MWIA CASE STUDIES

LIFELONG IMPACT OF CHILDHOOD ABUSE

Case 24: Elyse's Story

Objectives

- To highlight the long-term physical and psychological effects of childhood sexual abuse (CSA)
- To emphasise the doctor's important role in identifying patients with a history of CSA so that victim-survivors are treated holistically, using a multifactorial perspective with a biopsychosocial lens, which sees a complex interplay between past and present, physiological, psychological and social factors.[1]
- To underline that holistic, rather than symptomatic treatment will help prevent retraumatisation of victim-survivors (victims of CSA are much more likely to be raped as adults) as therapy helps them develop a stronger, more positive sense of themselves.[2] Doctors who understand the aftermath of CSA will also avoid inadvertent iatrogenic retraumatisation, for example with painful pap smears.

Narrative Case

When Elyse, a 28 year old nurse developed debilitating irritable bowel symptoms (IBS), she went to a new doctor. In response to the doctor's detailed questions as part of initial assessment, Elyse told her that work was okay but she was having a few problems with her boyfriend. Sex was sometimes painful, but she tried not to show it. She had occasional migraines, her periods were heavy and painful and she was treated with antidepressants for 3 years in her early twenties. She was a binge drinker as a teenager. She'd only ever had one Pap smear 8 years ago and it was excruciating.

The doctor said to Elyse that when women had a range of painful and debilitating symptoms like she did, sometimes something emotionally painful had happened to them in the past – physically or sexually. Elyse, to her surprise, felt safe enough to tell this doctor what she hadn't told anyone in over 20 years. Then again, no-one had ever asked. Her uncle had sexually abused her: but she couldn't see how what her uncle had done could be connected to any of her symptoms - it happened over 20 years ago!

After talking about the abuse for the first time, Elyse became anxious. The doctor was very supportive. She told Elyse that she was suffering from a form of posttraumatic stress, likening her experiences to a war warrior. She said Elyse must never blame herself; the shame belonged to the perpetrator. Having kept it all in for so long, Elyse had developed a range of physical and psychological symptoms as well as having the emotional pain of abuse to deal with. The doctor said that first they needed a plan to deal with the painful aftermath of disclosure, and then she wanted to see Elyse regularly to make sure that her physical and psychological health were attended to and treated holistically.

Background information

***Prevalence*:** In Australia one in three women are affected by a history of SV. The overwhelming majority does not tell anyone, including their treating health professionals, for decades, if at all.[3]

Learning Points

1. The long-term health consequences of sexual trauma in women include a range of psychosomatic symptoms including Irritable Bowel Syndrome (IBS), headaches, gynaecological and obstetric problems, various mental health problems and health risk behaviours as well as avoidance of preventative health examinations (such as pap smears). Such avoidance is of concern as these women have an increased risk for sexually transmitted infections, cervical dysplasia, and an increased prevalence of invasive cervical cancer. [2]

   Depression, anxiety, stress and posttraumatic stress disorder (PTSD) associated with historical SV may increase affected women's risk for other problems including alcohol and substance misuse. CSA victim-survivors also have a greater risk for suicide and accidental fatal drug overdose. [2]

2. A biopsychosocial model of diagnosis and treatment conceptualises symptoms such as IBS, vaginismus (pain with sex and/or Pap smears), recurrent headaches and gynaecological symptoms as psychosomatic symptoms: the symptom, expressed in the body (soma), has its origins in mind (psyche) and body and alerts us to painful feelings. Based on this understanding, an integrated approach which addresses painful feelings as well as treating bodily symptoms is required.[4]

3. Patients should be asked about a history of SV if they present with multiple psychosomatic symptoms or health problems, have a history of engaging in health-risk behaviours (e.g. drugs, alcohol or unprotected sex) or avoid or have difficulty with medical examinations or procedures,[5] (e.g. pain with Pap smears or avoidance of Pap smears.[6] Given that the biggest risk factor for cervical cancer is not being screened regularly, it is important to ask women if they have had their routine health checks, and if not, find out why not.

4. Most victim/survivors do not tell their treating practitioners about a history of SV unless they are asked.[3]

5. Doctors should only ask patients after a good rapport and trust has been established.

6. The doctor should only ask if she feels comfortable discussing these sensitive matters and dealing with the aftermath of disclosure. Undergraduate and postgraduate teaching should have modules to help doctors feel competent in this important area of practice.[3] The doctor needs to know of appropriate professionals she can refer to if she is not going to do the counselling herself,[5] as well as providing ongoing medical care to treat and prevent health problems.

7. Many patients think that they should have sex even if it hurts. Some doctors and patients believe that "getting a Pap smear over quickly" will shorten the duration of pain and therefore be helpful. However, doing this can inadvertently retraumatise a patient who has a history of sexual abuse (iatrogenic traumatic examination). To avoid this, doctors should never proceed with a Pap smear if the patient says it is painful or if she is afraid. Similarly, patients should be encouraged not to participate in painful penetrative sex, whilst still maintaining a sexual relationship. In both cases the pain or fear need to be treated first.

   In Australia, a referral can be made to a psychotherapist who can help the patient make connections between the physical (how it feels) and emotional (what has happened/ is happening in her life and how it has affected her). She can also be referred to a specially-trained physiotherapist with skills in patient education (anatomy, physiology of sexual response) and gentle examination. Penetrative sex can be resumes and a Pap smear can be done when the patient feels comfortable emotionally and physically (confident there will be no pain).

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References

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