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4 – Health Consequences of Emotional, Physical, and Sexual Abuse

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Abuse is widespread across all ethnic, cultural, and socio-economic groups. In the US population, 30 - 40% of adults report some type of abuse during childhood. Different forms of abuse often co-occur. Rates of abuse in other countries are variable, but comparable. Clinicians who believe abuse does not occur in their patients are just not looking for it.

Childhood Abuse – Mental Health Impact

A history of childhood abuse correlates strongly with mental health symptoms. A dose-response effect exists between multiple types and severity of abuse with magnitude of symptoms, and number of diagnoses. Post-traumatic stress disorder (PTSD) is extremely common in victims of abuse; symptoms may persist for years. Complex PTSD in response to multiple severe traumas combines prolonged symptoms of PTSD with those of other psychological conditions. Anxiety disorders, various eating disorders, and repeated episodes of major depression are common sequelae. Survivors also suffer from difficulty with relationships and trust, long-standing shame and guilt, poor self-esteem, and anger. Dissociative identity disorder is also a potential outcome when a young child experiences multiple severe abusive episodes for which adult memories may be elusive. In this condition, a more complex walling off of memories of abuse allows the person to develop more normally, free from memories of the abuse, although the boundaries between memories often start breaking down later in life. While controversial, the syndrome clearly exists and is more common than generally recognized.

Long Term Physical Health Effects of Sexual and Physical Violence

Abuse survivors commonly experience multiple physical symptoms, especially abdominal and pelvic pain, genitourinary symptoms, fatigue, and headaches. Although medical conditions may explain some symptoms, many remain unexplained despite extensive evaluations. Whenever studied, women with unexplained symptoms often give a history of childhood and/or adulthood physical and sexual abuse, and women with sexual symptoms are likely to have a history of sexual abuse or assault.

The Adverse Childhood Exposure Study found that adverse childhood experiences (including physical and sexual abuse and witnessing abuse of a parent) were strongly interrelated and that the number of categories of adverse exposures had a graded relationship to later adult diseases, including ischaemic heart disease, cancer, chronic

lung disease, skeletal fractures, and liver disease. Diseases associated with four or more categories of exposures included ischaemic heart disease (OR=2.2), cancer (OR=1.9), stroke (OR=2.4), COPD (OR=3.9), diabetes (OR=1.6), fracture (OR=1.6), and hepatitis or jaundice (OR=2.4).

Application of the strictly medical model to abuse survivors with chronic abdominal and/or pelvic pain, gastrointestinal symptoms, and dyspareunia may lead to multiple investigations and surgeries. Such painful, costly, and often re-victimizing interventions can lead to complications, including adhesions and more chronic pain. Since previously abused women are more likely to be overweight, smoke, drink, use drugs, engage in risky sexual behaviours, and not get pap smears, they also are more prone to sexually transmitted disease, HIV/AIDS, unintended pregnancies, and various chronic diseases. Violence tends to perpetuate itself with repeating patterns in subsequent generations. Mothers with childhood or adult abuse experiences may be less able to protect their daughters from an abuser. Helping patients to break such patterns is challenging, and most physicians are not trained, skilled, or comfortable in identifying and assisting with survivors of abuse.

Identification and Management

Victims of abuse seldom volunteer information about their abuse to clinicians but are generally willing to talk about their abuse histories when asked directly. Building trust before asking questions will enable patients to disclose abuse, even on a first visit, if asked in an appropriate manner. Using the “generalized other” technique can facilitate the inquiry, i.e., “Many of my patients have been threatened or hurt by others, as children or adults. Did anything like this ever happen to you?” If the patient answers yes, establishing safety for the patient and any children still vulnerable to the abuser is crucial. Another approach is to ask about abuse as part of the standard review of systems or as part of family history. Asking about a family history of alcohol and drug abuse can lead easily into questions about physical abuse of the patient and family members, followed by a question about sexual abuse. A subsequent question might be, “Since then has anyone ever tried to or made you have sex when you didn’t want to?” Another screening strategy is to ask the patient about to disrobe, “Is any part of this exam difficult for you?” - enabling disclosure before the vulnerability of being undressed.

Clinicians should ask these questions when they have time to listen and respond appropriately. When adequate time is not immediately available, the clinician should schedule early follow-up, indicating the importance of prior abuse to the patient’s medical care. Empathy is critical. The clinician must state that the abuse was not the patient’s fault and should never have happened. Discussing abuse with a supportive clinician can be very therapeutic, but referral to counselling with a therapist skilled with abuse survivors is often the best approach when the patient is ready. In the meantime, the clinician should explore how the patient would feel most safe and comfortable receiving medical care.

Clinicians need to consider the abuse history in the patient’s ongoing management, allowing survivors control over the timing and conduct of referrals and investigations. A complex, necessary task is helping survivors make the connection between the abuse and their physical and emotional problems, while not implying that symptoms are “all in their head.” Another task is acknowledging how ordinary health care can be frightening for abuse survivors; that exams and procedures considered part of routine care can easily re-traumatize them. Careful explanations and explicit consent for each aspect of disrobing and touch are critical. Because betrayal of trust is often a key source of trauma for abuse survivors, clinicians must continuously demonstrate honesty and trustworthiness for these clinical relationships to succeed. Giving patients control through attention to safety, and always allowing the patient accompaniment by a chosen safe person can facilitate the conduct of necessary and potentially empowering health care.

Take Home messages

- Abuse survivors commonly experience physical and psychological symptoms and syndromes.
- The only way to find out if a patient has been abused is to ask.
- Always affirm that the abuse was not the patient’s fault and should never have happened.
- Recognize that ordinary health care can be frightening for abuse survivors.
- Allow patients the maximum possible safety and control.

Original abstract

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