

THE ADVANCED PRACTICE NURSING ROLE OF CHANGE AGENT: AN
ANALYSIS OF IMPLEMENTING CHANGE RELATED TO CHILDHOOD SEXUAL
ABUSE SEQUELAE IN A FAMILY PRACTICE CLINIC

BY

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**The Advanced Practice Nursing Role of Change Agent: An Analysis of Implementing
Change Related to Childhood Sexual Abuse Sequelae in a Family Practice Clinic**

BY

Loredana Clemente

**A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University
of Manitoba in partial fulfillment of the requirements of the degree**

of

Master of Nursing

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ABSTRACT

The use of evidence-based practice necessitates the implementation of change. The advanced practice nursing (APN) role of change agent is explored in this practicum in reference to a change related to screening for childhood sexual abuse (CSA) prior to more sensitive physical examinations, i.e., pelvic, breast and rectal examinations. The literature describes a very high prevalence of CSA. One in three to four women and one in six to eight men have lived through a sexual abuse situation. Concurrently, the literature outlines substantial practitioner apprehension in screening for and addressing sexual abuse issues.

Goals of this project were to assess the process of an APN implementing a change in a family practice clinic composed mainly of physicians, and to increase practitioner sensitivity to this issue. Assessing the feasibility of implementing a brief assessment intervention during sensitive physical examinations and determining practitioner concerns relating to addressing issues of childhood sexual abuse were also explored.

The intervention consisted of an educational session to the physicians at the Family Medical Centre addressing issues surrounding the long-term effects of CSA. The evidence supporting the need for survivors of sexual abuse to have these issues addressed was also presented followed by an introduction to my own project asking those attending the session to implement two screening questions, "Is there anything about your past experiences that makes this exam particularly difficult for you?" and "What can I do to make it easier for you?" Those wishing to participate were then asked whether they had made a change in practice based on the intervention.

The data was analysed using content analysis. The Dracup-Breu and Bridges' change theories served as models to both guide the process and organize the results. Results indicated that a change agent's professional skills and personal attributes, active participation of participants, attention to the barriers and facilitators of change, and multiple strategies for change are all factors in the successful implementation of a change in practice.

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DEDICATION

To Donald, for his unending support, patience, and love.

To my parents, Grazia and Nicola Clemente for their love, support and encouragement, and my wonderful family and friends who did their best at keeping me grounded.

In loving memory of my Comara, Maria Creta who looked forward to the completion of my degree as much as I did and who reminded me of the important things in life.

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CHAPTER 1

INTRODUCTION

Evidence-based practice is essential in the primary care field and implies the implementation of change. Change can be defined as, “an attempt to alter or replace existing knowledge, skills, attitudes, norms and styles of individuals and groups” (Keyzer & Wright, 1998, p. 8). Change agents are necessary for this implementation. The role of change agent is included in the advanced practice nurse’s (APN’s) repertoire of skills (Hamric, Spross & Hanson, 1996). A change agent influences how, when, and where change will occur (MacLachlan, 1986). The role of change agent is multifaceted and includes various competencies and skills.

Qualifications of an effective change agent include competence in knowledge of nursing, research, practice, communication skills, and interpersonal relationships (MacLachlan, 1986). Norton and Grady (1996) add to this list some necessary personal qualities of the person wanting to be a change agent, these include: heightened interpersonal competence; authenticity, or knowledge that one’s perceptions are exclusively one’s own; mutuality, or a full appreciation for others; vulnerability, the ability to allow oneself to be susceptible to feeling hurt or inadequate; critical commitment, or devotion to a cause; and courage. The authors add that with heightened interpersonal competence, critical commitment and courage comes an essential quality of the change agent, the disposition toward risk taking (Norton and Grady, 1996).

Responsibilities of a change agent include establishing a need for a change, developing a rapport with the target population, analyzing the problem from the perspective of the target population, assisting the target population to select appropriate nursing research, implementing the change, and evaluating the results. Reinforcement

of the change and shifting of the target population's dependence to itself is the final step of the change agent role and thus terminates the relationship (MacLachlan, 1986). The importance of a change agent cannot be underestimated. Without an effective change agent, available research fails to be utilized to its potential and a valuable source of advancement is lost, translating into less than optimal patient care.

This project aims to explore the APN role of change agent and its impact in initiating a change into a multidisciplinary health care setting. The implementation of the intervention will be examined within a change theoretical framework. A literature review describing the necessity of implementing the intervention is presented followed by a description of the change theories that will serve as frameworks for the project, a description of the process for implementing the change, and the results of the project.

CHAPTER 2

BACKGROUND TO INTERVENTION

Prevalence rates of women with a history of childhood sexual abuse (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 CSA. 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 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 behaviors spanning from sexual comments, gestures, exhibitionism, fondling, and intercourse (Chalfen, 1993; Paxton, 1991).

Although the specific behaviors involved in CSA may vary, a common theme among all

abuse situations is the elicitation of fear 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) Long-term effects of CSA pertaining to the medical encounter, 2) Issues of routine screening by the practitioner, and the management of disclosure, 3) Recommendations regarding the needs of women survivors, and 4) The current state of practitioner knowledge, preparation, experience, and support surrounding caring for women with a history of CSA.

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, and somatic complaints without organic cause (Bala, 1994). 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 behaviors 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 subtle responses to uncomfortable stimuli or inadequate self-preservation skills (McKegney, 1993).

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). Also, 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 were 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. Also, 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 an 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 appropriately care for survivors, it is essential 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, Merrett-Hiley, McClure, Tudiver & Kreklewetz, 1997; Kitzinger, 1990; Stalker, Schachter & Teram, 1999). Personal accounts of health care experiences confirm this data (Grossman, Cook, Kepkep & Koenen, 1999; Rose, 1992). A personal account from a survivor who is a health care professional describes 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 behaviors and feelings such as regression under stress, suicidal gestures, self harm, distrust, boundary confusion and multiple somatization complaints, although important behavioral 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 behaviors 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 influences 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 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 inquiry. In the non-abused group, 64% 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). 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).

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 counseling facility, perhaps limiting the generalizability of the findings. Also, results may have been different had a larger scale study been conducted.

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 mammography technicians, dentists, or medical 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. Disclosing abuse to a person ill-equipped in managing the intense feelings, emotions and images can have devastating effects on a survivor (McKinney & Frank, 1998; Teram et al., 1999; Schachter et al., 1999).

Schachter, Stalker and Teram (1999), do an excellent job of describing 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 Regarding the Needs of 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 by various health care practitioners. Literature examining the effect that cultural factors may have on these recommendations and an examination of changes to the health care system that can be

adopted to facilitate survivors' experiences are 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 lives 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 and 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 a 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 (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 (McKengney, 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 to establish boundaries within the therapeutic relationship by setting very clear limits within the relationship. (Creedy et al., 1998; McKegney, 1993).

Culturally Sensitive Care

The impact of culture on these recommendations has not been given much attention in research, but is earning recognition in the study of CSA. Austin, Gallop, McCay, Peternelj-Taylor and Bayer (1999) studied 1,701 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 perhaps nurses rating themselves in the middle levels of self-perceived competency, 40% of the nurses studied, were in fact the most competent. This is owing to the fact that nurses rating themselves as having lower competency were aware of the impact of culture, but required knowledge and experience, and 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, Merrett-Hiley, McClure, Tudiver and Kreklewetz's (1997) study of eleven women with histories of CSA also underscores the importance of culturally sensitive care. One of the participants of this study was of Aboriginal ancestry. During the interview with the researcher this woman recommended the development of culturally sensitive treatment approaches and services for aboriginal women with a history of CSA. The woman's experiences indicated a lack of services of this kind and the need for their development.

Austin and colleagues (1999) have identified 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. The culture of the health care system can have an enormous impact on the care of women who have survived CSA. The health care system has traditionally disempowered women by medicalizing normal female processes (i.e., childbirth and menopause), and ignoring common female health problems (Malterud, 1993). A woman's care is often based on a male medical model that may pathologize feminine characteristics and use an aggressive and action-oriented rather than exploratory and educative approach. It is this approach that values spending the least amount of time possible with a patient, and fails to address the needs of women, specifically women with a history of CSA (Dyehouse, 1992; Ward, 1995).

The health care system's reaction to women who have been sexually abused is exemplified by the labeling of some of these women as 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, problems keeping appointments or arriving late, being overly controlling, or being demanding (Bala, 1994; Lechner et al. 1993; McKegney, 1993). These behaviors may elicit feelings of anger or frustration, 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 won't likely get the care they need (Bala, 1994; Lechner et al. 1993; McKegney, 1993).

Culture, whether personal or systemic, and its influence in providing care to CSA survivors has not been adequately studied to date. It seems logical that culture would have a tremendous impact on the relationship between the practitioner and survivor, and heavily influence a survivor's perception of and recovery from CSA. Literature regarding the perception of CSA by different cultural groups is sparse. This area is deserving of further study.

Health Care Services and Public Policy

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. Practitioner knowledge regarding the long-term sequelae of CSA is an area that needs attention (Hays & Stanley, 1996; Heinonen et al., 1997; Seng & Petersen, 1995), and will be addressed separately at the conclusion of this literature review.

Patient education and public awareness. General education for all patients regarding the sequelae of CSA may be beneficial in increasing awareness (Hays & Stanley, 1996). To increase awareness and comfort during health care encounters, survivors studied by Heinonen and colleagues (1997) suggested leaving pamphlets or specific 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.

Health care delivery. Several researchers offer suggestions to effect broader health care delivery, including influencing public policy to address social inequities that marginalize women (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, practitioners offering alternative and complementary therapies, and systemic changes allowing more time when seeing clients with a history of CSA. All of these efforts will be challenged by the current tensions in Canadian health care such as practitioner shortages and cost containment measures. The solution lies in putting patient needs ahead of economic priorities. The government can consider increasing the availability of practitioners offering services to meet the needs of survivors. Compensation by salary as opposed to fee for service would allow for more time to meet the needs of survivors during office visits. The APN could certainly fulfill the requirements of this role.

A variety of factors may impact on the practitioner-survivor relationship. Safety, trust, and boundary issues, and the impact of culture, both personal and systemic, are necessary to consider when providing holistic health care. Without an honest consideration of these factors, practitioners may never become aware of issues that impact their relationship with survivors of CSA.

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 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 work place support for practitioners faced with managing a survivor's care are examined.

Survey of Local Practitioner Preparation

In order to gain some understanding of the preparation of Winnipeg health care practitioners in meeting the needs of women with an abuse history, I conducted an informal survey. The survey included the departments of medicine, medical rehabilitation, nursing, dentistry, dental hygiene and mammography in the city of Winnipeg, Manitoba. This survey was aimed at determining formal curriculum content addressing the long-term effects of childhood sexual abuse in adult patients/clients.

The departments of mammography, dentistry, dental hygiene, and nursing do not teach about the long-term effects of CSA formally, but do address the acute effects of abuse through lectures and readings with the exception of mammographers. The school of dental hygiene covers this content with the EVOLVE program from Klinik Community Health Centre, 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 occupational therapy faculty felt that with their client-centered approach, their students would have 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 impact on a relationship with an occupational therapist. The physiotherapy department feels that their students are prepared to pick up the signs of CSA, through courses in Psychosocial Issues, Professional Issues, and Physical Therapy Treatment Modalities. Physical therapy has identified nation wide the importance of practitioner knowledge regarding both the long-term effects of CSA and 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 entity. It was felt, however, that if it is covered at all in the undergraduate curriculum, it is mentioned briefly 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. The post-graduate core curriculum and the family medicine residency program do include a session related to this topic.

Most schools preparing health care practitioners in Winnipeg do not formally teach about the needs of women with a history of childhood sexual abuse. they do however address the acute effects of abuse. Simply raising the question of curriculum content regarding the long-term effects of CSA was informative, as most departments were unaware that the long-term effects were indeed a separate entity from acute effects of abuse.

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). The awareness of this knowledge gap is exemplified by the following statement by a physical therapist, "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).

Workplace support may exist for therapists but is lacking for professionals who don't 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 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 are unfortunate. There are tremendous implications here for educational systems. The curriculum of all health care providers

should be re-evaluated to ensure the care of survivors is addressed at a discipline-appropriate level.

Conclusion

Childhood sexual abuse impacts many women. Chances are high that a practitioner will interact with a woman with such a history. 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. Knowledge of the long-term effects of CSA may be an initial step in addressing the needs of women survivors. 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 these needs, 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).

CHAPTER 3

PRACTICUM DESCRIPTION

There is clear evidence to suggest that many women suffer from the long-term effects of childhood sexual abuse. The literature also confirms the lack of knowledge and preparation of practitioners in meeting the needs of these women. The primary focus of this practicum project is to explore the APN role of change agent and its impact in initiating a change related to screening for CSA in a multidisciplinary health care setting.

The Family Medical Centre (FMC) served as the setting for this project. The FMC serves as a teaching facility for family practice residents at the University of Manitoba. It has approximately eight attending physicians. Six attending physicians are responsible for two to five residents at various stages of their residency.

With the knowledge of the long-term effects of CSA, an attempt was made to influence practitioner screening at the FMC for CSA before sensitive (i.e., breast, rectal, pelvic) physical examinations. The acceptance of the project would then be evaluated through informal and formal interactions, and observations. This type of project may be described as observational or descriptive, and is useful in providing a greater understanding of the process of behavioral change and to generate hypotheses for further testing in more rigorous evaluations (Grimshaw, Campbell, Eccles & Steen, 2000).

The focus of this project was to introduce an innovation into practice. Change theory was used to guide the process. A description of various change models followed by a more detailed project description follows.

CHAPTER 4

THEORETICAL PERSPECTIVES ON CHANGE THEORY

Models may offer a framework for change implementation. The Dracup-Breu model, the rational-empirical change strategy and Bridges' change theory will be described. These models offer different perspectives on change theory.

Dracup-Breu Model

A practical model used as a framework for research utilization is the Dracup-Breu model (MacLachlan, 1986). Six steps are involved in the process of research utilization according to this model: (1) identification of a problem, (2) selection of appropriate research, (3) the establishment of objectives, (4) an analysis of the setting and formation of a plan, (5) implementation of a plan, and (6) evaluation of outcomes (MacLachlan, 1986). This model is applicable to clinical practice and offers an overall framework for the entire change process.

Problems occur daily in clinical practice. Dracup and Breu (1977) stress the importance of clearly identifying a problem before attempting to utilize research results. They then suggest selecting research studies that provide possible solutions to the problem. Within this step Dracup and Breu (1997) suggest reviewing the literature to select a theory base that would serve as a foundation to the problem solving approach. This can provide all those involved with a common knowledge base to assist in establishing solutions to the problem. Research should be selected based upon a traditional evaluation of research and its applicability to the proposed setting.

Dracup and Breu (1977) suggest that five attributes proposed by Rogers and Shoemaker (1971) be evaluated before proceeding with a proposed change. These include; relative advantage, compatibility, complexity, trialability, and observability.

The first attribute, *relative advantage*, is the degree to which the innovation is perceived as being better than the idea it supersedes. Both the change agent and the staff should assess this attribute. *Compatibility* is the next attribute it represents the degree to which the proposed change is consistent with exiting values, past experiences, and needs. The term *complexity* describes the degree that a change is relatively difficult to use. The more complex the innovation, the slower the rate of adoption.

Trialability, the fourth attribute, describes the way that a change lends itself to limited experimentation. Participants are more likely to consider a change if little investment is required and if the change lends itself to a trial period. Finally, *observability* the last attribute, describes the degree to which the innovation is visible to others. Visibility is related to the amount of support and reward the staff will get (Rogers & Shoemaker, 1971). Proposing change in practice necessitates an assessment of the staff's view of the proposed change in light of these attributes (Dracup & Breu, 1977).

With the appropriate research selected for implementation, objectives for the planned change should be formed. Before proceeding further, the nurse needs to critically think about the setting of the proposed change. This includes a consideration of endemic factors in the system that work against the change itself or the effort to achieve the change. A model could be used to analyze the driving and resisting forces of the setting of the proposed change. Based on an analysis of the system, a plan may be devised that can include implementing the change and measuring the outcomes.

Dracup and Breu (1977) then suggest implementing the change after preparing the system. This can be done through meetings with those involved to further delineate the problem and by meeting with those in authority to elicit support for the project. In

this phase of the research it is important as a change agent to continually re-assess the driving and resisting forces within the system and to make any necessary adjustments in the implementation plan. The final step in this framework involves the evaluation of the outcomes.

Dracup and Breu (1977) emphasize the importance of a practical and systemic approach to solving clinical practice problems. Nursing research is irrelevant if it is not implemented into clinical practice. The Dracup-Breu model offers a convenient model for a research utilization project.

Rational-Empirical Change Strategy

The rational-empirical change strategy (Keyzer & Wright, 1998) provides a framework for implementing change within the FMC setting. This strategy is founded in the belief that all people are guided by reason and they will change their behavior if there is some vested interest in them doing so (Keyzer & Wright, 1998). The practitioners are educated in an environment that values the scientific process; they are therefore likely to find merit in the evidence brought forth in this project. Additionally, a client-centered approach is valued at the FMC. The main focus of the intervention is to analyze the process of implementing an evidence-based change into practice. Another is to increase practitioner knowledge and sensitivity to meet the needs of women with a history of CSA. The objectives of this project are therefore congruent with the philosophy of the FMC.

Bridges' Change Theory

An integral part of the process of change is the response that it generates. Bridges has developed a theory addressing the affective responses to change. These responses are described as critical to a change's implementation and adoption. The

distinction between change and transition is made by Bridges, who defines change as external and situational, while transition is an internal and psychological phenomenon (Norton & Grady, 1996). According to Bridges change may only occur if transition has occurred.

Three overlapping phases occur during transitions. The first, an ending, is the breaking of known relationships and routines secondary to an external force causing a change (Norton & Grady, 1996). This is known to be a difficult phase, as people are required to “let go” of something known only to face something unknown. People may respond to this loss with grief, which may be manifested as anger, anxiety, or sadness. A necessary role of the change agent is to acknowledge this grief, and understand and deal sympathetically with the losses that the individual or group may be experiencing.

The second phase of the transition is called the “neutral zone.” This is a period of unknowing and instability. It is within this phase that a redefinition of one’s relationships and routines occur. Affective responses to this phase are varied and may include anxiety, loneliness, a sense of being out of control, and amotivation (Norton & Grady, 1996). During this phase it is important to gain control and balance. Here, a change agent’s task is to reassure the individual or group as to the normalcy of a wide range of difficult emotional responses, and to provide opportunities for continued growth or progress. During this phase, the focus must be to do things differently and better. New thoughts and patterns can be encouraged through the use of brainstorming sessions, retreats and policy reviews. The importance of keeping individuals and groups in this phase informed cannot be overemphasized.

The last phase in the transition is a new beginning. This phase marks the end of the neutral zone, which was static and difficult, but less risky (Norton & Grady, 1996).

It is a time of new direction and challenge. The change agent's role in this phase is to clearly explain the purpose or expected outcome of the change. This can be done by describing the change in detail, phasing in the outcome, working from a plan, and involving everyone in the plan and outcome.

Bridges' change theory provides an ideal framework for analyzing the process of change implemented by an advanced practice nurse at the Family Medical Centre setting. It emphasizes the fact that change must involve an internal process of transition in order to truly be effective. Given that the change will involve residents and physicians yet be implemented by an advanced practice nurse, a role that is new to the FMC and not well established, it will be interesting to consider the reactions and affective responses to this change.

Application of Change Theory

The Dracup-Breu model provides a good overall framework for planning, implementing, and evaluating a change. It will be used to describe the change to be implemented, and will serve as a general guide for the entire project. The Bridges' change theory is ideal for examining the change in more detail in terms of its acceptance by the FMC residents. It will also be applied to this project, and will have a role in the data analysis portion of the project. The Bridges' theory's three phases of an ending, the "neutral zone", and a new beginning will add more detail to the last three steps of the Dracup-Breu model; the setting analysis and plan formation, the plan implementation, and the evaluation of outcomes. It will be most useful in expanding the plan implementation phase of the Dracup-Breu model (See Appendix A). For simplicity sake, the rational-empirical approach will not be used to examine the data only the Dracup-Breu and the Bridges' theories will be used for this purpose.

CHAPTER 5

PROCEDURE

The implementation of change can be facilitated through the use of a model. The change to be implemented will be described according to the framework provided by the Dracup-Breu Model.

Identification of the Problem

The problem established by the literature review is the lack of knowledge and preparation of health care providers in meeting the needs of survivors of childhood sexual abuse (CSA), specifically during examinations requiring touch. Health care providers include all professionals managing the health of women in some manner and includes but is not limited to: dental hygienists, dentists, mammographers, physical therapists, doctors and nurses.

The lack of preparation of practitioners in meeting the needs of survivors, although well defined in the literature, did not originate from the FMC physicians. This may have proven to be a limitation of the project, as the participants were not asked if the identified problem was indeed perceived as a problem in practice. The project originated from a study conducted by Heinonen and colleagues (1997) who explored the experiences of women survivors of childhood sexual abuse in seeking and using health care resources. This study concluded that there is a perceived lack of knowledge and preparation of health care providers in meeting the needs of women survivors of CSA. A follow-up study was then conducted looking at the knowledge and preparation of practitioners in meeting the needs of these women (Tudiver, McClure, Heinonen, Scurfield & Kreklewetz, 2000). My work with this research group in the latter study was the inspiration for this practicum project.

Selection of Appropriate Research

There is a strong body of literature supporting the difficulty women with a childhood sexual abuse (CSA) history have with examinations by various health care practitioners. The literature also reveals that although some health care practitioners may have knowledge regarding the acute effects of sexual abuse they may not recognize the long-term effects of CSA and the signs their patients may exhibit indicating their discomfort during exams. Aside from physical examinations, other components of patient care may be influenced by a CSA history; these include multiple somatic complaints, boundary issues, and safety and trust issues. Areas not well researched prior to the implementation of the change is the literature surrounding influencing a change in family physician practice, and attitudes of family physicians toward advanced practice nurses.

Based on the aforementioned literature review a session addressing practitioner issues related to CSA was developed, this became the intervention for the project. Topics of this session included; statistics related to CSA, long-term effects of CSA or “red flags,” the impact of previous coping strategies during abuse on current relationships with providers, methods of screening for CSA, issues of disclosure and responding to disclosure, and recommendations for meeting the needs of survivors. The session concluded with an overview of the project and a description of the intervention. The intervention consisted of the participants implementing two questions into their more sensitive physical examinations, i.e., pelvic, rectal, and breast examinations. The questions were a version of the following: (1) “Is there anything about your past that makes this exam particularly difficult for you?” with a follow-up question, (2) “What can I do to make it easier for you?” (Seng & Petersen, 1995, p.29). Disclaimers and

information sheets were distributed and there was time for questions or comments.

Analysis of Attributes

According to the model presented by Dracup and Breu (1977) a major consideration in choosing appropriate research is its adaptability to the consumer's clinical setting. A change may be analyzed according to the five attributes mentioned in the Dracup-Breu model, relative advantage, compatibility, complexity, trialability, and observability, prior to proceeding with a change. The first attribute, relative advantage, is to be assessed through both the change agent's and the staff's perspective. Time constraints did not allow for an assessment by the staff at the FMC. From the perspective of the change agent, however, the change, or screening for CSA, is a positive change as it allows for open communication and an increase in comfort during sensitive physical examinations, particularly for those who have survived an abuse history. There is no economic implication to implementing this change other than perhaps some extra time invested should there be a positive response. Implementing this change would serve to improve the physician-patient relationship by opening the lines of communication.

This change is certainly compatible with the existing values and philosophy of the FMC. Patient-focused care using the principles of family medicine are emphasized at this clinic and involve gaining a better understanding of the patient's perspective of their health. This philosophy is well internalized at the FMC among the staff and the residents. The questions I have proposed are tools to better understand the patient's perspective. These questions will help to meet the needs of survivors of CSA in particular, but all patients who have difficulties with more sensitive physical examinations will benefit from this change.

Complexity is the third attribute in assessing the degree to which a change will be adopted. The proposed change does not require a great deal of added energy from the staff. The questions are simple and direct, and can be modified to what suits the practitioner best. There is no requirement for extra charting or formal evaluation of any type. The only investment needed is attendance at a session regarding the change. This session is mandatory for all residents on a weekly basis, therefore does not add to already existing obligations. Evaluation will be informal and include casual conversation with myself regarding the implementation of the change.

The change certainly lends itself to trialability. The investment is so limited and non-invasive that a trial period is very plausible. In fact, the entire practicum project may be viewed as a trial period.

A change is more likely to be adopted if it is observable. The change proposed was not observable. This may contribute to a lack of compliance with the change. A great deal of support, the outcome of more observable changes, was not overtly given during the change process. The mechanism of evaluation, informal questioning, did lend itself to the offering of support and praise for those incorporating the change into their routines. There were no major visible rewards to implementing this change. Dracup and Breu's model however, applies to implementing change in nursing practice and the physicians at the FMC may not respond to external rewards in the same manner as the nurses in Dracup and Breu's literature.

In summary, the proposed change appears to have high advantage, compatibility, and trialability, and low complexity. In the change agent's perspective, all of the attributes are viewed favorably with the exception of the observability of the change. Of course this analysis does not take into account the perspective of the staff involved in the

change due to time and feasibility constraints.

Objectives

The identification of objectives is the next step in the Dracup-Breu Model following identification of the problem and the selection of appropriate research (MacLachlan, 1986). The primary objective of this project is to describe the process of implementing a change in a family practice clinic. The acceptance or rejection of the change by family practice residents and physicians will be examined, specifically in reference to the change being initiated by a nurse in the advanced practice nursing (APN) role. Other possible outcomes of the intervention that will not be assessed per se, but remain objectives of the intervention include the following: (1) to increase the knowledge and sensitivity of primary care practitioners regarding the needs of survivors of CSA, (2) to assess the feasibility of implementing a brief assessment intervention during sensitive physical examinations, and (3) to determine practitioner concerns related to addressing issues of childhood sexual abuse.

Setting Analysis

The setting of the proposed change implementation is the St. Boniface Family Medical Centre (FMC). It is a teaching clinic comprised of eight family practice physicians working in collaboration with two to three family practice resident physicians each. Medical assistants, receptionists, a social worker, dietitian, and clinical nurse specialist adds to the multidisciplinary composition of the FMC. A variety of patients are seen at this clinic ranging in age from early in-utero to late nineties. Both males and females with a variety of complaints and conditions are managed.

Barriers and Facilitators to Change

Several barriers were identified in the process of implementing this change. The first involved the role of the advanced practice nurse and its acceptance by family physicians. Further detail regarding this issue will follow in a subsequent section. Another barrier was the time allowed for the entire change process, ten weeks. This did not leave very much time for setting up the change, monitoring its long-term effects, or allowing participants to graduate through the phases of the Bridges' change theory. Also, accessibility to the physicians was difficult considering that most of the time at the clinic was spent in patient interactions. It was at times difficult to have a moment to engage them in conversation.

Political barriers to implementing change existed. The dynamics between the faculty of medicine and nursing in the areas of access and ethical approval became particularly evident as my educational session approached. This barrier served as a reminder of the need for clear and adequate communication.

A barrier that became more critical than anticipated was the need for me to overcome vulnerable feelings associated with asking the participants regarding the change. Boundaries became obscured as my role of researcher and colleague blended. This dilemma provided a deeper understanding of the concept of risk taking and courage when initiating a change in practice.

Finally there was resistance by the physicians to the proposed change because of the sensitive nature of the change itself. Sturmberg (1999) describes a general fear of change as an important obstacle to a change in practice. This coupled with the sensitive nature of the change itself became a barrier to the acceptance of the change.

These barriers are similar to those described by Wensing, Wiejden, and Grol

(1998). They describe common barriers as inadequate practice organization, lack of time, negative financial incentives, negative attitudes in colleagues, and resistance from patients. Assessment of those issues that lead to non-compliance can be an initial step in facilitating a change (Morgan, 2000).

There were also facilitators to the change. Facilitators commonly identified in the literature include social influence and management support (Wensing et al., 1998). I had been involved with the FMC during a clinical practicum earlier in the year therefore I had met many of the residents that were to participate in the project. This allowed for some coalition-building resulting in a better acceptance of the change. Although there may have been issues regarding my role as an APN, I seemed to be well liked. I feel that my communication and interpersonal skills are adequate. These are necessary skills of a change agent (MacLachlan, 1986) and facilitated the change process.

The proposed change was fairly straightforward and did not require any resources or a great deal of time. The educational session was integrated into the setting and did not require any additional commitment from the physicians. The non-invasiveness of the change itself likely served to facilitate the change.

The philosophy of the FMC also served to facilitate my change. Evidence-based practice and the application of research are valued and involvement in research is respected. These philosophies are consistent with the rational-empirical change strategy. Although not overtly used, this strategy remained an underlying component of the change process.

Some of these barriers and facilitators were identified at the start of the project others were identified only after some reflection of the process. They do provide a better understanding of the dynamics involved in implementing a change. Some are

more overt than others and some have a greater impact but all influence the acceptance of a change in practice. Interventions that maximize facilitators and minimize barriers are felt to be the most effective change strategies (Kaner, Lock, McAvoy, Heather & Gilvarry, 1999). Change models looking at overcoming barriers would have provided additional guidance for the change process (Kaner et al., 1999).

Plan Implementation

Family resident physicians often confer during lunch hour for lunches and presentations sponsored by drug companies. The proposed intervention involved introducing the topic of the long-term effects of childhood sexual abuse and the purpose of the practicum project with a half-hour session held during lunch hour. The participants were asked to implement two questions into their more sensitive physical examinations (i.e., pelvic, breast, and rectal exams). The questions were a version of the following: (1) "Is there anything about your past experiences that makes this exam particularly difficult for you?" and (2) "What can I do to make it easier for you?" (Seng & Petersen, 1995, p. 29). At the conclusion of the session an information sheet (Appendix B), which highlighted the key points of the session, was given to those in attendance along with a disclaimer (Appendix C). These sheets also were to be distributed among the physicians and residents who were unable to attend the session.

Some modifications to this plan were made during the preparations stages of the change process. These are described further in the results section. This reflects the concept advocated by Dracup and Breu (1977) of re-assessing driving and resisting forces within a system and making necessary adjustments in the implementation plan accordingly.

The intervention was implemented four weeks after my commencement at the

Family Medical Centre in the hopes of coalition building. This concept is described by Norton and Grady (1996) and involves: clearing the investment, or eliciting support and agreement from those in positions of authority; making cheerleaders, or promoting the idea among as many individuals as possible; horse-trading, or promising a reward or favor for support; and securing blessings (Norton & Grady, 1996).

Evaluation of Outcomes

Evaluation of the outcomes is the final step in the Dracup-Breu Model and included journaling of all formal and informal interactions, as well as any observations made during the entire change process. Informal interactions did not include direct observation of patient-physician interactions during examinations, but were in the form of questioning by myself weekly or biweekly of all physicians involved regarding whether the questions were being implemented and any feedback surrounding their implementation. Informal interactions may have occurred outside of the FMC at Journal Club dinners. Information may have also been gathered through formal case discussion rounds. General observations may have included any formal changes in procedures or teaching resulting from this change and any comments observed in charting regarding this change. In a study conducted by Curry and Purkis (1986) self-reports of behaviour change accurately represented actual behaviour change. Therefore, this was likely to be a valid method of evaluating behaviour change in this practicum project.

The focus of the project was on the process of implementing a change. The interactions noted during the change process were examined within the Dracup-Breu and Bridges' change theoretical frameworks and analyzed using content analysis.

Burnard (1991) described a method of analyzing qualitative research in his summary article. Due to the nature of a practicum project, there was more flexibility in

the steps I took to analyze my data. Burnard's method assumed that semi-structured, open-ended interviews were carried out and recorded in full, in my project the data collection was more informal. Most stages of Burnard's model did apply, however, for example writing notes regarding topics of the interactions, creating general themes, open coding, and the development of broader categories. Burnard's model then described the removal of repetitive statements, confirmation that headings represent the actual data, a division of the transcript of data into categories and a summarization of the categories. Some sections, which included eliciting input from colleagues regarding the appropriateness of categories and tests of validity by asking respondents to verify their comments in the context of the headings, were not necessary or appropriate in the context of this practicum project.

Conclusion

Change is necessary in order to advance in today's fast-paced health care system. The advanced practice nurse's role of change agent is integral to the process of change. The need for increased knowledge and sensitivity of practitioners in meeting the needs of female survivors of childhood sexual abuse has been established. An attempt to increase this knowledge and sensitivity during sensitive physical examinations will be made and is in the form of an educational session and a proposed intervention. The Dracup-Breu model and Bridges' change theory will facilitate the change process and allow for its analysis.

CHAPTER 6

ETHICAL CONSIDERATIONS

It is necessary to protect the rights of subjects when conducting any type of research. Guidelines for nurses conducting research are provided by the Tri-Council policy statement entitled, Ethical Conduct for Research Involving Humans (1998). Section 1C of this statement describes the concept of minimal risk,

“If potential subjects can reasonably be expected to regard the probability and magnitude for possible harms implied by participation in the research to be no greater than those encountered by the subject in those aspects of his or her everyday life that relate to the research then the research can be regarded as within the range of minimal risk” (Section 1C, p.1.5).

The two questions the physicians are requested to include in their encounters with patients: “Is there anything about your past experiences that makes this exam particularly difficult for you?” and “What can I do to make it easier for you?” (Seng & Petersen, 1995, p. 29) are questions that would likely be a routine component in an encounter between a patient and health care provider. The only foreseeable risk to the patients and health care practitioner is the emotional difficulty involved with the disclosure of an abuse history. As described in the literature review, however, most sexual abuse survivors are grateful for the opportunity to discuss and disclose a history of abuse, however traumatic it may have been at the time.

Although there appeared to be minimal risk involved in this practicum project, the acquisition of ethical approval was still felt to be necessary. The practicum project was approved by the Ethical Review Committee of the Faculty of Nursing at the University of Manitoba through an expedited review. Voluntary participation and

informed consent were both reinforced verbally during the information session and in writing on the disclaimer given to all participants.

CHAPTER 7

RESULTS

Data for this practicum project was collected between March 10 and July 7, 2000. This time frame encompassed the period in preparation of the practicum, through to the last day of the practicum. The literature review was started in January of 2000. The information collected was open-coded and categorized according to the last three steps of the Dracup-Breu model: analyzing the setting and devising a plan, which involved preparing the system; implementing the plan; and evaluating the outcomes. It was then further analyzed according to the three phases of the Bridges' change theory: an ending, which was chosen to also represent those responses that indicated a refusal to change or accept the change; the "neutral zone," representing a lack of motivation or apathy regarding the change, these people did not make changes but were not opposed to the idea; and a beginning, these people were "on board" with the change and implemented it into their practice immediately. Throughout, the barriers and facilitators of the change are identified. The results of the journal entries are summarized.

Analyzing the Setting and Devising a Plan

Preparing the System

In order to ensure access to the Family Medical Centre, and acceptance of my project by the major stakeholders, the first step I made was to introduce my topic to an administrative leader at the FMC. This was part of a top-down approach in an effort to gain "buy in" by the major stakeholders, the attending physicians at the FMC, and to ensure access to the clinic for my practicum project. At this time my project was to include a brief introductory session on the sequelae of CSA and the purpose of the practicum project. All interested staff were to attend the session including residents,

physicians and nurses, and it was to take place during lunch hour. Those attending would be asked to incorporate screening questions into their more sensitive physical examinations, “Is there anything about your past experiences that makes this exam particularly difficult for you?” with a follow-up question of, “What can I do to make it easier for you?” (Seng & Petersen, 1995, p. 29). Evaluation was to include focus groups and individual interviews and the data was to be analyzed using content analysis. The goal at that time was to increase the sensitivity of practitioners to the issues facing survivors.

Some suggestions regarding the need for a guide to aid in responding to disclosures and a referral resource list were made. It was then decided that the proposal for the project would be presented at a meeting attended by the attending physicians. As I could not attend, it was decided that the administrative leader would represent me. A factor that later served as a barrier as there was some miscommunication surrounding the outcomes of that meeting. This will later be described in greater detail.

The practicum changed in focus about two weeks later as a result of a meeting with my practicum committee. The objective now became the process of incorporating change into a clinical setting. My role as an advanced practice nurse and change agent, and the process of incorporating a change in practice would be analyzed within a change theoretical framework, to determine how change is accepted and internalized by the physicians. The change itself remained the intervention previously outlined. Evaluation was now to be more informal including observations and journaling of informal and formal interactions.

This change in the focus of the project proved to be a barrier to implementing the change, as the literature surrounding changing the practices of GPs had not been well

explored. Further, effective elements of implementing change into practice, including eliciting participation of those involved during the planning stages, and using evidence-based strategies for implementing change were now difficult to incorporate into the plan.

Meanwhile, the board approved my practicum project and gave me access permission to set up a meeting with the physicians at my convenience. I began to elicit some feedback from other stakeholders as to the most feasible method of gathering together as many physicians as possible. There was consensus that a meeting during morning rounds would be better attended than a noon-hour meeting.

A component of the system preparation involved ethical approval. This took place at a relatively late stage and certainly represented a barrier. Time constraints made it difficult to produce all of the required information for an unanticipated expedited review just prior to my session. Some exceptions regarding time deadlines were made and the process was completed to the satisfaction of the nursing ethical review board prior to my session.

In order to provide the necessary information to the ethical review board, a letter of access was necessary from the FMC. Although the FMC had not given permission in written form, verbal consent was given. Still the letter of access became a barrier to my change. Issues surrounding the politics of nursing versus medical ethics were discussed and there was a great deal of miscommunication, as noted earlier, regarding the specifics of my practicum project and whether access had indeed been granted at the meeting with the attending physicians described earlier.

A component of the debate for access permission involved the apprehension in dealing with issues of CSA that are noted in the literature. One physician felt that a topic as sensitive as CSA should not be used to describe the process of implementing

change. In order to gain the support of this stakeholder, it was decided that an outline of my session would be available for review to address ahead of time any concerns that may exist.

Analyzing the System

It was necessary to take some time at the early part of my practicum to simply become more familiar with the events at the FMC, the politics, and the physicians. This process was a form of coalition building. The importance of interpersonal competence was evident in this stage and throughout the change process. It was evident that without strong interpersonal skill, a change agent would have difficulty influencing change. I took some time to determine how my project may be incorporated into the ebb and flow of the clinic. This assessed the change's compatibility, one of the five attributes described by Rogers and Shoemaker (1971).

Devising a Plan

It was necessary by May 15, 2000 to consider an appropriate time and date for my session. June 2, 2000 was chosen. The session would take place during the last part of case discussion rounds, a weekly meeting used to discuss case studies. The appropriate administrators were notified and information regarding the session was disseminated through the "FMC Weekly Schedule" and a special memo (Appendix D).

An Ending

Participants' reactions of anxiety and apprehension were observed in relation to the proposed change. During the preparation stages of the change there were opportunities to discuss the practicum project with various physicians. There were some indications when the topic was introduced casually to individuals, of the perception that it was an overwhelming, difficult topic to undertake. This discomfort represented the

hesitancy of physicians to deal with CSA issues, a theme that is prevalent in the literature.

Further hesitancy to deal with this topic was noted during the meeting organized to discuss the outline of my presentation. There was opposition to some of the content included in the outline, specifically surrounding the use of task-centered disclosure, which was felt to be incongruent with the principles of family practice. Also, the two screening questions were felt to be contrived and inconsistent with the patient-centered approach advocated by the clinic. Some of the content was thought to be insulting to the residents as it was felt that they had been well educated regarding the sensitivity necessary in a physical examination. I made an attempt at this point to provide information regarding the change and to validate the concerns that this person expressed, in order to facilitate the change process.

This person's views of the session were perceived to be barriers initially to the change process, as this person had the power to influence others against accepting my change. The information gained from this meeting was used to increase my own sensitivity during my presentation to the education the residents had received regarding sensitively performing physical examinations. This added sensitivity might have helped to facilitate the change. One thing is certain; courage, critical commitment, and devotion to a cause were very necessary characteristics to possess during this phase of the process.

The "Neutral Zone"

The "Neutral Zone" is characterized by a period of unknowing, instability and a redefinition of relationships. This phase is characterized by amotivation and anxiety. Following the meeting indicating that the session may be insulting to the residents, a

resident was asked for feedback regarding the nature of my presentation. This person indicated that although the session would not likely be insulting, it was also unlikely to result in a change of practice. This person stated that they are aware of a patient's comfort during an internal exam, and if discomfort were perceived, it would then be explored. Otherwise it is not addressed and there is no indication to do so.

My role as a change agent at this stage was to provide information and literature supporting the difficulty in perceiving some people's distress. I did not do this however. At the time I felt that this person was not at a stage where they were ready to make a change in practice and any further information by myself was unsolicited and futile.

A Beginning

The phase, "A beginning," indicates a willingness to incorporate a change. There was positive feedback regarding the feasibility of this project, pending the approval of those at the meeting of attending physicians, by two key stakeholders. One of these people described the topic as interesting, important, and outlined that if the physicians lacked knowledge in this area it would provide a valuable experience for them to learn a skill they should possess. A top-down approach is supported in the literature as a facilitator of change (Wensing et al., 1989).

After the dissemination of the date and time of my session on CSA, through the weekly reminder and the memo, I received some positive feedback. There was certainly an interest in attending my session and one physician informed me of an anecdote of a case of CSA that he was involved in, and the difficulty it presented. There were also some comments made indicating that this was my area of interest during related educational sessions. A concept that I feel facilitated the process of change, i.e., the view of me as somewhat of a specialist in the area. If this was indeed the case, several

studies have found that general practitioners tend to make changes in practice if the change is advocated by a specialist in the area (Littlejohns & Cluzeau, 2000; Sarasin, Maschiangelo, Schaller, Heliot, Mischler, & Gaspoz, 1999)

Implementation of the Plan

Implementation of the plan involved the session presented on June 2, 2000. The thirty-minute presentation went uninterrupted and thirteen people attended, five residents, five attending physicians, and three other staff members. The presentation covered some statistics related to CSA, the long-term effects of CSA or “red flags” pertaining to the medical encounter, the impact of previous coping strategies during abuse on relationships with health care providers, methods of screening for CSA, issues of disclosure, responding to disclosure, and recommendations regarding meeting the needs of women survivors. At the end of the presentation I provided an overview of the practicum project, distributed disclaimers, and information sheets, and allowed time for questions or comments. As a result of the comments made, a resource list for survivors of CSA (Appendix E) was created and distributed within five days. The comments from this session will be organized into Bridges’ transition phases.

An Ending

A comment following my presentation was made indicating an unwillingness to deal with a disclosure, due to a perceived lack of preparation. It was suggested by this person that at minimum a resource list should be distributed indicating agencies where survivors could be referred. Prior to incorporating my proposed screening tool, this person felt that a plan for positive responses should be identified. This person did not feel that the session provided sufficient detail to engender a feeling of preparation in dealing with the issue of CSA. Two others at the meeting supported the distribution of a

resource list.

There is a strong body of evidence in support of most physicians feeling that they lack the ability, skill, and knowledge to deal with a disclosure of abuse (Austin et al., 1999; Friedman et al., 1992; Gallop et al., 1995; Hays & Stanley, 1996). This is, in fact, a very typical sentiment. Ironically, the physicians at the Family Medical Center, who practice a patient-centered approach, have more skill and more knowledge of resources than most practitioners. Even with this additional preparation, the physicians expressed discomfort in dealing with disclosures of CSA during the educational session. This motivated the distribution of the resource list and indicated their ability to identify their knowledge deficits. The expression of discomfort supported the necessity of educational sessions regarding the long-term effects of CSA, and refuted the sentiment that additional training would be redundant based upon the FMC practitioners' existent training and knowledge.

There was clearly some anxiety involved in accepting this change, a common theme for this transition phase. The role of change agent at this time involved acknowledging this anxiety, normalizing the feelings, and providing as much information as possible. A resource was prepared to address the need for more information. This resource included a list of local agencies providing services to adult survivors of CSA along with a reading list of books and articles addressing practitioner issues in dealing with survivors.

The "Neutral Zone"

I had gained some understanding regarding the education the residents have in sensitively performing physical examinations and this was evident in my presentation. I stated that the people in attendance are likely already screening for CSA during sensitive

physical exams. As a result, one physician commented that in fact this was not true for him. Another comment made was that a section regarding changing the behaviors of GPs had not been included in my literature review and was an important topic to address. It was agreed by this particular individual as well as those on my practicum committee that it would be appropriate to include this literature in the discussion section of my practicum project. One person in attendance at the session offered a review article describing effective interventions for implementing innovations in general practice. This article began the literature review that became a major component of the discussion session that is to follow.

Directly following the presentation I received some positive feedback by two physicians regarding the impact of the session. I was told that some of the issues I presented provided a heightened awareness of the issues many people face with regard to sensitive physical exams.

A Beginning

At this time there was no actual change or willingness to change evident.

Evaluation of the Outcomes

Shortly after my session I began receiving feedback regarding the implementation of my intervention. I did not officially solicit responses until two weeks after my presentation. This gave the participants a chance to internalize the change and implement it where possible, it also gave me the chance to develop and distribute the CSA survivors resource list.

There was a period of time that I found data collection to be challenging. Some of the essentials qualities of an effective change agent described by Norton and Grady (1996) are the disposition toward risk taking, courage, and the ability to allow oneself to

be susceptible to feeling hurt or inadequacy. There were many vulnerable feelings associated with asking about my influence in making a change in practice, particularly with the method chosen for data collection, face to face conversations. My roles of researcher and colleague were blended. It was difficult to separate the two due to the nature of the data collection procedure. I never received comments regarding the duality of my intentions, but was sensitive to it nonetheless. This prevented me from mentioning the research for some time, to allow participants to see that I could have interactions with them without being connected to the role of researcher.

In addition to these feelings serving as barriers, data collection was further hampered by time constraints and energy. A majority of my time and physician time at the clinic was consumed with patient care. Finding added time and energy required to collect data was, at times, difficult. I had wanted to access physicians that were at the clinic only a half-day per week, and did not attend my session. This proved to be difficult, as the contact time with these people was limited. I did introduce the topic to two of these individuals and received positive feedback from both, but did not have the opportunity to follow-up either one with questions as to whether or not the change had been implemented. This was a limitation to the change process.

An essential component of implementing change according to Dracup and Breu (1977) is to continually re-assess driving and resisting forces within the system and make changes to the implementation plan accordingly. As a result the physicians on their half-day back were not incorporated into the project for time and feasibility reasons. The creation of the resource list was added as a result of some of the resisting forces noted during my session. Also, during the course of data collection it was noted that further data regarding participants' perception of the change process and

recommendations for future change implementation strategies may be beneficial to include. This data is summarized in the “Exit Interview Recommendations” section.

An Ending

There was one individual who made no changes to their practice, and offered no further information. It was my impression that this particular individual had some issues with the APN role and this influenced acceptance of the change. This conclusion was drawn based on several interactions in the clinic. Those physicians with whom I had built a good rapport seemed more willing to accept the change I presented. As stated earlier, the importance of interpersonal and communication skills was evident.

The resource list I had created was observed to be in the garbage. There may have simply been an excess of them printed, or someone uninvolved with the project may have received a copy. It may have been an indication of a lack of respect for my project, or an unwillingness to change.

One participant had simply not remembered to implement the change. This person had not been interviewed throughout the process, therefore received no reminders to implement the change. Also, few opportunities for this person to implement the change existed.

The “Neutral Zone”

There were various responses indicating that screening questions were already being asked prior to my session. Although changes were not made as a result of my session, some form of screening was already in place by five individuals. Had some type of assessment been made prior to initiating this intervention, the prevalence of screening would have been identified, and would have perhaps had an impact on the project.

One individual commented that routine screening for CSA would not be appropriate in their role. However, with employment at the FMC they have gained an awareness of these issues. Should there be an indication that other factors influencing the patient's health may exist, issues of abuse are explored.

A Beginning

Various responses indicated an acceptance of my change. The questions were accepted and comfortable to use by two physicians who volunteered this feedback. The women asked by these physicians replied with negative answers and seemed "non-chalant" about the questions. These interactions offered the opportunity to discuss the importance of being sensitive during physical examinations and brought awareness to the fact that not all providers offer this type of sensitivity.

Two other physicians had not had the opportunity to do more sensitive physical examinations but were willing to make this change in practice. There was a comment made that it should not have been necessary for me to provide a resource list, it is something that the physicians at the FMC should have the skills to access on their own. There were positive comments about my presentation with the exception that I spent too much time defending the physicians and their capabilities. I had the opportunity to build a positive rapport with these particular participants, a factor that may have facilitated the implementation of change.

I was asked permission for my resource list to be distributed to another agency.

Exit Interview Recommendations

Toward the end of the research process an informal exit interview was conducted with the participants. The purpose of these interviews was to determine if there were any recommendations for the implementation of change at the FMC. It became very

obvious at this time that the information provided would have been useful at the initial stages of planning for the change process. A concept advocated by action research literature (Hampshire, Blair, Crown, Avery & Williams, 1999).

Four of the physicians surveyed recommended that a reminder be placed in the chart. Physicians in a study with the purpose of assessing successful implementation of guidelines, felt the insertion of guidelines in patients' charts to be the most useful method of dissemination (Sarasin et al., 1999). The importance of reminders was noted in other studies looking at effective strategies for change (Gutierrez et al., 1994; McPhee, Bird, Jenkins & Fordham, 1989; Wensing et al., 1998).

A checklist was recommended by one participant along with a separate chart for information regarding the abuse should screening reveal an abuse history. This chart would serve the purpose of ensuring confidentiality for the patient and was thought to enable disclosure. It was also recommended that patients be asked verbally as opposed to screening in written form. Follow-up meetings to reinforce the change were also suggested in order to provide reinforcement to those individuals adopting the change, support for those having received positive responses, and to provide an opportunity for those involved to comment on their experiences in asking the screening questions.

One person commented that the intervention was done well. Postponing the session until the physicians were more familiar with me facilitated the change, as did providing the session in the form of a presentation as opposed to a memo outlining the proposed change. Freemantle (2000) confirms that the distribution of written educational materials has only a very small effect on practice. This person also commented that answering all the questions and providing the reference list in a timely fashion were also facilitators to the change. Involvement of participants is well

described in the literature as a positive change strategy (Gutierrez, Guiscafre, Bronfman, Walsh, Martinez & Munoz, 1994; Hampshire, et al., 1999; Kaner et al., 1999; Kimberlin, Berardo, Pendergast & McKenzie, 1993; Onion & Bartzokas, 1998; Sarasin et al., 1999; Zerr, Beccaro & Cummings, 1999).

A barrier noted by one non-physician participant was a perceived lack of endorsement or “buy in” by some key people attending the educational session. This person felt that had they been in the medical field that perhaps they would have had similar concerns. The importance of having the “buy in” of key people was also emphasized by another participant and is supported by the literature (Littlejohns & Cluzeau, 2000; Sarasin et al., 1999; Sturmberg, 1999; Wensing et al., 1998). If respected members of the community are not supportive of the intervention, it creates a significant barrier.

There was one comment on the difficulty some male staff may have had in asking the screening questions for fear that they had a suggestive tone. Of note, there were no others that felt this was an issue. There was also a suggestion made that clinical teaching associates, who train the residents to do sensitive physical examinations, should teach the residents to ask the screening questions and communicate the fact that not all physicians will ask these questions, but that this should not deter the physicians from doing so.

One of those interviewed had not participated in the study but offered an interesting analysis of my topic. This person had some questions regarding the yield of the two screening questions and patient perception of the questions. Possibilities for “yes” responses were offered including; CSA history, client’s perception of the awkward nature of a male performing a pelvic exam on a female, and previous bad experiences

with past practitioners. This person felt a peripheral question such as “Have you had difficulties with these exams in the past?” would be an appropriate opening question, so the patient is not asked a question of a sensitive nature from “out of the blue.”

This person also described a gastroenterology conference discussion. At this conference the association between constipation and CSA history was noted. The specialists preferred not to screen for abuse in their patients for a variety of reasons; they did not feel they were good at screening, they would not or could not address a positive reply, they did not feel it was a part of their role, and the information would not be applied to the patient’s care. The individual interviewed has an understanding of abuse issues and their relation to somatic complaints. This information further supports the need for this change.

Effects of Role on Change Implementation

An educational program at the graduate level for nurses wanting to specialize in the advanced practice role is new to Manitoba. The FMC has traditionally trained family practice residents. My training at the FMC was a change to a longstanding educational system. Universal agreement regarding my place at the FMC did not exist. The debate of the nurse practitioner versus the general practitioner is long-standing, and found a place in my project, having had an influence on my ability to effect change.

Physician resistance to the role of the APN is prevalent in the literature. A survey of 2,741 nurse practitioners indicated a lack of support from physicians as one of four major barriers to practice (Anderson, Gilliss & Yoder, 1996). Recent editorials have clearly outlined the resistance physicians may have with the APN role. There is fear that nurse practitioners undermine general practice as a profession, remove the right of patients to see a doctor without consulting a nurse first, and allow non-medically

qualified people to practice as doctors (Alcolado, 2000; Kassirer, 1994; Ventura, 1998). Without entertaining the debate in great detail, it is important to note the influence of this issue on my ability to implement change into the FMC.

The effect of my role on my influence in implementing change was obvious in several interactions. During the planning stages of the session I was told that my presentation was to be brief, five to ten minutes, and carefully scheduled so as not to interfere with the resident's educational opportunities. The FMC is designed to educate the residents, in this context that comment is understandable; my education took less priority. Perhaps this was not a role issue but an educational priority issue on the part of the FMC.

Dynamics of the doctor versus nurse dilemma were also noted during the discussion of whether medical ethics should approve my practicum project. I had my project approved by the faculty of nursing at the University of Manitoba, yet this did not seem sufficient to one of the physicians at the FMC. Perhaps it was felt that medical ethics are more rigorous. Nevertheless, this seemed to be an issue related to the doctor versus nurse debate.

Some comments made about my role were overt. One such comment identified the difficulty in my convincing people to make a change at the session I provided considering that some may not approve of the APN role. I believe another person hid their attitude in a resistance to make a change. The impact of my role as an APN in effecting a change was an undeniable force.

CHAPTER 8

DISCUSSION

Implementing change is a challenging task. Multiple factors influence a practitioner's willingness to adopt a change in practice (Halm et al., 2000). Halm and colleagues concluded that long held beliefs can be difficult to modify, even with rigorous implementation strategies (2000). And as one group of authors commented, "...physicians, like all people, will only change their behavior if they are so motivated" (Grimshaw et al., 2000, p. S11). This comment addresses the personal factors that affect one's acceptance of a change that are difficult to control for in a randomized clinic trial. Other factors influencing a practitioner's adoption of a change include amount of experience, with more experience negatively impacting on the will to change (Halm et al., 2000), personal attitudes toward a particular change (Halm et al., 2000; Morgan, 2000), organizational and practice barriers (Morgan, 2000), and a general fear of change (Sturmberg, 1999).

Certain strategies are cited in the literature as being more effective than others in implementing a change in GP practice. A major theme is the active participation of all of those involved in the entire change process (Gutierrez et al., 1994; Halm et al., 2000; Hampshire et al., 1999; Kaner et al., 1999; Kimberlin et al., 1993; Onion & Bartzokas, 1998; Sarasin et al., 1999; Zerr et al., 1999). Onion and Bartzokas (1998) found in their controlled trial that an hour-long discussion was superior to an hour-long lecture in effecting enduring attitude changes. Participation of practitioners leads to a sense of ownership by the participant and a better understanding of the practical issues in implementing a change for the researcher (Hampshire et al., 1999).

The strategies I chose had a limited component of active participation. Active

participation in the change process included the comments and discussion at the conclusion of my educational session and the feedback I received during my evaluation interactions and the exit interviews. Although the information gained from the latter source was valuable, due to the nature of the exit interview, I was unable to apply the information gained from these interviews toward the current change process. The need for the physicians to ask questions of patients themselves in order to participate in the project may also encompass active participation. Participation of all involved in the earlier planning stages and throughout would have had greater impact in effecting change.

Information transfer is a necessary component of any change process (Kaner et al., 1999; McPhee et al., 1989; Wensing et al., 1998). This is congruent with the rational-empirical change strategy which stresses that people are guided by reason and will change their behavior if there is some vested interest in them doing so (Keyzer & Wright, 1998). However information transfer alone only results in relatively short-lived changes (Freemantle, 2000; Onion & Bartzokas, 1998; Wensing et al., 1998). Information transfer is more effective if combinations of multiple strategies to achieve a change are used (Freemantle, 2000; Halm et al., 2000; Gutierrez et al., 1994; Kaner et al., 1999; Littlejohns & Cluzeau, 2000; Onion & Bartzokas, 1998; Sarasin et al., 1999; Wensing et al., 1998). A good combination, noted in the review article by Wensing and colleagues (1998) summarizing 61 studies, consisted of social influence and management support coupled with information transfer. Most interventions consisting of a combination of three or more interventions proved to be effective in the studies examined by Wensing and colleagues (1998).

The use of a well-respected colleague specializing in the area of change to

disseminate information was useful in supporting a change in some research findings (Littlejohns & Cluzeau, 2000; Sarasin et al., 1999; Wensing et al., 1998). Others felt this method to have uncertain efficacy (Freemantle, 2000). Also as noted earlier, the use of reminders for practitioners regarding the change is well supported in the literature (Gutierrez et al., 1994; McPhee et al., 1989; Sarasin et al., 1999; Wensing et al., 1998).

There certainly could have been a greater effort to implement several strategies into the change process, particularly the addition of reminders, a recommendation made frequently during my exit interviews. A debriefing session led by a respected colleague specializing in CSA a few weeks into the change process would have facilitated the change by providing an opportunity to discuss the issues and concerns surrounding the change, and providing support to those experiencing personal or professional difficulties with the topic. Management (i.e., senior physician) support was sought, but for various reasons this became a difficult facilitator to consolidate. I do feel that information was transferred appropriately considering the time limitations. Information was given both verbally and in written form in addition to the resource list provided.

Freemantle (2000) in his review article looking at implementation strategies concluded that "...[I]nterventions intended to change professional behavior are developed and understood inadequately and appear, at best, to have only a modest effect upon practice" (p. S8-S9). One should make an attempt to use all of the information that is currently available when implementing a change into practice. Littlejohns (2000) and Sturmberg (2000) provide guidelines on successful guideline implementation. Freemantle's comment suggests that more effort should be made to expand the existing knowledge base in this area, so that the strategies we employ will indeed be effective in influencing a change in practice; particularly when the change agent does not have a lot

of social or professional influence in the system.

CHAPTER 9

SUMMARY

The Dracup-Breu model proved very useful in providing an overall framework for the process of implementing change. It's emphasis on the barriers and facilitators of change and an analysis of attributes of an effective change provided a necessary analytical look at the process of change. One limitation of this framework was that it did not provide a guide to overcoming the barriers perceived by individuals. Freemantle (2000) suggests this to be a valuable component of a change theory.

Bridges' change theory served as a useful guide in determining people's affective responses to change. There were few if any individuals who followed the phases as outlined, going from "an ending" to "a new beginning." There were many that simply chose a phase and stayed with it. There were others still that slightly regressed within the phases. Perhaps there was insufficient time to see a true progression through the stages by the participants. The time needed in guiding the participants through these phases was limited. It was useful in the data analysis to use the phases of the Bridges' change theory to indicate the extent to which people accepted the change.

Perhaps the use of nursing change theory to guide a change in physician practice deserves further attention. The attributes described within the Dracup-Breu model, specifically "observability," did not seem applicable for use with physicians. This attribute describes the degree to which an innovation is visible to others and therefore the amount of support and reward the staff will get for incorporating a change into practice (Rogers & Shoemaker, 1971). Physicians are likely to respond to internal rewards as opposed to external rewards rendering this attribute inapplicable to incorporating change into physician practice.

The Bridges' change theory seems more applicable for use in a situation where staff needs to make a change in practice and are given little flexibility. At the FMC the change in practice was more of a suggestion than a policy implementation. Therefore the phases of grieving through to acceptance of the change were not applicable. The individual physicians decided whether or not they felt the change was appropriate. A model that APNs could use to implement change into multidisciplinary practice, and to gain an understanding of the rewards applicable to different professionals would be beneficial to future research utilization projects involving multidisciplinary teams.

Limitations

A limitation to research using an observational or descriptive approach is that although it is useful in providing a greater, general understanding of behavioral change, it lacks the rigor of controlled trials (Grimshaw et al., 2000). The conclusions made cannot necessarily be attributed to the interventions, but may be a factor of other population characteristics (Grimshaw et al., 2000). This was a known limitation of this practicum project, which had as a main objective the description of implementing change. Had the rigor of the research been more of a factor, a cluster-randomized trial would have been the optimum design for a change implementation study (Grimshaw et al., 2000).

This type of project required a substantial amount of self-reflection, intuitiveness, and insight on the part of the change agent, qualities that a change agent should possess. The information gained from this project was very rich, but it was the process and involvement of the change agent that resulted in the data obtained.

Limited participation on the part of the physicians and stakeholders at the FMC was certainly a limitation of this process. As described, the involvement of those at the

FMC would have helped to internalize the change and would have added to the success of the change. Of course this process would have required a significantly greater amount of time than that available. The time allotted for this change was limited and did not allow for an assessment of enduring attitude or practice changes.

Multifaceted interventions including reminders, “buy in” by people in positions of power, and discussion sessions led by a respected specialist would have also added to the success of this project. The process would have been more efficient had there been better communication right from the project’s inception both between the faculty of Nursing and the faculty of medicine, and between me and the stakeholders at FMC.

A major barrier to change was the nature of the change itself. All change comes with some degree of resistance but a change as sensitive as one associated with childhood sexual abuse adds even greater resistance and fear to the process. Although the topic was important and worth the reflection and effort, it was perhaps a more difficult change to incorporate into practice based on its sensitive nature.

Conclusion

The main objective of this project was to analyze the process of implementing change. Hampshire and colleagues (1999) outline the difficulty in assessing the impact of change. To quantify the impact my strategy had on implementing change, one could look at the individuals who did and did not make the suggested change, with a consideration of all of the possible variables involved. One person did not make a change in practice, one did not remember to make the change, another did not find screening for CSA to be appropriate in their practice, and five participants had already been doing some form of screening. Four of the participants did make a change or were willing to do so, and one of the thirteen at the session I presented was not available for

comment.

A peripheral objective of this project was to increase the sensitivity of practitioners to the difficulty women with a CSA history might have with sensitive physical exams. I felt that the introduction of this issue in itself increased the sensitivity of the practitioners at the FMC to this topic. Some discussion following my presentations gave me this indication, particularly those conversations addressing how we can make the physical exam easier for women in general.

An analysis of the feasibility of implementing screening questions prior to sensitive physical examinations was also an objective of the project. The proposed questions did appear to be feasible within the context of a physical exam. Some practitioners chose to omit the screening questions depending on their schedule that particular day. The feedback that I received regarding the questions, along with my own experience in asking these questions, has been very positive and indicative of the feasibility of these questions in general practice.

There were a few practitioner concerns mentioned in the implementation of these screening questions, the third peripheral objective. There appeared to be a fear of “opening a can of worms” and a fear that the practitioner would not have the skill to deal with what should ensue. Of course the literature supports screening and in fact points to the negative effects of not screening (Bala, 1994; Courtois, 1993; Doob, 1992, Varallo et al., 1998). The perception that there was an inadequate system in place for support for both the patient and practitioner may have been well founded. Practitioner support in dealing with these sensitive issues is certainly lacking in most facilities (McKegney, 1993; Seng & Hassinger, 1998).

Change is a multifaceted dynamic process. A change agent requires a variety of

professional skills and personal attributes. Advanced practice nurses are in an ideal position to effect change in both nursing and medicine. Resistance to change should be anticipated, however, and managed with an upfront problem solving approach. The perception of the sensitivity of issues surrounding survivors of childhood sexual abuse supports the need for practitioners to become more familiar with and address the needs that survivors express.

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Appendix A

DRACUP-BREU MODEL

1. Identify the problem
2. Select appropriate research
3. Establish objectives
4. Analyze the setting and devise a plan
5. Implement the plan
6. Evaluate the outcomes

BRIDGES' CHANGE THEORY

An Ending

The "Neutral Zone"

A Beginning

Appendix B

LONG-TERM EFFECTS OF CSA or "RED FLAGS" PERTAINING TO THE MEDICAL ENCOUNTER

PTSD-Like Symptoms:

- Hyper-arousal
- Flashbacks
- Insomnia
- Nightmares
- Anger control problems

Psychological Effects:

MORE PREVALANT IN WOMEN WITH AN ABUSE HISTORY:

- Depression
- Anxiety
- Low self-esteem
- Suicidal gestures/attempts
- Sleep disturbances
- Personality disorders
- Dissociative disorders
- Panic attacks

Relationship/Interpersonal Problems:

- Marital/sexual dysfunction
- Difficulty with intimacy
- Parenting problems
- Social isolation
- Trust issues
- Safety
- Boundary confusion

Self Abuse:

- Alcohol or drug abuse
- Eating disorders
- Self-injury
- High risk behaviors

Somatic Complaints without Organic Cause:

- | | | | |
|---------|----------------------|--------------|------------------|
| COMMON: | -Chronic pelvic pain | LESS COMMON: | -Chest pain |
| | -Chronic headache | | -Throat pain |
| | -Abdominal pain | | -Resp. symptoms |
| | -GI complaints | | -Musc. symptoms |
| | | | -Neuro. symptoms |

TASK- CENTERED SCREENING FOR CSA

1. "Is there anything about your past that makes this exam particularly difficult for you?"

With a follow up question such as,

2. "What can I do to make it easier for you?"

RESPONDING TO DISCLOSURE

Inappropriate Responses:

- Ignore the disclosure
- Act negatively to disclosure
- Overwhelm survivor with things they “should do”

Appropriate Responses:

- Acceptance and acknowledgement** of abuse and its **consequences**
 - Convey message that abuse is **not their fault**
 - Encourage survivor to **stay grounded in safety of the present**
 - Apply information** to increase patient's sense of trust and safety
 - Provide information regarding the **long-term effects of CSA and prevalence**
 - At conclusion of visit try to bring a sense of **normalcy** to feelings of the survivor
 - Survival thus far reflects **strength/courage** and symptoms now are remnants of survival skills
 - Offer a **link to the future**- check back in a few days
 - Validation, support and education may be all that some survivors require**
- Also
- Can offer survivors a reading list (Bala, 1994)
 - Information regarding self help groups, therapists other resources
 - Report situation if ongoing risk to other children

RECOMMENDATIONS REGARDING MEETING THE NEEDS OF WOMEN SURVIVORS - To Increase Safety and Trust and Protect Boundaries

- Increase patient's sense of **control** in all exams where touch is required, particularly with sensitive exams (i.e., pelvic, rectal, oral, breast).
- Respectful, calm, accepting approach
- Listen carefully
- Be sensitive to individual needs
- Offer choices where possible
- Examine gently
- Ask permission before touching
- Offer support person of gender patient feels most comfortable
- Careful/thorough examinations of procedures
- Warn about pain
- Encourage questions
- Confirm with patient ability to stop procedure at any time (empowering)
- Awareness of potential for boundary confusion**
- Examining one's own responses and feelings**
- Establish boundaries by setting clear limits**

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Appendix C

Disclaimer

You are invited to participate in the practicum project **“The Advanced Practice Nursing role of Change Agent and its Impact in Initiating a Change into a Family Practice Clinic”** the project will be conducted by Lori Clemente, a Masters student from the University of Manitoba in the Advanced Practice Nursing (APN) stream, as partial fulfillment of course requirements for a master’s degree. Participation in the project is entirely voluntary. You are under no obligation to do so. The study has been approved by the Ethical Review Committee of the Faculty of Nursing University of Manitoba.

My project aims to document the process of implementing a change. The change will be introduced at a brief introductory session during Case Discussion Rounds on June 2, 2000. This session will focus on the long-term effects of childhood sexual abuse (CSA). The change itself involves the incorporation of two questions into your more sensitive examinations (i.e., pelvic, breast and rectal). The questions include:

1. Is there anything in your past experiences that makes this exam particularly difficult for you?

And if yes...

2. What can I do to make it easier for you?

Data collection for this project involves journaling of informal interactions, discussions, and conversations as well as general observations. This will NOT include direct observations of patient-physician interaction during examinations, but will be in the form of questioning by myself weekly or biweekly regarding whether the questions are being implemented, and any feedback surrounding their implementation. Informal interactions may occur outside of the FMC at Journal Club dinners. Information may also be gathered through formal case discussion rounds. General observations may include any formal changes in procedures or teaching resulting from this change and any comments observed in charting regarding this change. Information will be gathered between June 5, 2000 and July 7, 2000.

The information will then be analyzed (using change theory) to determine whether the proposed change has been accepted and incorporated into practice, and to provide an understanding of the process of implementing a change. All information will be typed by myself, and all information will be kept confidential. Your name or any names mentioned will not be used on any reports about the study or in any future publications. Any specific details which might identify you or those you may mention will not be included. Only my practicum committee and I will have access to the gathered notes. Benefits to you personally for participating in this study include an increase in knowledge and sensitivity regarding the needs of women with a history of childhood sexual abuse and an improved physician-patient relationship. During and after the research, all journal material will be securely locked, and kept for seven years then destroyed.

You have the opportunity to have all your questions answered. Any additional questions you may have can be asked at any time. Please inform me if you do NOT wish to take part in this project. You may withdraw from the project at anytime and your comments and input will not be recorded for my report.

You have been offered a copy of the summary of the project
Date _____

If you have any questions or concerns I may be contacted at the following numbers:

237-2863 (office) 338-7156 (home)

The chairperson of my practicum committee, Dr. Annette Gupton (UofM), can be reached at: 474-7135 (office)

Please send me a copy of the summary of the research report.

Send to; _____(Name)

_____ (Address)

Appendix D

interoffice MEMORANDUM

to: All FMC Faculty and Residents on Block Time

from: Arlene J. Wiley

subject: Presentation – Lori Clemente
Friday, June 2, 2000 (1030-1100)

date: May 26, 2000

Please be advised that Lori Clemente (APN Student) will be presenting on the above date during the latter half of Case Discussion Rounds. Her topic will be **The Advanced Practice Nursing Role of Change Agent: An Analysis of Implementing Change Related to Childhood Sexual Abuse Sequelae in a Family Practice Clinic.**

Thank you for your attention to the above.

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Appendix E

RESOURCES FOR SURVIVORS OF CHILDHOOD SEXUAL ABUSE

- LAUREL CENTRE for Women Sexually Abused as Children
62 Sherbrook Street-----783-5460
(Free counselling for women with a CSA or adolescent abuse history and wish to resolve the long-term effects of the abuse that may include addiction problems)
- Fort Garry Women's Resource Centre
1088 Pembina Hwy -----477-1123
(Offers free individual or group counselling for various issues including abusive relationships, childhood abuse, self-esteem, separation, and divorce)
- Klinic Community Health Centre
870 Portage Avenue-----784-4090
(Free individual or group counselling; videos and books available)
- 24 Hour Klinic Crisis Line-----786-8686
Toll Free: 1-888-322-3019
- 24 Hour Klinic Sexual Assault Crisis Line-----786-8631
Toll Free: 1-888-292-7565
- North End Women's Centre
394 Selkirk Ave-----589-7347
(Free individual counselling, group programs and information sessions)
- Ma Mawi Wi Chi Itata Centre
600-338 Broadway-----925-0366
(Aboriginal agency provides free counselling on a variety of issues including sexual abuse; offers healing circles)
- Interfaith Marriage and Family Institute
2S03-515 Portage Ave-----786-9251
(Individual, family and marriage counselling provided with payment on a sliding scale according to income)
- The Family Centre of Winnipeg
401-393 Portage Ave-----947-1401
(Individual, couple and family counselling; workshops on family violence and sexual abuse provided with payment on a sliding scale according to income)
- Native Women's Transition Centre
105 Aikens Street-----989-8240
(Provides safe housing for aboriginal women and their children, offers support groups, counselling, childcare and sharing circles for their residents free of charge)
- Village Clinic
705 Broadway-----940-6000
(Free counselling provided for HIV positive survivors)
- Home Care Intake-----940-2655
(Access to a community mental health care worker for rural areas)

READING LIST**FOR WOMEN SURVIVORS:**

- Bass, E. & Davis, L., (1988). The courage to heal. New York: Harper & Row.
- Bass, E. & Davis, L., (1993). Beginning to heal: A first book for survivors of child sexual abuse. New York: Harper Collins.
- Bass, E. & Thorton, L., (Eds.), (1991). I never told anyone: Writings by women survivors. New York: Harper Perennial.
- Blume, S., (1990). Secret survivors: Uncovering incest and its after effects in Women. New York: Ballantine Books.
- Danica, E., (1988). Don't: A woman's word. Charlottetown, NC: Gynergy Books.
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- Grossman, F., Cook, A., Kepkep, S. & Koenen, K., (1999). With the phoenix rising: Lessons from ten women who overcame the trauma of childhood sexual abuse. San Francisco: Jossey-Bass Publishers.

FOR MALE SURVIVORS:

- Grubman-Black, S., (1990). Broken boys, mending men: Recovery from childhood sexual abuse. Blue Ridge Summit, PA: TAB Books.
- Hunter, M., (1991). Abused boys. New York: Fawcett Printers.
- Lew, M., (1990). Victims no longer. New York: Harper & Row.

FOR PARTNERS OF SURVIVORS:

- Gil, E., (1992). Outgrowing the pain together: A book for spouses and partners of adults abused as children. New York: Dell Trade Paperback.
- Graber, K., (1991). Ghosts in the bedroom. Deerfield Beach, FL: Health Communications Inc.

FOR PRACTITIONERS:

- Chalfen, M., (1993). Obstetric-gynecologic care and survivors of childhood sexual abuse. AWHONN's Clinical Issues in Perinatal and Women's Health Nursing, 4(2), 191-195.
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