CARING FOR SURVIVORS OF SEXUAL TRAUMA

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Goals for Clinicians

1. Recognize the need to cast a wide net of suspicion for sexual trauma in all patients, while recognizing red flags in individuals.
2. Understand how health care settings can trigger patients.
3. Interpret patient behaviors that annoy us and provoke our judgment as normal physiological and social-emotional signs of trauma.
4. Use specific language and procedural techniques to give control to the patient and help her feel safe, **thereby improving outcomes.**

Trigger Warning

- During this activity we will talk in detail about childhood sexual abuse, rape, and intimate partner violence which may trigger intense emotional responses.

A Rite of Passage?

- 1 in 5 girls will be sexually abused by an adult by age 12
- 1 in 4 teenage girls and women have survived a rape or attempted rape.

Common Red Flags

- Current or past IVDU.
- Obesity.
- Lack of appropriate gyn care.
- Frequent somatic complaints.
- Early diagnosis of PTSD, bipolar, depression, anxiety.
- “Difficult” or “High-maintenance” patient who complains of pain and fear.

Risk Factors

- Everyone is at risk, but…
- Other adverse childhood events.
  - Parental addiction or mental illness
  - Death or incarceration of a parent
  - Violence in the home
  - Participation in foster care or correctional facilities.
- Native girls and women
- Girls and women with disabilities.
- Gay and trans children, teens and adults

What Constitutes “Trauma?”

- Must it be penetrative?
- Must it hurt?
- Must we call it “rape” or “abuse?”
- Must it be perpetrated by a person?

The Spectrum of Sexual Trauma

- Torture←----------→Misogyny and Shaming

Triggers

- Emotional
  - Shame
  - Fear
  - Powerlessness
- Physical
  - Pain
  - Any sensation on certain body parts (genitals, anus, inner thighs, abdomen, breasts, neck, mouth)
  - Shallow breathing or breath holding
  - Muscle tension
  - Tachycardia

Shame

- While guilt is “I did a bad thing,” shame is “I am a bad person.”
- It exists on a very basic level in most survivors of sexual trauma.
- It increases often during pregnancy, desired or not.

The Shaming of the Poon

- Cultural-Social shaming of female sexuality and female bodies interwoven with a total media obsession with objectifying female sexuality and the female body.
- *Poon* and *Poontang* are common slang words for female genitalia or the act of having sex with a woman.
- Originates from the French *putain,* meaning *whore.*

Anxiety and Fear

- She isn’t “a hard patient”, her experiences have been hard.
- Having difficulty with gynecological exams is a normal reaction to those experiences.
- Our bodies have memory.

Power and Control

- The motivation behind rape is removal of power and control, it's not about sex.
- Sex is the weapon chosen to inflict pain, violence and humiliation.
- A medical visit should not create more pain, violence and humiliation.

Set her up to be in control

- It starts when you are ready to start
- Ask for a break when you need one
- Tell us when something bothers you, we want to know.

The Control Continuum

- Knock and pause before entering,.
- Ask what questions she has, rather than if she has any questions.
- Ask to listen to heart and lungs before touching.
- Ask if she wouldn’t mind undressing.
- Ask if she is ready to get started before pulling up the drape.

The Feedback Loop

- The catch is that you have to make good on your word.

If she discloses past abuse/assault…

- “I’m so sorry that happened to you.”
- “You didn’t deserve that.”

Other tips:

- Value her communication
- Value her participation
- Will sedation help? Or make her feel even less in control?
- Avoiding other triggers:
  - “Relax”
  - “Trust me”
  - “Sweety, honey, darling, etc…”
  - Touch in certain places:

Speculum Placement

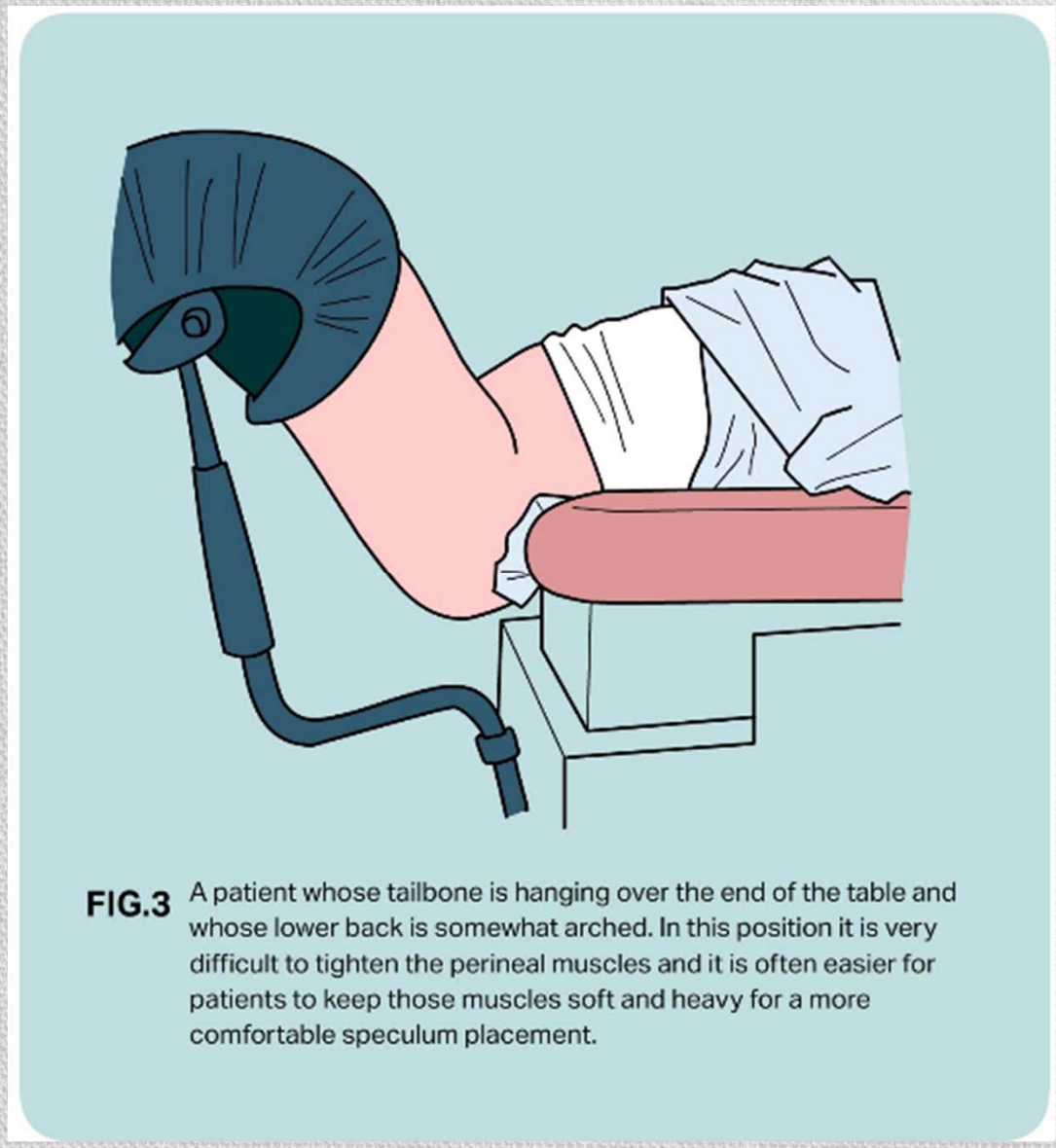

FIG.3 A patient whose tailbone is hanging over the end of the table and whose lower back is somewhat arched. In this position it is very difficult to tighten the perineal muscles and it is often easier for patients to keep those muscles soft and heavy for a more comfortable speculum placement.

Wait until she is ready

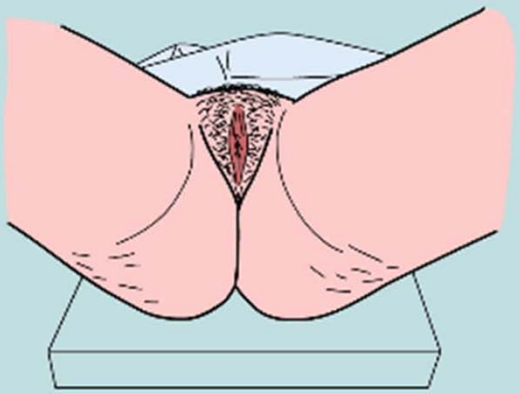

FIG.2a A patient who has clenched pelvic muscles and clenched buttocks, indicating that she is not ready for the speculum to be placed.

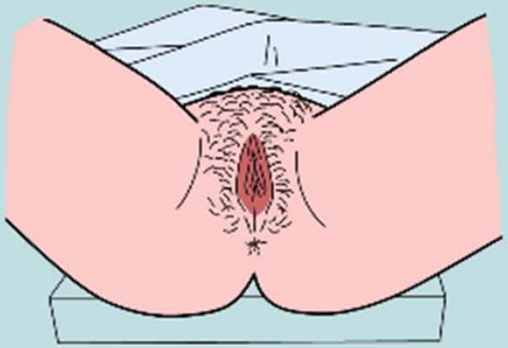

FIG.2b A patient who appears ready for speculum placement. The perineal muscles are soft, the buttocks are sinking towards the floor and the thigh muscles are not engaged.

Once the exam has begun you can teach her easy cues to remember to make the hips soft and heavy again.

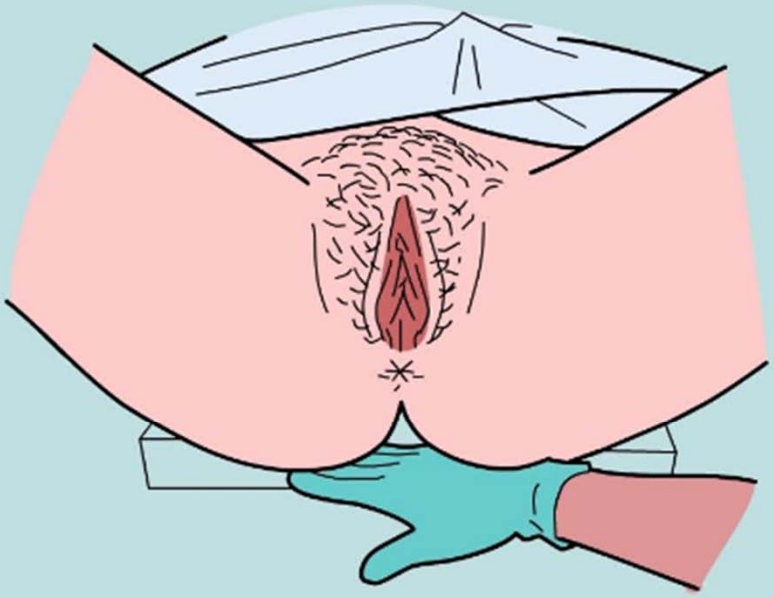

FIG.4 By placing a hand underneath the patient's hips and asking her to push that hand down towards the floor with her hips, we are able to instruct her to create the body positioning seen in the previous side view picture that may make speculum placement a lot more comfortable for her.

But what if instead…

- She becomes completely silent and immobile, responding to commands slowly but surely, not speaking, her eyes are closed.

Thank you to my teachers:

- Marissa
  - Universal Precautions
- Destiny
  - Be creative
- Yvette
  - Sometimes nothing works

Self-care

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