Post-traumatic Stress Disorder in a Medical Setting: Responding Effectively and Sensitively to Sexual Trauma Survivors

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Why is this important?

- Abuse impacts mental *and* physical health
- Abuse can affect a patient's experience of medical care

Disclosure

- Nothing to disclose

Prevalence of Sexual Trauma

- 1 in 4 females and 1 in 6 males have experienced sexual assault or abuse by the age of 18.[1]
- 302,000 adult women and 92,000 adult men are forcibly raped in the U.S. each year.[2]

Objectives

- Identify symptoms of PTSD and how they present differently from other mental health issues.
- Identify appropriate and effective questions to screen for trauma in patient population.
- Identify validating and supportive statements to use when working with survivors.
- Recognize potentially re-traumatizing medical procedures.
- Identify aspects of effective PTSD treatment, including referrals.

Connection between CSA and Health

- Survivors of child sexual assault more likely to have a mental health, pain disorder and/or general medical diagnosis.[3]
- 2½ times as likely to have pelvic pain and pelvic inflammatory disorder, breast diseases, and yeast infections.[4]

Symptom Clusters Most Associated with Sexual Abuse Histories[5]

- Abdominal pain and gastrointestinal disorders
  - Double the risk of reporting GI symptoms
- Pelvic Pain and gynecological disorders
  - Double the risk of pelvic pain, vaginal discharge, pain during intercourse and menstruation
- Headache
- Physical symptoms of anxiety, panic and PTSD
  - Significantly more reports of shortness of breath, chest pain, dizziness

Post-traumatic Stress Disorder (PTSD)[8]

Criterion A

- The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: **(one required)**
  - Direct exposure.
  - Witnessing, in person.
  - Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
  - Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.

Impact on Mental Health

- Depression
- Substance abuse
- Relationship problems
- PTSD

PTSD (continued)

Criterion B: Intrusion symptoms

- The traumatic event is persistently re-experienced in the following way(s): **(one required)**
  - Recurrent, involuntary, and intrusive memories. Note: Children older than six may express this symptom in repetitive play.
  - Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).
  - Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may reenact the event in play.
  - Intense or prolonged distress after exposure to traumatic reminders.
  - Marked physiologic reactivity after exposure to trauma-related stimuli.

Criterion C: Avoidance

- Persistent effortful avoidance of distressing trauma-related stimuli after the event: **(one required)**
  - Trauma-related thoughts or feelings.
  - Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).

Mental Health Impact

- Women raped as girls were three times as likely to develop psychiatric disorders or abuse substances than twins who were not abused.[6]
- A review of several studies found that sexually abused boys were[6]
  - four times more likely to suffer from major depression
  - three times as likely to be bulimic
  - two times as likely to have antisocial personality disorder
- Mayo clinic study found a statistically significant association between sexual abuse and lifetime diagnosis of[7]
  - Anxiety disorder
  - Depression
  - Eating disorders
  - PTSD
  - Sleep disorders
  - Suicide attempts
    - Associations between sexual abuse and depression, eating disorders, and posttraumatic stress disorder were strengthened by a history of rape.

PTSD (continued)

Criterion D: Negative alterations in cognitions and mood

- Negative alterations in cognitions and mood that began or worsened after the traumatic event: **(two required)**
  - Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol, or drugs).
  - Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous").
  - Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
  - Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame).
  - Markedly diminished interest in (pre-traumatic) significant activities.
  - Feeling alienated from others (e.g., detachment or estrangement).
  - Constricted affect: persistent inability to experience positive emotions.

PTSD (continued)

Criterion E: alterations in arousal and reactivity

- Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: **(two required)**
  - Irritable or aggressive behavior
  - Self-destructive or reckless behavior
  - Hypervigilance
  - Exaggerated startle response
  - Problems in concentration
  - Sleep disturbance
- **Criterion F: duration**
- Persistence of symptoms (in Criteria B, C, D, and E) for more than one month.
- **Criterion G: functional significance**
- Significant symptom-related distress or functional impairment (e.g., social, occupational).
- **Criterion H: exclusion**
- Disturbance is not due to medication, substance use, or other illness.

Mental Health Within the Larger Health Care System

- Failure of providers to address mental health symptoms and needs in the medical setting
  - Not taking the time to diagnose/treat/refer
  - Misdiagnosing PTSD as depression or anxiety
    - Screening would alert them to this possibility
    - Leads to inadequate care

PTSD (continued)

***Specify if*: With dissociative symptoms.**

- In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:
  - **Depersonalization**: experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream).
  - **Derealization**: experience of unreality, distance, or distortion (e.g., "things are not real").

***Specify if*: With delayed expression.**

- Full diagnosis is not met until at least six months after the trauma(s), although onset of symptoms may occur immediately.

Trauma Survivors in the Health Care System

- Many trauma survivors may not have access to appropriate medical and psychiatric care
  - Get wide array of needs met in general medical practices
- Traumatized individuals make 4x as many physician visits[9]

Why Do Some Develop PTSD and Others Don't?

- Risk Factors
  - Presence of personal or family history of psychiatric disorder[9,10]
- Factors related to nature of trauma[9]
  - Interpersonal violence
  - Severity of trauma
  - Chronicity of trauma
  - Fear of dying
  - Recovery environment associated with secondary stressors

How is Medical Care Experienced by Survivors?

- Survivors report more discomfort, shame and vulnerability during gynecological examinations[11]
  - 62% report feeling overwhelmed by emotion
  - Nearly half report other trauma-related symptoms (detachment from body, intrusive thoughts and triggered memories)
- Several studies indicate an increased likelihood for survivors of avoidance of care and treatment noncompliance[12]
- Pregnancy specifically can trigger memories of early childhood sexual abuse and impact prenatal care
  - Genital invasion, attention to body, physical changes, loss of control over body

How Does the Health Care System Address These Realities?

- 82% of survivors and 87% of controls reported they weren't asked about a history of sexual abuse or assault[11]
- 82% of physicians reported never asking about a sexual abuse history in a new patient visit and 85% report not asking during a yearly patient visit[12]

Assessment (screening) Tools for Sexual Trauma

- "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."

How to Change Practices to Better Address Needs?

- Routine inquiry around IPV is common
  - Often focuses on current abuse only
  - Sometimes fails to inquire about sexually abusive experiences, past or recent
- Why is it important to modify these practices?

Assessment (screening) Tools for Sexual Trauma

- "Has anyone every 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 uncomfortable?"

Modifications for Assessment of Sexual Trauma

- Inquiry can trigger a cascade of memories that may or may not have been experienced before
  - Different from current/recent abuse happening that may be more present in patient's awareness
- No need to ask about childhood abuse at every visit since we aren't assessing for ongoing experiences
  - Balance between keeping lines of communication open on an ongoing basis for those who may not disclose right away vs. continuing to ask at each contact after someone has denied having the experience.

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."

Sensitive Post-disclosure Responses

- "You deserve help in dealing with something so difficult. Would you like me to connect you to someone you could talk more to?"
- "Let me know how I can make you more comfortable as I take care of your medical needs."

Suggestions on Avoiding Revictimization

- Explain what you plan to do and the reasons for the prodecure 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.

Possibly Retraumatizing Procedures

- Gynecological examinations
- Rectal examinations
- Oral examinations
- Procedures in which a patient's mouth is held open or when instruments that stimulate the gag reflex (i.e. tongue depressors)
- Vaginal ultrasounds
- Conscious sedation
- Loss of physical control and increased vulnerability that can come with a wide array of medical procedures
- Change in medical provider, especially if used to only female providers

Suggestions on Avoiding Revictimization

- Move at the patient's pace and take breaks as necessary.
- Use grounding techniques if the patient seems to be in distress or disconnected.
  - Calmly remind patient where they are, that they are safe, that the abuse is not currently happening.
- Restore a sense of control for the patient by providing her/him with as much choice as possible.

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.

Referral and Treatment

- Three aspects to the management of PTSD[9]
  - Education
  - Psychosocial support/psychotherapy
  - Psychopharmacologic Treatment

Psychoeducation on PTSD[13]

- A *normal* reaction to an *abnormal* event
  - Becomes problem when our bodies experience anxiety when there is no longer a threat or danger
- Universal, animal reaction to a life threat in the face of helplessness
- Lack of spontaneous resolution of freeze/immobility response
- Autonomic dysregulation and vagal dominance
  - Impairment of *regulation* and autonomic cyclical instability may explain chronic pain without identified cause
- Symptoms result from residual representations of sensory messages of threats in procedural memory

Effective Psychotherapy Approaches for Trauma

- Approaches are evolving as more research is done
  - Trauma-informed cognitive behavioral therapy
    - Relationship between thoughts, feelings and behaviors
    - Trauma narrative
    - Exposure/in vivo mastery of triggers
  - EMDR (Eye Movement Desensitization and Reprocessing)
  - Brainspotting

Education on Coping Skills

- Deep Breathing Exercises
  - Simple counts forward and backward
  - Belly Breathing
  - Smartphone apps (Breathe2relax, Relaxation Breathing)
- Progressive Muscle Relaxation
- Distraction
- Engaging in healthy physical activity

Pharmacologic Treatment of PTSD[9]

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

Education on Coping Skills

- Grounding techniques help to remain in present moment
  - Orientation: Name and describe objects in the room; name time, date, location
  - Cognitive: Say alphabet backwards, name objects in alphabetical order (animals starting with A)
  - Sensory: Run water over hands, hold ice cube, loud music, bite into lemon, sniff essential oil

Referrals

- Become familiar with DV/SA agencies and resources in your area
  - Statewide organizations usually have info sheets, resource cards you can have on hand
  - www.rainn.org
- Crisis lines for local shelters and agencies
- Support groups

References

1. Finkelhor, D., Hotaling, G., Lewis, I., & Smith, C. (1990). Sexual abuse in a national survey of adult men and women: Prevalence, characteristics, and risk factors. *Child abuse & neglect*, *14*(1), 19-28.
2. Tjaden, P., & Thoennes, N. (2000). *Full Report of the Prevalence, Incidence, and Consequences of Violence Against Women: Findings From the National Violence Against Women Survey: Research Report*. Washington, DC: National Institute of Justice.
3. Walker, E. A., Katon, W. J., Hansom, J., Harrop-Griffiths, J., Holm, L., Jones, M. L., ... & Jemelka, R. P. (1992). Medical and psychiatric symptoms in women with childhood sexual abuse. *Psychosomatic Medicine*, *54*(6), 658-664.
4. Illinois Coalition Against Sexual Assault. Emotional and Physical Effects of Sexual Assault. Available at www.icasa.org/uploads/Health_Information.pdf. Accessed October 18, 2004.
5. Leserman, J. (2005). Sexual abuse history: prevalence, health effects, mediators, and psychological treatment. *Psychosomatic medicine*, *67*(6), 906-915.
6. New Hampshire Coalition Against Sexual Assault and Domestic Violence. A Fact Sheet About Sexual Assault: The Mental Health Impact. Available at http://www.nhcadsv.org/uploads/Sexual%20Assault%20The%20Mental%20Health%20Impac%20Fact%20Sheet.pdf. Accessed May 11, 2014.
7. Chen, L., Murad, MH., Paras, M., Colbenson, K., Sattler, A., Gorenson, E., Elamin, M., Seime, R., Shinozaki, G., Prokop, L., Zirakzadeh, A. (2010). Sexual Abuse and Lifetime Diagnosis of Psychiatric Disorders: Systematic Review and Meta-analysis. *Mayo Clinic Proceedings* , 85(7), 618 – 629.

References (continued)

8. American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
9. Ballenger, J. C., Davidson, J. R., Lecrubier, Y., Nutt, D. J., Foa, E. B., Kessler, R. C., & McFarlane, A. C. (2000). Consensus statement on posttraumatic stress disorder from the International Consensus Group on Depression and Anxiety. *Journal of Clinical Psychiatry*.
10. Hidalgo, R. B., & Davidson, J. R. (2000). Posttraumatic stress disorder: epidemiology and health-related considerations. *Journal of Clinical Psychiatry*.
11. Robohm, J. S., & Buttenheim, M. (1997). The gynecological care experience of adult survivors of childhood sexual abuse: a preliminary investigation. *Women & health*, *24*(3), 59-75.
12. Havig, K. (2008). The Health Care Experiences of Adult Survivors of Child Sexual Abuse A Systematic Review of Evidence on Sensitive Practice. *Trauma, Violence, & Abuse*, *9*(1), 19-33.
13. A Neurologist's Explanation for Trauma, Dissociation and Chronic Pain. http://www.traumahealing.com/somatic-experiencing/whiplash-syndrome-neurophysiology-treatment.html . Accessed May 10, 2014.