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Treating without Traumatizing: Clinical Approaches to Trauma Survivors in Healthcare Settings

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Despite the high prevalence of sexual and physical abuse in women, physicians rarely identify these experiences in their patients; it seems essential in medical practice that physicians elicit such a history (Leserman, Toomey, & Drossman, 1995, p. 23).

According to the American Medical Association (1995), all healthcare providers periodically see patients who are difficult to treat, and don't respond to typical treatment protocols. Many of these are abuse survivors. Even though past abuse is related to many chronic conditions, healthcare providers rarely ask about it. And patients don't tend to offer this information. In one study, fewer than 2% of sexual abuse survivors in a rural family practice had discussed their abuse with their physician, despite having many health symptoms (Springs & Friedrich, 1992). When health care professionals don't recognize the impact of past abuse on their patients, they perpetuate the secrecy and shame of that experience and expose patients to unnecessary and costly procedures (American Medical Association, 1995).

Despite high use of healthcare services, abuse survivors often have a difficult time in healthcare settings. Many procedures designed to collect necessary health information can feel demeaning, or even traumatizing. In this chapter, I describe approaches to patients who have been abused. The main focus is how to provide treatment while caring for patients' emotional needs. I highlight aspects of medical situations that are potentially traumatizing, and indicate how to assess patients for current safety.

When to Suspect Past Abuse]

Some patients will chose not to reveal their history of abuse, even when asked. There are some specific signs that can indicate past abuse, however (Drossman, 1995). These signs fall into four general categories, and are listed below. It is important to keep in mind that not everyone with these symptoms is an abuse survivor, but these symptoms can at least raise abuse as a possibility in your mind.

Psychological Issues

Patients who are mistrustful of others, or have difficulty relinquishing control may have been abused. Another possible sign is patients who act helpless and dependent, or who report feelings of guilt and shame.

Medical Disorders

Some medical conditions may also be red flags for past abuse. Chronic refractory pain is one possible sign. The presence of depression or PTSD is another. Patients with eating disorders, sexual dysfunctions, or STDs may have also been abused. These disorders can also occur in people who are not abuse survivors, but their presence indicates that abuse is a possibility.

Patients' Behaviors in Medical Settings

Another possible indicator is use of healthcare services. A patient who makes frequent and excessive use of diagnostic procedures, treatments and surgeries may be an abuse survivor. However, many patients with chronic illnesses, who are not abuse survivors, also have high patterns of healthcare use. So this information must be considered along side the other healthcare data.

High use of services is one indicator, but avoidance is another. Frequent cancellations or appointment changes may indicate abuse (American Medical Association, 1995).

Illness behaviors might also provide some insight. This includes the degree and manner to which symptoms are reported, including their frequency, severity, and description. Patients who have been abused may have a level of disability that is disproportionate to the clinical data. They may want their healthcare providers to assume responsibility for their illness. These patients may also strenuously deny the role of psychogenic factors, and refuse to comply with treatment. Again, these characteristics may also appear in people who have not been abused, but abuse is a possibility.

How to Inquire about Past Abuse

Once you suspect that past abuse may be an issue, there are a number of specific steps you can take. Men and women will not reveal abuse if they do not feel safe. Taking time to get to know the patient, and establish rapport is an essential first step. Once rapport is established, the patient may volunteer this information to you. Or you can look for natural windows of opportunity where you can indicate that you are receptive to discussing their past experiences. You might begin by talking generally about how trauma is frequently part of the history of people who have chronic pain, for example. Tell them that many types of trauma including childhood abuse, loss of a parent, car accidents, or serious illnesses during childhood can be related to health problems. This often opens the door to future discussion. If patients suggest that things were “difficult” in their childhoods, you can ask an open-ended question to encourage them to elaborate. Open-ended questions are frequently helpful.

Drossman (1997) suggests that healthcare providers prepare for possible revelations of abuse by having referral sources in place, and knowing where to send patients. He recommends that healthcare providers continue providing care for patients who reveals childhood abuse. If you discontinue care, patients may assume that you are rejecting them once you have learned their secret.

Ask about past abuse in private, in a setting where there will be no interruptions. If patients deny the abuse, but you suspect otherwise, simply observe this and leave the topic open for future discussion. If the patient becomes very uncomfortable, you can end the discussion but be willing to talk about it another day. Many abuse survivors honestly don't see any connection between what happened in childhood and their current health. A strenuous insistence on your part can leave the impression that you don't see their health problems as "real," or that you are somehow blaming them for their current health problems.

Routine Screening

The AMA (1995) recommends routine screening for family violence. Questions about past and current abuse can be part of a review of systems, or can be asked while taking a social or sexual history. Abuse can be asked about when women are contemplating pregnancy, are currently pregnant, or if they report a recent change in family relationships (e.g., recently married or divorced). After an initial screening, periodic screening is helpful. The goal of finding out about past abuse is to provide safe and appropriate care in healthcare settings. It is also to assess current safety, documenting past or current abuse, providing treatment for medical or mental health conditions, and being a conduit to other resources in the community (American Medical Association, 1995).

Healthcare providers may be uncomfortable eliciting information about traumatic experiences and providing emotional support. In an era of managed care, you may feel pressured to move patients through the system, and don't feel that you can take the time to learn about their past experiences. Patients' stories of abuse can also remind practitioners of their own abusive experiences, and can make them want to distance themselves. While these reactions are understandable, the AMA (1995) cautions healthcare providers not to deal with their discomfort by distancing themselves, or pathologizing the patient, since this can mimic the dynamics of the abuse experience, and can also be traumatizing. Healthcare providers might also go too far the other way, and become too involved. This approach compromises the patient's autonomy and can lead to professional burnout.

Abuse Survivors May Deny Abuse

Patients may not admit to a history of abuse on your first attempt. As we discussed previously, abuse survivors are often mistrustful of others. You may have to demonstrate that you are going to preserve their confidentiality. When asking, it might

be helpful to indicate why you want to know, and what you plan to do with the information before patients reveal anything to you. Some survivors are very concerned that their employers will find out via their health insurance company. While we all hope that medical records are confidential, leaks do happen. Before asking about this type of information, think through what you will do with it. Will people at the health insurance company or the patient's company have access to it? A violation of a trust or confidence can be highly damaging to patients who already have difficulties trusting others. Proceed with caution.

Another factor is whether abuse survivors feel you can handle the information. While it is perfectly normal to react with horror at the news some patients share, it is important that you, as the professional, stay in control of yourself. It is appropriate to say "that must have been awful for you." But if you react strongly, patients will stop sharing with you. Since I am a family-violence researcher, people frequently share their stories with me. I have found, over the years, that people will often send up "trial balloons" that hint at an abusive past to see how I handle the information. Sometimes when I suspect past abuse, I will make a general statement about the impact of traumatic events on health. That often opens the discussion.

Finally, in considering whether you should ask, honestly ask yourself if you can handle this information. Not everyone can. If you are going to be very upset in front of the patient, or have trouble relating to the patient after he or she has revealed this information to you, it is probably better that you don't ask. You don't always need to know for sure. Sometimes you can have a working hypothesis and proceed "as if" the patient was an abuse survivor. You don't have to know for certain in order to devise a treatment plan.

Possible Amnesia

Another reason patients deny abuse is that they honestly don't remember their abuse experiences. Amnesia for abuse-related events is common. Williams conducted a prospective study of adult survivors who had been treated in an emergency room of a large urban hospital during the 1970's. All had documented cases of sexual abuse. When she re-contacted these women 20 years later, she found that 38% had experienced full or partial amnesia regarding their abuse experiences (Williams, 1994). Subjects in this study were willing to share information about drug abuse, criminal behavior, prostitution, pregnancies and abortions. It is unlikely that they were simply withholding information about their past sexual abuse.

In two other studies, researchers found that characteristics of the abuse predicted whether adult survivors would be amnesic about their abuse experiences. Herman and Schatzow (1987) found that age of onset, duration of the molestation, and degree of violence were related to whether women repressed memories of sexual abuse. Women whose abuse experiences started at an earlier age, were of short duration, and included force or violence were more likely to repress memories of abuse than those whose abuse started later, ended in adolescence, or did not include force or violence. The authors

speculated that repression might have been one of the few resources available to young children to help them deal with overwhelming trauma. Similarly, Briere and Conte (1989) studied this issue with a larger sample ($N=279$). They also found that subjects whose molestations were at an earlier age and included violent abuse were more likely to experience amnesia regarding their abuse experiences.

If Patients Share Their Abuse History

If patients indicate that they have been abused, acknowledge that you know that this information was difficult to share, and validate their experiences. State that past abuse is fairly common, and it can have an impact on health. Ask if they would like information on referral sources. Once you know about their past abuse, you need to note it on their medical records. You must assess their current safety. And, if appropriate, you also have a duty to report and warn. These tasks and obligations are described below.

Charting Abuse Information

If patients reveal past or current abuse, the AMA states that you must document it in their medical records. This revelation, along with relevant observations and laboratory results should all be recorded. Healthcare providers may be held liable for failure to recognize and respond to ongoing abuse (AMA, 1995). Be factual in your reports, using phrases such as “patient reports history of child physical abuse” or “patient reports childhood sexual abuse.” If there are physical injuries or scarring, document these as well, describing the location and type of injury. Document whether this injury was ever treated, and when treatment took place. You may also enquire about past illnesses, including a history of childhood STDs, urinary tract infections, or fractures that support claims of abuse. Abuse and its sequelae should be listed on the master problem list for each patient (AMA, 1995).

If injuries are current, document them by type, severity, and location. A body map is helpful, as are photographs (with the patient’s written permission). You should also record what the patient says about these injuries. Particularly with ongoing abuse, medical records may be used in court proceedings (Georgia Commission on Family Violence, 2002).

Documenting family violence in medical records should be relatively straight forward. However, there are ethical issues that arise because of third-party reimbursement, and the use of electronic medical records. Confidentiality becomes an issue when information about past abuse can be accessed by health insurers, employers, family members, or via the Internet. Don’t include any abuse information on forms to employers, and make sure that only authorized people have access to patient records.

The American Psychiatric Association has also indicated that since there is a growing vulnerability of medical records, practitioners need to be circumspect about what they record. They recommend not writing anything that would expose their patients to a

breach of privacy and confidentiality. They also recommend recording only factual and descriptive information, and not anything related to process or content of what was said, or practitioners' personal observations of patients (American Psychiatric Association, 1999).

Assessing Current Patient Safety

Unfortunately, the risk of ongoing abuse is high with survivors of childhood abuse. You may find that they are currently in abusive relationships. It is essential to talk to patients when they are alone, and not in the presence of partners, family members, friends, personal assistants or non-official translators. Before asking patients whether they are in abusive relationships, you must make clear any limits to confidentiality including mandatory reporting of partner, elder or child abuse (AMA, 1995).

Some indications of current abuse include presentation at an Emergency Department or in primary care with an injury that does not look like it could be have caused in the way that it was described. Also concerning are injuries during pregnancy, patients who come for treatment one or two days after receiving an injury, or patients who have several different injuries in various stages of healing. Some other symptoms of current abuse include repeat ED or primary care visits, unexplained somatic complaints, drug overdoses, suicide attempts, or self-mutilation. Finally, you should question ongoing abuse if the patient is accompanied to the visit by an overly attentive or aggressive partner (Georgia Commission on Family Violence, 2002).

Ambuel and Hamberger (1995) recommend screening for partner violence during annual physical exams, adolescent general exams and sports physicals, initial visits with first-time patients, pre-employment physicals (but don't make a note of it on the employer's form), OB visits and premarital exams. They suggest the following screening question.

Are you in any relationships now where you are afraid for your personal safety, or where someone is threatening you, hurting you, forcing sexual contact, or trying to control your life?

If you determine that domestic violence is occurring, your top consideration is for the safety of your patient. You should make referrals to community resources such as battered women's shelters, support groups, legal assistance, or mental health professionals for individual or group psychotherapy. Offer patients a chance to use the telephone even before they leave your office or the hospital (Georgia Commission on Family Violence, 2002). Medication may be necessary too, but the AMA (1995) cautions that healthcare providers be cautious in their choice; medications that impair patients' ability to accurately assess their safety, and act protectively should be prescribed with extreme care. This includes many of the tranquilizers that are often prescribed.

You must also assess the safety needs of your older patients. Elderly patients may be currently abused by their spouses, caregivers or adult children. Each state has their

own requirements for reporting elder abuse, so it behooves you to become familiar with your state laws if you have not already done so. Adult survivors of childhood abuse are at increased risk of revictimization throughout their lives (AMA, 1995), but elder abuse is frequently overlooked in healthcare settings.

Other Legal Obligations

Healthcare providers that learn of ongoing family violence have other specific legal responsibilities. These include the duty to report and the duty to warn.

Duty to Report. All states require that healthcare providers report cases of ongoing child abuse. A report may be necessary if an adult survivor has minor children, and is involved with an abusive partner. The adult survivor may also be abusive or neglectful if they are incapacitated due to mental illness or substance abuse.

Similarly, healthcare providers are also mandated to report elder abuse in most states. The abuse survivor may be either victim or perpetrator. Finally, many states have a law requiring physicians to report injuries that come about via the use of deadly weapons, so even if the abuse isn't specifically covered under mandated-reporting laws (e.g., domestic violence), it would have to be reported if it involved a weapon (AMA, 1995).

Duty to Warn. Healthcare providers have a legal obligation to report a patient's intention to harm a third party, although states vary in their definitions of the scope of this duty. This might involve encouraging patients to turn in weapons, using medication to lessen homicidal ideations, and possibly hospitalizing patients (AMA, 1995). Since these actions breach patient confidentiality, patients should be informed of this ahead of time.

Treating Without Traumatizing: Approaches to Patients in Medical Settings

Once you have determined that a patient is an abuse survivor, the next step is providing healthcare services in a way that does not cause additional trauma. To help you anticipate and avoid some common problems, it is helpful to see procedures from the patient's perspective. Many medical procedures involve authority figures touching, manipulating and invading body parts. These procedures can be especially difficult for sexual abuse survivors because the dynamic is very similar to their abuse. The American Medical Association (1995) indicated that procedures such as general anesthesia, muscle paralysis, confinement or immobilization (e.g., for an MRI), or insertion of catheters can be difficult for abuse survivors.

Invasive procedures like breast exams and mammograms, pelvic exams, pap smears, catheterization, or rectal exams can trigger flashbacks. Dental exams have even been shown to increase anxiety among abuse survivors. Disrobing and lying supine on an exam table can cause difficulties (AMA, 1995; Laura Miller, 1999). Pain syndromes, which are common among abuse survivors, may lead to even more invasive procedures.

For example, a vaginal ultrasound or uterine biopsy may be necessary for a woman with chronic pelvic pain. She may also require gynecological surgery. For patients with lower abdominal pain, colonoscopies, sigmoidoscopies, barium enemas might be part of the diagnostic workup. Hospitalization can also be intimidating, as is lack of control basic bodily functions; and a parade of caregivers who are strangers. Seclusion and lack of privacy can also cause problems (AMA, 1995).

Because patients have been disempowered by their previous experiences, you will want to empower them as much as possible. Below are some specific suggestions about ways to make patients feel more comfortable during exams and procedures. Chances are, these procedures may already be part of the way that you approach patients. But I reiterate them here since a reminder is often helpful when working with a vulnerable population (AMA, 1995; Laura Miller, 1999).

Talk to Patients Before Any Procedure and Warn Them about What to Expect

This is a good practice for any patient, but it is especially helpful for abuse survivors. If it is an emergency, you may have to talk as you go. Patients will feel better about a procedure if they had a say in whether it was performed. If there wasn't time in the midst of an emergency, talk to them about it once the danger has passed. In the hospital, keep the number of caregivers to a minimum, provide explanations and advance warnings for each procedure, and introduce all new team members to the patient.

Ask Permission Before Touching Patients

Again, this is always a good idea with any patient but it is especially important for abuse survivors. This is particularly important when touching "private" body parts such as the breasts, genitals or rectums. But a touch anywhere without permission is likely to feel invasive. Some practitioners have also found that it is helpful to have patients assist by putting their hands over the physician's to guide the exam.

If You Know That Someone Is An Abuse Survivor, Ask What They Normally Do To Cope

A particular patient that you are working with may already have a way to cope with things that remind them of their abusive experiences. They may distract themselves, practice relaxation techniques, or listen to music. Give them permission and encouragement to use whatever technique they need to cope with the present examinations and procedures. Also realize that some standard "stress reduction" techniques, such as hypnosis or guided relaxation, may actually increase stress in abuse survivors since patients feel they are losing control of their bodies.

Allow Patients to Have Emotional Support During Exams Or Procedures

Abuse survivors might cope better if they have a support person is with them during a procedure. Offer this option, but do not force it. A "support" person that the

patient does not want could actually make the patient feel more exposed in an already vulnerable situation.

Warn About Any Procedure That Is Likely To Be Painful

Be truthful when describing the amount of pain that you expect patients to feel. Also bear in mind that many abuse survivors have lowered pain thresholds; something that you would not expect to be painful, might in fact be very painful for your patient.

Allow Ample Time For Exams

If you know, or suspect, that a particular patient is an abuse survivor, be sure to allow extra time for examinations. That will be necessary for you to explain everything thoroughly, and allow the patient breaks as you go. If you are hurried or rushed, you may be tempted to dispense with parts of the exam that take extra time (such as explaining things). Your patients may leave your office feeling revictimized by their medical experiences.

“Check-In” With The Patient From Time To Time

As you proceed through an exam or procedure, periodically check in with patients to make sure they are OK, or if they need a break. It might take several appointments before a procedure can be completed.

Be aware of situations that make patients feel vulnerable

As described above, some specific types of procedures or examinations may make abuse survivors feel vulnerable. If at all possible, discuss these with your patients, let them know why the procedure is necessary, or describe what the other options are. Some patients may be fine with various procedures, while others may have a hard time.

Patients are likely to feel vulnerable when unclothed, or when laying flat on their backs

Try to minimize this position as much as possible. If part of the exam can be done sitting up, do as much as you can from this position. Also try to keep patients' exposure of their bodies to a minimum since this can dramatically increase vulnerability.

Using a Team Approach to Care

Treatment for adult survivors typically involves mental health services that are delivered separately from medical services. This approach is generally inadequate. Considering the co-morbidity of physical and mental health concerns, the most effective treatment plans are those that address both. Interestingly, it is the gastroenterologists who have led the way in this, in their remarkable position statement on the treatment of irritable bowel syndrome (American Gastroenterological Association, 1997a). In this

statement, the AGA recommended that practitioners include a mental health professional on the team for the treatment of psychiatric disturbances, such as major depression and a history of abuse, that may interfere with the patients' adjustment to their illness. The mental health professional should be considered an integral part of the treatment team for the patient's overall care.

How you present the mental-health component of care will influence your patient's willingness to accept it. When presenting this option, frame it in such a way that the patient sees that it is part of the treatment plan. Explain how past abuse can influence current functioning. Patients are much more likely to accept a recommendation if the mental health provider is someone you personally know, and if you are going to be involved in their ongoing care (AMA, 1995; Drossman, 1995).

A mental health intervention does not mean that the patient is "crazy," but you are suggesting it so the patient can break the cycle of depression, psychological distress, painful symptoms and other chronic conditions (Drossman et al., 1995). Improvement in psychological distress can help patients make a better overall adjustment to illness. If patients don't want to use mental health care services, however, Drossman suggests that you continue normal care.

Finding Clinicians in your Community

In order to begin a team approach to treatment, it is important to locate clinicians who can participate. To compile a list of mental health providers with experience in treating family violence, begin by contacting local victim advocacy groups including battered women's shelters, rape crisis centers, and family-violence hotlines. State psychological associations also generally keep a list of clinicians who treat trauma. Before adding someone to your list, it's best if you make contact yourself. Find out what types of clients they accept, whether they are willing to receive referrals from you, and what type of payment they require. This can be particularly important for survivors who require low-cost options (AMA, 1995). If possible, offer patients more than one option so they can select a mental health provider with whom they are comfortable and have rapport.

Identify Co-Morbid Psychological Conditions

One important role of mental health providers is to identify psychiatric conditions that might be hampering medical treatment such as depression, anxiety, PTSD, eating disorders, and substance abuse. The mental health provider can also ask about a history of abuse if you have not already done so, or can confirm a history of abuse that you have already identified. The mental health practitioner can also gather more information about these experiences, and this history can become the focus rather than simply one part of a medical history. However, patients should not be forced or coerced into dealing with abuse issues until they are ready to do so. If patients aren't ready to confront their abusive pasts, mental health providers can still help them cope with their current situation and illness.

Ideally, there should be on-going collaboration between the healthcare provider and mental health provider as to the best way to approach and treat a particular patient. This might lead to adding psychopharmacological treatments to the plan, and/or specific psychological interventions, such as cognitive therapy to address maladaptive health beliefs. In cases where psychological disturbance is extreme, the mental health practitioner may assume the primary treatment role for this patient, but you should continue to be involved (Drossman et al., 1995).

The Use of Support Groups

Support groups are another important adjunct to treatment for abuse survivors. Depending on which need is more pressing, patients may attend groups addressing survivor issues, substance abuse recovery, or specifically address their illness. The one caveat is that the groups must be formatted so that they focus on positive coping, and don't just dwell on the negative aspects of their conditions or lives. Negativity in groups is contagious, and members can often leave feeling worse than they did before they arrived.

Conclusions

Past and current abuse can lead to serious health consequences. There are some specific steps you can take to make it safe for adult survivors in your practice. A team approach is the most effective for helping abuse survivors with health problems, and can keep you from shouldering the load alone. In the next two chapters, I describe protocols for clinical management of two conditions that often present in healthcare settings: depression and chronic pain.

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