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**AIM** To evaluate the training needs and awareness of Childhood Sexual Abuse among clinical staff taking cervical screening samples in one inner city Primary Care Trust (PCT).

**BACKGROUND** Studies exploring sexual abuse and non-participation in cervical screening have demonstrated that women can experience re-traumatization if care during examinations is insensitive to their particular needs.

**DESIGN** This was a mixed methods, service evaluation in three phases.

**METHODS** A literature review, a questionnaire to cervical screening staff in an inner city PCT and a focus group of four staff drawn from questionnaire respondents to explore themes raised in the questionnaire data.

**RESULTS** Data analysis of both quantitative and qualitative data showed that clinical staff underestimated the frequency of CSA although they were aware of the difficulties and reluctance some women experience undergoing gynaecological examinations. When women did disclose CSA or when staff suspected a history of CSA, staff reported feeling unsure of how they should proceed. There was no support or clinical supervision and unmet training needs were identified.

**CONCLUSIONS** Nurses expressed anxiety around the potential of the screening test to cause more harm than good and at their inability to provide more help than listening. Staff wanted support and further training after completing their cervical screening training course to assist in their provision of sensitive care to patients who have experienced CSA.

**RELEVANCE TO CLINICAL PRACTICE** While our results cannot be generalised to a wider population, they may be meaningful for the community of cervical screening takers. We argue that screening staff require further training and professional support (clinical supervision) to increase their confidence when providing safe and sensitive practice for CSA survivors. If staff feel more confident and competent when responding to disclosure of CSA in screening situations, women who have experienced CSA might participate in the screening programme more readily.

**KEY WORDS**

Childhood sexual abuse

Cervical screening

Sensitive care

Clinical supervision

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## **INTRODUCTION**

The target for cervical screening coverage amongst the population is set at 80% and is the remit of the NHS Cervical Screening Programme (Walker 2009). This target is set to maximise the benefits of screening and reduce the risk of cervical cancer in the five years following a screening test, depending on the age of the woman (Sasieni 2009). This target is not always achieved, especially in inner city areas and little is known about the reasons for non-attendance. However, it is known that the intimacy of the gynaecological examination which is part of the screening test may cause difficulties for adult CSA survivors and contribute to non-attendance in this sub-group (Havig 2008). Using a service evaluation our project explored whether staff who regularly take cervical screening samples felt competent and confident when taking smears in women who have experienced CSA. The full results from the study are reported elsewhere (Walker 2009).

Following Polit & Beck (2006) and Clarke & Dawson (1999) we used a mixed methods evaluation designed to explore stakeholders' (cervical sample takers) feelings, experiences and beliefs. It had been intended to evaluate the service in collaboration with the CSA Association, The National Association for People Abused in Childhood (NAPAC). However funding was not forthcoming, but the London QARC pressed ahead with eliciting the staff's views and perceived training needs.

The NHS Cervical Screening Programme (NHSCSP) requires sample takers to be able to pick up verbal and non-verbal cues from women during the screening test. But the needs of CSA survivors are not explicitly acknowledged by the

NHSCSP nor is it known whether clinical staff feel adequately trained in providing sensitive care. The participating staff were nurses or doctors working in primary care within an inner London Primary Care Trust (PCT). The project worker is a cervical screening sample taker, and the co-author have an interest in psychosexual awareness in women's health nursing.

### **THE NHS CERVICAL SCREENING PROGRAMME (NHSCSP)**

All women with a cervix between the ages of 25 and 65 who are registered with a GP are sent two invitation letters from their local screening recall department, and at least one from their GP (NHSCSP 2012).

The rationale for screening is that it can prevent cervical cancer by detecting early abnormal cell changes which may be pre-cancerous. These abnormal cells can be removed to prevent cervical cancer developing (NHSCSP 2012) by a colposcopist who also carries out further investigations to ascertain the nature and level of any abnormality (NHSCSP 2012). Treatment may be required depending on the findings of these investigations and the woman frequently has to attend for more examinations and more frequent cervical screening tests (Bankhead et al 1997).

The test itself is intimate and invasive (Armstrong et al 2011) as it requires a speculum to be inserted into the vagina by a nurse or doctor, which can be uncomfortable and even painful (Armstrong 2011). Women describe feeling exposed and vulnerable during the test and can feel as if control of the examination lies with the doctor or nurse (Leeners 2007). Farley (2002) argues

that in the case of CSA survivors distress may be experienced during the test at any point and if the doctor or nurse is male, this can make the experience worse.

## **BACKGROUND TO CHILDHOOD SEXUAL ABUSE (CSA)**

Cawson (2000) estimates that 10% - 20% of women have experienced sexual abuse before the age of sixteen and that CSA can have serious and long term effects on survivors' physical and mental health. CSA is defined as:

“Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive ‘something’ (for example, food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of performing sexual activities and/or another performing sexual activities on them. Child sexual exploitation can occur through use of technology without the child’s immediate recognition, for example persuasion to post sexual images on the internet/mobile phone with no immediate payment or gain. In all cases those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person’s limited availability of choice resulting from their social/economic and/or emotional vulnerability”. (Jago & Pearce 2008, p.4)

The abuse is defined as abuse irrespective of whether it happened on only one occasion or repeatedly.

## **STUDY DESIGN**

Using a mixed methods, service evaluation design incorporating stakeholder perspectives (Polit & Beck 2006; Clarke & Dawson 1999; Holloway & Wheeler 1996), the project consisted of three phases: a literature review, a questionnaire to all cervical sample takers in an inner London Primary Care Trust (PCT) and a focus group to further explore themes raised in the questionnaire data analysis.

### **Stage 1: Literature review**

The focus of the literature review was the literature on cervical screening and CSA. Searches were conducted using Medline, National Library for Health and Social Care Online. The search terms were: cervical screening/adult survivors of

sexual abuse/ childhood sexual abuse/training needs/cervical screening attendance/speculum examinations. Twenty eight relevant articles were found and four broad themes were identified. The first concerns the mental and physical health effects of CSA. Women who experience CSA may experience sexual and reproductive health problems such as unwanted pregnancies as well as higher levels of smoking, excessive use of alcohol and engaging in high risk sexual behaviour (Walker 2009). Itzin (2006) reports that women may also report sexual dysfunction. Springs & Friedrich (1992) report that women who experience CSA start sexual relationships earlier and have more sexual partners than the general female population (and as a result of early intercourse are at risk of contracting the Human Papilloma Virus (HPV)). There are a few articles on the patient experience of having cervical screening tests. Both Farley et al (2002) and Harsanyi *et al.* (2003) suggest women who experience CSA may avoid cervical screening through fear of the gynaecological examination. Evidence shows that women who survive CSA and associated traumas are unlikely to have had a smear test in the past 2 years (Farley *et al.* 2002; Dole 1999). Both Leeners *et al.* (2007) and Havig (2008) argue that cervical screening procedure can cause distress to survivors and women can suffer re-trauma if screening is not managed sensitively. Women who have experienced CSA also have a higher incidence of mental illness (Department of Health [DH], 2002), and demonstrate a reluctance to attend for screening.

The second theme was how trust in health care workers by women undergoing cervical smears is affected by CSA. Dole (1999) suggests that women CSA

survivors tend not to trust medical practitioners in the cervical screening situation, and generally are fearful of medical and gynaecological examinations.

The third theme concerned disclosure in health care settings. Weiner (1995) advocates disclosure and discusses the potential benefits of disclosing.

However, disclosure may not always be managed sensitively and may cause harm. For example, Leeners (2007) showed that 46% of the women in the study group had already tried to discuss their history with their gynaecologist and had received a negative reaction. Moreover, 75% of women in his sample felt that disclosing their CSA history to their gynaecologist would be unhelpful.

The last theme is whether health care practice meets CSA survivors' needs (Friedman 1992). Friedman (1992) argues that clinical care fosters a feeling of safety with women who have experienced CSA when women feel they are treated respectfully; they can establish a safe rapport which safeguards physical and emotional boundaries; they feel they share control; they can consent meaningfully to medical interventions/care; and are aware that the professional understands the issue of CSA. However there is inconsistent evidence that these are unfaillingly present. For example, Teram (2006) suggests that women survivors felt that when the healthcare provider reacted sensitively to their disclosure, it enabled an understanding of their physical pain. However he also found that not all staff value routinely asking patients whether the women have experienced CSA. Significantly for women with a history of CSA when undergoing cervical screening, it was noted that even when the relationship is brief, women still perceive staff to be trustworthy and safe. Women have

described qualities in staff which foster trust to include: warmth, a willingness and ability to form relationships, however brief, and an ability to react sensitively to challenging behaviour (Hampson & Nelson 2008)..

## **Stage 2**

The questionnaire was designed to elicit cervical smear takers' knowledge, professional and training experience and their continuing needs; Likert scales and open questions were used. This method was chosen to elicit data for further exploration at a focus group (O'Driscoll 2009). The questionnaire was piloted with eight practice nurses in the PCT who undertake cervical screening tests. Two questions were added following the pilot; namely on adult sexual assault/rape and training needs of respondents on their ability to talk with women who have experienced CSA. The questionnaires were distributed to the whole population of smear takers in the PCT (N=226). The questionnaire results were analysed using descriptive statistics and these findings informed the focus group interview schedule.

## **Stage 3**

Focus groups were chosen because they allow participants to interact with each other, to disagree and richer data is considered a possible outcome especially in a sensitive topic area (Allan 2004). The focus group members were recruited from questionnaire respondents. The focus groups were two hours in length, led by the project worker; her supervisor observed. Participants included four female nurses working in local GP surgeries. The discussion was audio taped and then

transcribed verbatim. Data were analysed thematically and then analysed integratively with the quantitative data (Moran-Ellis *et al.* 2006).

## **FINDINGS**

### **Stage 2: Questionnaire data**

226 questionnaires were distributed and 62 were returned (27% response rate) (Walker 2009). Only 51 respondents identified their staff group.

*Insert table 1 here*

The questionnaire data showed that, across groups, staff were unaware of and underestimated the prevalence of CSA. But they were aware of verbal and non-verbal cues from women which they would interpret as reluctance to undergo a vaginal speculum examination.

#### *Prevalence of CSA*

Just over a quarter of respondents accurately estimated the level of CSA in the general population (Table 2). One of the open comments “I hope it’s not more than this (1%)” suggests this lack of awareness may be an unwillingness to acknowledge the extent of CSA and the high numbers of women affected because it is a difficult issue.

*Insert table 2 here*

*Do patients do or say anything to make you consider that she has experienced sexual abuse as an adult or a child?*

Respondents identified the following behaviours, feelings, symptoms and histories in response to this question (Table 3):

*Insert table 3 here*

In answer to an open text question about what might make respondents think that a woman had experienced sexual abuse, the following comments from patients were quoted “Get it over and done with”; “I hate anyone touching me there”; “What a horrible job for you” and “it reminds me of my stepfather”. One practitioner stated that they did not consider whether a patient might have experienced CSA when undertaking a smear test.

#### *Experience of CSA disclosure*

Responses to the question, what experience have you had about CSA disclosure are given in table 4:

#### *Insert table 4 here*

Open comments about their feelings on disclosure included: “Difficult to answer unless incident had happened to me”; “I would like to think I would stay very professional about the matter”; “Upset for her”. One comment in particular indicated the strength of the clinician’s discomfort with disclosure: “Main thing, don’t flinch”.

#### *How confident and competent do staff feel in undertaking cervical screening for women with a history of sexual abuse/assault?*

This section was designed to explore staff competence and confidence when carrying out intimate examinations on women. Just over 50% of respondents felt confident and 66% felt competent to undertake cervical screening testing for CSA survivors Table 5).

#### *Insert table 5 here*

#### *Did your smear taking training include discussion of sexual abuse?*

Discussion of CSA had been raised in smear training for just over 50% of respondents and raised in other training for 82% (Table 6).

*Insert table 6 here*

*Should smear taker training include discussion of abuse/assault?*

While over 50% said that CSA had been acknowledged in previous training, the majority (94%) of respondents thought that training in improving sensitive care when taking cervical screening samples for abuse survivors would be helpful (Table 7).

*Insert table 7 here*

Additional open comments in response to this question included: “Useful as such an emotive and sensitive issue”; “Yes, definitely – after attending a training session and hearing a woman’s account of attending for a smear who had suffered childhood sexual abuse, should be mandatory – it really made me think”

*What training would you find useful?*

Here responses included training in responding to disclosure, in whether or how to take a smear if the procedure is difficult for the woman and a wider contextual knowledge of CSA (Table 8).

*Insert table 8 here*

### **Stage 3: focus group**

There were four main themes in the focus group data analysis.

*Describing and estimating CSA.* The focus group participants agreed that CSA involves children under the age of 16 and includes contact or non – contact

abuse (watching children inappropriately on the internet); they also saw female genital mutilation as CSA. Participants did not quantify the prevalence but agreed that a lot may be hidden:

“I think it’s probably a lot higher than we can even imagine because people don’t talk about it so you don’t know”

“And so many are unreported”

“And it’s hidden”

Participants agreed that the experience of having a smear test induced the same feelings of distress for women irrespective of the nature of their abuse and irrespective of when it had occurred i.e. independent of age. They also suggested that the smear test can provoke anxiety for women who have experienced CSA:

“She was still going through the sort of... this is many years ago and she’s still going through the, you know, late 20s now but... and she was absolutely wonderful, I mean it wasn’t quite as much as “get on with it’ but you knew it was... it’s still alive and kicking”

*CSA in the nurse/patient consultation.* Participants described observing distress in women who attended for smear tests. Participants picked up on verbal and non – verbal cues which indicated a woman’s distress to them during a smear test. If a woman asked a nurse to “get it over and done with” and appeared to be in a hurry/urgency, this might indicate distress which needed to be explored in the consultation:

“I have come across with women that they have been sexual assaulted and they are very anxious... well I've come across with one that had been to counselling before, but just the experience of coming for a smear test made her cry because it took her back to memories”.

They described a scenario where there might be a discrepancy between the woman's verbal consent and her body language, for example, the woman might tell the nurse to carry on while displaying signs of physical pain:

“They have said ‘it hurts but just keep going’”

One nurse mentioned disinhibited behaviour:

“I think it's the same when you get a woman that comes in and she starts almost stripping off before you....you know you haven't even said hello”.

The participants were unsure as a group whether holistic care was enhanced by disclosure. One nurse felt strongly that disclosure is essential to the provision of holistic care but not everyone agreed:

“Yes, you might be able to do it without any disclosure at all but do you think you will give proper care to this patient? Well, personally, no!”

“I think disclosure is a very difficult issue and I don't know whether all women want to disclose or not and I don't know and neither do they probably”

The participants observed that asking for information about sexual violence may be a mirroring of the physically invasive nature of the cervical screening test.

They were anxious about “opening up” memories by encouraging disclosure.

“I don’t think it’s okay for me then to say “sit down” and try and pry things out of women when they don’t want... I know when they want to open up so I leave them be”

“If she’s not ready to disclose the information obviously I’m not going to keep on pestering her to disclose information because that wouldn’t be professional on my side to keep on pestering that patient”

One way of improving the experience of having a smear test is through self-insertion of the speculum. One of the nurses who routinely offers speculum self-insertion as a way of enabling all women to take some control of the cervical screening test, argued strongly for the benefits of disclosure for the patient. Her rationale for this approach with women who have experienced CSA is that a CSA survivor will have had little control of her body and what happened to it as a child so as an adult she connects lack of control with a feeling of being unsafe.

Allowing her to share and take some control will help her to feel safer and less vulnerable. (Wolverhampton Sexual Abuse Forum Sensitive Practice Guide 2006).

“I ask women to actually hold the speculum themselves, have a feeling of the speculum and I teach them how to insert it themselves and I found from my small study that women find it much more relaxing, they take their

own time, they don't feel pain because they are in control of their own bodies and they're inserting it themselves"

*How the nurse feels when examining women who have experienced CSA.*

The participants described clearly how they used their feelings during the smear test as a barometer to the woman's feelings and potential past experience of CSA:

“...at one level you don't want to do it because it's so invasive again”.

It is the word again which indicates an awareness that the present insertion might be re-enacting the previous abuse.

One nurse said, “I don't have any feelings” but went on to talk about how she judges intuitively whether women are ready to disclose or not. If she senses they have something to disclose, but do not, she respects their decision to keep quiet and does not probe. During analysis, this apparent discrepancy in what she said and what she described doing in respect of patients' feelings was interpreted as the nurse denying her own feelings and working with the feelings from the women.

The participants were sad and felt helpless when women disclosed CSA. They felt that listening to the patient was not enough because they could not provide anything else in the consultation:

“I feel I really lack, it's all very surface and I'd love to do, you know say the right thing or talk to them a bit more about it but I'm thinking that's a

counsellor's job, I don't know what to do really, I'll go down the wrong avenue and..."

"We are on our own, we have no one to support us..."

None of the participants described formal structures in place to support them in their difficult work but some participants had informal support. However not everyone experienced anxiety at not providing enough; they recognised that for some patients, being able to talk about their abuse was therapeutic in itself:

"They will tell you and they will feel much more comfortable..."

### *Training*

One aspect of training discussed concerned the verbal and non-verbal cues they used to pick up on possible CSA. Some attributed these skills being innate, rather than studied/learned:

"I don't think that you can train someone to pick up those cues though"

"I think they're... being a human..."

However, in further discussion, they felt that witnessing other nurses working with patients had in the past helped them learn how to deliver sensitive care:

"Observing someone else do the procedure...what they say to the patient and how they react and you think oh such and such does it a lot nicer than...you're the bystander that can watch the whole scene unfold so you can pick up certain cues there and learn from that".

The participants described how influential mentors were in modelling skills that could not be taught in a classroom, especially as they had found learning how to

do smears “daunting”. One nurse spoke about how she mentors nurses now as a result of her own positive experience of being mentored:

“I guide them through it, I hold their hand...until they feel comfortable and if they can't find the cervix I'm always nearby. I think it's important that you're there behind them or with them”.

The participants felt that nurses would benefit from an update 6 or 12 months after the training for taking cervical smears and proposed they could keep a diary of case studies to discuss with their mentor at that point.

A further training need was how to negotiate and maintain boundaries if there was disclosure of CSA:

“So how do we keep that professional... if we're feeling anxious and upset...this is a difficult situation we're in, we know the patient is anxious and upset and we start to feel anxious and upset, how do we maintain the professional distance then, how do we make sure that we can actually not let our own feelings muddy the waters, how can we manage our own feelings at the same time as enabling that patient to feel that she is safe?”

## **DISCUSSION**

This study demonstrates that there may be training needs for staff in relation to smear taking with survivors of CSA. The literature presents evidence that there are adverse mental and physical effects on the health of CSA survivors, including fear and avoidance of gynaecological examinations. This study has identified that healthcare staff who take smears need to know more about how prevalent CSA is, the long term effects on health and health behaviour, local and national

services for adult CSA survivors and how to provide appropriate and sensitive care.

Clinical staff in this study expressed anxieties about their ability to provide appropriate and sensitive care for CSA survivors, for whom the examination can trigger memories of abuse. Providing a safe space in which patients' pain can be acknowledged and "held" by healthcare staff is in itself therapeutic (Menzies 1960) But the nurses in the focus group were not always able to acknowledge their capacity or competency to do this in their work. Clifford (2000) describes how the process of being aware of and listening to patients' pain can be troubling for healthcare staff as they too experience the patients' anger, pain and distress in the here and now of the clinical encounter. This pain was evident in the data presented in this paper. Psychosexual clinical supervision acknowledges and addresses these difficult feelings by allowing healthcare staff to reflect on troubling patient encounters. The Balint style supervision provided by the Association of Psychosexual Nursing is described by Irwin (2000) as a process which enables practitioners to develop and enhance their skills without turning them into "experts" in sexual problems. Irwin (2009, 6-7) suggests that ultimately what many patients are seeking are practitioners with the "courage, sensitivity and skills to listen". The clinical staff in this study did not have clinical supervision in place to address the feelings which arose in patient encounters where CSA was suspected and they expressed some anxiety about their perceived inability to provide appropriate care. Balint style supervision is a widely accepted and respected method of case discussion which supports practitioners to enhance

and develop their listening skills in their everyday work so that they are able to recognise that the listening itself is a valuable therapeutic tool.

## **CONCLUSION**

Our findings suggest that staff who take smears are aware of CSA in their practice with individual women but feel they lack training in how to respond to disclosure and possible referral pathways. We suggest that staff who take smear tests need to build knowledge and skills to feel more confident and competent to meet women's needs in order to lessen the risk that CSA survivors might be disadvantaged by a system which does not recognise their needs.

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Table 1 respondents by staff group

Practice nurse	28
GP	10
GUM clinic nurse	8
Walk In Centre nurse	2
Nurse colposcopist	2
HIV clinical nurse specialist	1

Table 2: estimations of CSA

Less than 1%	7 (11.7%)
Between 1% and 5%	14 (23.3%)
Between 5% and 10%	23 (38.3)
More than 10%	16 (26.7%)

Table 3: What might a patient do or say to make you consider that she has experienced sexual abuse as an adult or a child?

Refusal or avoidance of cervical screening test and reluctance to be examined	28
Observed body language	19
Symptoms such as dysuria, continence problems, sexually transmitted infections (STIs), sexual dysfunction, painful sex, vaginismus, abdominal pain	18
Feelings observed in patients such as anxiety, fear, anger, lack of trust and impatience.	14
History of risky sexual behaviour and health issues such as inconsistent use of contraception; emotional/mental health issues, for example, eating disorders, low self-esteem, relationship problems.	5

Table 4: Experience of CSA disclosure

Yes	37 (62%)	No	23 (38%)
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Table 5: Assessment of levels of confidence and competence in undertaking cervical screening for women with a history of sexual abuse/assault

<b>I feel confident</b>		<b>I feel competent</b>	
Strongly disagree	7.7%	Strongly disagree	3.8%
Disagree	13.5%	Disagree	9.6%
Undecided	25%	Undecided	21.3%
Agree	42.3%	Agree	53.8%
Strongly agree	11.5%	Strongly agree	11.5%

Table 6: *Ascertaining whether any training had been undertaken in the areas of sexual abuse.*

<b>Raised in smear taker training</b>		<b>Raised in other training</b>	
Yes	57.7%	Yes	82.3%
No	42.3%	No`	17.7%

Table 7: Would it be helpful for smear taker training to include the issue of abuse/assault?

Yes	51 (94%)
No	1 (2%)
Unsure	2 (4%)

Table 8: *What kind of training would be useful?*

information about referral pathways and services	12
training in communication and counselling skills	12
in relation to the smear test; techniques for helping women to relax, how to give women some control as well as recognising when not to do it	7
to hear about and understand survivor's views and experiences	4
speakers with expertise in sexual violence and abuse	3
help with identifying women who have survived CSA	3
cultural issues	2