CSA, and the organizational structure of MBSC. They also noted several barriers for women with disabilities.

The major problem for all staff interviewed related to lack of time. One respondent said, "You have to really know how to quickly do what you need to do effectively/efficiently, very hard with short amount of time, especially if you don't know what you are dealing with." One of the mammographers described the high-pressure nature of the MBSC where each nurse or mammographer is booked to see 25 women each day. Very limited time for each exam was a source of frustration

There was more to this [patient's reaction] than the mammogram, and I could console her for that moment and get what I needed out of her without, believe it or not, wasting another half hour...would have been great to pour her a cup of tea so we could sort of discuss this, but I couldn't do that.

One nurse examiner suggested that some prior knowledge about a client's history of CSA before the appointment would allow extra time to be booked. In some cases when women telephoned for appointments, they have indicated they had concerns surrounding abuse issues and might find the examination difficult. When women are anxious it makes doing the mammogram physically difficult. One mammographer stated,

One of the things about mammography is that it is important for the patient to be relaxed in order to do a good job; the breast attaches to the large pectoral muscle, so the more tense she is, the harder it is for you to pull this tissue.

A complex situation in terms of management can result when a distressed woman tells the examiner,

Just do it, get it over with... that puts you in a difficult position because you know they don't want you to do it and yet they are telling you to do it. You don't want to do it because you don't want to hurt her and yet you know it's good for her to have it done, so there's a whole mix up and you risk the chance she's never going to come back.

Obviously the staff have a commitment to the breast screening program. They have a quota of clients that must be seen each day, and at the same time are trying to figure out the best way to support any distressed clients.

The gender of the mammographer was seen as a potential barrier to effective service delivery for women, as the staff interviewed felt strongly that the women clients preferred female providers. One staff member said, "I hear from women that a female provider helps them. It makes it tolerable." One woman client was quoted as saying, "I can handle this because I know it's another woman who has the same body parts as me and some of the same concerns." An exception mentioned by one of the mammographers was a situation where the abuser was a female. There are no male mammographers in Manitoba or male nurse examiners at the MBSC.

Lack of education about meeting the needs of women with a history of CSA and the reality of confusion/frustration in coping with difficult situations was expressed. One participant said, “[We’re] Certainly not taught really how you handle these type of women because you don't know they're those type...how do you know which ones you're supposed to be treating any different?”

One nurse wondered if the structure of the MBSC might be a barrier for some women who have anxiety as, “You come in the front door and you sit; and you come and get changed and you sit. All the bits and pieces that make up this visit might act as a barrier to you; sitting in the lounge with other women might be a problem.” She also added, “Early on our (MBSC) numbers were lower, there was a real sensitivity and as our numbers increased...you lose a little bit of that sensitivity.”

Other barriers mentioned were for women with disabilities. One mammographer stated, “People who have a cerebral palsy type, they can't get their hands away from their body and then it becomes very forceful and we really don't like to do forceful things.” Mentally challenged women were sometimes brought by staff for mammography. One mammographer relayed,

They can't communicate...the kind that cry outthat really bothers me; the caregiver who is with them ...will say, 'That's just how she communicates' [The mammographer replied] 'I think she's trying to tell you something; I don't really think she wants this done.' And I have a difficult time forcing that when I can see there is somebody challenged that really doesn't want to have this done. I think they're sending a very clear message. That puts us in a difficult position because the caregiver, who you would expect knows them very well, wants them to have it done. We feel it's forcing her to have it.

Improving services for women survivors of CSA

When considering adaptations that would improve services for women survivors of CSA, the staff suggested more peer support, additional information, and further educational opportunities for discussing the implications for, and approach to women clients with this background. “A lot of people [staff] don't get it...how should we act with them?” One of the experienced mammographers reiterated the advice she gave younger technologists, “Women like to know what you are doing without talking down to them...explaining everything...I'm going to do this right now'...be encouraging, for example...that's better but let's do it etc.”

When considering the fact that many survivors of CSA may not respond to the invitational letter to attend the MBSC, it was suggested that,

Maybe a phone call by the time a third invitation had not been responded to; possibly by someone who has the time to sit and go into these issues; they're going to be the ones that find out that there is something and then that information could be passed on to the tech who can therefore change her behaviour or something; try to book accordingly...we do that with wheel chair patients.

One of the rural mammographers suggested that having the same individual do both the physical breast exam and the mammogram gave the client a better continuity of care and perhaps reduced anxiety. One of the registered nurses recommended that the clinic might set aside certain times to spend with women who are having problems (including information sessions) so that if women have concerns, they could be invited to come in and voice their concerns before their appointment. This could be mentioned as an option in the invitation letter. Another strategy to prepare for and support women with potential difficulties was networking with other health care providers. One participant said, “Somebody in the community would connect with us prior to her appointment re: a client's concerns or history. [This client] had a tough time in the past and wanted to do this but wasn't sure that she could.”

While the presence of trainees was not seen as a problem at the MBSC, it was raised by one of the nurses as a significant deterrent in other teaching settings. How the question is addressed with the client is crucial. One participant stated,

The woman should always [be] asked beforehand 'Would you mind if somebody (with a description of the sex and status of the student) comes in?'; not with the student standing there, so they're given the option, without having to say in front of somebody, 'No I don't want you there.'

Preventive health care procedures

The staff interviewed at MBSC saw the recruitment of women for screening as a process of targeting a specific age group of Manitoba women and offering convincing information that this is a good preventive health strategy. One mammographer's perspective was,

We send them letters and if they don't respond... sort of keep bugging them; they think they almost have to come even though they don't. Perhaps they don't respond due to fear of finding cancer but could be that we need to touch them and maybe that frightens them too ...the recruiting letter tries to reduce the fear...give them the idea that finding a cancer soon is good, that it is not a scary thing...it doesn't really focus on what is actually done to you. [It] describes the visit as one on one, confidential, private, professional.

One of the mammographers suggested that asking women survivors of CSA for their input regarding what they would like to see in terms of preventive health education and approaches would be useful.

A message that emphasizes safety and comfort to prospective clients was the approach promoted by one of the nurse examiners. She recommended different types of presentations and encouraging interested but possibly anxious women to ask questions, "If you have concerns you can talk to different people... available resources to provide information might be placed at health fairs... use of pamphlets, posters for low literacy groups." The same nurse spoke of the "hard to reach group" who do not respond. The screening program in Manitoba aims for 70% of the population. "Whether the women aren't responding.... because...they don't want to, that there are abuse issues, or if they've already had mammography and it was a bad experience."

The importance of honesty when describing the screening was raised by one participant, "It's not a piece of cake, it's getting into your space, your body being compressed and poked at...if you recognize this and tell people, it goes a long way." This respondent recalled when she was giving public presentations, she had not considered asking women why they might not attend for screening, and indicated she would incorporate this in the future. The fact that anxiety plays a significant role in any type of testing was significant in this nurse's experience and level of awareness.

A second nurse examiner reviewed the patient completed questionnaire which allowed her to become familiar with the client's family and medical history and to reinforce preventive health approaches. She would follow this up with the patient afterwards by saying things like, "I notice you do breast self examination, that's good." She underscored the importance of mentioning the patient's strengths and looking for the positive things patients have done - "You know it's excellent you are here today."

Providers' support networks

All respondents felt there was very little support available for staff when dealing with their own, or client issues of CSA. While several respondents used city agencies to refer women for counselling (Hope Centre, Klinik) they all suggested more in-services and preparation be provided.

Education

The staff had little formal or continuing education regarding CSA and the implications for women seeking health care. There was consensus that it was a neglected but important issue for health care providers especially those who are required to carry out sometimes intrusive and/or uncomfortable examinations. One said,

I think definitely education would help a lot because it's very hard to understand what somebody is going through when you've never experienced it, so you don't know how bad you could feel. It's very touchy, it's very difficult to deal with, that's why I say some people can not, as professionals, deal with it.

Some mammographers expressed a lack of awareness and experience in identifying the signs of CSA and dealing with clients' reactions. One urged,

Start with 'Here's the warning signs to look for' so at least we could know, because I wouldn't know what they were...what did you want me to look for?, and okay, if I see it what did you want me to do?

While staff were prepared to try and put all obviously anxious clients at ease, other than awareness of anxiety over discovering cancer, there appeared to have been little consideration of other causes of fear or avoidance. One of the mammographers indicated that she had anticipated the interview (for this study) was dealing with issues of physical/domestic abuse and acknowledged that she had never considered the implications of CSA in her work experience.

A highly experienced nurse suggested that educational curriculums should recognize the extensive prevalence of CSA and ensure that it is addressed. She recommended that education be inclusive of the client- providing information to the specific areas where women are going for clinical exams, screening exams, obstetrical areas. She suggested that "As we become more comfortable with knowing that a lot of people have experienced this, maybe we will have a better ability to sit down and brainstorm and come up with the best ways to do it"

Discussion

Breast screening for all Manitoba women between the ages of 50 and 69 has been recommended as a preventive health strategy over the past five years. Despite the intimate and intrusive nature of breast examination and mammography, most of the staff interviewed had no specific educational preparation as to how a CSA background might influence the client's experience and perception of this screening process. While the staff interviewed, particularly the nurse examiners, were alert to signs of anxiety/distress, they tended to attribute these reactions to the woman's fear of finding cancer, or they were aware of a problem but could not figure out what was going on. Due to pressures of time and lack, experience, and resources, they were generally not comfortable in inquiring about a history of abuse or in pursuing the reasons why a woman might be having difficulties.

It was suggested that as the breast screening program was voluntary, many women who might have great difficulty with the examination simply would not respond to the invitational letter. Perhaps this represents denial based upon the time constraints that the staff presently have to work within. One of the respondents indicated that early on, just after the screening clinic opened and the numbers seen were smaller, the sensitivity to identify anxious women was greater.

Despite these temporal and systemic problems, there was a keen interest in acquiring more information through educational opportunities, peer support/discussion, and developing strategies to assist women with backgrounds of CSA. There was consensus that education about CSA had been inadequate and should be improved in future. Suggestions to improve the current approach at the MBSC included a different intake process, and networking with other community resources before recruiting women in order to adapt some procedures to meet the needs of women who might have some difficulties with the present system. Women's need for control and understanding of what to expect was appreciated, although the interviewees varied in terms of how much autonomy and adaptation they were prepared to offer. A senior staff member seemed to feel that many possibilities were feasible when the staff were prepared in advance and given the time to work with the client on a mutually agreed upon process. More junior staff members were less forthcoming perhaps due to lack of experience, inflexibility, and/or lack of confidence or authority to bend the routine approach.

Conclusions

Interviews with five staff members at the MBSC suggests a growing awareness of the prevalence of CSA although they did not all recognize the longer term links with subsequent health care experiences including screening procedures. The responses of the nurses and mammographers indicated an openness to consider how their practices might be adapted to better meet the needs of all women. The structure of the organization in terms of the internal flow and time allocated for each client seemed to be a barrier when particular attention and adaptation are

required. While the entire system can not be based upon the possibility of adjustment or longer visits, prior knowledge of difficulties was cited as having been helpful in making flexible arrangements for specific clients. An invitational approach that confronts the reality and prevalence of CSA and its long-term impact might inform women and other community caregivers that this is a safe setting where their individual needs and concerns will be supported.

Recommendations include the following:

- 1) Developing resources, information/ education at the basic and continuing education levels for staff about CSA and how to approach the implications in the specific clinical setting.
- 2) Establishing mechanisms to pre-identify women who might have difficulties with the breast screening process.
- 3) Creating a work environment where adaptation, flexibility, and enhancement of client control, are options for individuals who have special needs.
- 4) Identifying strategies that staff can use to support each other when dealing with women who have special needs.
- 5) Establishing some pre-screening educational sessions for women that include a discussion of why women may not wish to attend and how the staff could be available for support.
- 6) Developing educational resources for women and caregivers that inform the reader of the link between CSA and health experiences; how and where to find supportive health services.

V. Sonographers

Five sonographers were interviewed for the study -- four women and one man. All worked at either of the two major teaching hospitals in Manitoba (several knew each other and worked in the same unit). They had previous training in x-ray or nursing and four had changed careers to sonography in the early to latter 1980's; and one in the mid 1990's. Several commented that they were motivated to become sonographers because they were bored with radiology or because there were few full-time positions in that field; they saw opportunities and challenges in the new area of ultrasound. One of the sonographers had been involved in teaching and administration. Most were very satisfied with their current careers and the diversity of the work they did. As one sonographer said, "It's still expanding and you're always learning. No two bodies are the same so it's not monotonous."

The sonographers did a variety of scans:

Obstetrics, a lot of obstetrics, gynecology, abdomens for any abdominal thing whether it be cancer or even simple gall stones, kidneys. We do a lot of vascular work for blood clots, liver transplants, kidney transplants, carotid artery disease for people having strokes, we have to see how much their arteries are clogged. Breasts, we do a lot of working hand in hand with mammography. They see a lesion, now they want to know is it a solid lesion or a cystic lesion so they send them to us...Thyroids, you name it, just about any body part. The only thing we don't do is hearts because that's another specialty field so that's in another department.

In addition to these, other sonographers mentioned scans of eyes and scrotums. Since hospital protocols require that male sonographers have a female staff present when endovaginal examinations are performed, male and female sonographers often scheduled patients so that males did fewer obstetrics/gynecology and therapeutic abortion (TA) scans. The male sonographer interviewed indicated the men did more scrotums and vascular work than obstetrics/gynecology. He also called attention to a particularly invasive scan, in which a catheter is inserted into the vagina and fluid injected into the endometrial canal:

I'll make sure that a female technician does it. ...That to me seems a little more invasive in some ways because they have their feet up in stirrups for those, it just seems a little more invasive in some ways than the endovaginal scan. You're spending a lot more time doing that test.

Other invasive tests included biopsies performed vaginally or aspiration of a cyst. One sonographer noted that scanning for deep vein thrombosis necessitated starting at the groin, a delicate area that many women (and men) feel uncomfortable exposing. Overall, there was agreement that the endovaginal ultrasound was invasive. As one sonographer put it, “What could be more invasive than someone putting something inside of you?”

Ages of patients ranged from 12 to over 90, with the youngest category usually being pregnant girls. The female sonographers estimated their client load between 65 to 80% female, while the male saw slightly more women than men. The two major teaching hospitals drew from a diverse client base, but one of the hospitals was located in the core area of the city and all the sonographers noted that hospital tended to have a larger concentration of lower income clients and greater ethnic diversity. Pre-abortion ultrasounds were only done at the hospital where abortions were performed.

Training and familiarity with CSA

Four of the five sonographers stated that their training offered no mention of issues related to sexual abuse. In fact, almost no attention was paid to any psychological or emotional issues that clients might be experiencing. One sonographer remembers feeling uncertain how to respond when a woman she was scanning disclosed that she had experienced a sexual assault. Two sonographers became more aware of these issues through friends who volunteered as crisis counsellors. As another sonographer noted,

Absolutely none. We have very little patient care training at all. People come into ultrasound with either a radiology, a nursing background. Actually, they're now taking people without even a medical background. ...So people are coming in without a lot of patient care. Certainly the nurses get it and yes, as radiology people, you get it. It is not included in the ultrasound course, patient care, because it is so heavy...There is no psychological side at all. I mean we're never taught how to deal with miscarriages or any of that type of thing. I mean, we're not - that's not part of our job is to deal with that. We have no time which is extremely unfortunate but I still think there should be some kind of training or I guess continuing education in that area so that - people are with patients for a very short period of time at least they should be aware of the proper things to say or not to say.

This absence was attributed to the preoccupation with the technology and “Just getting the work done. The technology and everything else was a big issue and I guess it just never came up.” Significantly, the most recent graduate (1994) recalled one lecture in her training pertaining to clients who may have been sexual abused. She also attended a workshop on the subject at a conference in the U.S. which she found very useful:

Not necessarily specified for childhood sexual abuse but we did have a nurse ... coming in to talk to us about women who had been sexually abused. Now I guess that could have been at any time during the life span of an abusive relationship. Because we do a lot of internal ultrasound and they were trying to say that these women might come across as either really gruff, rough or they pretend they don't understand what you're talking about. They'll be evasive or they'll just refuse and just how to deal with these things and ‘Yes this is out there, this is a big part of our world even though we don't like to think about it.’ Just basically to be aware; not to say ‘That was a real dumb patient.’ To be sensitive is, I think, the key word and try to be understanding and if they do refuse, to honor their refusal. So we did have some of that and experience is the best teacher...it was right in the training. While we were doing our OB/GYN when we got to the part where we were starting to learn to do internal ultrasounds.

This recent graduate also indicated that there has been more lectures about how to better meet the emotional needs of diverse patients (elderly, immigrants, people who don't speak English). A several day seminar focusing on Aboriginal and Inuit cultures was particularly helpful in understanding women's shyness and reticence as well as cultural perspectives on community and family support. The occurrence of abuse on reserves was also noted.

Cues and clues to CSA history

As detailed below, the structure of how ultrasounds are conducted does not encourage client disclosure of their past history to a sonographer. Only a few of the sonographers had encountered a situation where a woman directly told about a history of sexual abuse.

One of our residents is doing a study on women that ... have adenomyosis in the uterus and the next day they're going for a hysterectomy so we scan them before ... We had one woman who the resident told me: 'She has been abused in the past and she still wants to go ahead with the endovaginal exam.' So we both knew and he explained it to her and he introduced me and explained it again how the test works and we just kept asking her throughout to 'Tell us at any time if you want to stop.' and just kept asking her 'Are you okay?' and then continued with the study. ... you could tell, she was having a hard time with it and then after she said - well, at one point where we had asked her again, 'Do you want us to stop?' and she said, 'No', she needed to do this for her own benefit. After the test she had just said she appreciated the way we handled it, but we could have maybe explained more of what we were seeing on the ultrasound, involve her more in the actual study and the pictures and the machine and get her mind off of the procedure. That was just a couple of weeks ago... and that was the only person that has ever that I knew of and disclosed it to us and told us something after, and I said, 'I appreciated knowing that'... You could definitely see her fighting mentally with herself to keep going and get through this.

Another sonographer described a disclosure,

One lady... the doctor had palpated a mass and there was a history of cancer in her family so there was a strong concern for ... ovarian cancer. So he really wanted the internal done and she was one of the ones that was climbing off the back of the table - and I said, 'I really want to do this scan to see what's wrong because the doctor has some really strong suspicions and you have a really strong history. Could you help me, what can I do to make you more comfortable? What can I do to make it easier for you? Do you want to touch the probe yourself while I'm scanning?'... She says, 'You know what? I've been married 25 years, I have three children, I haven't had sex with my husband for 20 years because I can't stand it anymore because my dad used to rape me constantly.' ... So yes, she just told me all these things. I said, 'I understand.' and she put her hand on the probe and I says, 'I promise I'll go as fast as I can.' and she sort of laughed and she said 'Okay' ... it was a good thing we did it because there was a suspicious mass, she ended up having surgery and it was removed. But you know it was good. She even came back later and thanked me which was really nice.

Another identified some of the possible signs that someone may have experienced past sexual abuse:

Body language and how they react to the way you touch them, how they pull away, how they look away, sheets clenched up to their neck, the legs not spreading open. I don't know if they feel bad, they feel dirty, I'm not sure what's going through their mind when they don't want to do that. I think more, again it's body language, how they look at you, how they don't look at you, how they are very evasive on answers. I think those are a lot of the key - and you have to learn to read people's reactions and not let it get you in a tizzy thinking this person is stupid, like you don't think things like that.

One sonographer estimated that no more than 10% of patients fit this category. Others said that they see between two to four patients a month who are very fearful of the examination. Often pregnant teens - but also older women - were very hesitant to pull their pants down so she could carry out the scan. This was particularly the case for endovaginal scans. When women are fearful, the sonographers took extra time to describe the examination and give women a choice whether to proceed. One sonographer admitted that until hearing about this study, she had not considered the possible reasons for this.

But the ones, it seems like the ones that are the most scared of this will say, 'No just do it then.' Sometimes they're so anxious like that, I'll just put 'refused'... I could see how upset they are about it and

I don't feel like I should be doing something like that to them... maybe these are the ones... that are sexually abused.

Another sonographer described situations in which she had to stop the examination because a woman complained of pain or would not relax sufficiently to have a complete exam. In relation to breast ultrasounds, she noted that it was difficult to know the cause of a woman's fears, "A woman who does not want to be touched at the breast may just not want another woman touching her there; she may be scared of breast cancer being found; or she might have a history of sexual abuse."

In response to a question about whether any patients appear to dissociate during the examination, this same sonographer described the patients who don't want to pull their pants down as not talkative, "They're just laying there like stone." Another made the point that some of the Aboriginal clients "Sometimes get more withdrawn. Maybe going through with the test but just trying not to be really aware of what's going on." The sonographer noted that could be a different cultural response to the situation and not necessarily a sign of past sexual abuse. Some of the sonographers had clients who were recently sexually assaulted, in some cases more than once. This included a woman who was having an abortion and who indicated that her partner had "wrecked her down there." Another described several cases of teenagers who disclosed they were raped by family members. Other young girls had experienced date rape when given Rohypnol, a hypnotic drug slipped into their drink. Some pregnant women appear very upset, suggesting to some of the sonographers that they may have been raped. As one pointed out, when women are very fearful of an internal examination, you may not know if the abuse occurred "...in her childhood, last week or whatever. Or they may be in an abusive situation right now. I'm often thinking that maybe the person they're with right now is abusive to them."

Finding the best approach: Helping women gain control

The sonographers discussed a number of ways they tried to help women feel more comfortable and less anxious. Several commented that it was important for women to have some control in the test situation, even in small ways. Ultrasound clients no longer have to change out of their clothes. Ironically, as one of the sonographers commented, this change was made because of problems getting clean laundry and not because of greater sensitivity to patient needs. "It's not as convenient for us certainly, but they like it better. If they're going to wait an hour at least we can make it a bit more comfortable."

Care was taken to ensure women had some privacy while changing and were draped or covered as much as possible.

I never seem to have anyone for breast ultrasound that has seemed uncomfortable. I always get them to keep the one side that we're not scanning keep that covered up. They change for breast and for endovaginal, I step out of the curtain, they can change...Just keep them covered up until I'm ready to scan...In our department we're just curtained so it's not very private... They're covered with the sheets, they're not wide open.

Some seem to be quite delighted when you say 'Just the underwear and pants', 'Oh I can keep my top on.' You'll get that reaction quite often and they'll say 'Can I keep my socks on?', 'Yes you can keep your socks on'. Little things seem to help a woman a lot. See, we're in the profession so we're a lot more relaxed about exams, body parts and that and some people know nothing and their exposure - it's like going to the doctor I get checked and I go home. So I find that we're a little bit too relaxed whereas they're on the other end and there has to be a happy medium.

The sonographers discussed situations where women were very hesitant to have an endovaginal scan. They let the women know they have choices (e.g. external scanning vs. internal probe), including refusing the particular test.

I try to feel out the patient, how comfortable they are and make sure that we stress that if they don't want to have the test done (intravaginal) that's not a problem. They can speak to their doctor or whatever...they don't have to be afraid to say no.

Patients could also request a female sonographer rather than a male. They tried to make women feel more comfortable by explaining what would happen during the test, how far the vaginal probe would be inserted and when it would be removed. Some of the sonographers showed women that a condom was placed on the probe and talked about how it was sterilized. Others noted that when the patient might have a mass or a serious condition, they encouraged a woman a bit more, explaining what could be seen through the particular test. Sometimes, they would get the radiologist to talk with them. All the sonographers said they offered women the option of inserting the probe themselves.

Even when we insert the probe we let them do it. We pass it to them under the sheet and they'll guide it in. So I guess for them they don't feel like they've been almost like an assault. They've introduced the probe themselves and I always tell them 'This is not like a doctor's test because there is no speculum..' So we don't have that coldness, that opening and that discomfort. I say, 'It's a small probe', we show them, we always show them first. We tell them it's covered in a condom and sterile gel so the safety issues are covered. Then we tell them 'You can insert it yourself.' and that seems to give a lot of them relief and then usually 'Oh, that doesn't hurt'. You just see them relax.

One sonographer sometimes helped women relax by showing them the screen:

Sometimes I turn the screen, that takes their mind off of it and I'll go 'This is your uterus, this is your ovary, I'm just going to take some pictures, I can't talk a lot but go ahead and watch.' That has been a big help I find because they're interested, they're seeing their own body live and you can point things out to them. Also it's taking their mind off of where they're being scanned from.

Another made a point of saying they tried to establish rapport, taking an approach to "Try and be equal" to the patient, "Try and make them comfortable that way too so that they're sort of in control in that sense too." Another talked a lot to the patients to try to get their mind off the examination.

Maintaining a non-judgmental philosophy was considered important by some, especially in relation to women having abortions, "They could have been abused, raped, hurt and it's an unwanted pregnancy and we're not to judge. No one is allowed to judge another person. ... I wouldn't want to be in their shoes for whatever reason."

Sonographers tried to ensure an authentic process of informed consent for patients who did not speak English, either through an interpreter, or clearly gesturing where the probe was to go. If there was any doubt that the woman did not understand, they called in the radiologist. Depending on what medical condition was being explored, the sonographer might decide not to proceed with the ultrasound at that time, but refer the woman back to her doctor. They were aware that this might take a long time; but felt even urgent tests had to be conducted with the woman's full consent.

While the hospital policy did not usually permit support persons to be present during the examination, the sonographers discussed situations in which a woman who was distraught or a very young girl was permitted to have someone with her. If a male radiologist needed to come into the examination (e.g. to view a cyst or mass), one sonographer noted that they try to give the woman as much control and respect as possible. For example, the patient is given the option to have the sonographer repeat the ultrasound while the radiologist observed and guided, rather than have a male do it. The woman is offered more covering. They recognized that she might be uncomfortable with a "man she has never met and probably will never meet again."

Barriers to responding to women's needs

One barrier raised by all the sonographers related to the limited amount of information they were provided about the client. Despite the feeling on the part of the sonographers that their work was important to the overall diagnostics of the patient, they were expected to carry out their testing without knowing much about a patient's history. As one said,

The thing is we don't know anything about the patient's history. We receive a requisition with one line on it or two lines and half the time you can't read the physician's writing in the first place, you're guessing, you have no idea how many patients don't have a clue why they're here. So you have no concept of what you're doing or why. ...Half the time the patient doesn't either. So really you're in the room for five minutes, ten minutes max and you cannot talk while you're doing the examination because you have to concentrate on what you're doing. So you have such a short period of time to interact with them.

No, we don't see it [the chart]... approximately 70% of our patients are outpatients, 30% are inpatients and we would only go into the inpatient chart only if we're looking for something in particular and that would be very rare and lots of times we don't even have that chart. We just don't have access to any of the patient information.

Two sonographers noted that some requisitions from community health centres identify issues of “abuse” or “assault” on the form, or a doctor might specify that no vaginal probe should be used and the sonographer inferred that abuse had occurred. Another noted that she often had detailed information provided on requisitions from nursing stations in the north, making it very helpful to know about a client’s history and help her feel more comfortable. Sonographers could refer to inpatient charts, as in the case of psychiatric in-patients, but in the majority of situations they felt they would not know whether a patient had a traumatic background.

Time constraints were other major barriers to considering some of the needs that fearful clients might have. One sonographer was frustrated when patients would not pull down their pants:

Then I just say, ‘I can’t do the test unless you pull down your pants, it’s that simple... ‘We’re wasting time.’ Because I think of them being like a little stubborn 14 year old, that’s how I think. Like I’ve never really thought this kid could have been sexually abused...if you get a little bit behind then you’re behind in your whole schedule. We’re on a time constraint.

Some of the sonographers reflected on their early experiences with clients and felt that there were situations in which they were not sensitive enough or in tune with the client’s needs.

There’s a lot of pressure when you’re a graduate and you’re trying to get the job done and you’re still kind of learning how to do things well. There’s more pressure there and you’re probably overlooking other issues that should be dealt with...Even now I don’t always get a sense if there is some sort of abuse. I can only go by - I look at the person and I guess a sense of whether they’re comfortable or uncomfortable and that’s really the only thing I have to go with.

Lack of privacy was noted as another barrier. At one of the major hospitals, there were four machines in each room, with cubicles separated by curtains. Other patients and sonographers could easily hear what was being said. As one sonographer stated,

Not only that, you've got a person here that's having a miscarriage, you've got a person here and her husband says, ‘Look at the baby, look at its arms.’ Then you have another person here having a TA, and this all the time, no privacy in our rooms, it's horrid.

Space, heat and noise constraints also contributed to a policy of discouraging support persons to be present during examinations. Accessibility was seen as another barrier to meeting the needs of CSA survivors. An ultrasound area in one of the hospitals did not have wheelchair accessible bathrooms.

The gender of the sonographer was also mentioned. Some sonographers noted that women patients might not feel comfortable with a male technologist, although they felt the males were “very professional.”

Lack of preparation of the patient was perceived as a potential barrier. The women often do not know why they are there, or that they were to have an endovaginal ultrasound. This put the sonographer in a difficult situation of

providing support and answering questions at the moment, without adequately knowing a woman's situation and history. One sonographer estimated this occurred in seven out of ten women she encounters having threatened miscarriages - a trying situation for any woman, and one which might be especially difficult for a woman with a history of past emotional traumas such as sexual abuse.

Limits to what patients can be told by sonographers restricted information sharing and communication. While legal issues limit what sonographers can say to clients about their condition, there were differences among them in what they might tell a patient in response to questions.

I'm not able to give a report to a patient or discuss what I see with a patient so that very much restricts your discussion with the patient. You can very nicely talk to them and you refer them to the physician but that's all you can discuss with them.

Another phrased it:

We're not really supposed to give them anything I guess but we all volunteer a certain amount of information. I take it from individual - if they're emotionally stable and reasonably intelligent, I'll tell them a lot. If they ask me direct questions, they're pregnant and they have a dead baby or something and they ask me if there is a heart beat, I'm not going to lie to them about that. I say, 'I don't see one' but then I'll say, 'I'll have to check it with the doctor'. I tell them a lot...As long as I've got some sort of good news to go with it, then I have no problem telling them...if they can handle it.

Language barriers created particular problems for securing informed consent, particularly concerning endovaginal examinations.

We get a lot of East Indian women or Filipino women - if they have a family member with them that speaks English then we'll bring them in the room to explain everything and tell them about, say the endovaginal exam and ask them is that okay with them. ... I usually say 'Are you sure she understands where I'm putting this?' Usually if there is an interpreter with them it's been okay but if there is no interpreter there and we don't think they understand at all then we don't do it or if you feel uncomfortable that you don't think - sometimes the husbands won't explain quite - they'll just say 'Yeah, yeah she needs to have it done.' or something. Then we'll say 'You need to tell her what she's having and if that's okay because if it's not okay with her we're not going to do it.'...We get a lot of patients that don't speak English properly. Sometimes I will point to myself where - point down - where I'm going or point to them and ask do you understand and if they don't then just forget it.

The quality of the ultrasound equipment was also a potential irritant to one sonographer - although it was not mentioned that this might prolong the examination for the client and make her more anxious.

Ergonomically it's not the best. You always want to have a good picture and some equipment can make it or break it sometimes. It's just frustrating when you have to fiddle a lot with your machine...we don't have a lot of time booked so we're busy, we're backed up. You kind of want a machine that's just going to do the best. We're lucky, our equipment is all new... It may not be all top of the line but at least it's all new and it's been upgraded.

Policies about support persons were mentioned as another barrier to meeting the needs of women with a history of CSA. Women - and even young girls in for abortions - or women who know they are having a miscarriage needed to justify having a support person with them before they were allowed to do so. "We sort of have a general policy where you don't allow people in the room." The major reasons given were that it distracts the sonographer, and space constraints. One sonographer elaborated on being distracted, giving examples that they may find a fetal death or a mass and might be asked too many questions. Also noted was a discomfort with having a spouse present when an intravaginal examination was being done. "We don't allow people in unless the patient is under severe distress. Some people needed to have someone with them and you cannot deny that to them." While exceptions

were sometimes made, they were rare. One sonographer noted, “They don’t seem upset, I’ve never had any that are that upset, they just take it as that’s the way we do it.” Another sonographer suspected some of the more insistent husbands who wanted to come in the room may be ones who are physically abusive to their wives. She has had situations where the patient indicated she was relieved her partner was not permitted to come in. One sonographer stated that in taking a medical history, it could sometimes be detrimental to have a mother in the room with a pregnant teen unless the mother knew about the pregnancy.

A lack of awareness of issues pertaining to CSA on the part of the sonographer may obscure the emotional reasons a woman might want a scan stopped, but not feel comfortable admitting this. One of the sonographers only recognized physical pain as a reason for her to stop a scan:

The only reason you'd have to stop in the middle would be for pain, not anything psychological or that the pain be psychological, I don't know. But, yes pain would be the only reason we would stop the examination - physical pain... the pain from the probe being on the inside. So if they have an ectopic pregnancy or an ovarian cyst or something like that, it can cause a lot of pain.

A lack of training to deal with psychiatric patients was noted by one sonographer who stated she was uncomfortable to even attempt endovaginal ultrasound on patients with psychiatric problems. Some of the patients had expressed fears about “men doing things to them.”

Several of the sonographers referred to the “technical nature of ultrasound” as an inherent barrier to addressing psychosocial issues.

I think just the nature of ultrasound. It is a technical type of job. Just that nature makes it a more sterile type of job, you're not being very personal with the patient. I think we're more personal than some other technical fields like x-ray, where they're just getting them in and out as quick as they can. We have a schedule to keep up with too, but we're spending a lot more time with the patient so it does become a little more personal. But it's still a technical feeling, there is some impersonal - there is a barrier of being impersonal, I think.

Cutbacks in the health care system were noted by one sonographer, to the detriment of overall patient care. She remarked:

Unfortunately, I think that we tend to be too technical because that's what our base is, is totally technical get the test done and sometimes they forget about the person. Because of the time restraints as well. I mean it's so difficult now. You don't even have time to take somebody to the bathroom. There's nobody to take them. So you get an older patient who – ‘I need to go to the front of hospital,’ – ‘Sorry I can't take you.’ – ‘Well get an orderly.’ – ‘Well I don't have one.’ ... That's really, really unfortunate... I think patient care has decreased tremendously, the quality of it and it's very evident in the health care workers leaving. We've lost radiologists ... these people aren't leaving because of money. It's very unfortunate.... It's not the money issue, it's the can't do your job properly, we can't look after patients and your job is providing health care and we can't do it. It's evident in every part of the system. I'm sure your job is exactly the same. You just can't do the things that you know you need to do.

Strategies for improving care -- “Little things seem to help a woman a lot.”

The sonographers offered a number of suggestions for ways to improve the situation of testing for women. These included: providing relevant client information, increased patient preparation, support persons available, attention to privacy and room décor, decreased waiting time for procedures and sensitive practitioner qualities.

The sonographers recognized the limitations of their role, but most felt it would be useful to be alerted by the physician to a woman’s past trauma.

I mean we don't need to know details but if there was some way of just saying "past history" or something just to alert us. We don't need to know the rest of it. Otherwise for us to ask that I don't think is appropriate...and then we're getting into a whole other thing. We're just supposed to be doing the diagnostic test, not 'the before.'

Physicians should prepare women more thoroughly for what the ultrasound would involve, particularly in the case of an endovaginal exam. It is invasive and women are apprehensive enough; confronting an unexpected test adds to their anxiety. Sonographers noted that information could be provided in the form of booklets and posters that clearly describe the test and tells why it is important. Cartoons could be used, especially if literacy in English is an issue.

This is a very important exam. If they think, 'I'm getting a really special test' I think that's important too, if you make a woman feel like she's getting really special care, they're more willing, whether they've been abused or not, they still will be tense but they might still want it, and it might make a difference to their diagnosis.

A support person can be pre-arranged. It was recognized that a woman with a history of CSA might feel more secure with someone of her choosing by her side. The need for a female chaperone policy with breast ultrasound was noted by one sonographer. Separate rooms for examinations would allow needed privacy or room for a support person when needed.

Women often suggested that posters be put on the ceiling of the examining rooms and although staff had raised the idea, it had been dismissed.

It was noted that Manitoba has one of the longest waiting times in Canada to receive ultrasound (Fall, 1999). A reduced waiting time for this procedure was seen as a way to improve care for patients in general, and for women with a CSA history in particular.

Some sonographers identified certain professional qualities which would improve the care of women with a history of CSA. These included: being patient, non-judgmental, and a sensitive, and receptive listener.

Continuing education and dissemination of findings

In response to a question about whether continuing education in this area was warranted, one sonographer bluntly stated, "Continuing? Just some education! ... It never even occurred to me... I mean I should be thinking of these things... We all have been since we got the notice of your study." All the sonographers felt that further information and training about CSA would be beneficial in helping them better read a patient's body language and learn techniques or ways of sensitive questioning. As one sonographer put it:

I think there is a lot of subtle things there that we don't recognize. If we know that they are able to cue in on those subtle little behaviour patterns. I get a sense that there probably is some distinct differences but we're not really recognizing them because we haven't been really shown or taught that these are the cues to look for.

It was suggested that a lecture by a practitioner or counsellor who works with women survivors of childhood sexual abuse would be useful to help identify the signs of sexual abuse or assault and what stages a woman goes through in dealing with it. They felt the information should be practical and specific to the practitioner's needs. The sonographers have weekly in-services or "reading sessions," one of which might be used for a discussion of these issues. Sometimes, the doctors have attended as well. Rounds were also suggested.

Just having someone come and talk. I mean it doesn't have to be a long talk, maybe an hour or two. Just talking about 'Okay you've got a woman who's been sexually abused.' Someone who's had a lot of experience talking to a sexually abused woman, so they can give us their point of view... Someone who has dealt with a lot of young girls who've been sexually abused and say 'Look these are why these girls do this, this is why they might mouth-off at you,' and maybe give us hints and how to maybe properly ask

questions without offending them or scaring them. So maybe that would be you know - and sometimes all you need is a one time lecture because those things tend to stay with you. Because we do such intimate exams, it would be very beneficial.

Several sonographers suggested that the researchers submit articles for the journal of their national association. Presentations through provincial associations of sonographers would reach the majority in any province. One sonographer mentioned that there is information about ultrasound on the Internet and that might be a useful location for our information as well.

There was particular interest in knowing about the findings from the first phase of the study and what the women survivors of CSA had themselves suggested for improving the quality of care. This could be done through a pamphlet or paper. One sonographer suggested that client pamphlets explaining what an endovaginal examination is, might be adapted to mention issues of CSA, either directly or indirectly.

We do have pamphlets - I mean I don't think we have in our department but I know they do make pamphlets and we might have had at one time about describing an endovaginal exam. So I know that is out there...It won't say if you've been abused. It will just explain what the test is and why you're having it. I don't know what else we could do to give them that or to help them without...Even if we had a pamphlet and it said in there 'If for any reason you feel uncomfortable about that please tell your technologist' or 'If you prefer to talk to your doctor' and a lot of times our techs will say that 'If you don't want this part right now we can re-book you and you can talk to your doctor a bit more about it first and if they still want you to have this part then you can come back.' We've had that.

Another sonographer noted that there are pamphlets that address the emotional aspects of miscarriage and ectopic pregnancies to reassure women that it is not their fault or due to something they did. While not everyone reads these, they open the way to other resources. It was also suggested that we convey some of the problems sonographers face, particularly dealing with a lack of information about a patient so that it might be addressed.

Conclusions

The interviews suggest that there is a need to raise awareness of issues pertaining to childhood sexual abuse among these professionals. While a few sonographers had patients who disclosed a history of CSA to them and others suspected patients showing acute anxiety during examinations may have experienced abuse, others seemed to be considering this issue for the first time. All felt the issue was important and merited further education and discussion.

The lack of training in how to deal with patients with anxieties and known or suspected histories of CSA, particularly very young women and psychiatric patients, was identified as barriers to quality client care. As discussed above, the sonographers identified a number of ways in which such training might happen. Many of them recognized that there was a difference between explaining about the test, and addressing how someone might feel about its intrusiveness.

Discussions with the sonographers reinforced an important aspect of the health care system - i.e. the fragmentation of care. The separation of ultrasound testing from other areas of care is reinforced by not providing sonographers with background history of the patient, except in unusual circumstances, and by the very limited information provided to the patient by their family physician about the test (what it can reveal and what it involves) and then by the sonographer. Ultrasound testing is perceived by sonographers (and others) as inherently technical in nature, and not a setting in which to pay particular attention to psychosocial issues of the patient. Despite this perception, some of the tests done are highly personal and invasive. They may be fraught with meaning, related to pregnancy and loss, past traumas, and anxieties. In addition, many patients may have waited weeks to have the test; receive very little information during the test and then experience a further gap in time until they speak with their doctor, causing further anxieties.

Whether more integrated, client-centred models of testing can be developed is an important challenge to the health care system. Certainly, allowing for more privacy and opportunities for relaxation and distraction of the patient -- whether they choose to disclose anything about their background to a care provider or not -- should be minimal standards. The design of technological equipment can also help to ensure greater comfort for some women during a test. Thus, while the vaginal probe may be considered invasive particularly by women fearful of internal examinations, the probe makes the examination easier for other women since they do not have to have a full bladder. Designing and offering women options are important aspects of control.

Because sonographers know so little about the patient, "universal precautions" seem warranted. All patients could be treated as if they might have a current or past history of abuse. Sonographers need more training to be able to recognize possible signs and provide necessary support.

Most of the sonographers stated that they had considerable job satisfaction in terms of the variety of their work, diversity of patients and the satisfactions of determining whether a pathology was present or not. Through their skills, patients can move on to deal with their condition. Knowledge and training related to CSA within a sonographer's scope of practice can only enhance client care.

Dissemination of Research

The Need for Consumer and Practitioner Information

A number of requests received from health care providers indicated strong interest in this topic. This is not surprising, since it is known that at least a quarter of women patients will have had a history of sexual or other forms of abuse, requiring appropriate caring responses from health professionals. Many practitioners in this study wanted written information about ways of approaching CSA issues and addressing client needs in a manner that had practical application to their clinical setting. All participants wished to have the results of this study circulated to their professional organizations and beyond. As well, in our previous study, survivors identified a need for consumer information that would highlight ways they might better cope with invasive examinations and other medical encounters (Heinonen et. al, 1997).

As more information and experience is compiled in this area, care providers can support and learn from each other and their clients which strategies are workable and helpful. Collaboration between providers and consumers, accompanied by advocacy will be essential in establishing a safer and supportive network of regional based primary health care services to meet the needs of those involved.

As part of the dissemination of this study, we are committed to developing resources that benefit from the rich perspectives and experiences of survivors and of their care providers, and that may be adapted to a variety of consumer and practitioner needs.

The next steps to be taken for this research project involve dissemination, including the following:

- 1) conference presentations and/or health care practitioners' meetings
- 2) articles which describe the findings and their implications not only for professional practice but also for women who seek health care services, and
- 3) consumer/practitioner information developed will be posted on the Canadian Women's Health Network website: <http://www.cwhn.ca>.

Final Conclusions and Recommendations

There is limited research focusing on the experiences of health professionals with patients who have a history of childhood sexual abuse. This qualitative study, based on 25 interviews with five different categories of health practitioners, was an attempt to partly redress this gap. This research explored practitioners' level of knowledge and training about childhood sexual abuse and their experiences with CSA patients. This study also identified a number of issues and recommendations concerning appropriate care for women patients with CSA histories.

While the study participants cannot be considered representative of all providers within and among these professional disciplines, nor of other types of health practitioners, our findings are consistent with other research in this area and, we feel, add depth to that emerging literature. The suggestions from this study will be put forward for further comment and refinement to professional schools, associations and to a broader range of health providers and consumers. In this way, we hope this research will contribute to enhanced standards of care among health professionals.

Specific conclusions relevant to each category of health practitioner were included in the appropriate sections of the text. Some conclusions were reflected in all categories and are highlighted here.

A. Identification of Past Childhood Sexual Abuse as an Issue in Patient Care – “Universal Precautions”

While all the practitioners interviewed recognized the prevalence of current abuse in Canadian society (e.g. spousal abuse, sexual assault, current child abuse), there was considerable variation within each category of practitioner in awareness about past CSA and the possible physical and emotional sequelae of such a history to a patient. The experiences of providers varied greatly between those who had encountered many clients with such histories, others who suspected some clients had been sexually abused in the past, but had not verified this suspicion, and others who admitted that they had never considered the significance of CSA issues in their professional work prior to the interview.

All study participants felt that CSA merited more attention in education within their individual professions than it was presently given. How issues might be addressed depended on the nature of the practitioner’s scope of practice. For example, nurse practitioners or physicians confronted with a woman experiencing chronic pelvic pain or gastrointestinal problems with no other determined causes, might explore whether there was a history of CSA and, where appropriate, refer the patient for therapy. For these practitioners, knowing the current research literature in this area and understanding how the nature of a childhood trauma may affect a woman later in her life cycle, may be crucial to accurately diagnosing and treating somatic and psychosomatic complaints. Care providers who see patients over a period of time are in a key position to build rapport and a relationship of trust, which may lay a basis for disclosure and willingness to engage in appropriate treatment and/or a therapeutic process. As well, patients who are highly anxious about invasive examinations or tests may benefit from a practitioner who acknowledges anxieties and their possible causes, even indirectly, and asks for the patient’s help in finding ways to make examinations more comfortable.

Mammographers and sonographers occupy different roles from physicians and nurses in diagnostic testing and screening. Usually, they see a patient only once, and have almost no information beyond what is specified by a physician on a requisition form. As the interviews indicated, most mammographers and sonographers regularly encounter patients with severe anxieties who are unable to proceed with certain invasive tests, sometimes to the detriment of a needed diagnosis. Those interviewed also noted the difficulty of securing an accurate mammogram or ultrasound without the patient being in a somewhat relaxed state. Without patient disclosure, these practitioners have no way of knowing the causes of such anxiety; nor do they receive any training as to how to handle such situations. Their challenge is to make the patient feel more relaxed in a relatively short period of time, knowing almost nothing about them.

Dentists and dental hygienists occupy different roles again. Patients may see them on an ongoing basis, and so there is a high potential for developing rapport and trust. Yet, oral care is not structured to encourage regular discussion between client and practitioner. The work dentists and hygienists perform is invasive, and for patients who may have experienced oral sexual abuse, preventative or restorative dentistry may involve procedures that create acute anxiety. The dentists and dental hygienist in this study witnessed many patients with anxiety, but unless a patient had disclosed a history of CSA or other reasons, they could only speculate about the causes of the fear and anxiety.

Many practitioners pointed out that it might be difficult or inappropriate in some situations to encourage disclosure (e.g. when the patient was only seen once). They feared that the act of asking about it might open a “Pandora’s Box” or “A can of worms” which they would not have the time or skills to address. Asking a patient about past CSA also assumes that a patient consciously links a history of abuse with current anxieties or fears, which may not be the case. Some practitioners also worried that some clients might be offended by direct questioning about CSA.

There was, however, general support for an approach of “universal precautions”, in which all clients would be asked routinely whether there were any ways the practitioner could help them be more comfortable with the

examination/test, or whether there was anything the practitioner should know before proceeding, etc. Complementary to this was widespread support for practitioner education on issues related to CSA, appropriate to the providers' scope of practice.

Recommendations:

* That the health professions, through standards of practice committees, consider adopting "universal precautions", which consider a possible history of childhood sexual abuse. These "universal precautions", would include an approach to all patients that demonstrates respect for the patient and offers them control and input to the situation (e.g. test, examination, procedure). A question such as "Do you have any special concerns about this procedure?" or "Is there anything that would make this examination more comfortable for you?" may provide the opportunity for the patient to take some control of the situation and offer suggestions, without necessarily needing to disclose their history. Disclosure might never occur, or be offered only in certain circumstances, if they choose.

* That all practitioners be trained in ways appropriate to their scope of practice about the implications of a history of childhood sexual abuse. This would include awareness about CSA: the patterns of its effects over the course of a woman's life cycle; possible sequelae; and strategies for addressing particular fears and anxieties a patient with such a history may have in a clinical setting. Knowledge of community resources for referral is also important.

Specific approaches to education and training include: curriculum development, continuing education, development of standards of practice guidelines, case reviews, and a variety of informal educational methods. The use of childhood sexual abuse survivors as educators was suggested as a way to provide a powerful learning experience. It is also suggested that the impact of CSA and ways to improve the patient's experiences with medical encounters be taught, not as a separate subject or module, but interwoven through a core curriculum, and within topics presented as continuing education. (For example, when teaching students how to examine a thyroid gland, which involves putting both hands on a patient's throat, the instructor should point out the particular problems this may present for CSA survivors, and discuss ways to make this experience more comfortable for the patient.)

B. Transforming Health Care Encounters

Attention to the possibility that a client may have a history of CSA, presupposes an environment in which such a history might safely be disclosed. This requires some flexibility in time and in how medical environments are structured. Currently, most medical environments are intimidating, rather than accommodating to patients.

In addition to their own lack of knowledge and training about CSA issues, the practitioners in the study identified a number of obstacles in medical environments to addressing the needs of women survivors of childhood sexual abuse. These included: a lack of sufficient appointment time to be able to explore past history in depth or to talk with a patient about their fears; health care settings which did not allow for sufficient privacy to discuss sensitive matters, including space, heat and noise constraints; clients not having adequate information about tests or procedures, including why they were being done, and thus being surprised and fearful when a test was invasive; and a preoccupation in many medical specialties with equipment, technologies and procedures at the expense of psychosocial issues that might arise in the medical encounter. As well, some clients required the services of language interpreters, making it more difficult to address these issues. Some practitioners also mentioned the pressures of fee for service funding and staff shortages as further obstacles to addressing psychosocial needs.

Most practitioners offered women some degree of control in the medical setting. However, only a few had considered changing the setting to allow for more privacy. In most cases, decisions about restructuring the environment were made at an administrative level, to which some practitioners felt they had no, or little input.

Recommendation:

* Practitioners and patients need to advocate for greater flexibility within the health care system in order to accommodate the needs of clients with traumatic histories. Hospital boards, clinics, and private practices that have not already done so should consider options for designing environments that contribute to a patient's ease (models of these include B.C. Women's Hospital). Issues of time, adequate space and privacy, and accommodating support persons for patients who need them (particularly for invasive testing and screening), could be addressed in the design and structure of health services. More flexible staffing would accommodate patients who need extra time and support or who request a practitioner of the opposite gender. Greater collaboration between practitioners (e.g. physicians providing sonographers or mammographers with relevant information about a patient's background and needs) can only contribute to the quality of patient care and in the longer term, to more effective diagnosis and treatment. Often, even small changes (cartoons, artwork, music, informational posters) can make a difference to ensure an environment feels more safe and welcoming to anxious patients.

C. The Need for Further Research

This study and our previous one (Heinonen et. al, 1997) points to a need for further research on clinical practices, specifically on ways of making examinations and testing/screening more acceptable to patients with traumatic histories such as childhood sexual abuse. We currently have little evidence-based knowledge about the options for women with CSA histories to achieve greater control and ease in an examination setting. The perspectives of both women survivors and practitioners are essential to this research.

As well, more sensitive research is needed concerning the impact of CSA on women's physical and emotional health through the life cycle and in relation to specific diseases and conditions. The complex links between childhood abuse and chronic pain are well documented (Roy, 1998). Causal links are harder to determine. A history of CSA may become significant at particular points and under certain conditions or stressors in a woman's life, such as childbirth. We know less about the impact of past trauma as a woman ages and in relation to specific disorders (e.g. eating disorders, premenstrual syndrome, fibromyalgia, etc). It is important to identify the implications of childhood sexual abuse within diagnosis and treatment, so it does not receive too much or not enough attention.

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Appendix 1 -- Interview Guide

1. Could you talk about your professional background? (Where you were educated; at what age you took your training; why you chose this area of work; and your work experiences since you completed your education)
2. Could you estimate what proportion of your present practice is female?
3. a) During your basic professional training, or in any continuing education was the issue of Childhood Sexual Abuse (CSA) ever presented?
b) If yes: could you describe this (e.g., reading ? courses?; was it practical or applicable to your practice?)
c) If not useful, could you explain why?
4. Since you have been in practice, do you feel that it would have been useful to have had basic or additional information in this area? Could you describe any specific situations where this might have been helpful?
5. a) Do you feel CSA has any impact upon individual clients in receiving health care services?
b) Can you give any instances from your practice where it has been a significant issue, and how frequently you've been made aware of this?
c) How prevalent do you think a history of CSA is within your practice?
6. a) Do you routinely have any way to inquire about a history of CSA as part of client history?
b) If yes: please explain why you do this; for how long has it been part of your practice ? How do you ask about this, in an interview, pre filled-in questionnaire? What have been client reactions to this question?
c) If no: under what circumstances do you feel you might ask about this?
7. In your work experiences, have any clients voluntarily disclosed that they are survivors of CSA? Could you describe the situation and how you handled it?
8. Would you feel that your gender and that of the client affects whether they would talk to you about a history of CSA; any specific situations that led you to this view?
9. Have there been any particular medical conditions or behavioural clues with clients, that have made you wonder about a background of CSA? Could you describe these?
10. For some clients certain types of procedures or medical tests can be difficult and act as triggers to recall painful memories: have you had any such indications of procedures being especially aversive or avoided. If yes: could you describe the situation, how you dealt with it; did you feel satisfied with how you handled it; would you do it differently if it happened again?
11. It has been suggested that women with a background of CSA need to have a sense of control during a health care encounter; can you comment on this and suggest ways that this could be encouraged in your work situation?
12. In our previous study, the women interviewed with histories of CSA, made suggestions how care might be provided to make things easier for them (e.g. having a support person with them; being asked before any examination what might make it easier; explanation of any examinations or procedures; more privacy in terms of gowns/drapes provided; dimming lights etc.). Do you think that these would work, or be possible to integrate in your work situation?
13. In your opinion are there barriers or particular difficulties in responding to the needs of survivors of CSA?

14. Do you have any suggestions for adapting your practice setting or the health care system generally to meet the need of clients with a history of CSA?
15. Can you think of any preventive health care procedures/ strategies that might be difficult for CSA clients to accept due to the circumstances of their abuse; do you have any ideas how a different approach might be developed?
16. Where can health care providers find peer support and information about the provision of care to CSA survivors? Given the high incidence of CSA, if a health care provider had this personal background, would further support resources be available? Ideally, what might some additional forms of support look like?
17. What kind of educational experiences (basic and/or continuing education) would you like to see provided in the future to assist health care professionals in providing health services to clients with histories of childhood sexual abuse?
18. Are there other issues related to this subject area that you would like to comment on?

Appendix 2 -- Consent Form

Women Survivors Of Childhood Sexual Abuse: Knowledge And Preparation Of Health Care Providers To Meet Client Needs

The purpose of this research study is to investigate health care providers' preparation for, and experiences working with woman clients who are survivors of childhood sexual abuse. The ultimate aim of the study is to use this information and information gained from a previous study (which looked at the survivors' experiences with health services) to develop educational and other relevant resources for health care providers like yourself who may be working with sexual abuse survivors.

The researchers involved are Lynn McClure, N.P., from Klinik Community Health Centre, Tuula Heinonen, D.Phil, from the Faculty of Social Work, University of Manitoba, and Sari Tudiver, Ph.D. and Carol Scurfield, M.D., from the Women's Health Clinic.

In this study, we are interviewing physicians, dentists, nurses, sonographers, and mammographers. As a health care provider, you will be interviewed about your training and preparation for working with women who were sexually abused as children. As well, you will be asked what you have learned from working with these clients that may be useful for other health care providers in the future. You will also be asked to comment on the practicality of incorporating various suggestions made by women sexual abuse survivors into your practice.

The interviews will be conducted in person, at a convenient location and time chosen by you. The interview will last approximately one hour. With your consent, the interview will be tape-recorded, in order to make it easier for the researcher to listen to you and to ensure accuracy. During the interview, you may choose not to answer a specific question. You can ask that the tape recorder be turned off at any time. You also have the right to end your participation in the study at any time, without any penalty. There is no obligation to continue once you have given your consent to be interviewed.

The tapes and any notes from the interview will be kept in a secure, locked cabinet. To maintain confidentiality and protect your privacy, no names, only code numbers will be used. Any information which could identify you will be removed when we transcribe the tape or work with the information from the interviews, including when the findings are written in the final report. A portion of this study will form the basis for a Master's degree in the Department of Community Health Sciences, University of Manitoba.

It is possible that some people may find discussing this topic uncomfortable or distressing. Should this occur for you, please let us know and we will be able to provide information about counselling assistance. We will be glad to provide you with a summary of the findings of the research once completed. Further information about publications or reports based on this research will be available on request.

The researchers may be contacted at the following numbers to further discuss the procedures and goals of the study. Lynn McClure 784-4090 Carol Scurfield 947-1517 Tuula Heinonen 474-9543 Sari Tudiver 947-2422, ext. 135. The mailing address for the project is: Health Care Provider Research Study, c/o Sari Tudiver, Women's Health Clinic, 3rd floor, 419 Graham Avenue, Winnipeg, Manitoba, R3C 0M3

Funding for this project was received from the Prairie Women's Health Centre of Excellence. This project was approved by the Human Subjects Research Ethics Review Committee, Prairie Women's Health Centre of Excellence and the Faculty of Social Work Research Ethics Committee, University of Manitoba. If you have any questions or concerns about your rights or treatment as research participants, you may contact Ms. Linda DuBick, Director, Prairie Women's Health Centre of Excellence at (204) 786-9048.

I have read and understood the information above and give my consent to participate in this study. I understand that I will receive an honorarium of \$40.00 to acknowledge the time spent to participate in this interview. I have received a copy of this consent form.

Participant's signature: _____ Date: _____
Name (please print): _____ Phone number: _____
Researcher's signature: _____ Phone number: _____

Would you like a copy of the summary research report? Yes ___ No ___

If yes, please provide a mailing address here:

Thank you for participating in this research project. Your contribution will be helpful in furthering knowledge about good health care provision for women survivors of childhood sexual abuse.