

Post-traumatic Stress Disorder Within a Primary Care Setting: Effectively and Sensitive Responding to Sexual Trauma Survivors

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ABSTRACT

It is estimated that 1 in 4 females and 1 in 6 males have experienced sexual assault or abuse before the age of 18.¹ While the response to such experiences vary, a significant number of survivors will develop post-traumatic stress disorder or another mental illness. Post-traumatic responses can persist for years and may impact a patient's experience of medical care. Unfortunately, consistent inquiry around sexually traumatic experiences is not implemented in primary care settings. As a result, patients may feel retraumatized while receiving care or their mental health symptoms may be misdiagnosed, resulting in inappropriate treatment or referrals. Screening for sexual trauma and gaining an understanding of how to respond empathically to post-traumatic responses enable primary care physicians to provide sensitive and effective care to trauma survivors.

INTRODUCTION

The experience of sexual trauma impacts a considerable segment of the general population. Results of studies exploring prevalence of sexual assault and abuse vary somewhat due to factors including population, methods, and scope of behaviors explored, but most estimates suggest that between 12% and 25% of women will experience sexual violence at some point in their lifetime.¹⁻³ A national survey of adult women and men found that 1 in 4 females and 1 in 6 males have experienced sexual assault or sexual abuse before the age of 18.¹ Furthermore, 302,000 adult women and 92,000 adult men are forcibly raped each year in the United States.² The sequelae of sexual abuse or assault is variable, ranging from mild disruption in functioning to the

development of post-traumatic stress disorder (PTSD) and/or other mental illness. Both Resnick et al⁴ and Breslau et al⁵ found results suggesting that assault and rape are the most frequent traumas associated with the development of PTSD in women, and Kessler et al⁶ found rape as the trauma most likely to be associated with PTSD in both men and women. Studies have shown that almost half of rape survivors will develop PTSD⁷ and that rape victims are 3 times more likely than non-victims of crime to have experienced a major depressive episode in their lifetime.⁸ Such figures suggest an obvious connection between the experience of sexual trauma and mental illness.

Post-traumatic stress disorder includes 3 subsets of symptoms: reexperiencing of traumatic event(s), avoidance behaviors, and hyperarousal. The complete criteria for PTSD, as described in the DSM-IV R, are included in Table 1. PTSD has been described as one of the most common anxiety disorders, with prevalence rates ranging from 5% to 10%—almost half that of major depression.⁹

Several studies have explored the factors that may contribute to the development of PTSD in victims of sexual trauma. One factor related to the individual that is consistent across research is the presence of a personal or family history of psychiatric disorder.^{9,11} Several factors related to the nature of the traumatic experience have been described as predictive factors, including the involvement of interpersonal violence, severity of the trauma, chronicity of the traumatic experience, whether it involves a fear of dying, and most importantly, whether the recovery environment is associated with secondary stressors, such as pain, relocation, job loss, or blame.⁹ If sexual assault or abuse is measured against these factors, it can be suggested that sexual trauma is an experience very likely to result in the development of PTSD. For example, all experiences of sexual assault and abuse are interpersonal and violent

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Table 1. Diagnostic Criteria for 309.81 Post-Traumatic Stress Disorder

- A. The person has been exposed to a traumatic event in which both of the following were present:
 - the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
 - the person's response involved fear, helplessness, or horror.
- B. The traumatic event is persistently reexperienced in 1 (or more) of the following ways:
 - recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions
 - recurrent distressing dreams of the event
 - acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated
 - intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
 - physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by 3 (or more) of the following:
 - efforts to avoid thoughts, feelings, or conversations associated with the trauma
 - efforts to avoid activities, places, or people that arouse recollections of the trauma
 - inability to recall an important aspect of the trauma
 - markedly diminished interest or participation in significant activities
 - feeling of detachment or estrangement from others
 - restricted range of affect (e.g., unable to have loving feelings)
 - sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)
- D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by 2 (or more) of the following:
 - difficulty falling or staying asleep
 - irritability or outbursts of anger
 - difficulty concentrating
 - hypervigilance
 - exaggerated startle response
- E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

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by nature, and childhood sexual abuse often assumes a chronic course. Furthermore, secondary stressors are common in the context of sexual assault and abuse. Specifically, it is widely known that self-blame is common in sexual assault survivors and many disclosures are met with victim-blaming attitudes and responses by others. Many victims of sexual assault and abuse have to relocate due to danger or fear and still others are unable to continue to fulfill work or school obligations due to the nature of post-traumatic symptoms (i.e. flashbacks, insomnia, avoidance behaviors).

PTSD AND THE HEALTH CARE SYSTEM

Many who suffer from PTSD or post-traumatic symptomatology do not seek, or have access to, appropriate treatment. In response, many trauma survivors attempt to get their physical, emotional, and mental health needs met through a primary care setting. Traumatized patients make 4 times as many physician visits as non-traumatized ones⁹ and survivors of childhood sexual abuse report more somatic complaints and are more likely to have a mental health, pain disorder, and/or general medical diagnosis.¹² Child sexual assault survivors are 2½ times as likely to have pelvic pain and pelvic inflammatory disorder, breast diseases ranging from fibrocystic changes to cancer, and yeast infections.¹³

Unfortunately, sexual assault and abuse histories are not regularly completed in medical care settings. In a study that compared the gynecological care experience of adult survivors of childhood sexual abuse to those of non-abused women, 82% of survivors and 87% of non-abused controls reported that they were not asked about a history of sexual assault or abuse.¹⁴ The authors use the responses of those surveyed to conclude that providers should be routinely inquiring about sexual abuse because most survivors reported feeling unable to bring up the topic themselves. The lack of screening around sexually abusive experiences could be related to a number of factors, including, but not limited to, discomfort or lack of familiarity with sexual abuse issues and time constraints present in the current structure of many health care settings. However, studies show that screening for intimate partner violence (IPV) in medical settings has been effective in identifying victims and that patients are not offended when asked about current or past IPV.¹⁵ It is safe to assume that these results would be similar for sexual violence survivors as well. Abuse experiences (physical or sexual) are often saturated in shame, and, therefore, people find it difficult to offer the information spontaneously without some as-

urance that their disclosure will be met with support and understanding. The mere asking of a question related to sexual trauma implicitly suggests that the provider values the importance of such experiences.

Some primary care physicians may also fail to address mental health needs while providing care to their patients, either by not assessing the patient's symptomatology or assuming that the patient is accessing treatment through a mental health professional. This is often not the case. Even if mental health symptoms are assessed, PTSD can be misdiagnosed as depression or anxiety, due to a similar clinical presentation. The likelihood of such a misdiagnosis could be decreased with the completion of a thorough abuse history screening that would provide information highly relevant in treating patients who report symptoms consistent with that of PTSD. If post-traumatic syndromes are misdiagnosed as depression or anxiety, the patient will likely receive care that is not trauma-focused, which is inconsistent with best practice guidelines for the treatment of PTSD.

There are further consequences related to the failure to screen for trauma histories, in addition to those that relate to identifying and responding to mental health needs. Survivors of abuse may require modifications in the care they receive from their physician, based on post-traumatic responses that may be triggered by physical examinations and testing procedures. There is limited research focusing on how trauma survivors experience the medical care they receive, but one study did specifically explore the gynecological care experiences of adult survivors of childhood sexual abuse.¹⁴ Survivors reported more discomfort, shame, and vulnerability during gynecological examinations than those in the control group. Many reported experiencing a number of trauma symptoms during their visit, with 62% feeling overwhelmed by emotion and nearly half reporting other trauma-related symptoms, including feelings of detachment from their body, unwanted or intrusive thoughts, and triggered memories.

For the aforementioned reasons, it behooves primary care providers to regularly and thoroughly screen for abuse experiences and include deliberate efforts within their practice to provide care that is responsive and sensitive to the needs of survivors. It is crucial that physicians are educated about trauma response and post-traumatic stress disorder, along with referral sources for trauma-focused treatment.

TRAUMA-INFORMED PRIMARY CARE TREATMENT

One of the most important ways that physicians can

address the impact of sexual trauma in their patient population is to implement a process to assess for abuse experiences. In many primary care settings, nurses or medical assistants ask patients about current intimate partner violence at the beginning of each visit. While this is absolutely a needed aspect of the abuse screening process, it excludes all abusive experiences in a person's past and all abusive experiences that are sexual in nature. Due to differences between the dynamics of sexual assault and intimate partner violence, it is recommended that a slightly different process be utilized to explore sexual violence issues.

Simply asking a question around sexual abuse can trigger a cascade of memories for a survivor, some or all of which may never have been experienced or addressed prior to that moment. In such a situation, a survivor would be put into a state of crisis or trauma without warning and possibly without adequate support. While time constraints may be present for physicians in the current health care system, it would be more appropriate for this matter to be discussed between patients and their doctor, as opposed to a medical assistant who may be ill-equipped to respond to a disclosure. This ensures that appropriate follow-up can be provided to address any post-traumatic responses. Also, if the patient's physician completes the inquiry, a message is being delivered that the physician values the importance of such experiences, which would likely enhance the doctor-patient relationship, which in turn could only enhance all aspects of the care the patient receives.

Additionally, asking about a history of sexual abuse or assault at every visit is unnecessary, which is another difference from that of intimate partner violence. A patient would likely find it disruptive, or even traumatizing, to be asked at every visit if they were sexually abused, especially if they have already disclosed at a previous visit. If the physician has discussed this issue with the patient, however, it would be understood that the issue is revisited only if the patient so desires or specific concerns arise. Ideally, as a result of addressing the issue directly and sensitively, a relationship would be developed that would support the patient feeling comfortable disclosing new experiences of assault if they were to occur because they would have confidence that their provider would respond appropriately.

Many health care providers understand the importance of addressing abuse issues in their practice, but are unsure how to phrase the questions or how to approach the subject during a visit. Phrases and direct questions that may be utilized alone or in combination as sexual trauma screening tools in a primary care setting are in-

Table 2. Sexual Trauma Screening Tools

"Because abuse is so common in people's lives, I've begun to ask about it routinely."

"Unfortunately, sexual assault and abuse are common and can affect people in many different ways. I've started to ask my patients about these experiences to ensure that I can help them in the best way possible."

"Has anyone ever had sex with you or touched you in a sexual way without your consent?"

"Were you sexually abused as a child?"

"Were you sexually abused or assaulted as a teenager?"

"Have you had sexual experiences that felt confusing, hurtful, or violent?"

Table 3. Sensitive Post-Disclosure Responses

"I'm sorry you were hurt in that way."

"What happened was not your fault."

"You are not to blame for what happened to you."

"Thank you for trusting me with such an important and private experience."

"You deserve help in dealing with something so difficult. Would you like me to connect you with someone you could talk to about this?"

"Let me know how I can make you more comfortable as I take care of your medical needs."

Table 4. Possibly Retraumatizing Procedures

Gynecological examinations

Rectal examinations

Oral examinations

Procedures in which a patient's mouth is held open for extended periods of time can trigger memories of oral assault.

Instruments such as tongue depressors can stimulate the gag reflex, which also may be retraumatizing.

Conscious sedation

Loss of physical control and increased vulnerability can mirror feelings of helplessness experienced during abusive incident(s).

cluded in Table 2. They are designed to be used in conjunction with questions related to domestic violence.

The aforementioned questions are designed to create an environment that is safe and supportive enough for a patient to disclose their experiences of abuse. It then becomes important that medical providers are well equipped to respond empathically, sensitively, and comfortably to a disclosure. Phrases and statements that can communicate support and empathy to a survivor are included in Table 3.

Sexual trauma can affect how a person experiences touch from others, even years after they were victimized. Memories can be triggered by seemingly innocuous stimuli, so it is imperative that providers avoid making assumptions about what could be frightening or confusing to abuse survivors. Procedures that could be potentially revictimizing or uncomfortable for survivors of sexual abuse or assault, depending on the nature of their experience, are outlined in Table 4.

When a person has identified as a survivor, a physician can empower the patient by creating opportunities for the expression of discomfort during procedures and openly discussing ways to modify and enhance care they provide to survivors of sexual trauma. The suggestions included in Table 5 will assist in avoiding re-traumatization of the patient during medical examinations and creating a safe environment for the patient.

The final aspect to providing care that is sensitive to trauma survivors includes referral for appropriate treatment. There are 3 aspects to the management of PTSD: education, psychosocial support and/or treatment, and psychopharmacologic treatment.⁹ Education regarding post-traumatic responses may come from a number of sources including mental health professionals and medical providers. Normalization of post-traumatic responses such as nightmares, flashbacks, and intrusive thoughts can assist survivors in understanding their experience, which may decrease additional anxiety. Information on healthy coping strategies is also useful as an educational tool.

Trauma-focused cognitive-behavioral psychotherapy is widely accepted to be most effective in the treatment of PTSD. Ideally, physicians would be well acquainted with a wide network of providers who work with trauma survivors in their area and could provide a referral that is a good fit with their patient's clinical needs and financial resources. However, such a process could require more time than is available in many clinic and hospital settings. Most communities have access to a rape crisis center or state sexual assault coalition and such organizations can serve as an excellent "first call for help" in connecting callers with appropriate referrals. Therefore, it may be most efficient to have these numbers on hand to provide to patients who share experiences of abuse.

Finally, pharmacologic treatment can be effective in managing moderate to severe PTSD symptoms. The International Consensus Group on Depression and Anxiety⁹ recommend the following clinical guidelines for the pharmacologic treatment of PTSD in a primary care setting:

- Selective serotonin reuptake inhibitors (SSRIs) are generally the most appropriate choice of medication for PTSD.
- Benzodiazepines are generally ineffective in treating PTSD and may worsen the clinical condition of patients.
- Continue effective drug therapy in most patients for 12 months or longer.
- Refer to a psychiatrist those patients who are refractory to initial drug therapy at 3 months and those with complicating comorbid conditions.

SUMMARY

Sexual assault and abuse survivors represent a significant portion of any primary care patient population. However, consistent inquiry around sexually traumatic experiences is not yet implemented in most health care settings. As a result, mental health symptomatology may go undetected, misdiagnosed, or inappropriately treated when it is not considered within the context of trauma. Additionally, patients may find that medical examinations and procedures can trigger post-traumatic responses, such as flashbacks or feelings associated with abuse. By inquiring about trauma histories, primary care physicians are sending a message that they recognize the importance of such experiences and are willing to serve as a resource for addressing their patient's needs. Offering empathic responses to disclosures, modifying medical care to decrease discomfort and anxiety, and connecting patients with appropriate treatment referrals serve as effective ways to optimize the care that is provided.

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Table 5. Suggestions on Avoiding Revictimization

- Greet the patient while she/he is still fully dressed.
- Avoid positioning yourself between the patient and the exit door.
- Ask what you can do to make the examination easier and less frightening.
- If possible, offer the presence of a third person in the exam room.
- Explain what you plan to do and the reasons for the procedure before performing any exams or testing.
- Ask permission to touch the patient.
- While you are providing the care, keep patient informed as to what you are doing as you are doing it.
- Check in regularly as to how the patient is feeling.
- Move at the client's pace and take breaks as necessary.
- Use grounding techniques (i.e. calmly remind patient where they are, that they are safe, and that the abuse is not currently happening) if patient seems to be disconnected or in distress.
- Restore a sense of control for the patient by providing her/him with as much choice as possible.

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