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Moving on to strengths

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Moving on to Strengths

IT CAN NO LONGER BE in doubt: a quarter of the women who physicians see every day have had some experience of sexual abuse, and fully a third have sustained physical abuse. The article by Sansone et al¹ in this issue of the ARCHIVES confirms the commonality of past abuse experiences among middle-class women in the health maintenance organization setting. Their finding of a 25.8% rate of prior sexual abuse among women seeking Papanicolaou tests at a health maintenance organization in Tulsa, Okla, is comparable to the frequency of prior sexual abuse among women seen in family practice settings across the country. Without statistically validated instruments, the Tulsa data are not strictly comparable with other research; nevertheless, their results are consistent with the rate of prior sexual abuse of 22.1% that was found among women attending a rural clinic in Wisconsin² and of 26.0% at a Michigan family practice residency clinic.³ Their results are somewhat lower than the 37% rate of childhood sexual abuse and 29% rate of adult sexual assault found among women attending the family practice residency clinic at the University of Washington.⁴ Likewise, the rate of past experience of physical abuse of 36.4% in Tulsa was of the same order of magnitude as the rate of physical abuse reported by women at two family practice sites in Sioux Falls, SD (minor physical abuse, 44%, and severe physical abuse, 28%),⁵ and as the lifetime rate of physical abuse of 38.8% reported by female patients at another midwestern family practice clinic.⁶

There also is no doubt that prior trauma is harmful. The literature makes it clear that physical and sexual abuse result in significant immediate and long-term morbidity for women.⁷⁻⁹ In every setting, those of us who are survivors of physical and sexual abuse emerge as bearing an excess of symptoms compared with women who have not been abused. Women in the community,¹⁰⁻¹² women at college,¹³⁻¹⁵ women attending primary care clinics,^{3,4} women employed by a health maintenance organization,¹⁶ and women professionals¹⁷ all show the same findings. Our distress may be psychological or somatic or both; evidence is strong that the more severe the trauma, the more symptomatic we are likely to be.^{18,19}

What kind of harm does trauma cause? Certainly, it can be the root cause of psychiatric illness. Careful inquiry has revealed that most patients who meet the criteria for borderline personality disorder have sustained devastating, repetitive physical and sexual vic-

timization in childhood.²⁰ The emerging understanding of this presumed etiological link between devastating childhood trauma and borderline personality disorder has led to the recent reinterpretation of this diagnosis as a type of complex posttraumatic stress syndrome.²¹⁻²³ Using a screening instrument (the Personality Diagnostic Questionnaire-Revised [PDQ-R]²⁴) that was derived from a list of criteria for borderline personality disorder from the *Diagnostic and Statistical Manual of Mental Disorders, Revised Third Edition*,²⁵ Sansone et al¹ have applied the lens of psychiatric diagnosis to the women in their sample. Unfortunately, as they point out, the PDQ-R overestimates the extent of psychiatric illness; even with patients seeking admission to a psychiatric hospital, the PDQ-R overdiagnoses disorders compared with diagnostic psychiatric interviews.²⁶ In a screening of women whose main concerns are not psychiatric, it is even more likely that the PDQ-R will exaggerate the extent of psychiatric diagnoses.

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The finding that 28.3% of the medical patients in the study by Sansone et al acknowledged at least one symptom from the list of criteria for borderline personality disorder cannot be narrowed to mean that all these women had "borderline personality symptoms." Rather, we can restate the matter as follows: about a quarter of women will acknowledge having at least one symptom typical of people who have been severely abused. If these symptoms are so common among primary care patients, they may be a part of the normal human response to exploitation and victimization and may actually be adaptive or helpful defenses.²⁷ Linking the symptoms to a personality disorder belies the fact that many trauma survivors have a successful outcome.²³ The high prevalence of abuse among nonpsychiatric patients should give us pause about the high cost to ordinary women of having survived traumatic events.

The term personality disorder implies an indwelling pathological permanence from which one cannot recover. The reality of women's lives around the world contradicts psychiatric classification. Anyone who has had the privilege of working over time with an incest survivor or other trauma survivors knows the tremendous courage that survivors bring to their daily lives and the enormous will to live and to love that enables them to recover and thrive. Failure to recognize and

characterize survivors by their strengths and insights condemns them (and those of us physicians who are survivors of abuse) to prejudicial pejorative diagnostic categorization. Twenty-seven percent of professional women (in a sample drawn from social workers, nurse practitioners, attorneys, engineers, and eight other occupations) acknowledge a history of childhood sexual abuse.¹⁷ Survivors are at least 27% of the women readers of articles like those of Sansone et al.¹ Family medicine needs a framework that allows us all, survivors and nonsurvivors alike, to think of ourselves and our patients with respect.

WOMEN WHO HAVE sustained physical and sexual abuse are survivors—women of enormous strengths and vulnerabilities who have made it through the events and have lived to tell us about them. Increasingly, we have the privilege of reading survivors' accounts documenting the preciousness of life and the pain of survival.²⁸⁻³⁵ Often these accounts are so terrifying that we wish we could escape the memory of having read them. More commonly, the sexual abuse that women sustain is ordinary: an uncle grabbed her crotch and forced his tongue into her mouth, a grandfather tweaked her nipples while she practiced the piano, a stepfather stealthily increased his nightly advances until she responded, a brother-in-law raped her when he was drunk—plain ordinary family experiences. A quarter to a third of women will tell you if you ask them. Not the devastating childhood torture that forms the backdrop to multiple personality disorder or the repetitive violations and punishments that shake the foundations of personality. Just ordinary men taking sexual advantage of the girls and women who happen to live in the same family. Yes, these women have symptoms too.

Violence is not good for people; it makes them feel vulnerable or contaminated, and sometimes they feel that life is not worth living. Not surprisingly, those of us who have been victimized have more trouble taking care of ourselves. We make more office visits,¹⁶ we are more likely to be obese,³⁶ and we are more likely to smoke and to have problems with drugs and alcohol; we are less likely to wear our seat belts and to have timely Papanicolaou tests performed.² Previously victimized women have first intercourse at a younger age and are more likely to become pregnant as adolescents.^{2,37,38} Women victimized both in childhood and adulthood are less likely to use barrier methods of contraception and are more likely to have unintended pregnancies and abortions.³⁹ Not surprisingly, among people with risk factors for acquiring human immunodeficiency virus infection, sexual abuse survivors are overrepresented.⁴⁰ Understanding the dynamics of abuse, clinicians attuned to the frequency of prior trauma may choose to focus on recovery and survival, knowing that self-respect will need to precede self-care in the pursuit of healthier lifestyles.

The choice of the PDQ-R as an instrument to

examine trauma survivors' symptoms misconstrues our lives and experience. For family practice clinicians and investigators, instruments with more diagnostic neutrality may be more helpful. To measure symptoms among women who have been victimized previously, other trauma researchers have applied a variety of validated scales: the Hopkins Symptom Checklist,^{2,13,18} the Rand Corporation Mental Health Index,¹⁶ and the General Health Questionnaire and the Present State Examination.¹² Each of these instruments has enabled investigators to measure psychological symptoms without applying psychiatric nomenclature to survivors of abuse. One scale already piloted in a family practice setting⁴ is the Trauma Symptom Checklist,¹⁷ a tool that construes symptoms as the effect of trauma, not the building blocks toward a psychiatric diagnosis.

Without doubt, the most problematic symptom for trauma survivors and the clinicians who care for them is self-destructive behavior. Along with the PDQ-R, Sansone et al administered a not-yet-validated questionnaire about past self-harm to the women in their sample. Consistent with other research on women who have been victimized, they found a correlation between self-injurious behavior and a history of physical and sexual abuse and witnessing of violence.^{41,42} Unfortunately, they included having "engaged in physically abusive relationships" among the items on their Self-Harm Inventory. This inclusion clouds the picture. Being battered must be clearly separated out from self-harm. It can lead to self-harm; for instance, living in a chronically abusive relationship is not an unusual precipitant to suicide attempts.⁴³ Women who have been victimized in childhood and adolescence are more at risk of subsequent victimization.^{11,14} This still is not self-harm. They may have difficulty protecting themselves and do not value themselves highly. They may be more vulnerable to potential abusers who are able to discern their fragility. They are easy targets for men who may wish to use them for prostitution⁴⁴ or for therapists, who may engage in sexual activity with them.⁴⁵ Some may feel a kind of involuntary helplessness (akin to posthypnotic suggestion) that renders them incapable of protecting themselves from victimization or violation.²⁷ Calling episodes of repeated victimization "self-destructive behavior" takes the emphasis off the wrongdoer and locates the problem again in the woman who appears to exhibit psychopathological behavior.

Family medicine is integrative work. We know that healing occurs both through what we do and how we relate to people. We know that our words, our actions, and our touch all have meanings that patients interpret through the lenses of their own, often painful, experiences. I take issue with Sansone et al that our strategy to treat women with symptoms meeting the criteria for borderline personality disorder, which I take to mean women symptomatic from previous abuse, should be to "separate the medical and psychological issues and redirect the psychological issues to a mental health professional."¹ It is the very impossibility of separating the medical and psychological issues,

particularly for physically and sexually traumatized patients, that makes family medicine the appropriate discipline to care for patients who are survivors of abuse. The vulnerable areas of safety, trust, and boundaries guarantee that the most basic medical activities, eg, taking a history, performing a physical examination, and engaging in intimate caring behaviors that involve touch, will raise the specter of past abuse for survivors. The psychological issues cannot be separated from the physical issues because, for many survivors, it is exactly the body that was at stake.

THE FAMILY PHYSICIAN who recognizes the previously undetected survivor of abuse in his or her practice has gained an insight to make sense of reactions that appear irrelevant or out of proportion, such as fear, panic, or rage.⁴⁶ The knowledgeable clinician will be able to interpret patients' confusion over boundaries and how and why the clinician maintains them. If the clinician knows that a person is a survivor of abuse, he or she will find it useful to make an inquiry into whether routine health maintenance activities (eg, pelvic examinations and mammography) or the workup of a medical problem will itself be a form of revictimization, causing flashbacks or dissociation. Astute clinicians will acknowledge how their own gender may restimulate issues of betrayal and abuse by parents or caregivers of the same gender. They also recognize "the power of touch for patients whose previous experiences of touch were painful, exploitative, or both."^{46(p489)}

Of course, survivors of abuse need the help of more than one person. Rape crisis centers, battered women's shelters, and some self-help groups offer a setting in which survivors may untangle their pain in the company of other women who do not think that they are the ones who have the problem. Although some survivors do need to engage in psychotherapeutic work to undo the harm that was inflicted years before, this therapy is best practiced with physicians and mental health providers engaging in collaborative care. Truly integrated psychological and medical treatment requires ongoing communication between clinicians that can only occur when all the treating clinicians work in the same setting together, making a clear and consistent alliance with the patient for her health rather than splitting her body and mind. Ruddy⁴⁷ recently offered us an exemplary model of such integration in the collaborative treatment of Sara, a woman with multiple personality disorder.

For generations, women who suffered physical and sexual abuse have held down jobs, raised families, upheld relationships, and bravely pursued their lives, carrying the secret of their violation in silence. Historically, the recognition of childhood sexual abuse has waxed and waned.⁴⁸ As soon as public consciousness gave way to accept the reality of abuse, the forces of denial and repression swung into play, pushing the knowledge of childhood trauma and its devastation

back beneath awareness. Even today, awareness of the commonality of women's abuse experiences is being clouded by forces denying women's credibility: If she did not fight back, was she willing? If she forgets and then remembers, is it a "false" memory? If it happens more than once, is she "asking for it?" If she overdoses or dissociates or feels empty, is she a "borderline"? It was not the intent of Sansone et al to contribute to the contemporary backlash. Nevertheless, a research project that begins with criteria for personality disorder can only conclude by finding the symptoms and behavior of survivors psychopathological. Such a diagnostic framework will inevitably serve the forces that tolerate and perpetuate victimization.

We are practicing in a world where a quarter of women have been sexually abused, a third have been physically abused, and images of violence against women continue to surround us daily. Abuse is so common that all clinicians must regard it as a fact of life. Survivors of abuse are competent people who have carried this trauma much of their lives. They are exquisitely aware of the reactions of others and can often tell what we are thinking before we even say it. If survivors choose to disclose their past experiences to us, they are well on their way to getting the help they need. Our job should be to recognize their tremendous strengths and to promote their self-healing and self-protective abilities. Knowing what all girls and women go through trying to protect themselves, we can join with survivors of abuse to demand safety for women and children.

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