

## Research Letter

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### Physicians' Perceptions of Adult Patients' History of Child Abuse in Family Medicine Settings

*To the Editor:* Childhood abuse places adults at risk for adverse psychological and physical health sequelae.<sup>1</sup> In the Adverse Childhood Experiences (ACE) study, Felitti et al<sup>2</sup> found a significant dose-response relationship between the number of childhood traumatic experiences and a variety of adverse outcomes: poor self-rated health, various chronic diseases, disability, and early death. The experience of childhood abuse is common: 44% of a sample of men and women patients in primary care reported a history of childhood physical, sexual, or emotional abuse.<sup>3</sup> Estimates of the proportion of women in primary care with histories of child sexual abuse range from 18% to 23%,<sup>4,5</sup> and of child physical abuse from 12% to 14%.<sup>4</sup> Although in the last decade public health and medical organizations have endorsed guidelines for screening for adult interpersonal violence, physician inquiry into childhood physical or sexual abuse has received little attention.

Physicians may be unaware of the potential consequences of childhood physical and sexual abuse and will thus be unlikely to screen for it. Indeed, only one-third of women who have been abused have discussed it with their doctor.<sup>6</sup> Nevertheless, the majority of adults in primary care actually favor routine physical abuse inquiry (75% of women and 83% of men) and sexual abuse inquiry (63% of women and 75% of men) by their primary care physician.<sup>7</sup> Primary care patients with a history of childhood abuse are willing to be screened and believe that physicians can help with these problems.<sup>6,7</sup> Given that there are important health consequences of childhood abuse and evidence of patient willingness to engage their primary care

physician in addressing needs that may originate in their abuse history, a small exploratory study was designed to identify primary care physician perceptions of the significance of child abuse history among their adult patients. The study explores the clinical experiences and perspectives of a group of family practice physicians in community health settings in central Massachusetts. We aimed to identify the major conceptual themes in an area in which no systematic research exists.

### Methods

We invited 47 faculty family practice physicians associated with 4 University of Massachusetts Department of Family Medicine and Community Health sites to participate in a focus group to explore attitudes and opinions about the importance of adult patients' disclosure of child abuse histories in the clinical setting. Focus group methodology is an appropriate technique for exploring under-researched and sensitive topics. Six physicians participated and completed a demographic questionnaire at the beginning of the group. The group was facilitated by a skilled qualitative researcher and was tape recorded and transcribed. The session lasted 90 minutes and was held in the evening at a University conference room site. Institutional Review Board approval was obtained. A set of 8 questions guided the discussion, starting with general questions about physicians' usual ways of asking patients about their psychosocial history and violence. In the second part of the session, we used specific questions to clarify some of the participants' statements. Using the transcript and following procedures for extracting themes from focus groups,<sup>8</sup> themes were initially coded by the group facilitator and then reviewed and confirmed with the first author, who independently reviewed the transcript.

### Results

Six family physicians (mean age 48.5 ( $\pm$  8.7), 50% female, 19.7 ( $\pm$  9.4) average years in practice) participated in the group. Most providers did not see a compelling reason for routine screening for childhood abuse. Five themes emerged concerning their

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willingness or the perceived usefulness of such inquiry: (1) providers typically did not pursue question about abuse unless there were somatic symptoms that could not otherwise be explained; (2) providers who had more training about childhood abuse or had a standard screening form with a related item were more likely to raise the issue; (3) providers felt more proactive about the need to identify and address current adult abuse situations than opening up histories of child abuse; (4) providers disagreed whether inquiry about long ago abuse would result in precipitating new emotional problems or could be helpful to the patient's long-term coping; and (5) providers indicated that they would be more willing to inquire about childhood abuse histories among adult patients if access to information and referrals for patients were available.

For example, one provider noted the circumstances under which she/he would ask about childhood abuse as *"I will just ask if somebody has a pain that seems out of proportion, chronic pelvic pain, obesity, if a patient is avoidant of paps."* Another provider clearly stated: *"In general, I only ask about things I feel competent to address."* In contrast, a provider whose practice had a standardized question about violence was more willing to routinely ask about current or past personal victimization.

On the issue of distinguishing between past and current abuse, most did not think that a history of prior child abuse would have a significant impact on current health complaints. Further, providers thought exploring the impact of child abuse was better left to psychology or psychiatry. For example:

*"With ongoing adult violence there is something there, a more immediate danger. Something that happened 20 years ago is probably something a psychiatrist should be addressing, not his doctor. We may see the consequences of that in their current behavior, but I don't think we are really trying to bring that up and stimulate people to think about how they were abused when they were 5 years old and then go into what that means."*

Related to the worry that exploration of childhood abuse was best left to specialty behavioral health providers to address, there was ambivalence about the consequences of patient disclosure. One provider noted:

*"You are opening a can of worms. Maybe it is something that is best left alone. Let sleeping dogs lie. It was*

*something that happened a long time ago and they seem to be functioning well now. They are happy, why drag that up and make them think about it."*

Another provider, however, noted that uncovering the past history can be helpful:

*"There is the potential for being witnesses of the trauma history and to use it in healing. . . It makes a difference for the relationship that I have with the patient and that this is a piece of what their past is."*

Finally, providers worried about appropriate follow up and services. One provider noted that screening was feasible when: *"I can give them information, refer to a social worker who can be a helpful person and would have the time to make phone calls that I don't have time to make or help the patient do that."*

## Conclusions

The family physicians in our exploratory study seemed to lack awareness and strategies about how and when to incorporate inquiry into a history of child abuse in their clinical assessment. Contradictory discourses exist among them about the potential significance of routine inclusion of child abuse history in the initial and/or ongoing assessment of adult patients. Despite the fact that primary care providers are in an ideal position to identify and treat the physical and emotional sequelae of early abuse, and that patients, including those with abuse histories, favor screening about childhood physical and sexual abuse, these family physicians expressed reluctance to enter these troubled waters.

The potential benefits of a patient's disclosure of a history of childhood abuse to his or her family physician are many: A survivor might feel relief from the burden of the secret and might finally hear that the abuse was not his or her fault. The patient might be able to make a connection between current emotional and physical symptoms with past abuse and might take the opportunity to engage in counseling or psychotherapy around these painful issues. The patient might realize that his or her own body is not shameful and start to be able to take better care of it and make healthier lifestyle choices.<sup>9</sup> Finally, a caring relationship with a non-abusive adult such as a family physician may facilitate healing and speed a survivor's journey to recovery.<sup>10</sup> The potential for such inquiry to have a therapeutic effect deserves further investigation.

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