Editorial

Caring for Victims of Childhood Sexual Abuse

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In this issue of *The Journal of Family Practice*, Walch and Broadhead[1] contribute to the literature on the incidence and prevalence of sexual victimization. It is now beyond dispute that family physicians, on a daily basis, see patients who have experienced incest and other forms of childhood sexual abuse. Whether such sexual abuse is identified, and how it is managed, can play a pivotal role in the patient's recovery process. Awareness of the scope and impact of incest and childhood sexual abuse, and confidence with respect to intervention, can lead to more effective support by the physician for the victimized patient.

Statistics alone cannot reflect the pain and suffering of current victims, or adult survivors, of childhood sexual victimization. They do, however, indicate the magnitude of the problem.

Since the mid-1970s, reports of child incest victims have increased dramatically. Before that time, rates were grossly underestimated, and incest was believed to be a rare occurrence with an incidence of one case per 1 million population.[2] Current estimates indicate a very different reality. Examples from the literature include the following: 16% of adult women in San Francisco were sexually abused by a relative before the age of 18 years, and 31% reported abuse by a nonrelative by the age of 18 years[3]; three of every five sexual assaults occur when the victim is 17 years of age or younger, and nearly three of every 10 cases occur when the victim is 10 years of age or younger[4]; the prevalence of childhood incestuous abuse among members of psychiatric populations ranges from 44%[5] to 70%.[6]

These data are illustrative of the growing evidence of how widespread sexual abuse is in this country. Equally consistent and convincing is the documentation of the long-term effects of incest and childhood sexual abuse.[7–9] Survivors of such victimization often suffer from depression, suicide attempts, anxiety, panic attacks, insomnia, pelvic pain, stomach pain, headaches, vertigo, eating disorders, substance abuse, problems with sexuality, and generalized aches and pains that defy diagnosis. Less common symptoms include pseudoseizures,[10] pseudohypoglycemia,[11] and conversion disorders.[12,13]

Given the prevalence and myriad long-term effects of sexual victimization, many of these victims will be treated by family physicians. Yet sexual victimization, like hypertension, is a "silent disease." Outwardly, the victim may appear quite well. Inside, however, there is an emotional time bomb waiting to explode. For the sexual abuse victim, the explosion may take the form of suicide, depression, or any number of the somatic complaints listed above.

As with hypertension, sexual abuse is usually identified through screening. The vast majority of incest and childhood sexual abuse victims do not volunteer this information.[14] Therefore, it behooves family physicians to become skilled in and comfortable with screening patients for such histories. Such screening should be conducted differently for adults and children.

For adults, the first consideration is whether to screen all patients or only those presenting with symptoms that may be sequelae of sexual abuse. Once that decision has been made, physicians can consult excellent guidelines provided by Whalen.[14] In them the history-taking process is described as one of the most difficult parts of the assessment of an adult who was sexually abused as a child. Whalen suggests certain phrases that physicians can employ, 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 important to note that even when the questions are carefully phrased and asked in the "right" tone by the physician, not all patients with abuse histories will be

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able to admit to their experiences. Often, sexual abuse survivors need to test their physician to make sure that he or she can be trusted with such information. In other cases, survivors may have repressed their feelings for so long that they do not have access to the memory 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 as essential to comprehensive health care. Further, by such questions, the physician will convey that he or she is an appropriate ally and resource for such patients, if and when they choose to reveal the abuse history.

The American Medical Association[15] provides useful principles to keep in mind when investigating cases of real or suspected child abuse, such as interviewing parents separately from children, using age-appropriate language, not pushing the child to talk if he or she is reluctant, assuring the child that you have talked with other children who have been abused, and praising the child for having the courage to share such information.

Once a sexual abuse history has been identified, 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 announcing 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, that they know of others who have gotten through the healing process, and that awareness of the abuse helps them to better 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 identify and 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.

Special mention should be made of the mandatory reporting laws in every state for the physical abuse of children. Most of these laws specifically require reporting of child sexual abuse as well, but even those that do not are broad enough to encompass sexual abuse implicitly. Reporting laws apply to all physicians, not only to those treating children. Further, physicians may be obligated to report suspected abuse even if they have never seen the child (eg, when an adult patient makes a revelation involving abuse of a child).[15]

Physicians are in a unique position to assist victims of sexual abuse during the healing process. Awareness of childhood sexual abuse and how to intervene when childhood sexual abuse is suspected, however, are not part of most physicians' basic training. Developing these skills may be one of the most valuable ways for a family physician to expand and improve the care he or she provides.

If you are a physician, it is very likely that at least one patient that you saw today presented with a symptom rooted in past abuse. Do you know which one?

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