

## Women survivors of child sexual abuse *How can health professionals promote healing?*

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### ABSTRACT

**OBJECTIVE** To explore how health professionals can practise in ways sensitive to adult women survivors of child sexual abuse.

**DESIGN** Qualitative semistructured in-depth interviews.

**SETTING** Small and midsize cities in Ontario and Saskatchewan.

**PARTICIPANTS** Twenty-seven women survivors of childhood sexual abuse.

**METHODS** Respondents were asked about their experiences with physical therapists and other health professionals and asked how practice could be sensitive to their needs as survivors. A grounded-theory approach was used. After independent analyses, researchers achieved consensus on the main themes. Findings were checked with participants, other survivors, and mental health professionals.

**MAIN FINDINGS** A crucial theme was the need to feel safe when consulting any health professional. Participants described specific ways for clinicians to facilitate the feeling of safety. Disclosure of abuse history was another key theme; analysis revealed no one "right way" to inquire about it.

**CONCLUSION** Women survivors of child sexual abuse want safe, accepting environments and sensitive, informed health professionals with whom to work in partnership on all their health concerns.

### RÉSUMÉ

**OBJECTIF** Explorer comment les professionnels de la santé peuvent adapter leur pratique de manière à être sensibles aux femmes adultes survivantes d'abus sexuels durant leur enfance.

**CONCEPTION** Des entrevues qualitatives semi-structurées en profondeur.

**CONTEXTE** De petites et moyennes villes en Ontario et en Saskatchewan.

**PARTICIPANTES** Vingt-sept femmes survivantes d'abus sexuels durant leur enfance.

**MÉTHODES** On a posé des questions aux répondantes concernant leurs expériences avec des thérapeutes physiques et d'autres professionnels de la santé et on leur a demandé de dire comment ces derniers pourraient faire en sorte que leur pratique soit réceptive à leurs besoins en tant que survivantes. On a eu recours à une approche de théorie ancrée. À la suite d'analyses indépendantes, les chercheurs se sont entendus sur les principaux thèmes. Les constatations ont été validées par les participantes, d'autres survivantes et des professionnels de la santé mentale.

**PRINCIPALES CONCLUSIONS** La nécessité de se sentir en sécurité lorsqu'on consultait un professionnel de la santé, quel qu'il soit, était un thème central. Les participantes ont décrit des approches spécifiques que peuvent adopter les cliniciens pour leur inspirer un sentiment de sécurité. La divulgation des antécédents d'abus comptait au nombre des autres thèmes principaux; l'analyse a révélé qu'il n'existe pas de «bonne façon» de poser des questions à ce sujet.

**CONCLUSION** Les survivantes d'abus sexuels durant l'enfance veulent des environnements sûrs, sans critique, et des professionnels de la santé sensibles et informés avec qui travailler en partenariat en ce qui concerne toutes leurs préoccupations de santé.

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In Canada, prevalence rates for child sexual abuse range from 11.1%<sup>1</sup> to 22%<sup>2</sup> for women and 3.9%<sup>1</sup> to 10%<sup>2</sup> for men. A review of primarily American studies<sup>3</sup> concluded that “enough credible figures cluster around or exceed 20% to suggest that the number of female victims has been at least this high” and that a conservative estimate for men would be from 5% to 10%.

Numerous studies have reported an association between child sexual abuse and various medical conditions, including chronic pelvic pain, gastrointestinal disorders, irritable bowel syndrome, and recurrent headaches.<sup>4-9</sup> Researchers have also reported that, compared with control subjects, survivors of child sexual abuse have a higher prevalence of medical problems, somatization, high-risk behaviours, family physician visits, hospitalizations, and surgeries.<sup>8,10-12</sup>

While this research<sup>13,14</sup> has methodologic problems, Fry<sup>14</sup> concluded, after a rigorous critique of several studies, that “recurring themes [in the research] to do with child sexual abuse and later ‘nonpsychological’ consequences appear to be in the areas of somatic anxiety... and health-care utilization associated with a range of physical symptoms.” This conclusion is compatible with research showing that women with chronic illnesses are more likely than other primary care patients to report a history of physical or sexual abuse (in childhood, adulthood, or both) or a history of dysfunctional parenting,<sup>15,16</sup> and with evidence that hypothalamic-pituitary-adrenal axis and autonomic nervous system hyperreactivity can contribute to psychopathologic conditions in adult survivors of childhood abuse.<sup>17</sup>

Researchers have explored the questions and issues that shape interactions between physicians and female patients who are currently in abusive relationships<sup>18-26</sup> and have begun to explore the interactions between health professionals and child sexual abuse survivors.<sup>27-29</sup> Recommendations to

enhance health care experiences of survivors of child sexual abuse have been developed from the literature on psychological and medical problems of survivors.<sup>27</sup> Use of an experimental gown has been shown to result in less anxiety for survivors during gynecologic examination.<sup>28</sup> A case report concludes that severe abuse can result in predictable difficulties in physician-patient relationships.<sup>29</sup>

Unlike these examples, our study builds on the premise that health professionals need to hear and reflect on the perspectives of abused women explaining how clinical practice might be more sensitive to their needs. It explored the clinical practice issues for women survivors of sexual abuse who were treated by physical therapists.<sup>30,31</sup> This study is relevant to family physicians for several reasons. While touch is required less frequently in visits to physicians than in visits to physical therapists, touch and other forms of physical contact are still often a part of examinations. In addition, many components of the practitioner-patient relationship are similar for the two professionals. Physicians refer women to physical therapists and need to be aware of how these referrals could affect their patients. Last, in the course of our study, participants spoke about their interactions with physicians.

## METHODS

We interviewed 27 women who survived childhood sexual abuse and who had received or been referred to physical therapy. Survivors were recruited through agencies, groups, and people providing counseling and support for survivors in Saskatoon, Saskatchewan, and in London, Guelph, Kitchener, and Waterloo in Ontario. We asked agencies and counselors to display information about the study and mention the study to survivor clients. Survivors who were interested in participating in the study contacted us. In order to participate in this study, women were required to have either formal or informal support around issues of sexual abuse through, for example, counseling or self-help groups. We ceased recruiting participants when saturation of themes was reached.

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Participants provided informed consent and were offered \$20 honoraria for their participation in semi-structured interviews lasting approximately 60 minutes. Two authors (C.L.S. and C.A.S.) conducted the interviews, which were audiotaped and transcribed. Following the conventions of grounded-theory research,<sup>32,33</sup> no attempt was made to predefine relevant data or to use predetermined questions. Thus, each interview was different, as we concentrated on issues raised by each participant. The focus of each interview, however, was on emotions and concerns related to contact with physical therapists and other health professionals. No specific questions about physicians were asked; however, if a participant referred to a physician, she was asked to describe her experiences and ideas.

Using the constant comparative method, data analysis began when data collection commenced and guided the ongoing interview process. Patterns emerging from the data were used to develop a theory that encompassed survivors' experiences and ideas for sensitive practices.<sup>30,31</sup> Using Folio Views 3.1 Infobase Management Software, three authors (C.L.S., C.A.S., and E.T.) each analyzed the data independently and then discussed the data as a group. Although there were variations in labeling of some categories, consensus was reached after a brief discussion of the main emerging themes.

Our interpretation of the data was shared with participants in an effort to ensure that it reflected their reality. Each participant received a summary of the data interpretation and was invited to respond. Participants' feedback confirmed the centrality of the themes that we identified and the representation of their thinking in our analysis.

Both survivors and health professionals validated the relevance of our analysis in subsequent phases of this study. During the second phase, carried out in Saskatoon and Waterloo, survivors and physical therapists met together in working groups to offer practice recommendations based on the interview findings. During the third phase we developed a handbook on sensitive practice<sup>34</sup> by combining the initial analysis and working group recommendations into a draft of the handbook and then seeking feedback on successive drafts, in writing and from

focus groups, survivors, counselors, and physical therapists across Canada.

After completing this process, we returned to the transcripts of interviews to examine themes that emerged from survivors' comments about their interactions with physicians. After a survey of data to identify comments made about interaction with physicians, two authors (N.A.R. and C.L.S.) analyzed the data independently and then reached agreement on the analysis. Authors E.T. and C.A.S. also examined the data and analysis to confirm findings. Results are presented below under "Themes related to physicians". This study was approved by the University Advisory Committee on Ethics in Human Experimentation (Behavioral Sciences) at the University of Saskatchewan and by the Research Ethics Committee at Wilfrid Laurier University.

## FINDINGS

Mean age of participants was 39 years (range 19 to 62). Participants listed occupations as homemaker, librarian, life skills coach, minister, teacher, nurse, nurse's aid, receptionist, social worker, student, writer, and unemployed. One woman identified herself as Metis; 26 participants identified themselves as white. Twelve women were single, seven were married, one was separated, and seven were divorced.

### Sense of safety

The first and most predominant theme was the need to feel safe when interacting with health professionals.<sup>30</sup> One woman summarized this sentiment, saying, "I now am beginning to understand that my physical wellness is really very connected to my emotional state, and if I'm not comfortable, if I'm feeling unsafe, then I'm not going to progress as quickly as a physiotherapist would want me to."<sup>30</sup>

Participants spoke of many feelings and experiences commonly associated with long-term effects of childhood sexual abuse that threatened their sense of safety. Most reported anxiety and fear of being abused during appointments and spoke about how their perceived lack of control during appointments compromised their feeling of safety and treatment adherence.

Participants reported that their feelings of being unsafe were also related to the pain for which they sought treatment, because the experience of physical pain was cognitively associated with past abuse. Most participants described being “triggered,” that is, experiencing flashbacks, dissociation, or overwhelming emotions (such as fear, anxiety, terror, grief, or anger) that they linked with various components of the examination that left them feeling unsafe.

## Disclosure

The second theme centred on disclosure of past abuse to a clinician.<sup>30,31</sup> While not all women thought that physical therapists should inquire about past abuse, most advocated for inclusion of more limited forms of inquiry that included questions about patients’ discomfort or sensitivity with components of the examination or treatment, such as disrobing and touch of specific body parts. Some women also suggested inclusion of an open-ended question, such as, “is there anything else you feel I should know before we begin?” to give survivors an opportunity to disclose as much as they might want to.

The key lesson from our interviews is that there is no one right way to facilitate disclosure of childhood sexual abuse. A common theme was that disclosure will not occur if a woman is unsure about how such information will be received. If a clinician gives her reason to believe that a disclosure of abuse, first of all, will be believed, and, second, will be responded to with calmness, compassion, and concern, the woman is more likely to take the risk.

## Sensitive practice

The third theme centred on practical suggestions of ways that clinicians could practise more sensitively.<sup>30,34</sup> Suggestions stemmed from survivors’ desire to be treated with respect and from their wish for clinicians to be understanding and knowledgeable about abuse issues. Participants urged clinicians to be attentive to boundaries, to learn more about the effects of traumatic experiences on the body, and to demonstrate their awareness of the prevalence and sequelae of violence. They advocated understanding the conflict some survivors feel when seeking assistance for a body about which they feel ambivalence. One woman pointed out

that the amount of attention “[I give to my body] ebbs and flows too, depending on where I’m at and how well I’m choosing to take care of my body. Which is a very difficult thing for me physically to do, because when you don’t live there, it’s just sort of a vehicle to get around.”<sup>30</sup> Many also encouraged clinicians to understand and respect that, because healing from childhood sexual abuse is not a linear process, survivors can manifest changing levels of tolerance for the many aspects of examination and treatment. One woman pointed out that “... parts of my body at different times might be untouchable. It’s gonna change depending on what I’m dealing with. So, you’re not going to be able to make a list and count on that every time kinda thing; it’s gonna be a check-in every session.”<sup>30</sup> They urged that clinicians work in partnership with patients, sharing control and information and encouraging patients to become active participants in their health care.

## Themes related to physicians

Many similarities between participants’ experiences, comments, and suggestions about interactions with physical therapists and physicians were evident (**Table 1**). The need to feel safe was the predominant theme for both. The fervent wish for physicians to address the power imbalance by sharing control and information with them was also common.

[T]hey tell you to get undressed, and then this person comes in and talks to you, and you’re sitting there talking to someone who’s fully clothed... and you’re naked. It’s a totally unequal situation;... the best bet is to talk first and explain what’s gonna happen and everything, and then get the person to get undressed.<sup>30</sup>

**Table 1. Summary of common themes related to physicians:**

*Survivors’ opinions on physician-initiated questions and methods of inquiring about history of abuse varied.*

Need for feeling of safety when seeing family physicians
Desire for family physicians to share information and control with survivor
Desire to work in partnership with family physicians
Desire for family physicians to understand issues of child sexual abuse
Desire for referral to practitioners and psychotherapists who understand issues of childhood sexual abuse
Desire for coordinated care through interdisciplinary treatment teams



Issues concerning disclosure were also similar. Survivors indicated that they felt that the abuse they had experienced was relevant to their health. One woman said, “[F]amily 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 [that] it has to be treated.”<sup>31</sup> Participants talked about feeling apprehensive about physicians’ response to disclosures of past abuse. One woman illustrated this apprehension saying, “When I go to a new doctor, it’s rare that I tell them, because I don’t know where they stand on it.” A 19-year-old woman said:

I’ve had two doctors say that [with] my stress level, I should be around 45 and have a mortgage and have four kids!... And it’s frustrating because they wanna know, but I don’t know if it’s safe. I’m not gonna say anything unless I know there’s a door open, that... it’s safe for me to talk about it.

Opinions on inquiring about past abuse were also similar for physicians and physical therapists. At one end of the continuum of opinions on this matter, a woman asked, “[Do doctors] have that right?” At the other end of the continuum, another woman said, “I think it’s important that they ask questions about abuse as part of a medical history;... anyone dealing with women’s pain who doesn’t ask questions about violence in a woman’s life is not doing their job.”<sup>30</sup>

Participants’ ideas about their relationships with physicians in many ways mirrored their ideas about sensitive practice for physical therapists. Participants stressed the importance of their working in partnership with family physicians:

And that’s one thing, probably, I’ve learned as part of my healing process:... that I’m responsible for my own health care.... I direct as much as my doctor does. We discuss plans and approaches to things I’m experiencing, and we discuss how much the abuse plays havoc in my life today, physically and mentally.

This partnership was described as the most comfortable way the survivors could approach problems, such as pain, for which there may be no simple answer. One woman illustrated this, saying,

“I think it’s very difficult for doctors to know what to say [about my pain]. My family doctor and I now discuss this quite often.”

The need for referrals was also discussed. One woman described her partnership with her physician, saying, “I’ve been going through some real chronic physical problems, and when I recommend to [my doctor] that it might be time to see a specialist, she follows through with that, but she doesn’t go ahead and make decisions for me.... We discuss everything.” Another woman said: “And [the physician should] be ready to make referrals... if it becomes necessary. I mean, I needed intense, intense therapy.... My family doctor did not do that for me.” Survivors also spoke about the need to be referred to female health professionals and to clinicians whom the physician knows are sensitive to survivors and knowledgeable about the effects of traumatic experiences.

Last, many participants presented formation of an active health care team as an ongoing need. “I think that we’re talking about really long-term partnerships with a number of medical people, maybe a physiotherapist, a psychotherapist, a family doctor. We need those nuclei of support, and they all need to be in touch with each other.”<sup>30</sup>

## DISCUSSION

In this study, the themes that emerged give some insight into how physicians might practise. Limitations of the study must first be acknowledged. Race, culture, class, sexual identity, stage of recovery from childhood trauma, and other factors affect survivors’ response to health professionals. Our findings are clearly limited by the sampling, which included only women who had formal or informal therapeutic support, and by asking women to focus primarily on their experiences with physical therapy. While participants spoke about experiences with physicians in the interviews, they were not asked predefined questions about family physicians; last, physicians were not part of the external validation of the data. Thus the findings do not inclusively describe every aspect of clinical practice that is sensitive to survivors.

While acknowledging these limitations, this study highlights the importance of the perspective of women sexual abuse survivors on relationships with health professionals. We believe that the findings offer all health professionals both a useful framework and many broadly applicable suggestions for all types of practice.

Key findings centre on survivors' need for a feeling of safety and their need for encouragement to work in partnership with physicians. Implicit in the idea of working in partnership in a safe therapeutic relationship is physicians' commitment to honour and respect survivors' perspectives on their health and the health care they receive. This approach is certainly congruent with a patient-focused physician practice style<sup>35</sup> and with results of extensive research on patient-centred medicine.<sup>36</sup> Ideas expressed by participants are consistent with practice that all patients would perceive as sensitive. For survivors, however, having physicians committed to facilitating safe relationships, comfortable environments, and partnerships with patients could be the only way that they are able to make caring for their health a realistic goal.

Since the need to feel safe was described as crucial and could be addressed through practical issues, we encourage physicians to consider factors that affect the sense of safety in the office environment. (Examples are: how soundproof are your examining rooms? Do you provide opportunities for a third person to be present? Are your patients asked to remove clothing before you have talked with them? Do you ask permission to examine every time you do so?) How individual physicians apply and negotiate these issues with their patients will depend on their practice setting, but the importance of sensitivity about such concerns is apparent.

Another key finding for physicians is the complexity of issues regarding disclosure of sexual abuse to health professionals. All our participants indicated that deciding to disclose a history of sexual abuse was difficult for them. The lack of consensus among the survivors about how physicians should handle this issue is consistent with earlier studies of domestic abuse<sup>20,26</sup> and reinforces recognition of the complexity of this area for all health professionals.

The challenge for physicians working in an environment that continually attempts to reduce complex issues to algorithmic approaches is to convert the ideas expressed by women into sensitive practice. Participants offered some useful direction. First, women suggested that physicians be informed about child sexual abuse and other forms of abuse as a health issue, and develop some familiarity and comfort with the subject. While further research on disclosure is clearly needed, this study highlights that there is no one correct way to ask about past abuse but that patients do want physicians to facilitate disclosure by creating a safe environment, being sensitive to the topic, remaining open to listening to attempts to disclose, and being willing to refer knowledgeably if appropriate. How physicians translate this into action will vary, but they should be ready to develop different approaches to work with different patients.

The study also raises additional questions about disclosure. Are there different issues for disclosure of histories of childhood sexual abuse, childhood physical abuse, partner abuse, sexual assault, and other traumatic events? If issues are different, what are the common themes? Research that canvasses the experiences and ideas of both survivors and family physicians is needed to address specific issues in different practice situations with respect to disclosure.

How can physicians best refer patients with histories of abuse and chronic pain to sensitive physical therapists or other health professionals? This study reinforces the need for coordinated care<sup>27,29,37</sup> in which physicians and psychotherapists (and other clinicians involved in patients' care) would be in regular contact to provide proactive support rather than reactive support<sup>29</sup> and care. Research is needed to clarify how this can be best achieved.

The guidelines developed from this qualitative study are extensive, and physicians are encouraged to become familiar with this material.<sup>30,31,34</sup> The women in this study clearly want to establish collaborative, respectful relationships with health professionals.

## CONCLUSION

Women survivors of childhood sexual abuse are at high risk of chronic pain and long-term medical problems. This research suggests women want partnerships with their health professionals, and while they express a diversity of opinions about disclosure of abuse experiences, women clearly want safe, accepting environments and sensitive and informed health professionals with whom to work in partnership on all their health concerns. ✱

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### Contributors

**Dr Schachter** developed the concept and design of the study, procured funds, recruited subjects, collected and analyzed data, and managed the project. **Dr Radomsky** helped to analyze data. **Dr Stalker** procured funds, recruited subjects, and collected and analyzed data. **Dr Teram** helped develop the concept and design of the study, procure funds, and analyze data. All the authors participated in writing this article.

### Competing interests

None declared

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### EDITOR'S KEY POINTS

- Previous studies have reported that women who have been sexually abused have a range of health problems. This qualitative study of 27 survivors of sexual abuse explored women's ideas and perceptions of the health care provided by physiotherapists and physicians.
- The predominant theme was the importance of patients' feeling safe when consulting health professionals. Most felt anxious or feared being abused during appointments, a factor that compromised their compliance with treatment. Women wished physicians to share information and the decision-making process with them.
- Respondents disagreed on the pertinence of divulging their history of sexual abuse and on ways of raising the subject. Asking a general question or approaching the subject in an open-minded way were ways to facilitate disclosure of a history of sexual abuse.

### POINTS DE REPÈRE DU RÉDACTEUR

- Les études antérieures rapportent que les femmes victimes d'abus sexuels présentent un éventail de problèmes de santé. Cette étude qualitative chez 27 femmes victimes d'abus sexuel explore leurs attentes et leurs perceptions face aux soins dispensés par des physiothérapeutes et des médecins.
- Le thème prédominant est l'importance du sentiment de sécurité éprouvé par ces femmes dans le cadre de leur relation avec des professionnels de la santé. La plupart se sentent anxieuses ou craignent les abus durant les visites, ce qui compromet leur fidélité au traitement. Les femmes souhaitent que le médecin partage l'information et le processus décisionnel avec elles.
- Il n'y a pas de consensus sur la pertinence de divulguer l'histoire d'abus sexuel et sur la façon d'aborder ce sujet. Poser une question générale ou aborder le sujet en faisant preuve d'ouverture d'esprit sont des moyens de faciliter la divulgation des antécédents d'abus sexuels.

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