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Childhood Sexual Abuse and Adult Physical and Dental Health Outcomes

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1. Introduction

This chapter addresses the negative health outcomes for adult childhood sexual abuse (CSA) survivors. It is now well established that CSA survivors have a myriad of long-term physical health related disorders and disease processes (Boscarino, 2004; Irish, Kobayashi, & Delahanty, 2010; Monahan & Forgash, 2000) mental health difficulties, (Briere & Scott, 2006; Briere & Weathers, 2005; Brown, 2009) and dental health issues (Teram; Leeners, Stiller, Block, Görres, Imthurn, Rath, 2007). Many of these individuals will exhibit health risk behaviors as well (Felitti, Anda, Nordenberg et al, 1998; Owens & Chard, 2001; Chartier, Walker, Naimark, 2008; Liebshutz et al., 2000; Meade, Kershaw, Hansen, Sikkema, 2009). Additionally, oral and dental health has been recognized as a strong predictor of physical health problems. Recently, the dental health of CSA survivors has been an area of investigation.

The trauma field has long recognized the association between childhood trauma, PTSD symptomatology and health issues (Schnurr, 1996). One of the most recognized studies to date is the Adverse Childhood Experiences (ACE) study which gathered information from 17, 337 adults 50 years and older (Felitti, Anda, Nordenberg et al, 1998). Information on current health status and childhood adverse experiences such as vitriolic divorce, abuse and neglect, a parent dying, and witnessing one's mother being beaten, were collected. The study found that 30.1% of the respondents reported being physically abused, 19.9% reported sexual abuse, and 11% reported being emotionally abused (Felitti, Anda, Nordenberg, et al, 1998). Moreover, the study found that childhood stressors are strongly related to the development and prevalence of risks factors for disease and health and social well-being throughout the life span (Felitti, Anda, Nordenberg et al, 1998). The authors state,

The ACE study reveals a powerful relationship between our emotional experiences as children and our physical and mental health as adults, as well as the major cause of adult mortality in the United States. It documents the conversion of traumatic emotional experiences in childhood into organic disease later in life (p. 245).

In addition, the more adverse experiences one reported, the more likely one was to develop severe, life-threatening health outcomes such as heart disease, skeletal fractures, stroke, diabetes, and cancer (Filetti, Anda, Nordenberg et al, 1998; van der Kolk, 2005). The ACE study points out that childhood abuse has life-long impact on the health and well being of the victim. Filetti (2001) questions, "How does one perform reverse alchemy, going from a normal newborn with almost unlimited potential to a diseased, depressed adult? How does one turn gold into lead?" (p. 1).

2. Factors that contribute to deleterious outcome

There are several significant factors that contribute to the deleterious outcome from childhood sexual abuse. These factors, age at time of abuse, frequency of abuse, duration and severity of the abuse, originally identified by David Finkelhor (1984), formulates the “how and why” children can be so harmed by sexual abuse.

The age of the child when the abuse occurs signifies the interruption of a normal developmental trajectory. The traumatic sexualization occurs at a time when the child is not developmentally capable of understanding and processing sexual behavior and subsequently robs the child of childhood innocence.

Frequency and duration are two issues that create anticipatory fear and hyperarousal in a child. Frequency is how often the abuse occurs during a given time period. Duration is the ongoing nature of the abuse, (e.g., months, years) and can create a sense of futility in the child in that the abuse appears to be never ending. The longer-term consequences of frequency and duration are that they contribute to the socialization of trauma, creating a sense of victimhood.

The severity of the abuse creates fear, negative feelings regarding sex, (Sprei & Courtois, 1988; Jehu, 1989) and a general physiological hyperaroused state for the child (Teicher, Andersen, Polcari, Anderson, Navalta, 2002; van der Kolk, 2011). In cases where there was extreme, on-going abuse, the child may have been physically and genitally harmed.

While Finkelhor (1984) discusses the traumatic sexualization of the child as the core issue creating negative outcomes it is not, in and of itself, the primary contributing factor. The closer the relationship of the offender to the child, the stronger the level of betrayal, feelings of mistrust, and a damaged world-view and belief system. Courtois (2005) states, “Abuse by a stranger does not generate the divided loyalty and resultant denial or dismissal of abuse disclosure that is the case when abuse is intrafamilial, especially when it occurs in the nuclear family (involving parent and/or siblings)” (p. 95).

The presence or absence of familial support when disclosing abuse (Paine & Hansen, 2002) is another significant factor in the recovery process. There is significant literature that addresses the notion that when one is supported and believed by family members, the ability to heal and begin the recovery process has a better prognosis (London, Bruck, Ceci, & Shuman, 2005; Priebe & Svedin, 2008). The manner in which the family responds to disclosure is also important. Families who respond with demonstrations of aggressive anger and threats to the perpetrator in front of the victim only serve to instill fear and regret about disclosing, due to the nature of the adults seemingly “out of control” behavior.

Resilience and the interplay of genetics combined with risk and protective factors have been examined with children in high-risk environments for over 15 years. Cicchetti and Blender (2004) define resilience as, “... comprehending the factors contributing to positive outcomes despite the presence of significant adversity...” (p. 17325).

Previous anecdotal information relied on the conceptualization that social support alone (a significant family member, a teacher, etc.) could provide the at-risk child with the required coping mechanisms to mediate adversity. Social support combined with the child’s innate capacity to ward off the negative aspects of adversity are thought to be the primary predictors of the child’s ability to deal with and successfully survive maltreatment, and thus considered resilience.

Cicchetti and Blender (2004) point out that predictive factors have been narrowly focused. They state, "...adequate prediction of either disturbance or resilience requires considering multiple risks and protective factors and their interplay" (p. 17325).

3. Attachment

Bowlby (1980) presented the significance of early caregiving experiences on the ability of a neonate to attach to its caregivers, and thus internalize "working models" or representations of positive caregiving experiences. Van der Kolk (2005) states, "A child's internal working models are defined by the internalization of the affective and cognitive characteristics of their primary relationships" (p. 402).

For humans, brain development is optimally done in a social context, that is with primary caregivers providing not only sustenance but nurturance as well. When the caregiving relationship is less than optimal or in fact abusive, such as in the cases of neglect or physical and sexual child abuse, the child will experience deleterious outcomes.

For the CSA survivor's health, neglect may have reverberations on many levels throughout his or her life. Psychological and physical health, interpersonal functioning, and overall well-being are impacted by levels of neglect. A significant consideration is that the CSA survivor may lack the primary belief that he/she is an individual of worth, deserving to take care of her physical health. Therefore, her ability to be an educated health consumer, to ask questions during medical exams, and her ability to follow-up with annual visits, required immunizations, and diagnostic testing, etc., may all be compromised.

The CSA survivor may not have experienced good role models and thus may not have learned that brushing ones teeth every day is a necessary component of good health care. He or she may not have learned about the necessity of hygiene, immunizations, and annual check-ups and treatment for childhood illnesses, such as ear infections. Not having a good role model may have taught her that these types of behaviors are not a necessary part of life and certainly not a consideration for good health.

Posttraumatic Stress Disorder (PTSD), chronic PTSD, and Developmental Trauma Disorder

CSA survivors can suffer with posttraumatic stress symptomatology and PTSD. PTSD is defined as exposure to a traumatic event in which the threat of death or serious injury or witnessing threat or serious injury or the threat to physical integrity has occurred. In addition, intense fear, helplessness, or horror responses to a traumatic event may have occurred (DSM IV, TR p. 428). Symptomatology include avoidance of the initial traumatizing event or environment, frequent dreams or nightmares of the event, intrusive thoughts and images, flashbacks – feeling as if the event is occurring again – which is generally triggered by sensory stimuli, and physiological reactivity, e.g. a heightened state of agitation, motor activity, or physical reactions.

Chronic PTSD generally occurs when there is more than one traumatic event and/or if the initial ongoing traumatic event was severe and ongoing, e.g., combat situations. The CSA survivor may have been abused by a family member as a child, experienced dating violence, married an abusive spouse, and/or may have been sexually abused again by a stranger and/or another family member. Very often, these types of lifelong traumatic experiences involve the notion that many survivors carry; that life usually entails traumatic events that

one cannot escape. CSA survivors with chronic PTSD often experience hyperarousal and hypervigilance that are continuous physiological states. Chronic PTSD frequently includes the inability to self-soothe and emotionally regulate. Health risk behaviors such as alcohol and substance abuse, cigarette smoking, eating disorders, and self-injurious behavior (cutting) are correlated with childhood sexual abuse. These health risk behaviors can be considered attempts by the CSA survivor, albeit poor ones, in the adaptive struggle in which self-medicating is necessary for survival. They may also be attempts to avoid intrusive memories.

The sexual abuse field has struggled with the inadequacy of the PTSD diagnosis for child victims of sexual abuse. Because the nature of sexual abuse is chronic, usually perpetrated by a caregiver, and occurs during childhood, it impacts critical periods of neurobiological development (van der Kolk, 2011). When caregivers are abusive, absent or neglectful, and/or helpless in the face of trauma, children cannot develop a sense of safety and stability that emanates from the caregiver nor can they rely on that caregiver to restore a sense of calm and reliability. The child's responses to stress become diffuse and inadequate. The ability to self-soothe and emotionally regulate – managing stress, impulsivity, and anxiety – are markedly impaired. A significant issue is that the child experiences a sense of betrayal and perceives the world as a hostile and attacking environment.

Mental health practitioners and researchers have examined the concept of complex PTSD (Herman, 1992a, 1992b) and the tentative diagnosis of Developmental Trauma Disorder (Cook et al, 2005; van der Kolk, 2005). Cook et al (2005) state, "A comprehensive review of the literature on complex trauma suggest seven primary domains of impairment observed in (traumatically) exposed children: attachment, biology, affect regulation, dissociation, (e.g., alterations in consciousness), behavioral regulation, cognition, and self-concept" (p. 392). Included in these domains are the child's worldview and functional impairments such as academic, interpersonal, legal interactions, and vocation (van der Kolk, 2005). This tentative diagnosis, yet to be wholly accepted by the trauma field, appears to encompass the chronic and devastating nature of trauma to the developing child.

4. How does trauma change your health?

Traumatic events are now known to change not only psychological well-being but also the basic structure of how the body perceives painful events, processes them and produces physical reactions. But how does this happen? How do traumatic events in childhood such as sexual abuse change health status? It is important to note that not all individuals exposed to traumatic events will experience noxious outcomes, therefore genetic predisposition/vulnerability (Neigh, Gillespie, Nemeroff, 2009) and environmental factors are suspected when examining etiology. Stern's oft quoted metaphor (Kazaks & Stern, 2005) "Genetics load the gun, and environment pulls the trigger," appears apropos.

Humans have the capacity to react to stressful events in ways that will protect them. Many people have heard of the fight/flight/freeze reaction to threatening events. This is the body's stress reaction alerting the individual to either stay and fight, run away from the stressful event, or sometimes freeze in place. Each reaction is designed to assist the individual to survive and is directly attributable to the autonomic nervous system and the endocrine system working together to deal with the stressful event.

The hypothalamic-pituitary-adrenal (HPA) axis is a mediating pathway of the stress response (Neigh, Gillespie, Nemeroff, 2009, van der Kolk, 2011) and it's the function of the HPA to modulate hormones that address stressful events. To promote survival, a chain reaction of powerful hormones and neurochemicals are produced to assist the individual in dealing with the immediate stressful event (Neigh, Gillespie, Nemeroff, 2009). Deactivation of these hormones occurs through a "negative feedback loop" alerting the individual that danger is no longer present. Neigh, Gillespie, and Nemeroff (2009) state,

However, if the stress response becomes chronic due to repeated exposure to stressors, defects at different levels of the negative feedback system, or both, the result is a sustained increase in the level of stress hormones and the initiation of pathological changes across multiple physiological systems, resulting in stress related diseases (p. 391; also see McEwen, 2008).

The sympathetic nervous system (SNS) is dominant over the parasympathetic nervous system (PNS), and will not yield to the PNS until some form of resolution takes place. Resolution can take the form of fighting, jogging, meditating (Howard, 2006). The adrenal glands release enough adrenaline to get your attention at the first sign of stress. Adrenaline also helps to "imprint" an emotional or traumatizing event. If the stress continues, the hypothalamus secretes corticotropin-releasing factor. In this process cortisol is also released.

Cortisol is a steroid hormone that is produced naturally in the body to assist in the adaptive struggle when an individual is facing acute traumatic situations. When the stress or the traumatic situation is chronic, high levels of cortisol become toxic. Prolonged cortisol production impairs the immune system and thus, healing. Vulnerability to stress-related disorders and diseases, such as gastrointestinal disorders (ulcers) and heart disease commences. Chronic trauma and stress induces lower cortisol production and this decrease creates an enhanced autoimmune system. In the absence of any other illnesses, the autoimmune system will attack various systems within the body and create illnesses such as Fibromyalgia, Chronic Fatigue Syndrome, thyroid diseases, and Krohn's disease (Bergmann, 2011). Howard (2006) states,

Minor results of this stress-related impairment include colds, flu, backaches, tight chest, migraine headaches, tension headaches, allergy outbreaks, and skin ailments. More chronic and life-threatening results can include hypertension, ulcers, accident-proneness, addictions, asthma, infertility, colon or bowel disorders, diabetes, kidney disease, rheumatoid arthritis, and mental illness. Killers that can result include heart disease, stroke, cancer, and suicide (p. 816).

Chronic trauma, coupled with the severity of the abuse itself, has long-term devastating impact on health and mental health due to the chronicity of these physiological states.

5. Mental health features of the CSA survivor that impede their health outcomes

CSA survivors may experience shame and self-blame regarding the sexual abuse and approach both mental health practitioners and health professionals with distrust, fear, and anxiety. CSA survivors may also experience a range of PTSD symptomatology that includes avoidant behaviors, depression, and dissociation.

The survivor may not have had good health care models to emulate or his or her health care needs may have been neglected and minimized. Cycles of negative emotions, stress, pain and self-defeating beliefs may perpetuate physical problems. Years of avoidant behavior regarding health issues may have passed before the CSA survivor reaches the health care professional, thus warranting more intensive and costly treatment.

6. Health risk behaviors

In an effort to self-soothe, the CSA survivor may have tried to self-medicate using a variety of maladaptive behaviors and methods. No one would doubt that the prevalence of addiction difficulties with substances such as drugs and alcohol in the United States is of epidemic proportion. Eating disorders, closely correlated with sexual abuse, is a mental health difficulty with severe physical consequences. Unprotected sex, sexually risky behaviors, and prostitution have their etiology in sexual abuse trauma (Tarakeshwar, Fox, Ferro, Khawaja, Kochman, Sikkema, 2005). Self-injurious behavior such as skin carving has long been thought to alleviate some of the internal stress experienced by CSA survivors.

7. Medical issues

Before reviewing the medical issues of CSA survivors one must consider the often mistaken assumption that the somatic complaints of the survivor have no physical etiology, and therefore they are often overlooked and/or misdiagnosed. This phenomenon occurs both with the health and mental health care professional as well as the CSA survivor.

Psycho-physiological changes coupled with psychological changes create multi-systemic problems common to CSA survivors. The American Medical Association 1992 addresses these changes when they state,

The event has such physiological and psychological intensity that it overrides and impairs the individual's neurophysiological mechanisms of adaptation. The resulting damage is not merely emotional. The person's biological capacity to tolerate and regulate internal and external stimulation can be altered. These changes, in turn, compromise the person's ability to organize perceptual stimuli and cognitive information, making them susceptible to a range of somatic illnesses and a spectrum of anxiety and depressive disorders (p 35).

Psychological distress also contributes to the CSA survivor having an impaired view of their health either through somatization and/or dissociation.

8. Types of health issues

Gastrointestinal symptomatology and disorders have been correlated with childhood sexual abuse. Gastrointestinal disorders include irritable bowel syndrome which is known to affect as many as 10%-20% of adults living in the United States (Hymowitz, 2011). Heim (2002), Drossman (1998), and Levy (2005) have discussed the relationship of genetic and environmental factors, joining with life stressors that influence physiological factors such as the Central Nervous System (CNS), and the Enteric Nervous System (ENS) (Hymowitz,

2011). All of these factors modulate functional aspects of the gastrointestinal system and later, symptoms. While IBS is influenced by several factors such as genetics, environment, and family environment, childhood sexual abuse is a contributing factor.

Gynecological problems such as difficult menses and pain when having sexual intercourse, sexual performance, as well as promiscuity, may also contribute to poor reproductive health outcomes.

CSA survivors may also suffer from Immune System Dysfunction, musculoskeletal difficulties, respiratory ailments such as Asthma, and rheumatic disorders. CSA survivors can also experience what is called Medically Unexplained Symptoms (MUS) such as fibromyalgia (Roelofs & Spinhoeven (2009). Other types of difficulties include urinary tract infections, migraine headaches, chronic pelvic pain and pain intolerance or sensitivity.

Addictive behaviors that lead to poor health outcomes are also associated with childhood sexual abuse such as eating disorders (anorexia, bulimia, and obesity), substance abuse (alcohol and/or drugs), and cigarette smoking. Table 1 lists the most common medical conditions for CSA survivors.

Autoimmune Diseases
Cardiovascular Disease
Pain Perception and Chronic Pain
Compromised Reproductive Health
Gynecological Issues
Diabetes
Eating Disorders (Anorexia, Obesity, Bulimia)
Gastrointestinal Disorders (Irritable Bowel Syndrome)
Immune System Dysfunction
Musculoskeletal difficulties
Respiratory Ailments (Asthma)
Medically Unexplained Symptoms (MUS) e.g., fibromyalgia
Rheumatic Disorders

Table 1. Common Medical Difficulties Reported By CSA Survivors

9. Dental health issues for CSA survivors

Dental health has gained increasing attention as a primary factor supporting overall health. Periodontal disease is now associated with upper respiratory illnesses such as pneumonia and cardiac conditions, even premature death (Eke, Thornton-Evans, Wei, Borgnakke, Dye, 2010). Given the importance of dental health in overall well-being, it is significant that by and large CSA Survivors have poor dental health, health seeking behaviors, and follow through with dental protocols (Hays & Stanley, 1996; Leeners, Stiller, Block, Gorres, Imthurn, Rath, 2009; Monahan & Forgash, 2000; Willumsen, 2004). As with physical health, dental health seeking behaviors can be defined as recognizing the necessity for dental care,

making and keeping appointments with the dentist, follow-through with dental advice and hygiene, e.g., brushing teeth, flossing daily, annual visits, and finally, follow through with necessary procedures.

CSA Survivors are resistant to dental treatment for much of the same reasons that they have difficulty with health issues. Feelings of un-deservedness, low self-esteem and self-worth, poor parental modeling and instruction of good dental care, and denial of dental health care needs are the primary issues that underscore the CSA Survivors lack of dental care.

Several other issues factor into the CSA Survivors lack of dental care. While the general population may experience reluctance and even phobia when it comes to dental care, the survivor may have experienced oral rape and this compounds her reluctance to seek dental care. Additionally, because of her overall fear and trepidation about the dental experience she may have experienced trauma in the dental chair, with a dentist unfamiliar with trauma victims. Lack of knowledge, experience, and patience in dealing with this type of situation, can cause iatrogenic trauma. Table 2 lists some of these issues.

Poor Dental Health Seeking:
<ul style="list-style-type: none">• Lack of or inconsistency in dental hygiene• Few to no dental check-ups in childhood or adulthood
Untreated Dental Pain, Periodontal Problems, TMJ, Malocclusions
Difficulty Sitting and Reclining in the Dental Chair
Difficulty Communicating dental fear or abuse history

This table was compiled using data from AMA, *Diagnostic & Treatment Guidelines on Mental Health Effects of Family Violence*, Chicago, IL.: AMA, 1995; Hays, K.F. & Stanley, S.F. (1996). The Impact of Childhood Sexual Abuse on Women’s Dental Experiences. *Journal of Child Sexual Abuse*, 5, 65-74; Monahan & Forgash, (2000). Enhancing the Health Care Experiences of Adult Female Survivors of Childhood Sexual Abuse, *Women & Health*, 30(4), 27-41; Randomsky, N., *Lost Voices, Women, Chronic Pain and Abuse*. New York, NY: Harrington Park Press, 1995; Sidran Institute, Dental Tips for Sexual Abuse Survivors

Table 2. Common Dental Difficulties Reported By CSA Survivors

Several studies indicate that respondents have experienced at least one painful dental encounter (Klepac et al, 1980; Vassend, 1993) and the general population still approaches dental experiences with some level of dental fear. Childhood sexual abuse survivors may experience a *pronounced* level of fear emanating from oral rape and therefore it is important to understand that sexual assault that involved the mouth may result in CSA survivors’ reluctance to address their dental health needs and avoid visits to dental health practitioners. (Stalker, Russell, Teram, Schachter, 2005; Teram; Leeners, Stiller, Block, Görres, Imthurn, Rath, 2007) Other reasons may include: viewing the experience as intrusive, experiencing loss of control coupled with a sense of powerlessness, and, most importantly, procedures that may be symbolic and trigger painful memories of childhood abuse (Monahan & Forgash, 2000; 2011).

Much of the same history gathering, rapport building, stabilization and collaboration is the same in cases of dental health for CSA survivors as with health issues. Educating both the CSA survivor and the dental and health practitioner regarding expectable reactions post-trauma and how to begin a purposeful, goal directed program toward health should be the primary goal. The following is a case example, from the second author, of earlier iatrogenic trauma and collaboration between the dentist and the mental health practitioner.

Mrs. C , 35 years old, had avoided dental treatment since moving out of her family home when she married at age 25. As a small child she was sexually abused by her grandfather who lived with the family. He frequently orally raped her and threatened to beat her if she ever told anyone about it. This abuse went on until he was moved to a nursing home when she was 10 years old. The family dentist did not believe in any analgesia for pain when he had to fill cavities or pull any diseased teeth. She felt that the dentist was being “mean to her” like her grandfather. By her teens she had dissociative amnesia concerning the abuse by her grandfather. She disliked going to the dentist and was very consistent in her dental hygiene, hoping to avoid cavities. By the time she was 35, she had entered therapy with symptoms of PTSD . She reported that was having a toothache, and bleeding from her gums. She had begun to remember some fragments of the sexual abuse and the harsh dental treatment from childhood. Her therapist taught her relaxation techniques, to alleviate some anxiety. She spoke with the dentist her husband saw who assured her he would do everything he could to make the experience as painless as possible. Her therapist coached her to tell him some general information about her abuse and early dental trauma. The therapist and dentist telephone conferenced and discussed some strategies to help the patient during and after the session in the dental chair.

The dentist was also well versed in relaxation techniques and was able to talk the patient through some exercises. He provided her with headphones and soft music of her choice. In her next therapy session, the therapist and patient reviewed what had gone well and planned for any additional skills the patient felt she needed. They both felt that the patient felt stabilized and safe enough to begin trauma work on the sexual abuse by her grandfather. The therapist was trained in a phased model of trauma treatment to work through and resolve the trauma. The patient also, with the help of the current positive dental experience, resolved the earlier dental trauma to the point that she was able to plan for long term dental and periodontal treatment. However, there were severe problems, notably, damage from clenching, grinding and teeth broken off at the gum line and bone loss from periodontal disease. This was the legacy of years of avoidance of dental care and the dental /childhood trauma.

Techniques for being a good health care consumer

As part of psychotherapy with this population, reviewing how trauma has impacted their health seeking behaviors and, ultimately their health, is imperative. As mentioned, CSA survivors may not have viewed their trauma histories as having any bearing on their conduct with their health, and/or believing that they do not deserve good health outcomes. Additionally, they may believe that they should not be assertive with health care professionals, have the right to ask questions, or get a second opinion. CSA survivors may demonstrate a lack of cooperation, poor decision making, or even the inability to retain important health information, and it is important for the health care professional to

understand that this lack of health assertive behavior emanates from fear, confusion, dissociation, poor health care modeling, and an over all sense that he/she does not deserve attention or good health care. Additionally, the psychotherapist can share and discuss information and how-to techniques on becoming a healthcare consumer with the patient. Many organizations produce informational brochures and flyers on health consumerism for sexual abuse survivors.

Psycho-education regarding health care needs and developing assertive behavior with health care professionals can improve the health outcomes for CSA survivors and is a necessary part of psychotherapy with the CSA survivor.

Teaching the CSA survivor how to modulate stress and improve health outcomes through psychotherapy

Psychotherapy with CSA survivors is generally constructed around a three-stage approach that begins with establishing safety, stabilization and emotional regulation (Ford, Courtois, Steele, van der Hart, Nijenhuis, 2005). While there are a variety of treatment models addressing the issues of trauma available today, most of these treatments are phase-oriented and focus initially on establishing safety for the patient and the therapeutic relationship as the foundation of the work in which processing trauma occurs. The therapeutic relationship becomes the “container” – the holder of painful memories, thoughts, and issues related to the traumatic event. More importantly, the mental health practitioner becomes the model for containment through support that is consistent, boundaries that are well established, and empathic interest in the patient (Ford et al, 2005). The patient will explore and reprocess the traumatic events and finally, achieve mastery and resolution of life issues.

The mental health practitioner should be a warm, genuine individual who can provide an empathic stance, thus formulating the foundation for a therapeutic alliance. It is important for the therapist to retain this empathic demeanor as well as a calm façade when hearing distressing histories from the CSA survivor, generally not a minor feat to accomplish. Sessions should be consistent and the mental health practitioner should provide the CSA survivor with what has been called, “a corrective emotional experience” (Alexander & French, 1946) throughout the course of therapy.

10. Phase I

There are many important components of the first phase. One is to take a history of the patient making sure to note previous abuse incidents and outcomes. Assessment should include patient symptomatology, previous treatment and/or hospitalizations, family history and current contact, health history, and vocational status. Psycho-education includes defining and normalizing triggers, flashbacks, dissociative symptoms and problems in controlling emotions as part of the normal reaction to traumatic events, and can reveal strengths. Ford et al (2005) state, “The client’s response to education also reveals strengths that can become a basis for overcoming helplessness without invalidating unmet dependency needs” (p. 438) (See also Steele, Van der Hart, Nijemhuis, 2001). Safety is established in this phase and issues such as suicidality, and maladaptive behaviors such as unhealthy risk taking and self-harm are addressed (Pearlman & Courtois, 2005; Ford, et al, 2005). The patient will learn and practice skills to manage these

symptoms as necessary preparation for phase two: trauma treatment. In this phase collaboration with existing support networks or developing them begins (Ford et al, 2005).

11. Phase II

Once safety and stability have been well established, identifying, exploring, and processing the traumatic experiences can take place. Additionally, emotions such as shame, guilt, and helplessness need to be understood and processed. As acceptance of past actions takes place, and responsibility for abuse is correctly assigned to the perpetrator, internal conflicts can be addressed and resolved. The patient can slowly begin to give up the victim role, practice new more assertive behaviors and beliefs, and begin to 'deserve' good health. Additionally, the patient begins to review and predict where in this process they may have difficulty, and apply some of the basic principles of "relapse" prevention, e.g, falling back to old behaviors that negated his/her rights to good health.

12. Phase III

In this phase, patients work to regain control of their lives and achieve healthy functioning and efficacy in life domains. They work on gaining positive self worth and identity and a sense of empowerment. The patient often reports seeing old events and relationships from more of an adult perspective. Additionally, they express feelings of competence and can attend to their healthcare needs as an adult.

It should be noted that in all phases of this work, but particularly in the beginning, the patient may test the mental health professional as part of reenactment of earlier rejection and betrayal by family members, or insecure attachment styles. The mental health practitioner may find that attunement through non-verbal, affective, and bodily communication takes on heightened importance (Ford et al, 2005; Fosha, 2000; Ogden, & Minton, 2000) during all the phases of therapy.

Collaboration between the healthcare professional and the mental health practitioner

Collaboration or a team approach provides a more comprehensive and successful outcome for the CSA survivor in accessing and following through with health care needs. Ethical practice always demands that consent be obtained to contact another treating professional. But more importantly, once a team approach is decided upon, obtaining consent from the CSA survivor to contact another health professional, often provides her with a sense of control.

The mental health professional can act as the patient's advocate and assist in explaining background, symptoms, and specific needs. The mental health practitioner may also explain some of the abuse issues and problems stemming from the trauma. In situations where flashbacks and dissociation are prominent, the mental health practitioner can explain these reactions and assist the health care professional in what to do. The mental health practitioner can let the health professional know the patient's stage of treatment and how that will impact medical treatment. The following case example describes collaboration between the mental health practitioner, the medical specialist, and the patient.

Mrs. N, 65 years old, woke up in the recovery room after a colonoscopy, screaming that a man was coming after her. The doctor was called in after the nurse could not calm her. She was able to tell the doctor that the man was a neighbor who had attacked her sexually and that she had not remembered anything about him in almost 60 years. She became very disoriented, weepy and had to be sedated. For several weeks she did not “feel like herself” and her family doctor referred her to a psychiatrist who medicated her and recommended that she see a trauma therapist. She grew to trust the therapist who was soft spoken and reminded her of her grandmother, even though the therapist was younger than Mrs. N. The therapist normalized the long-term dissociation and amnesia as survival techniques for a little girl who had alcoholic, unprotective parents. Mrs. N. stated that they were usually too drunk to listen or protect her and her siblings. The therapist was trained in Eye Movement Desensitization and Reprocessing (EMDR) a phase-oriented therapy validated for the treatment of PTSD. It included all of the three phases of trauma treatment as mentioned above plus a desensitization, reprocessing, and evaluation phases. As she learned relaxation exercises and practiced them in between sessions, she felt stronger and more in control of her life. She learned about triggers and made the connection between the colonoscopy and the childhood anal rape. Several months after, she felt strong enough to rehearse a planned visit to a gynecologist to discuss exploratory laparoscopic surgery for ovarian cysts. Both she and the therapist felt that she had completed the trauma work and would not be triggered by the procedure. She did tell the doctor about the earlier abuse and the incident triggered by the colonoscopy. They planned that the nurse would sit with her in the recovery room and say to her, “Hello Mrs. N. I’m here with you now. Would you like a drink of water?” That would be a cue that she was in the present, a common grounding technique. Her husband would also be brought right in and would hold her hand to provide comfort. There were several weeks of rehearsal and the medical protocol went well.

13. Conclusion

During the past ten years there has been a proliferation of research and clinical studies in the medical, dental, and mental health journals that unequivocally supports that childhood sexual abuse is epidemic and detrimental to the mental, physical and dental health of survivors. It has been defined as a public health issue, yet changes in bringing this knowledge and clinical expertise to core curricula (and not as an elective or special course) in Medical, Dental, Mental Health or Nursing Graduate programs has been slow. Collaboration with health professionals and mental health practitioners increases the probability that CSA survivors will begin to enjoy good health. One means toward that end is educating practitioners from all health fields on the issues of child sexual abuse and negative health outcomes.

The incidence and prevalence rates of child sexual abuse have held constant since we began collecting statistics in the late sixties. The human suffering and negative health outcomes of so many are only one part of this social problem. The financial expenses of medical and pharmaceutical needs, time lost at work, psychotherapy costs and substance abuse treatment, family support and help for survivors’ children makes this a social problem whose immediacy cannot be ignored. Isn’t it time to turn lead into gold?

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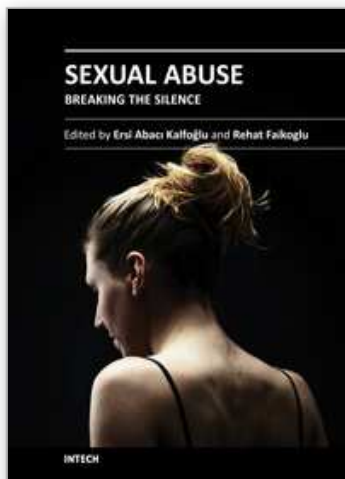
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Sexual assault can be considered as expression of aggression through sex. This, in turn, can have serious negative effects on a survivor's social and occupational functioning. This book has been organized towards that specific approach, by compiling the scientific work of very well-known scientists from all over the world. The psychological victimization of sexual assault, the physiological aspect of sexual abuse and the different attitudes in coping with sexual assault based on different cultural backgrounds are analyzed. Having in mind that one solution may not necessarily be suitable for all cases, we hope that this book will open a debate on sexual assault for future practice and policy and that it will be a step forward to 'break the silence'.

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