Editorials

Recognition Of Sexual Abuse

In this issue, Walker and colleagues[1] address an area that confronts family physicians on a daily basis. These authors contribute to the literature on the prevalence of adult female primary care patients with sexual trauma histories, their attendant psychological distress, and their attitudes toward physician inquiry into past sexual victimization. It can no longer be disputed that family physicians daily see patients with sexual abuse histories whose symptoms are rooted in their past abuse.[2] Adult survivors of sexual abuse often have myriad physical and psychological sequelae that cannot be understood apart from their contextual links to the sexual abuse histories. An awareness of the magnitude and impact of sexual abuse and confidence in recognition and intervention can greatly benefit physicians in their role of helping the patient's recovery process.

While statistics on sexual trauma can never speak of the pain and suffering of the victims, they do allow us to appreciate the magnitude of the problem. Walker, et al. found that approximately 40 percent of the women in their sample had experienced some form of childhood sexual contact, and 1 in 6 had been raped as a child. Twenty-nine percent of the women in their sample had experienced attempted or completed rapes as adults. In another study of the prevalence of lifetime sexual trauma among female patients in a family practice setting, Walch and Broadhead[3] found that 47 percent of their sample of 147 women reported some type of contact sexual victimization during their lifetimes, with 25 percent of these same women reporting rape or attempted rape.

The above statistics document how common it is for women with sexual abuse histories to be seen in primary care settings. Equally consistent and convincing is the documentation of the long-term effects of childhood sexual abuse and adult sexual assault.[4,5] Vogel, et al.[6] reported a greater number of medical problems in all body systems and an increased incidence of sexually transmitted diseases, pelvic inflammatory disease, and pelvic exploratory surgery among the childhood sexual abuse survivors in a primary care setting.

In a recent literature review on the effects of victimization, I examined the long-term sequelae found in many childhood sexual abuse victims and adult rape victims.[7] Sequelae of particular concern to physicians include the emotional sequelae of depression, anxiety and fear, lowered self-esteem, anger, guilt, and shame; the cognitive sequelae of perceptual disturbances; the biologic sequelae of somatic disturbances; such behavioral sequelae as suicide and substance abuse; and the interpersonal sequelae that become manifest in sexual problems and revictimization proneness.

Given the frequency and myriad long-term effects of sexual trauma, many victims will be treated by family physicians. In fact, as Walker and colleagues point out, primary care physicians will have far more contact with these sexually victimized survivors than will the specialty sexual trauma centers, whose mission is to provide help in this domain. The challenge to physicians is that sexual abuse is usually disclosed through screening; the majority of patients with such histories do not volunteer this information.

It is noteworthy that the authors of the study reported in this issue[1] found the majority of the women in their sample (61 percent) believed it was appropriate for their physicians to ask about previous victimization, yet only 4 percent had been asked. Other researchers[3,8] have reported strikingly similar results about patients' willingness to disclose such histories and about the infrequency of physician inquiry in this area.

Given that these sexual abuse histories often hold the key to unlocking the genesis of the patients' symptoms, and given that most patients will disclose such histories to their physicians if invited to do so, it behooves family physicians to become skilled in and comfortable with such screening.

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Dunn and Gilchrist[5] have asserted that physicians should routinely ask about sexual abuse histories when taking a psychosocial, gynecologic, or sexual history. Wahlen[9] has contended that the individual physician must decide whether to screen all patients for such histories or only those presenting with symptoms that might be sequelae of sexual abuse. Once that decision has been made, physicians can consult the excellent screening guidelines provided by Wahlen.[9] In them the history-taking process is described as one of the most difficult parts of the assessment of an adult with a sexual abuse history. Wahlen has suggested certain phrases that physicians can use, such as, "This may be a difficult question to hear, but the answer may help me to help you better . . . ," or "In my experience, some people who have symptoms similar to yours have had experiences in childhood of being abused or hurt in some way . . . ," or "Have you ever experienced being touched in a way which made you uncomfortable?" or "Have you ever felt forced to engage in sexual behavior?"

It is noteworthy that even when the questions are carefully phrased and asked in an appropriate tone by the physician, not all patients with abuse histories will be able to admit to their experiences. Often, sexual abuse survivors need to test their physician to make sure that the physician is trustworthy of such information. In other cases, survivors could have repressed their feelings for so long that they do not have access to such memories at the time of the physician's initial questioning. Despite the possibility that abused patients will not be able to respond positively to the physician's questions, they will be made aware that the physician is someone who considers such information to be essential to comprehensive health care. Further, by asking such questions, the physician conveys that he or she is an appropriate ally and resource for such patients, if and when they choose to reveal the abuse history.[2]

Courtois[10] has pointed out that while most victims of sexual abuse will disclose these histories to physicians who sensitively and directly ask, for some survivors of childhood sexual abuse, their previous contacts with medical personnel have been negative, thus making such disclosure very difficult. The following are areas of negative experience with medical personnel as commonly reported by childhood sexual abuse victims:

1. Missed diagnosis of sexual or physical abuse because of professional ignorance or denial of the problem despite obvious signs. Many survivors had symptoms whose origins were denied, which aroused little or no suspicion, or were misdiagnosed or went undiagnosed. In contrast, some survivors sought to hide or disguise signs or symptoms of their abuse. Identification could mean additional abuse or punishment.
2. Unnecessary or ineffective treatment based on lack of awareness and misdiagnosis. Some survivors have undergone surgeries, hospitalizations, drug regimens, shock treatment, and years of psychotherapy for the somatic post-traumatic manifestations of their abuse experiences without the abuse ever having been either discovered or identified as significant or causative.
3. Insensitive treatment by medical personnel. This experience was especially true for survivors believed to be malingering or diagnosed as suffering from psychosomatic illness or those who were phobic, adversarial, uncooperative, overdependent, or overcompliant.
4. Abuse by medical personnel. Although uncomfortable to contemplate, medical practitioners are among those professionals who have sexually abused patients or clients.[10 p 440]

Once a sexual abuse history has been made known, providing appropriate support to the victim is of great importance. Even family physicians who are highly experienced in counseling patients should not undertake counseling abuse victims unless they have specific training in this area. Referral to appropriately trained mental health professionals would be the proper next step in most situations. To avoid causing the patient to feel rejected when making such a referral, physicians should emphasize their intention to continue to be involved in the patient's care, their admiration for the patient's courage in disclosing the abuse, and their realization of the difficulty of sharing such information. They should also stress that the patient was not to blame for what happened, they know of others

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who have gotten through the healing process, and that awareness of the abuse helps them to understand the patient's physical symptoms.

The mental health professionals to whom physicians refer patients should be specifically trained and experienced in working with abuse survivors. Because of frequent substance abuse among sexually abused patients, training in this field can also be beneficial. These resources exist in most communities, but physicians need to evaluate them as aggressively as they would for any other type of consultation. Battered women shelters and rape crisis centers are often good starting points for locating therapists experienced in treating abuse survivors.[2]

Recognizing a sexual abuse history and its attendant post-traumatic consequences in physical, psychological, and behavioral domains is essential in differential diagnosis, treatment strategies, and patient care.[2,10] Although most physicians have not been taught such skills in medical school, acquiring these skills could be one of the most powerful ways to improve the care that a physician provides.

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Breast Cancer Care: A Beacon Of Change?

Breast cancer care in the United States demonstrates both the potential and the pitfalls of Western medicine. Through this one disease we can glimpse the horizons of science, the limitations of medical practice, and physicians' preoccupation with treatment rather than prevention and early detection. Breast cancer care also casts a beacon of light toward the future of medical practice.

The horizons of science expand through research. This research has led to such an exponential growth in knowledge that the *Index Medicus* lists 16,351 publications on breast cancer in the last 5 years.[1-3] We now have evidence that breast cancer is a systemic disease rather than a localized phenomenon,[4] that genetic markers identify some women at risk for developing this disease,[5] and that the development of cancer requires both a defect in cell repair and a change in cell development.[6] In addition, hundreds of studies, including randomized trials, have tested treatments for breast cancer and shown that breast-conserving treatments for stage I and II cancers work as effectively as mastectomy,[7,8] that radiation to the axillary nodes reduces recurrence,[9] and adjuvant chemotherapy should be considered for all women except perhaps

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