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Sensitive Practice: Fine-tuning Patient-Centered Care for Adult Survivors of Childhood Violence

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The *Handbook on Sensitive Practice: Lessons from Adult Survivors of Childhood Sexual Abuse* (2nd edition, 2009)[10] presents information that will help health care practitioners to practice in a manner that is sensitive to the needs of adult survivors of childhood sexual abuse and other types of interpersonal violence. This second edition is the product of a collaborative research project that included over 400 women and men survivors, practitioners from more than ten health disciplines, and counselors who work with survivors. The *Handbook* is intended for health care practitioners and students of all health disciplines who have no specialized training in mental health; it is not meant to encourage clinicians to step outside their scope of practice, but rather to help them to 'fine-tune' patient-centered care for those patients who have experienced violence as children. In this article, we introduce the *Handbook on Sensitive Practice*, briefly offer the rationale for its use, highlight some of the feelings and behaviours that survivors bring to the health care encounter, and introduce the Principles of Sensitive Practice. We present our perspective on effective responses to disclosures of abuse and ways to use task-specific inquiry and disclosure to enhance treatment. Lastly we discuss working with patients who become distressed during treatment. While the Handbook reflects experiences of both women and men survivors, for this article we have selected quotes from women survivors who participated in the research (in *italics*) to illustrate some of the information being presented.

As many as one third of women and 14% of men are survivors of childhood sexual abuse[4,5,6]. Childhood adversity – including sexual, physical, and emotional abuse – is associated with a greater risk of a wide variety of health problems, such as chronic pelvic pain, intractable low back pain, chronic headaches, as well as difficulties with pregnancy and childbirth (See Banyard et al 2009[1] for a range of information about trauma and physical health). This means that all physical therapists who work with adults – whether they know it or not – encounter adult survivors of interpersonal violence in their practices. Survivors are health care consumers of every age who seek all types of health services, and our hope is that the principles and guidelines of Sensitive Practice will become "routine procedures" in all health care encounters and that all health care consumers will benefit from them.

Childhood sexual abuse is a violation of body, boundaries and trust[2] and is typically experienced as traumatic.[7] Examinations and treatment can be distressing for survivors, because they may be reminiscent of the original trauma. The clinician's focus on the patient's body, the patient's lack of control in the clinical environment, the patient having to undress, and feelings of pain, vulnerability and powerlessness are examples of common experiences in the health care environment and may be extremely difficult for survivors because they mirror aspects of past abuse. While most clinicians automatically assume that touch involved in pelvic, rectal and breast exams may be difficult, this research had shown that other components of a health care encounter can also be distressing for survivors of interpersonal violence. Examples include interactions with support staff, aspects of the physical environment, clinicians' time pressures, issues related to clothing, to name a few. Thus, it is not possible to make a complete list of problematic situations. *The Handbook on Sensitive Practice* has been developed to address common difficulties that survivors experience and to help health care practitioners be more understanding of and responsive to the specific needs of adult survivors of violence with the goal of maximizing the benefits of consultation and treatment.

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What survivors bring to the health care encounter

In our research, many survivors told us that their responses to health care encounters are affected by their distrust of authority figures (which include the physical therapist), fear and anxiety, discomfort with persons who are the same gender as their abuser(s), ambivalence about their bodies, and conditioning to be passive. When they exist, these things make it difficult for survivors to seek assistance from health care practitioners and interfere with their ability to participate in their treatment.

> *[In the clinic waiting room, I felt] nervous, apprehensive, not exactly knowing what was going to happen ... as far as clothing was concerned or ... touch, just not knowing*. [9 p.252]

Examinations and treatment may 'trigger' or precipitate flashbacks, a specific memory or overwhelming emotion such as fear, grief or anger. Some survivors dissociate, that is, they experience a disruption in the usual state of consciousness during treatment (see the Handbook for further description). All of these feelings and behaviours leave survivors feeling unsafe and often have a negative effect on the effectiveness of the treatment they receive.

> *And the goop that they put on me for the ultrasound gave me flashbacks, nightmares, insomnia; I just couldn't deal with it.* [9p.257]

The Principles of Sensitive Practice

> *I now am beginning to understand that my physical wellness is really very connected to my emotional state, and if I'm not comfortable, if I'm feeling unsafe, then I'm not going to progress as quickly as a physiotherapist would want me to.* [9 p.251]

The primary goal of Sensitive Practice is to facilitate feelings of safety for the client. The nine themes outlined below were identified by virtually all participants as important to facilitating their sense of safety during interactions with health care practitioners. These themes are so critical to survivors' feelings of safety that we term them the *Principles of Sensitive Practice.* Through the course of our research, we have come to conceptualize safety as a protective umbrella, with the principles of Sensitive Practice being the spokes that hold the umbrella open. When the umbrella is open, *an individual feels safe*, and can participate in the examination or treatment at hand. While most of the principles are components of patient-centred care, they take on even greater significance within the context of childhood sexual abuse and other interpersonal violence.

The physical therapist's deliberate and ongoing attention to the principles (highlighted in bold in this section) can help to address the difficulties related to past abuse that survivors may experience during healthcare encounters. For example, abuse disrespects and disregards the child's autonomy and boundaries; hence, the physical therapist's active demonstration of **respect for the patient** and **attention to the survivor's boundaries** is very important. The lack of control experienced when a child is abused needs to be countered by conscious **sharing of control** during treatment. While this must apply to all components of treatment, seeking *ongoing* verbal consent stands out as crucial, beginning with the first contact. One woman explained the importance of consent, saying "being a survivor, I have to be in charge, I guess, and if I'm not in charge... it's an awful feeling...I want that person out of here…"[9,p255]

Time pressures can leave survivors feeling like a 'number' in a similar way that they were objectified during abuse. Thus **taking time** to connect with the patient and putting ongoing effort into maintaining **rapport** are essential. **Sharing information** both addresses fears about the physical therapist's actions and provides the opportunity for survivors to be *heard* as persons with valuable information to contribute their her health care. A woman explained that this was absolutely essential for her because *"…the element of surprise is just really, really difficult to deal with…[and if] there's a preparation…[it reduces] that fear of the unknown, and [it reduces] the likelihood then that I will be triggered by something that is done…into remembering something that*

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is abusive for me." [9,p255]

Fostering a mutual learning process stresses that survivors may be learning about caring for their bodies while at the same time, the clinician is learning about working more sensitively with survivors, a process that is dependent on mutual respect and cooperation. The final two principles speak to the importance of the clinician learning more about the long-term effects of interpersonal violence. The research participants told us that it is important that clinicians **understand that healing from childhood sexual abuse is not a linear process** and that the survivor's ability to participate in and tolerate treatment may vary unpredictably over time. As one woman said, *"Parts of my body at different times might be untouchable. It's gonna change, depending on what I'm dealing with. So, you're not going to be able to make a list and count on that every time kinda thing: it's gonna be a check-in every session."* [9,p255] As a result, clinicians must indeed 'check in every session', invite the patient to verbalize discomfort, monitor body language that suggests decreased comfort and be willing to change treatment if the patient cannot tolerate a certain approach, whether temporarily or permanently. The final principle emphasizes the importance of clinicians **demonstrating their awareness about interpersonal violence** through their actions and using aids such as posters and brochures (e.g. from a local sexual assault center).

The guidelines for Sensitive Practice address components of practice that range from interactions with administrative staff to referral to other health care practitioners. In this article, we will attempt to highlight some of the aspects of practice that evoked the most attention of survivors and clinicians who participated in the study. We encourage readers to reflect on all aspects of their own practice, and seek new ways to facilitate the survivor's feeling of safety.

The first appointment can be crucial for survivors—many spoke about feeling so unsafe that they could not return for further appointments. In all health care settings, steps must be taken to ensure that the first moments of an encounter set a tone consistent with Sensitive Practice. By introducing oneself, explaining the nature of the appointment, and asking patients how they wish to be addressed, practitioners convey respect for their clients and begin to build a positive relationship with them. Further, before beginning any examination, the physical therapist must ask clients about their expectations for care. Doing so establishes a relationship that involves two-way sharing of information and control. It also creates an opportunity for the clinician to gain quick insight into patients' potential apprehensions, which can help to avoid triggering negative reactions. In long-term health care relationships, the periodic revisiting of roles and responsibilities allows for renegotiation and communicates genuine compassion and concern. For survivors, these simple actions can have a tremendously positive impact on their care because they demonstrate that the clinician is taking many conscious steps towards facilitating the survivor's feelings of safety.

The issue of disclosure is one that quickly arises when we focus on working with survivors of childhood sexual abuse. We approach disclosure in a number of ways. First, is the question of whether the clinician should inquire about past abuse. The research evidence connecting health and childhood adversity is so strong that we believe the clinician should inquire about childhood violence as a routine part of the health history, and leave the decision about whether or not to disclose up to the patient.

> *I think it's important that [health care practitioners] ask questions about abuse as part of a medical history, particularly of women, and I think that anyone dealing with women's pain who doesn't ask questions about violence in a woman's life is not doing their job. I feel that very, very strongly*. [9p.93]

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By routinely asking about past violence and abuse, practitioners open the door for individuals to disclose if they choose to do so. In asking the question, practitioners: (a) demonstrate that they have an understanding of the relationship between interpersonal violence and health; (b) break the harmful silence surrounding abuse and violence; (c) signal that they recognize interpersonal violence as a health issue; and (d) validate their patients' experiences. Asking about a history of abuse can also lead to improvements in health care and may help avoid or reduce retraumatization, which often occurs in health care settings.

> *Surely [practitioners] realize that it's a part of who I am and it needs to be acknowledged, and it does have an impact in terms of how I need to be treated.*

Some survivors choose to disclose when asked, some may disclose at a later time once they firmly trust the physical therapist, and others may never disclose, for a variety of reasons. For those who choose to disclose, the clinician and patient can engage in a dialogue about the implications for their work together.

There will certainly be instances in which the patient does not disclose past abuse, even when asked. To understand how past abuse affects current health care, we recommend that clinicians use what we term *task-specific inquiry* to ask about patients' preferences for or potential difficulties with a specific examination, procedure, treatment or other aspects of the health care encounter. This provides an opportunity for patients to disclose information that is directly pertinent to the present situation without any reference to past interpersonal violence. Task-specific inquiry should be used during an initial meeting with a patient, before any new examination or procedure, and any time body language suggests that the patient may be uncomfortable or experiencing difficulty.

> *We send out signals ... to people that we have been abused ... I was sending signals out, and I don't think the people were listening really and picking up on them ... [I would] cringe and move and I often said "What are you doing*?"[9p.252]

Task-specific inquiry should not be reserved exclusively for examinations involving touch. While touch is problematic for many survivors, other health care interventions and actions (such as standing behind a client during an examination, taking a pulse or blood pressure, or immersing a painful swollen hand in ice water) can also provoke discomfort and trigger distressing reactions. Regardless of other factors, task specific inquiry should also be done intermittently during interactions as an ongoing invitation to offer feedback or to identify problems.

Task-specific inquiry involves a combination of closed- and open-ended questions that offer patients an opportunity to share anything that they consider relevant. A closed-ended inquiry might be, "Have you ever had difficulty with examinations/procedures like this one?" If the individual answers in the affirmative, then an open-ended question – such as "What can I do to make this easier for you?" – can help to minimize the patient's discomfort. Before the examination begins, the physical therapist can extend a broad invitation to share relevant information (e.g., "Is there anything else I should know before we begin?").

> *Asking if [the individual] has any issues or any concerns or are they uncomfortable, either physically or emotionally, is a really good way to start*.

The clinician's response to the task-specific disclosure is also crucial. Problem-solving with the patient provides the opportunity to identify possible solutions and demonstrate the physical therapist's willingness to share information and control; ignoring patient's difficulties and task-specific disclosure can undermine feelings of safety and trust.

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> *[It] would be even better ... if every time you went into a [practitioner's] office, they gave you a little survey ... asking you ..., "Do you have a problem with getting undressed, or being touched?" It would be great if they did that, 'cause then they'd have an idea of what kind of person they're dealing with when that person walks in that door. They're prepared – that person's prepared, because they think, or they'll know that the doctor or the physiotherapist has an idea of what they're going to be dealing with. That if this person says, "Mm, I don't feel comfortable with that," they're going to know. They're going to understand ... And I think that would be fantastic, if they did that. So then both parties would be aware of things.*[11p.93]

As with disclosure of past abuse, practitioners also need to be aware that, although they should make task-specific inquires prior to any examination, some individuals may not be able to talk about their difficulties until they develop a rapport with their physical therapist. Further, the ability or willingness to talk about task-specific difficulties may be a function of the survivor's stage of healing; certain components of an exam may be well tolerated at some times and problematic at others.

Dealing with difficult situations

Despite ongoing efforts to help the survivor to feel safe, (ongoing information sharing and informed consent, task-specific inquiry, repeated invitations to provide feedback, joint problems solving et cetera), it is sometimes impossible to avoid difficult situations in which the patient appears very upset or distraught and the clinician is unsure of what has happened and what to do. In such instances, reference to the "SAVE the Situation" model may be helpful. The model uses "SAVE" as an acronym for the following four steps: **S**top, **A**ppreciate, **V**alidate and **E**xplore. The "SAVE" approach can be effective in any difficult situation and is not reserved exclusively for work with survivors.

The acronym ***SAVE*** is a guide for responding effectively and compassionately in a variety of emotionally charged situations.

- ***S***top - Stop what you are doing and focus your full attention to the present situation.
- ***A***ppreciate - Try to appreciate and understand the person's situation by using the helping skills of empathy and immediacy. Empathy involves imagining the other person's experience (thoughts, feelings, body sensations) and communicating an understanding of that experience. Immediacy is verbalizing one's observations and responses in the moment, using present tense language. For example, 'Your fists are clenched and you look angry. What is happening for you?' or 'You seem upset' or 'I doubt there is anything that I can say that will make this easier. Is it okay with you if I sit here with you for a few minutes? If the person is unable or unwilling to answer, the HP can shift the focus to actions that s/he can do to assist the client, for example, 'How can I help you?'
- ***V***alidate - Validate the other person's experience. For example, "Given what you have just told me, it makes sense that you feel angry."
- ***E***xplore - Explore the next step. For example, "Who can I call to come and stay with you?" or 'This has been difficult for both of us. I am not sure where to go from here. Can I check with you tomorrow to see how you are doing and how you would like to proceed?"

If a survivor has been triggered

SAVE can be used as the first steps when a survivor is triggered by some aspect of the healthcare encounter. The following ideas may assist the clinician working with a patient who has been triggered.

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- Follow the SAVE protocol;
- Orient clients to the present by reminding them where they are and what was happening when they began to have trouble staying present;
- Encourage slow, rhythmic "4-6 breathing" (inhale to the count of four and exhale to the count of six) and (if possible) sitting up and placing their feet on the floor;
- Remind individuals to keep their eyes open and to look around the room;
- Encourage patients to notice physical sensations (e.g., the feeling of their back on the chair and their feet touching the floor, or the sensation of the air on their face).

As clients become more oriented and responsive:

- Do not touch them;
- Offer verbal reassurance in a calm voice;
- Avoid asking complicated questions or giving complex instructions; instead, ask simple questions to try to connect with the person (e.g., "Are you with me?", "Are you following me?", "Do you have ways of staying present?");
- Offer them a glass of water;
- Allow them the necessary time and space to regain their equilibrium (a quiet room may be helpful);
- Normalize the experience. If the patient has disclosed abuse prior to this incident, let her know that health care interventions commonly trigger flashbacks or emotional responses, but do not ask for details of past abuse that may have contributed to being triggered. If the patient has not disclosed abuse, frame the normalizing comments in terms of anxiety that many people feel when seeing health care practitioners;
- Ask what the clients need right now (e.g. do they want your company or would they rather be alone);
- Offer continuity of care care (i.e., if time constraints prevent you from staying with upset clients as long as you would like, explain this and ask if someone else can help, such as another staff member or a friend whom you could call).
- Ask whether the client feels able to continue the examination or treatment.

Being triggered can be a frightening or bewildering experience. Some clients may benefit from talking about the experience. Thus, clinicians can inquire about whether the patient has someone to offer support and whether they would like to contact that person now (e.g., "A new exam like the one we were doing today can be scary for many people and can bring about very strong emotions, as you just experienced. Sometimes it helps to talk about what happened. Do you have anyone you can process this with? Would you like to call this person to be with you now?"). If the patient would like to explore what has happened but does not have a support person or counsellor, the clinician can ask if she would like a referral to a counsellor or other community resource. If the individual is unaware of resources such as telephone help lines, the clinician can provide this information. Referral can be useful for some survivors, however, it is important to realize that offering a referral too quickly can be taken as a message that the clinician wants to avoid or ignore the incident.

The next time the practitioner sees the client it is important to mention the experience to ensure that they are feeling better and to reaffirm the message that the event does not alter the esteem in which they are held. This is a useful time to problem-solve with clients to identify what to avoid or modify in the future to prevent further triggering, keeping in mind that they may or may not be able to identify the trigger for a par-

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ticular incident. This is also a good time to learn from the individuals what techniques they use to stay present and grounded, including any reminders or instructions that the clinician can give them. As time progresses, if the survivor has repeated difficulty, a consultation with a mental health practitioner may enable the patient to develop additional strategies for coping with triggers.

A person who has been triggered or has dissociated may not retain or recall important information shared by the clinician. Thus, it is helpful for practitioners to repeat all instructions and write down instructions and recommendations in clear language. Individuals who have repeated experiences of dissociation during treatment may benefit from the use of a notebook to write information, instructions, and suggestions. Under such circumstances, the physical therapist and client can share the responsibility for ensuring that essential information is recorded before the end of the interaction.

Practitioners may need to seek the support of a colleague or counsellor to talk about *their own reactions* to disclosures of childhood sexual abuse or other difficult situations with patients. Obtaining this support can and must be done without breaching confidentiality. Seeking support is not a sign of weakness; rather, it is indicative of taking professional responsibilities seriously. Practitioners who have personal histories of childhood sexual abuse may be especially empathic towards other survivors, particularly if they have worked through and resolved their own wounds. However, practitioners who have unresolved abuse issues may face great challenges when working with other survivors.[2,7] It is recommended that individuals work through and come to terms with their own history of childhood sexual abuse to avoid confusing their own difficulties with those of their patients.

All forms of violence and abuse can leave an individual feeling disempowered and disconnected from others. Healing from abuse involves re-empowerment and reconnection with self and others.[7] Because the harm of abuse occurs in the context of relationships and because it affects individuals' ability to relate with others, healing can only occur in relationships. Relationships with caring others provide the substrate – the nutrient medium – for healing the parts of the self that were damaged by past trauma. Physical therapists can be allies in that process by offering effective and sensitive health care in the context of genuine human connection. They can also facilitate reconnection by helping survivors learn about their bodies and how they function in health and illness.

Handbook on Sensitive Practice for Health Care Practitioners: Lessons from Adult Survivors of Childhood Sexual Abuse is available free of charge in English (http://www.phac-aspc.gc.ca/ncfv-cnivf/pdfs/nfntsx-handbook_e.pdf) and French (http://www.phac-aspc.gc.ca/ncfv-cnivf/pdfs/nfntsx-handbook_f.pdf) from the Public Health Agency of Canada's National Clearinghouse on Family Violence.

References

1. Banyard V.L., Edwards, V.J., Kendall-Tackett, K.A, (Eds) (2009). *Trauma and Physical Health*. London: Routledge.
2. Blume ES. (1990) *Secret survivors*. New York: Ballantine Books.
3. Bohn, D.D. & Holz, K.A. (1996). Sequelae of abuse: Health effects of childhood sexual abuse, d mestic battering, and rape. *Journal of Nurse Midwifery, 41(6),* 442-456.
4. Bolen, R. & Scannapieco, M. (1999) Prevalence of child sexual abuse: A corrective metanalysis. *Social Service Review, 73*(3), 281-313.
5. Briere, J., & Elliott, D.M. (2003). Prevalence and psychological sequelae of self-reported childhood physical and sexual abuse in a general population sample of men and women. *Child Abuse and Neglect, 27*(10), 1205-22.

(Continued on page 23)

6. Finkelhor, D. (1994). Current information on the scope and nature of child sexual abuse. *The Future of Children, 4*(2), 31-53.
7. Herman, J. (1992). *Trauma and recovery*. New York: Basic Books.
8. Monahan, K., & Forgash, C. (2000). Enhancing the health care experiences of adult female survivors of childhood sexual abuse. *Women & Health, 30*(4), 27-41.
9. Schachter, C.L., Stalker, C.A., & Teram, E. (1999). Toward sensitive practice: Issues for physical therapists working with survivors of childhood sexual abuse. *Physical Therapy*, *79*(3), 248–261.
10. Schachter, C.L., Stalker, C.A., Teram, E., Lasiuk, G.C., Danilkewich, A. 2009. *Handbook on Sensitive Practice for Health Care Practitioners: Lessons from Adult Survivors of Childhood Sexual Abuse*. Public Health Agency of Canada: Ottawa, Canada.
11. Teram, E., Schachter, C.L., & Stalker, C.A. (1999). Opening the doors to disclosure: Childhood sexual abuse survivors reflect on telling physical therapists about their trauma. *Physiotherapy, 85*(2), 88-97.