COMMENTARY

Best Clinical Practices for Male Adult Survivors of Childhood Sexual Abuse: "Do No Harm"

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Perm J 2014 Summer;18(3):82-87

http://dx.doi.org/10.7812/TPP/14-009

Abstract

The health care literature describes treatment challenges and recommended alterations in practice procedures for female survivors of childhood sexual abuse, a subtype of adverse childhood experiences. Currently, there are no concomitant recommendations for best clinical practices for male survivors of childhood sexual abuse or other adverse clinical experiences. Anecdotal information suggests ways physicians can address the needs of adult male survivors of childhood sexual abuse by changes in communication, locus of control, and consent/permission before and during physical examinations and procedures. The intent of this article is to act as a catalyst for improved patient care and more research focused on the identification and optimal responses to the needs of men with adverse childhood experiences in the health care setting.

Introduction

One in 6 men are survivors of childhood sexual abuse, according to the literature.[1-3] The legal, mental health, and research definitions of childhood sexual abuse are not the same. This article uses the legal definitions of childhood sexual abuse that includes vaginal, anal, and oral penetration; child prostitution; participation in pornography; repeated and purposeful exposure to adult sexual acts including viewing pornography; and excessive adult nudity and gratuitous showing of genitals to children.[4] In the US, 1 in 71 men (1.4%) reports having been raped, with 27.8% of these men indicating their first experience of rape by age 10 years or younger.[5]

On the basis of 2010 US Census figures for the male population (n = 151,781,326), there could be more than 24 million male survivors of childhood sexual abuse in the US.[6] The number of potentially affected men indicates a need to educate physicians on best clinical practices for this at-risk population. Extensive research indicates that a history of childhood sexual abuse can have a major, long-term negative impact on the survivor's health, well-being, and life expectancy.[7]

Kaiser Permanente Medical Services and the Centers for Disease Control and Prevention in Atlanta, GA, sponsored the Adverse Childhood Experiences (ACEs) Study, which assessed a large population of adult survivors from among 17,337 health maintenance organization members receiving health care services. This study identified a sample of 2310 women and 1276 men who met the criteria for self-acknowledged physical childhood sexual abuse involving physical contact, and it used a multivariate logistic regression analysis to predict what would or would not occur to the men and women in the sample.[7] In addition, the researchers found that the presence of 1 type of child abuse made the potential for other types of child abuse more likely. The accumulation of abuse resulted in extraordinary increases in the risk factors to attempt suicide compared with those without any child abuse experiences, and an increased risk of alcoholism and illicit drug use as well as marital and family problems. The study demonstrated that the psychological, social, and behavioral outcomes of ACEs were identical for men and women.

Multiple studies of ACEs indicate the interplay between mental health and medical health. The psychological impact of an ACE may result in behaviors that diminish the overall health, exacerbate stress-sensitive conditions, and diminish a person's willingness to seek timely treatment for medical problems.[8-10]

Even though this research[8-10] indicates that the extent and impact of trauma for female and male survivors of childhood sexual abuse are the same, there continues to be a gender gap in the health care literature that focuses on the care of the male survivor. The literature in breast cancer and in obstetrics and gynecology addresses the issues of providing health care services to a sexually abused female patient. Physicians in these specialties perform genital examinations and related invasive procedures. The recommendations for physicians in these studies indicate the need to slow down the examination process to enable more communication with the patient as well as asking the patient for permission to proceed with the examination.[11-18] Medical internists and urologists examine men in a manner proximate to a gynecologist's examination of women. Yet, no recommendations exist to address the issue of childhood sexual abuse and its potential impact on adult male patients.

Health Issues Affecting Adult Survivors of Childhood Sexual Abuse

Health care clinicians have identified that childhood sexual abuse raises the risk of a number of medical conditions and illnesses sometimes labeled "diseases of trauma."[16] These health problems, studied in both sexes, include asthma, chronic fatigue syndrome, fibromyalgia, irritable bowel syndrome, migraines, and chronic pain, among others.[8,15,16,19]

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Therefore, physicians in numerous specialties are likely to have patients with a history of sexual abuse.

Male survivors of all forms of severe childhood psychological, emotional, or physical abuse resist disclosure of physical and psychological symptoms.[20] In addition, men are more reluctant to report sexual abuse than are female survivors.[20,21] A contributing factor to nondisclosure may be that men knew the abuser before the abuse, as suggested by literature reporting that the child usually knows the abuser a priori.[22] In these cases, the abuser is a parent, sibling, other family member, family friend, coach, teacher, clergy, or other familiar person.[22] This increases feelings of shame and betrayal. Adherence to the guidelines we propose when interacting with male patients with histories of trauma can be a powerful tool for helping deliver more beneficial health care to all men.[23]

Triggers and Triggering

Research has shown that although only a small fraction of physicians routinely inquire about historical traumatic incidents, most patients report that they would actually favor such inquiries.[24] Although it is beyond the scope of this article to address the complexity of posttraumatic stress disorder, four symptom groups are conceptualized: reexperiencing the trauma, avoiding situations that remind one of the trauma, alteration of thoughts and mood stability, and increased sensitivity to stimuli/increased reactivity to stimuli.[25] For survivors of sexual abuse, feelings of powerlessness can be pivotal.[26] The power differential between the physician and patient, added to the anxiety and fear a person may have about one's medical condition and symptoms, can render the health care environment particularly stressful to a person who feels emotionally and physically vulnerable in most environments.[27]

Volunteers from two peer support organizations (MaleSurvivor and Males for Trauma Recovery) provided vignettes of their distressing experiences receiving health care services. The men in these vignettes found certain aspects of their medical care "triggering," which is an aspect of the increased sensitivity to stimuli and increased reactivity to stimuli. A trigger is any sound, word, smell, sight, taste, physical or emotional feeling, and/or other stimulus that evokes some aspect of a previous trauma, in this case childhood sexual abuse.[28] Because of the obvious intimate nature of medical care, any number of triggers exists, among them the request to undress, physical contact, and positioning the patient's body.[28] As the literature indicates and the following first four vignettes describe, male survivors' issues of trust, expectation of betrayal, and negative associations to touch may result in the reactivation of the trauma with potentially harmful effects.[7,10,20-22,26,27]

Communication privacy management theory developed a way of understanding how people evaluate the amount and type of privacy they need or want in interpersonal relationships and the ramifications of decision making about disclosure.[29] This theory suggests that when the patient discloses a history of sexual abuse to the physician, the patient may initially feel less comfortable with the physician. This then renders the physician's response to the information as essential to establishing an optimal physician-patient relationship.[30,31]

Vignette 1

"With my last heart attack, I almost did not call 911 because I was so afraid they would insert an IV [intravenous catheter] into my groin. I had told my cardiologist of my problem. When I was

Recommendations for Best Clinical Practices with Male Survivors of Childhood Sexual Abuse and Adverse Childhood Experiences

Communication cluster

1. As part of history taking, ask about adverse childhood experiences of physical and/or sexual abuse, and family violence.
2. Listen to the patient and stop doing any other nonemergency activity.
3. Ask your patient about concerns and preferences in the biologic sex of his physicians. If there are gender concerns, allow the patient to discuss them.

Control cluster

4. If your patient indicates he is fearful, ask your patient about how to increase his feelings of safety.
5. For invasive procedures, ensure your patient understands informed consent and that he can change his mind at any point before sedation or anesthesia.
6. Help your patient anticipate the stressors of next steps before you order further tests or procedures.
7. Review procedures with your patient that involve undressing and touching.

Permission cluster

8. Inform your patient before touching and explain the specific purpose of touching.
9. Inform your patient at the beginning of the examination that you will request body positioning before making that request.
10. Take a "sounding" from your patient during invasive examination procedures ("How are you doing? Do you need me to … ?").

on the table in the operating room with IV Valium [diazepam] and morphine, I still, somewhere deep in my brain, realized that there was a needle stuck in my groin [for heart catheterization and implanting a stent]. I started flailing about in a full-blown panic attack. The doctor called for a crash team and had people hold me down while they administered restraints and got an anesthetist to put me completely under."

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Vignette 2

"Reluctantly I agreed to go to a gastroenterologist for a colonoscopy recommended by my internist because of blood in my stool. I had conscious sedation for the procedure. I told the doctor that I am a survivor of incest. During the procedure, I woke up feeling the scope inside my body and someone holding the cheeks of my behind open. I called out to the doctor that I was awake. I heard him tell the anesthesiologist to give me more sedation. Once I was in recovery, I knew what had happened, but the doctor did not mention it and acted as if nothing happened. Just like my dad after he would rape me, it was not mentioned, as if it never happened."

Vignette 3

"My internal medicine doctor referred me to a sleep study, and I knew it would bring up issues of my sexual abuse. The abuse frequently happened at night once my parents had fallen asleep. The thought of someone watching me sleep brought up a little apprehension, yet the thought of possibly dying in my sleep [because of obstructive sleep apnea] overrode my anxiety, at least in the beginning of this medical procedure. I was lying on the bed, when the nurse put the instrument that measures the breath through the nostrils, my understanding of the procedure and all the coping techniques I had went out the window. The instrument placed in my nostrils triggered my rape response. It was as if the perpetrator was there placing his hands over my mouth and nose all over again.

"When I left the facility [I was] holding back the tears the best I could for as far through the building as I could. I felt like vomiting, but nothing came out. I went home and just blanked out for a while, then fell asleep. The office never called my primary doctor to explain what happened."

Vignette 4

"I went to a urologist due to prostate symptoms. I was not able to find a woman urologist that would see adult male patients. I told the urologist about the sexual abuse when I was a kid, but he seemed not to get it. He told me to "drop 'em" (meaning pull down my pants) when he wanted to examine me. When he did the digital rectal examination, I winced due to the discomfort, and he joked: "And I didn't even buy you a nice dinner."

In contrast to these four vignettes, the following two vignettes demonstrate more effective physician responses to a patient's disclosure of a history of childhood sexual abuse.

Vignette 5

"I passed out in the street and cut my face up when I hit the pavement. I woke up in the emergency room, and I was very scared. The thorough examination included a rectal exam. I began to shiver, I guess I was nervous, and I refused the examination. The ER [emergency room] doctor explained that he needed to see if I was bleeding and if that was why I passed out. Crying, I told him that my brother forced me to have anal intercourse when I was a kid. He was really cool. He said it was my choice to be examined. He told me if I agreed I would feel some pressure but he would be very brief. So I agreed. After, he asked me if I was okay and if I wanted to talk to a social worker."

Vignette 6

"I had trouble swallowing and I was losing lots of weight. My regular doctor told me I needed to have a 'scope' [endoscopic examination] and sent me to another doctor for it. The new doctor told me what the scope was all about, and I freaked. I told him no way is anything going in my mouth and down my throat. He asked me if I had this test before or some other similar examination that upset me. I thought a moment and I said what the hell. I told [him] when I was nine, my hockey coach would get me drunk on beer and then I had to [perform oral sex on him]. The doctor looked shocked and sad. He told me I really needed this scope and he understood why I was upset about it. I knew he was right so I agreed to do it. The day of the scope, the doctor was very kind to me. He talked to me a lot about the scope and what he would be doing while I was sedated."

Communication privacy management theory indicates that disclosure of private information, such as a history of sexual abuse or other ACEs, relies on privacy rules.[29] Privacy rules focus on the issue of under what conditions disclosure occurs, such as the pluses or minuses of sharing private information in a specific situation or context. The men in these vignettes decided to disclose, which then altered the relationship with the physician. We suggest that the decision to disclose by a male survivor of childhood sexual abuse relates to the "triggering" discomfort/distress caused by the increased sensitivity/reactivity to stimuli. The success of the changed relationship requires an empathic physician response that recognizes the importance of the shared information for the patient and the patient's distress.[30-32] The physicians in Vignettes 1 through 4 responded without empathy. The resulting physician-patient relationship was unsuccessful in that the patients reported a negative experience. The physicians in Vignettes 5 and 6 responded empathically. The resulting physician-patient relationship was successful in that the patients reported a positive experience.

These six vignettes are neither representative nor an objective sample. Therefore, one cannot generalize from anecdotal information nor prove a cause-effect relationship. Yet, if physicians ignore, minimize, or deny the psychological debris of childhood sexual abuse for male survivors, they can inadvertently reinforce a survivor's unwillingness to seek appropriate help, comfort, or support. In this way, medical care risks being a reenactment of the sexual abuse that was characterized by similar abuses of power. The physicians who recognized their patients' distress and responded in empathic ways did not reinforce or reenact the patients' abuse experiences.

Recommendations

We have identified ten recommendations for best clinical practice in providing health care to male survivors of childhood sexual abuse (see Sidebar: Recommendations for Best Clinical Practices with Male Survivors of Childhood Sexual Abuse and Adverse Childhood Experiences). These recommendations cluster around issues of communication, control, and permission. The communications cluster focuses on asking about the man's sexual abuse history and, if one is present, the interpersonal aspects of processing the information as part of physician-patient relationship building.[21] Part of the control cluster focuses on integrating the process of anticipation of potentially triggering aspects of a medical examination, tests, and treatments. The permission cluster focuses on the interpersonal interchange that needs to take place before intrusive and intimate aspects of medical care begin. The gradual progression of a physical examination, which includes talking the patient through the process, is a way of pacing the examination at the speed the patient is most comfortable.

Communication between physician and patient is a crucial foundation of good medical care and cannot be limited to the physician asking questions of the patient and recording the answers. The typical busy medical practice poses a challenge to optimal communication. In addition, the electronic medical record can make it easy for a physician to gaze at the computer screen or the keyboard rather than actually face and interact with the patient. Most important is the physician understanding how to respond to the disclosure of a history of childhood sexual abuse empathically.[33] The physician's empathic response enhances the relationship with the patient who has taken the risk of disclosure.[31] This requires eye contact, not introducing another question, and not changing the subject but presenting concern and a willingness to learn more if the patient wants to continue to share (see Sidebar: Empathic Communication Techniques with Men Disclosing Histories of Childhood Sexual Abuse and Adverse Childhood Experiences). Asking a follow-up question is not an empathic response to disclosure; rather, it prevents the patient from sharing important information of how to proceed with his care. Following an empathic response to the disclosure of child sexual abuse, it tends to comfort the patient to ask how his experience of childhood sexual abuse affects him now.

The locus of control in the health care of the male survivor needs to be with him and not the physician. It is common, even in this era of consumer-oriented medicine, for a patient to be overwhelmed or intimidated during interaction with physicians. For some patients, physicians are an authority figure, and it is important for physicians to keep in mind that the abuser was often an authority figure as well. Consent is a moment in time, yet a male survivor is the type of patient who might believe that once he has agreed to a procedure or treatment, there is no other recourse but to acquiesce even if he has changed his mind. Pacing is a way of approaching things in a gradual rather than in a propulsive manner. A physician may proceed with an examination from body part to body part or organ system to organ system in a routine familiar and typical for the physician but unusual and extraordinary for the patient. Physicians need to continue to take a "sounding" from their male survivor patient to maintain an ongoing dialogue about

Empathic Communication Techniques with Men Disclosing Histories of Childhood Sexual Abuse and Adverse Childhood Experiences

1. Physicians need to hear the patient's words but also to listen to the patient's feelings through tone of voice.
2. Although not all cultural groups value or are comfortable with direct eye contact, most people of any culture believe a person is not paying attention to them if s/he is writing or keyboarding while talking. Physicians should pause (put down the pen, remove hands from the keyboard) and listen before recording the patient's answers.
3. Physicians can demonstrate empathy and understanding by responding to the patient's answers before going on to the next question.
4. Sounds of compassion and soft tones of voice also convey empathy.
5. Reflecting back using the words the patient has used in sharing information with you is a basic way to accomplish empathy.
6. The physician who hears a patient's disclosure of childhood sexual abuse is placed in the role of a witness. The physician's response needs to demonstrate respect of the importance of what the patient has shared.
7. A response with the word "okay" is easy to misunderstand because the word can have any number of meanings, some of which are insensitive and thoughtless.
8. Avoid using "placeholder" responses such as "I see," "Got it," "Really," or "I understand" because these can sound particularly callous or insincere to these patients.
9. Empower survivors to tell you how best to move forward with them. For example, the question "Thank you for sharing that. How can I work differently, given what you have shared?" can be an effective way to interact with a patient who has disclosed childhood sexual abuse.
10. Avoid physical contact with a patient in the immediate moments after disclosure. Even well-intentioned contact can be potentially triggering and upsetting.

the patient's comfort with the decisions he has made. A "sounding" is a clear, concrete request for information about a patient's experience and coping ability in the moment.

Permission is perhaps the most important aspect of the physician-patient relationship. We recommend that physicians specifically ask for permission. For particularly invasive procedures (eg, digital rectal examinations, testes examinations, retraction of the foreskin of the penis), it is best to specifically engage the patient in a "sounding" on how the patient is coping in the moment. As indicated by the first four vignettes and the introductory case material, the male survivors were not able to articulate their distress as it related to their abuse. A physician may believe that s/he has the patient's permission to examine him simply because the patient is in the examination room and complying with the physician's requests. Even if physicians inform a patient of what they will do during an examination or procedure, in the context of the physician as the authority, it implies the patient has no choice. This can easily replicate the patient's history of sexual abuse, in which his body ceases to be his own and the abuser uses his body in various ways.

… male survivors' issues of trust, expectation of betrayal, and negative associations to touch may result in the reactivation of the trauma …

Conclusions

Childhood sexual abuse affects a substantial number of men, making it imperative that physicians engaged in male health issues alter their practice to meet their patients' needs. Childhood sexual abuse has adverse long-term effects on the physical and mental health of survivors. In particular, childhood sexual abuse disrupts interpersonal relationships and can manifest itself in mistrust, fear, avoidance, and suspiciousness of authority figures in their lives. Best clinical practices with male survivors of childhood sexual abuse include physicians considering changes in the way they initially identify this patient population, communicate, respond, listen to, involve, examine, and plan for effective and empowering interactions with them. The male survivor population as a health care consumer group requires rigorous scientific research similar to the research that exists on women survivors. This could ultimately improve the medical care of male survivors. ❖

Disclosure Statement

The author(s) have no conflicts of interest to disclose.

Acknowledgment

Kathleen Louden, ELS, of Louden Health Communications provided editorial assistance.

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The Art

Too often is it forgotten that the science of medicine finds expression only in the application of the art.

— Denslow Lewis, MD, 1857-1913, American gynecologist and author