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Health Care and Female Survivors of Childhood Sexual Abuse: Health Professionals' Perspectives

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The present study explored health professionals' experiences with adult survivors of child sexual abuse in New Zealand. Face-to-face, semistructured interviews of up to an hour took place with 13 health professionals. The participants were asked about training, screening practices, their response to disclosures, and advice to other health professionals. A model—transition to ethical practice—emerged from the data, where delivering more sensitive health care to child sexual abuse survivors sits on a continuum from lack of awareness of child sexual abuse to delivery of care where all patients are comfortable. We recommend making sensitive care for all as the standard care of practice and providing training for health professionals on how to deal with disclosures.

KEYWORDS *adult survivor; sensitive care; disclosure; screening*

Sexual abuse of children is a significant problem, with estimates of female child sexual abuse (CSA) in Northern American studies ranging from 13 to 30% (unaggregated; Felitti et al., 1998; Havig, 2008; Hulme, 2000; Leserman, 2005; Stalker, Russell, Teram, & Schachter, 2005). In New Zealand (NZ),

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a large random household survey revealed that 1 in 4 young females had been affected by CSA before the age of 15 (Fanslow, Robinson, Crengle, & Perese, 2007). Many of these CSA survivors suffer immediate and long-term consequences, including a range of psychological and physical disorders (Kendall-Tackett, Williams, & Finkelhor, 1993). This article focuses on physical disorders that frequently include, among others, chronic pain, gastrointestinal problems and fear of gynecological examinations and dental procedures (Kendall-Tackett, 2002; Leeners et al., 2007; Leserman, 2005; McGregor, Jülich, Glover, & Gautam, 2010; Schachter, Stalker, & Teram, 1999; Spataro, Mullen, Burgess, Wells, & Moss, 2004). Given the prevalence rates of CSA in our communities it is likely that CSA survivors will be present as patients in health care domains.

VULNERABILITY OF CSA SURVIVORS IN A HEALTH CARE SETTING

The literature is contradictory regarding uptake of health care by survivors. There is some evidence for both higher use (Felitti, 1991; Grimstad & Schei, 1999) and underuse or avoidance of health care (Hays & Stanley, 1997; McGregor, Jülich, et al., 2010). However, survivor disclosures to health professionals (HPs—defined in this article as those working in clinical and medical settings but excluding mental HPs) tend to be quite low (Edwards, Anda, Felitti, & Dube, 2003; Maheux, Haley, Rivard, & Gervais, 1999; McGregor, 2003; Read, McGregor, Coggan, & Thomas, 2006). For example, in a NZ study of 191 female CSA survivors, only 4% of those who had been sexually abused in childhood disclosed abuse to a HP (Read et al., 2006). The most commonly reported reason for a low disclosure rate is the lack of inquiry about CSA history by HPs (Edwards et al., 2003; Maheux et al., 1999; McGregor, 2003; Read et al., 2006).

Lack of CSA disclosure has been found to dispose survivors to negative experiences during medical examinations such as invasive gynecological procedures (Hilden, Sidenius, Langhoff-Roos, Wijma, & Schei, 2003). For CSA survivors, practices that involve touch or pain, lying on a bed where they do not feel in control such as in hospital or consulting rooms, or having an authority figure (an HP) requesting the removal of clothing can be reminiscent of their abuse experience and may retraumatize them and elicit responses such as anxiety, dissociation, and other post-traumatic stress symptoms (Roberts, Reardon, & Rosenfeld, 1999). If HPs are not aware of patients' CSA history or lack awareness of the adverse effects of certain medical procedures for survivors of CSA, then they are less likely to modify their behaviors and procedures to minimize potential discomfort or trauma for survivors.

Consequently, fear of medical procedures, especially gynecological examinations, becomes a barrier to seeking health care for CSA survivors.

In a survey of 61 CSA survivors in NZ, almost two-thirds of the participants reported that fear deterred them from attending regular health checkups (McGregor, Jülich, et al., 2010). Avoidance of regular health checks can have harmful consequences as studies show that survivors of CSA are more prone to engage in sexual risk behaviors such as having first intercourse at a younger age, having multiple sexual partners, and being involved in sex trading (Senn, Carey, & Vanable, 2008). These kinds of behaviors increase the likelihood of contracting sexually transmitted diseases and increases risk of exposure to human papillomavirus (HPV), a common cause of cervical cancer (Farley, Golding, & Minkoff, 2002).

What CSA Survivors Want from HPs

Survivors of CSA have indicated that they would like to discuss their CSA experience with HPs and would appreciate an inquiry from them (Leeners et al., 2007; McGregor, Glover, Gautam, & Jülich, 2010; Robohm & Bутtenheim, 1997). Teram, Schachter, and Stalker (1999) found that survivors may selectively disclose to HPs they assess as being aware of and sensitive to abuse-related issues. There are mixed findings in terms of whether survivors want HPs to be specifically trained on CSA, to understand the range of possible effects of CSA, and to facilitate any disclosure of abuse. Participants of two studies (Monahan & Forgash, 2000; Schachter et al., 1999) did not indicate the need for specific training, while in another study (McGregor, Glover, et al., 2010) the survivors felt that it was a basic requirement for HPs to have this training before they inquire. Regardless of whether HPs have received specific training or not, all survivors want their interactions with HPs to be conducted with sensitivity and consideration (Leeners et al., 2007; McGregor, Glover, et al., 2010). In order to avoid triggering memories of abuse and to reduce feelings of anxiety and powerlessness, HPs are strongly advised to be aware of how they exhibit power, control, and authority while conducting medical examinations (McGregor, Glover, et al., 2010; Monahan & Forgash, 2000). Ideally, the HP–patient interaction should instill CSA survivors with feelings of empowerment (McGregor, Glover, et al., 2010; Monahan & Forgash, 2000; Roberts et al., 1999; Schachter, Radomsky, Stalker, & Teram, 2004; Stalker et al., 2005).

HPs' Experiences with CSA Survivors

There have been relatively few studies that have explored HPs' experiences with patients who are survivors of CSA. A UK-based study surveyed a group of general practitioners, practice nurses, and health visitors (Richardson et al., 2001). The results of the anonymous questionnaire ($N = 401$) showed that 28% had received training on helping CSA survivors, and over 80% of

respondents in each HP group indicated that they could do something to help CSA survivors. However, less than 10% supported routine screening for CSA. The study did not investigate HPs' reasons for disagreeing with the idea of routinely asking about CSA.

In Hurst, MacDonald, Say, and Read's (2003) survey of practice in Australasian sexual health clinics, doctors, nurses, and counselors' reasons for not inquiring about sexual abuse was explored. The four most common reasons for not asking, in descending order of relevance, included feeling concerned that clients will be distressed, finding it irrelevant to client's presenting complaints, not having enough time or funding for potential workload resulting from disclosure, and not feeling adequately trained to ask.

All HPs (e.g., physicians, nurses, dentists, dental hygienists, sonographers, and mammographers) in Tudiver, McClure, Heinonen, Scurfield, and Kreklewetz's (2002) study indicated the need for more education on CSA within their profession. Given the varying nature of practice among the HPs, it was emphasized that training be tailored to their scope of practice. In the Tudiver and colleagues (2002) study, there was a fear among HPs that screening for CSA might open "a can of worms" or a "Pandora's Box" that they would be unable to address due to lack of time or skills. Some were wary of offending their patients with direct questioning. Moreover, HPs commonly cited lack of sufficient appointment time, lack of adequate privacy in health care settings, clients being inadequately informed about tests or procedures, and medical specialties constantly prioritizing equipment, technologies, and procedures over patients' psychosocial issues as limiting factors to addressing the needs of CSA survivors. The study found general support for a practice whereby HPs routinely ask all patients how they can make their examination more comfortable and/or whether the patient would want to share anything before the HP proceeds with the examination/test. The authors termed this approach "universal precautions" and recommended that all HPs adopt this way of practice. By asking all patients questions about their concerns and how HPs could make things comfortable, this offers them control over these situations without having to disclose their history (Tudiver et al., 2002).

Present Study

As part of a broader program of research looking at health issues for CSA survivors in NZ, we asked some NZ HPs for their opinions on how health care can be more sensitive for survivors. HPs' opinions are important because they are well placed to improve health outcomes for adult CSA survivors by delivering a positive post-CSA intervention, and any proposed improvements would require their support.

METHOD

Participants

This was an exploratory qualitative study with a snowball sampling method. Professional organizations who clinically work with women were consulted with to identify key informant interviewees. A snowball sample of 25 HPs was approached to provide an interview. Twelve HPs declined for a variety of reasons, such as lack of time. Some could not see the connection between abuse and health effects. For example, two HPs were dentists, and one strongly disagreed with the notion that dentists should screen for CSA. We wanted to include dentists because CSA survivors have been found to avoid dental care (Hays & Stanley, 1997). Other HPs approached included doctors, midwives, and nurses. A wide variety of HPs were included to obtain expertise from HPs involved in performing a range of procedures or examinations that involve touch. Ethical approval for the study was obtained from the University of Auckland Human Participants Ethics Committee for three years from February 2003 (Reference: 2003/029). Criteria for the study included HPs who fulfilled the following:

- Worked in clinical/medical settings and/or who had particular expertise working with women.
- Were able to be interviewed in the Auckland area.
- Were willing to take part in one face-to-face audio-taped interview of up to an hour to talk about (a) approaches or interventions found to be useful when working with women with histories of CSA and (b) advice or suggestions for other health professionals, trainers, educators, or policymakers about working with the effects of CSA.

Interview Process

Face-to-face, semistructured interviews of up to an hour took place between December 2003 and December 2004. The interview was developed in consultation with a wide range of experts, including a questionnaire development specialist from Auckland University of Technology, members of Doctors for Sexual Abuse Care, and medical specialists. The interview contained four domains of open-ended questions: training (whether HPs had received any training on CSA and if so what information was covered), asking about CSA (questions surrounding whether HPs ever ask patients directly whether they have a history of CSA), HPs' practice (their perceptions of effect of CSA on patients and how they assist patients), and advice (what suggestions HPs would like to pass on to other HPs, trainers, educators, or policymakers).

Data Analysis

The audiotapes of interviews were transcribed and entered into Microsoft Word. Initially, a deductive approach (Thomas, 2006) was applied whereby themes were predetermined by the interview schedule as well as the theoretical framework from McGregor, Glover, and colleagues (2010), which explored female CSA survivors' opinions on how HPs could work better with CSA survivors. A qualitative general inductive approach (Pope, Ziebald, & Mays, 2000; Thomas, 2006) was also used to analyze the text. Inductive analysis allows for new or unexpected categories to emerge from the data. Each transcript was segmented into distinct meaning units, which were then assigned a category label independently by two of the authors. Where necessary, discrepancies in coding were tabled and those discrepancies were discussed until a consensus was reached (Silverman, 2000). All 13 transcripts were then combined into one Microsoft Word document maintaining the order of themes identified. Reading through the merged text, the themes were then categorized leading to the emergence of three superordinate categories. The subthemes were then summarized as text.

RESULTS

The participants were spread across six health professions. Four identified themselves as a doctor, two as a dentist, two as a midwife, two as a nurse, and one as a child birth educator. Another participant, who had trained and worked as a specialist gynaecological nurse, was included as an informant on maternity care, despite having subsequently retrained as a clinical psychologist. One participant identified as having a dual profession as both a nurse and a midwife. Only one participant, a dentist, was male. Years of experience as a HP ranged from 10 to more than 50.

Three superordinate categories emerged from the data around lack of awareness, conditional provision of sensitive care, and sensitive care for all. A model, transition to ethical practice (see Figure 1), depicts these categories. Delivering more sensitive health care to CSA survivors sits on a continuum from lack of awareness of CSA to delivery of care where all patients are comfortable.

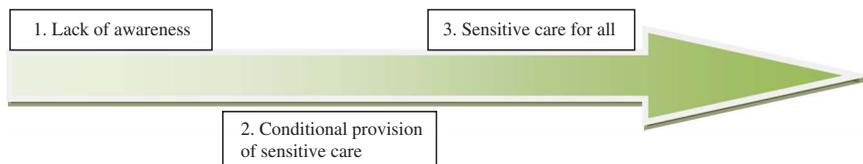


FIGURE 1 Transition to ethical practice (color figure available online).

Sensitive Care

According to the HPs, sensitive care encompasses a range of practice. Giving patients control back was most commonly highlighted as it was thought that “you lose it the minute you set foot over the threshold of the hospital door.” Restoring patients’ control was achieved by asking permission for “just about everything” that HPs do, negotiating “the sort of things they [patients] were prepared to do and not prepared to do,” giving them the option to stop the procedure at any time, and ensuring that they are comfortable throughout the examination.

Sensitive care further includes taking time with patients by “making them feel that they have time to ask questions,” “talking to them about what they want,” and generally being “caring” so that “women don’t feel victimized and abused all over again.” HPs also suggested “offering them [patients] a choice of female providers if possible” in order to increase their control and comfort level. However, one HP pointed out that just because HPs are female, it “doesn’t mean they’re any better [than a male].”

Lack of Awareness

Lack of awareness entails having no knowledge of the prevalence and effects of CSA on survivors. In our study, there was an awareness among the diverse range of HPs as all 13 of them demonstrated an understanding of negative effects of CSA on women survivors’ physical and mental health, their health-care-seeking behavior, and their interaction with HPs.

According to some respondents, this growing awareness only spans about two decades. One respondent explained that the way things were done regarding sexual abuse and sexual assault was “all rethought at Family Planning in the years after Cartwright [Inquiry],”¹ which took place in the late 1980s. Another HP said that it was only in the early 1990s that “there started to be little articles about how necessary it was for midwives to be aware of what was happening to women during birth when they had been sexually abused.”

Conditional Provision of Sensitive Care

As HPs were aware of the effects of CSA on survivors, they all reported that they provide sensitive care. However, there was a division between those HPs who provide sensitive care on a conditional basis and those who provide sensitive care for all.

Conditional provision of sensitive care refers to HPs adapting their care practice according to patients’ needs. All HPs indicated that they modify their practice when they are interacting with patients who disclose their CSA history or those they suspect to be CSA survivors as well as with patients

who panic or have difficulty with certain examinations. Therefore, there is a sense that most HPs do not provide sensitive care unless their patients demonstrate an obvious need for it. However, most HPs do not routinely screen for CSA to find out whether such needs exist.

There was diversity in HPs' screening practices. Only three HPs indicated that they routinely screen for CSA. A specialist health worker dealing with women's health expressed that for them, routine screening is "as natural as breathing." Another HP, a medical practitioner, felt that "if you can deal with the issues earlier on and get the appropriate support and management that it does make a difference." Four respondents reported that they screen if patients present with behaviors that give an indication of past abuse. These patients include those who "avoid smears," "have excuses to not have examinations," and "have chronic pelvic pain." Another three HPs indicated that they either screen indirectly or do it on a case-by-case basis. For example, one HP provides a pamphlet to her patients and during their next visit asks, "Is there anything in that pamphlet you'd like to talk to me about?" Another HP believed, "The whole idea of routine questioning is not just [being selective about who you ask], I ask everybody. It's a question of working out how you're going to do it."

There was one HP, a dentist, who felt that asking about CSA was beyond what patients expect from a dental visit and therefore considered it to be too invasive. The HP felt that "they're not coming for therapy or to talk about personal stuff; they're coming to have the job done in a dental surgery."

HPs' hesitations in conducting routine screenings were most commonly due to being "unsure about how they'll deal with it [disclosure]" and being "not quite sure where to refer afterwards." They did not want to broach the topic when they did not feel equipped to deal with the outcome. HPs need to "feel comfortable with what the outcomes could be"—they need information regarding the services that are available to survivors and when they should be referring patients to such agencies. However, one respondent pointed out that "there's such a gap out there in training for medical professionals and that's why we're all so terrified of dealing with it." Only two HPs indicated having received training on how to work with survivors of CSA. For both, it was part of their midwifery training and the information ranged from "ways of talking to the woman" to understanding what kind of impact CSA has on childbirth and being made aware of agencies to refer the woman to. Another HP reported that CSA "has come down into the medical school curriculum" but indicated that it was mostly for the pediatrics field.

Lack of time was another most frequently cited reason for not asking about CSA. As one HP said, "There's the fear that if you open this can of worms you're going to be there for an hour." Some HPs pointed out that there was a limitation on "how much you can do in one consultation" and therefore steered clear of dealing with CSA as they felt it would take "a lot of

time.” For some, limited time also meant being unable to establish enough of a relationship to raise the issue as “it can almost feel abusive in its own right coming in and asking that question when you’ve only met them.”

In order to encourage routine screening, HPs felt that training on CSA was necessary so they would know “how common is it, why don’t women talk about it, how can you be the best you can be and [be] present and not dismissive.” It would also make them aware of “what commonly happens after women have disclosed” and “what are the systems of referral.” In order for HPs to ask the questions they “need to have the support and backup in place” because “it’s one thing to ask the question but then, what do you do and how do you manage, and who are the people you can refer to support you?”

Many respondents believed that having a well-supported system means that HPs are not only aware of who is there for the patient but “also who’s there for them as well.” This could mean “having the opportunity to talk it through with a colleague” so that they “can be reassured themselves that they’ve done everything okay and just the chance to kind of let it out to somebody else” or having a counselor on site available for staff counseling when needed. Moreover, it is highly likely there are HPs who are CSA survivors themselves; as one participant put it, “If 20% of women have been sexually abused then 20% of our staff might go through it” so “have to stop and deal with them.” Without the proper support for HPs, one respondent warns that HPs are likely to “go mad and burn out” when already “the level of burnout within the health system is so high.”

Sensitive Care for All

There was a group of HPs who were of the opinion that sensitive care should be provided to all patients and not just CSA survivors because they felt that “you shouldn’t have to be a survivor of anything to need special care.” One HP believed that “despite the advances that we’ve made in Code of Rights and the Cartwright Inquiry and the Gisborne Inquiry² and all sorts of inquiries, there’s still a very strong culture with inequalities in it of doctor–patient in particular of male–female toward women.”

HPs believed that lack of sensitive care also generates negative consequences among those who are not CSA survivors. For example, one HP said, referring to cervical smears, “They [cervical smears] are a really crucial part that you get right because it’s abuse in its own right to have a bad experience” and that “there’s no way they’re going to trust you if you cause them pain and discomfort.” Another HP, who deals with childbirth, relayed that those women (both with CSA history and without) who were not dealt with sensitively during the birth process conveyed that “it felt like I was being raped.”

Therefore, these HPs advocate for health care to move to a stage where it becomes so “sensitive” that patients are never disempowered or triggered negatively. As one HP put it, they “don’t think any one person can ever know every trigger or every aspect or every impact that’ll happen.” By making sensitive care the normal practice it would make it possible to have “women come through that don’t need to tell us [HPs] their life stories but feel in control” and ensure that HPs fulfill their ethical requirement to make all patients “feel safe and less anxious.”

DISCUSSION

The study found that although HPs were aware of the impact of CSA on survivors’ health care experience, and while there was a transition toward ethical practice of providing sensitive care for all patients, most HPs did not modify their practice unless there was a demonstrated need to do so. Ironically, only a few HPs took active measures to find out if there was such need, while others relied on certain presentations or cues or waited for the patients to self-disclose.

The HPs’ reasons for not routinely screening for CSA are consistent with previous studies. Similar to our study, HPs in international studies expressed reluctance to ask about CSA when they felt inadequately trained and prepared to deal with the possible outcomes (Hurst et al., 2003; Tudiver et al., 2002). Lack of time was also a widely cited barrier to routine screening, as most HPs had an allocated timeframe for consultations and examinations and so were wary of opening “a can of worms” (Hurst et al., 2003; Tudiver et al., 2002). In contrast to the previous studies (Hurst et al., 2003; Tudiver et al., 2002), HPs in our study also identified a need for HPs to be supported due to the sensitive nature of the issue and the likelihood of having CSA survivors among HP groups.

Almost half of the HPs in our study were in support of providing sensitive care for all patients. This means ensuring that every patient feels in control by asking permission before conducting any procedures and giving them the opportunity to discuss with HPs how they can make examinations more comfortable without them having to disclose their history. HPs recommended sensitive care as the standard care of practice because they believe that all patients deserve to feel in control. Tudiver and colleagues (2002) also found a general support in their study for the provision of sensitive care, which they termed as “universal precautions.”

In our study, we consider the provision of sensitive care as ethical practice and recommend that all HPs aim to provide this level of care. Sensitive care is synonymous to power-sharing, a shared decision-making type of practice whereby patients and HPs are both involved in information exchange,

discussing treatment preferences, and where the decision to implement treatment is mutual (Charles, Gafni, & Whelan, 1999). This is a similar concept to the Patient-Centered Medical Home as described by Barr (2008). If this type of sensitive practice was normalized during HP-patient interactions then it would not be necessary to differentiate patients according to their history. Moreover, it takes the onus off of survivors to “demand” differential treatment.

The safe environment such practices create will still allow CSA survivors to disclose their abuse if they choose to. Therefore, HPs need to be better educated and trained on how to deal with such disclosures and be made aware of resources and places for referral. Furthermore, we recommend developing an evaluation tool to determine where HPs’ current practice fits on the transition to ethical practice continuum (Figure 1). By gauging how far away they are from providing sensitive care for all, appropriate measures can be taken to move them toward that end of the continuum.

Limitations

The study has a number of limitations: a small number of participants were interviewed, they were only from Auckland, and they came from a limited range of professions. This was, however, an exploratory design not intended to produce results to be generalized to all HPs. In addition, participants self-selected to be involved in the study, thus leading to the possibility of self-selection bias. HPs who do not see the link between their practice and a patient’s history of CSA are an important group for further study. Researcher bias was considered and partially addressed by the inclusion of authors from outside of the field. We all, however, operate within the NZ context of raised awareness and expectations to protect patients from unethical practice, disrespect, and disempowerment.

Conclusion

A strength of this article is the in-depth, qualitative nature of the study, which allowed for the model to emerge. Research is required to develop and test an evaluation tool based on the transition to ethical practice model. We envisage this tool could be used with different health professions to inform training and professional development and health practice policy.

NOTES

1. The Cartwright Inquiry was held from 1987–1988 to investigate the alleged malpractice of a gynecology and obstetrics specialist (Cartwright, 1988).
2. The Gisborne Inquiry was held to investigate Gisborne’s former pathologist’s negligence in reading certain cervical smears in 1999 (Duffy, Barrett, & Duggan, 2001).

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AUTHOR NOTES

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