

Disclosures of sexual abuse: what do you do next?

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Background

Sexual abuse, especially in childhood, often has severe and long-lasting clinical consequences, both physical and psychological.

Objective

This article outlines an approach to use when patients disclose a history of sexual abuse, and provides some resources to call on in those circumstances.

Discussion

This article addresses questions one might ask to uncover a history of sexual abuse, possible responses to disclosures of sexual abuse, and documentation of these disclosures.

Keywords

child abuse; doctor–patient relations; communication; mental health

Case 1

Rosanne, 40 years of age, had a history of chronic back pain, and attended clinic for prescriptions. Her scans showed disc bulges at two levels in her lumbar spine. Although the intent was to slowly wean her off opioids, her symptom complex seemed to progressively worsen. Emotionally, she was very fragile and often angry. The general practitioner (GP) had always felt they were playing ‘catch up’ with Roseanne, so decided to get her in for a long appointment at the end of a session. What unfolded was a childhood spent in an extremely dysfunctional family and years of sexual abuse from an older brother. At the end of this consultation, she admitted that her back pain sometimes mirrored her emotional state.

Case 2

Rhys, a big and slightly intimidating man of about 50 years, attended clinic for management of hypertension. One day, after the GP had known him for a while, he disclosed a history of sexual abuse by his grandfather when he was a young boy. He said that one result of this was that he never felt comfortable with the idea of having children in case he did the same to them. He also always felt uncomfortable when his friend’s young children were around.

Case 3

Dianne was in her mid 30s. Accompanied by her two young children, she presented with a long history of headaches, which seemed to be classic tension headaches. On being asked whether she had experienced any physical or emotional stress that could have precipitated the problem, she said no. About 1 week later, she presented again and disclosed a history of significant sexual abuse by a neighbour when she was young. Later she told the GP, among other things, that she had not breastfed her children because of the sexual connotations.

These cases are illustrative compilations and are not based on specific individuals.

Discussion

As demonstrated by these vignettes, the long-term physical and psychological consequences of sexual abuse are many, often somatic or psychological, and can have devastating consequences for the victim.¹

Occasionally, patients disclose a history of childhood sexual abuse. Early in my career in general practice, I struggled with where to go once something had been disclosed. Should I ask the details? What should I do next? Who should I refer them to? How should I record this information in the patient’s file?

Over the past 5 years I have been able to call on the services of a colleague who works as a psychologist in the area of sexual abuse. We decided some time ago to write an article about an approach to this tricky area of general practice. So here is a series of questions I posed to my colleague.

What questions might help uncover a history of sexual abuse?

A New Zealand study in 2006 found that the average time before disclosure of childhood sexual abuse was about 16 years.² The study of women who had been sexually abused in childhood and later treated by mental health services found that 63% had never been asked about childhood sexual abuse by mental health staff. Patients may not recognise that they have experienced sexual abuse because it has not involved vaginal-penile penetration, but in reality sexual abuse includes a wide range of acts and behaviours that are unwanted, coerced or committed without consent.³

Because so many health problems can be associated with childhood sexual abuse,³ and because of the low rate of spontaneous disclosure, it should be part of routine practice, especially in the mental health area, to enquire about childhood sexual abuse. There is an analogy here with suicide risk: if you don't ask, you may not be told.

A normalising statement before asking often eases the path to such enquiries: 'I'm going to ask some very personal questions now about things that happen to some people in childhood'. When asking about sexual abuse, I use the terminology 'unwanted sexual touching'. I have a range of things I ask about, and place sexualised touching in the middle of the list, so it may sound something like this: 'Have you, as a child, teenager or adult, experienced any form of physical abuse, emotional abuse, any neglect, unwanted sexualised touching or behaviours, the death of a parent/

grandparent, any major car accidents, or bullying at school?' You'll be surprised at what you get, so be prepared.

What's the best next step when someone discloses a history of sexual abuse?

Offer empathy rather than asking for details. In fact, be careful how you explore 'what happened'.

Comments such as: 'that must have been very distressing and hard for you', and, 'how did you cope?' demonstrate an empathic and non-judgemental attitude. The statement in essence is telling patients you believe them and you are not judging them. Many people carry guilt throughout their lives, believing that the sexual abuse was somehow their fault. If they receive a judgemental response such as, 'why didn't you tell someone at the time?' the patient's guilt may be reinforced and they may never tell anyone ever again. If self-blame does surface, do mention that this is a common reaction to this type of abuse, and affirm that it was not their fault.

If a child discloses any form of abuse, as trusted professionals, we are mandated to report the child's disclosure to the Victorian Department of Human Services (or similar services in each state/territory), who will investigate such matters. It is not up to us to investigate – only to report. Don't advise the parents that you are making a notification unless you are convinced that the person attending with the child is a protective parent and not the person abusing the child. It is not unusual for a child to disclose and then retract, fearing further abuse if the abusive person comes to hear that they have 'let the secret out'.

When and how would you ask for more details of what happened?

It is not necessary or advisable to ask all the details about what happened at the first disclosure.⁴ You may very easily

take the patient back to their traumas and they may decompensate in your office. The patient may not be ready to tell you the details. The GP could make comments such as, 'thank you for telling me, if you want to talk again about this issue either now or later, I'm ready to listen. I'll be guided by you'. Essentially, you are flagging that you have heard the disclosure. At a later appointment, you may obtain more details if the patient is comfortable telling you. Another useful question is to ask if the patient ever disclosed the abuse to anyone else and, if so, what was the outcome of the disclosure. Asking this question is important. If the patient decides at a later date to report the matter to police, they may name you as first disclosure source, and you may find yourself giving evidence or a statement; therefore, how you record the disclosure is essential.

At the end of this type of consultation it is important to check the patient's safety, for example, 'telling someone about what happened can bring up a lot of feelings and memories. How are you feeling about having told me, and how will you feel tomorrow?'

What is known about the victims and perpetrators?

Sexual abuse is not a crime about 'sex or passion'. It is a crime about power and control.³ Sexual abuse is not usually a spontaneous, uncontrolled act committed by strangers. Most acts of sexual abuse are premeditated, well planned and committed by someone known to the victim, such as family members, friends or other trusted individuals.⁵

Statistics inform us that 90% of perpetrators are male. One in three girls and one in six boys will experience sexual abuse before the age of 18 years. One in 10 women will experience rape after the age of 18 years. One in seven women will experience sexual abuse by a current partner and one in six by another male.³

Sexual abuse has been recorded throughout the ages. However, in the last 25 years the feminist movement has spoken openly about such issues, and we are now more aware of these things happening within our communities.⁶

Is it true that most abusers have themselves been the victims of sexual violence when they were young?

Statistics suggest that only one-third of males who have experienced sexual abuse during childhood will go on to commit such crimes themselves. It is possible that perpetrators who are caught and go through the justice system may make claims of childhood sexual abuse in order to receive a lighter sentence. In the majority of cases there is no way of checking whether these people have experienced sexual abuse.⁷

How should I record this information in the patient's file?

Documenting this information is important. Often, information about sexual abuse is only disclosed when the patient really trusts the doctor. Usually I will discuss with the patient that I have made these notes and why. Thus, careful thought needs to be given as to where the information is documented, including instructions about its use. I tend to make reference to the information in the patient's social history. I may make a note in the social history suggesting that further information can be garnered on the topic from an entry on a certain date in the progress notes. This is because some social history details may be included in summaries or referral letters, where it may not be appropriate. Again, remember to document clearly so that if the patient decides at a later stage to report to the police, the documentation will be helpful.

To whom can I refer people for help, and how do I contact them?

The Centres Against Sexual Assault (CASA) are located in every city and provincial centre in Victoria. Each state and territory has similar services. The centres are government-funded and provide free counselling by specifically trained and qualified staff to people who have experienced recent or past sexual abuse. If the patient is averse to state/territory-run services, then the Australian Psychological Society (Free Call 1800 333 497) can direct you to a psychologist in your area with specific training in sexual abuse work. Centres such as CASA, and psychologists with this specific interest area have up-to-date knowledge about relevant reporting and legal processes. Each state/territory has differing statute of time limitation, and differing reporting processes.

People can, and do, heal after experiencing sexual abuse. Disclosure to a trusted health professional may be the first step in this healing. How you respond can be critical. If you would like to do some further reading in this area of practice, the work of Read and colleagues is recommended.⁴

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