Part 2

Trauma Informed Care in Sexual and Reproductive Health

Patty Cason, MS, FNP-BC
Envision Sexual and Reproductive Health
Los Angeles, CA USA

patty@envisionsrh.com

Objectives

- Define trauma-informed care
- Describe three (3) suggestions for making interactions with patients less likely to be re-traumatizing
- List two (2) examples of non-stigmatizing language

The Four "R's" of Trauma Informed Care

- **Realize** the widespread impact of trauma
- **Recognize** signs and symptoms of trauma, (including in staff and clinical team members)
- **Respond** by fully integrating knowledge about trauma into policies, procedures, and practice
- **Resist** (actively) re-traumatization

(Ravi, A. (2017) *Am Fam Physician*
SAMHSA (2014) HHS Publication No. (SMA) 14-4884)

The Four "R's" of Trauma Informed Care

- **Realize** the widespread impact of trauma
- **Recognize** signs and symptoms of trauma, (including in staff and clinical team members)
- **Respond** by fully integrating knowledge about trauma into policies, procedures, and practice
- **Resist** (actively) re-traumatization

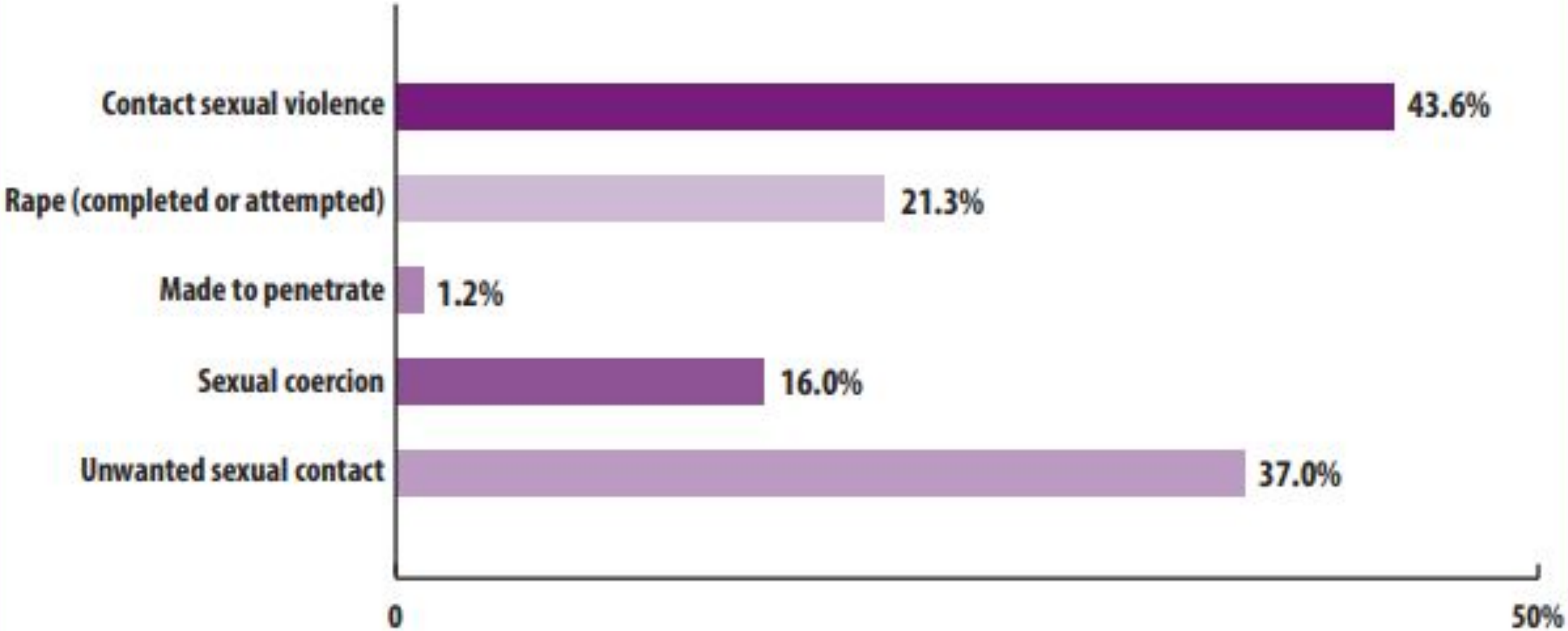
(Ravi, A. (2017) *Am Fam Physician*
SAMHSA (2014) HHS Publication No. (SMA) 14-4884)

Tarana Burke

"Empowerment through empathy"

Zahara Hill October 18, 2017 Ebony

Lifetime Prevalence of Sexual Violence Victimization—U.S. Women, NISVS 2015[1,2]



(Smith, S. G. (2018) *National Intimate Partner Sexual Violence Survey*)

[1] All percentages are weighted to the U.S. population.

[2] Contact sexual violence includes rape, being made to penetrate someone else, sexual coercion, and/or unwanted sexual contact.

Childhood Sexual Abuse

- 12-40% of children in the USA have experienced some form of sexual abuse
- Survivors come from all cultural and economic groups
- 7% of females 18–24 years whose sexual debut was before age 20 experienced non-voluntary first sex
- Male survivors are more reluctant to report sexual abuse than are female survivors

(Gallo-Silver, L.(2014) *Permanente Journal*
"Adult Manifestations of Childhood Sexual Abuse," (2019) ACOG)

HIV and Trauma

- Childhood physical and/or sexual abuse
  - 30% of HIV-infected individuals
- Intimate partner violence (IPV)
  - 68–95% of HIV-infected women
  - 68–77% of HIV-infected men
  - 93% of HIV-infected transgender people

(Sales, J. (2016) *Curr HIV/AIDS Rep*.)

Heteronormative Practices in Health Care

- Policies and providers that make assumptions about gender and heterosexuality recreate traumatic coming out processes
- This structural marginalization alienates and traumatizes sexual minorities who access healthcare services

(Searle, J. (2017) *J Clin Nurs.)*

CIN 2/3, VIN, EGW
Target Key Organs for Eroticism

Adverse impact on sexual desire, frequency, excitement, pleasure, and orgasm

(Nagele, E. (2016) *J Sex Med*
Cendejas, B. R. (2015) *Am J Obstet Gynecol*
Campaner, A. B.(2013) *J Sex Transm Dis*.
Graziottin, A. (2009) *J Sex Med*)

Less is Better

- Adverse psychosexual impact potentially increases with:
  - A greater number of interventions
  - More painful technique
  - Greater severity of scarring
- More conservative treatments (less disruption of genital anatomy) associated with less sexual dysfunction

Healthcare Re-traumatization

During exams, tests, and treatments:

- due to perceived similarities with the original abuse
- feeling submissive to authority figures
- undressing
- vulnerability in the lithotomy position
- examined by relative strangers
- Pain

(Schnur, J. B. (2018*) Palliat Support Care*
Robohm, J. S. (1996) *Women Health*
(ACOG "Adult Manifestations of Childhood Sexual Abuse," 2019))

Post Traumatic Stress Reactions

- Intrusive thoughts
- Traumatic re-experiencing
- Traumatic hyperarousal
  - Irritability/anger, difficulty concentrating
  - Hypervigilance, exaggerated startle
- Avoidance/numbing/perceived detachment from their bodies

(Schnur, J. B. (2018*) Palliat Support Care*
Khan, C. G. (2014) Violence and Gender
Robohm, J. S. (1996) *Women Health*
)

The Four “R’s” of Trauma Informed Care

- **Realize** the widespread impact of trauma
- **Recognize** signs and symptoms of trauma, (including in staff and clinical team members)
- **Respond** by fully integrating knowledge about trauma into policies, procedures, and practice
- **Resist** (actively) re-traumatization

(Ravi, A. (2017) *Am Fam Physician*
SAMHSA (2014) HHS Publication No. (SMA) 14-4884)

Possible Indicators of Past Abuse

- Pain; headache, pelvic, back, muscular, GI symptoms
- Disordered eating; obesity, weight fluctuations
- Sleep disturbance (insomnia, hypersomnia)
- Sexual problems
- Alcohol or drug use disorder
- Depression, self-harm, suicide ideation/attempt
- PTSD, dissociative states

(Raja, S. (2015). *Fam Community Health*
Schachter, C.L. (2008). Ottawa: Public Health Agency of Canada.)

Survivors of Sexual Violence

- Abnormal Pap Test 15%
- Positive STI test 9%
- A trauma background can limit how much information people take in

(Ades, V. (2019) Obstet Gynecol
Brooks, M (2018) *Australian Journal of General Practice*)

Cumulative Trauma

- *“There is always this feeling of how unlucky can one human be, why is this happening to me, and how worse can my life get? And lying on the table, all exposed makes it all hurt ever so much more”*
- *“I felt re-violated. It was as if I were receiving an additional punishment.”*

(Schnur, J. B. (2018*) Palliat Support Care*)

Patient Concerns About Gynecologic Exams

- Fear of pain
- Embarrassment about undressing
- Worries about cleanliness, qualms about vaginal odor
- Humiliating
- Previous bad experiences

(Yanikkerem, E. (2009). *Midwifery,*
Raja, S. (2015). *Fam Community Health*
Robohm, J. S. (1996) *Women Health*)

Modifiable Concerns About Gynecologic Exams

- Exposure of intimate body parts in a vulnerable situation
- Loss of control
- Cold instruments
- Lack of gentleness from the examiner

(Yanikkerem, E. (2009). *Midwifery,*
Raja, S. (2015). *Fam Community Health*
Robohm, J. S. (1996) *Women Health*)


examinations
reactive
fear
Pain
muscles
Control
embarrassment
Hyper
shame
Loss
rage
pelvic
muscle
Anxiety
contraction
involuntary
response
perineal
Memories
speculum
examination
abuse

Distress in Survivors of Sexual Violence

- Loss of control, powerless
- The power differential between patient and provider
- Anxiety, embarrassment, fear, shame, rage
- Touch to intimate areas of the body; upper thigh, buttocks, lower back, genitalia, pelvis
- Undressing; feeling exposed

(Ades, V. (2019) *Obstet Gynecol*
Weitlauf, J. C. (2008) *Obstet Gynecol*
Hilden, M. (2003) Acta Obstet Gynecol Scand
Leeners, B. (2007). Psychosomatics.
Schnur, J. B. (2018*) Palliat Support Care*
Sharkansky, E. (2014) *US Dept of Veterans Affairs website*

Re-traumatization Triggers Dissociation

“…any genital touch which is forceful or painful”

“Touch that catches me by surprise”

(Robohm, J. S. (1996) *Women Health*)

Distress in Survivors of Sexual Violence

- Having their body inspected, penetrated, commented upon
- Hyper-reactive involuntary pelvic muscle contraction with speculum examination
- Memories of the abuse

(Ades, V. (2019) *Obstet Gynecol*
Weitlauf, J. C. (2008) *Obstet Gynecol*
Hilden, M. (2003) Acta Obstet Gynecol Scand
Leeners, B. (2007). Psychosomatics.
Schnur, J. B. (2018*) Palliat Support Care*
Sharkansky, E. (2014) *US Dept of Veterans Affairs website*

Triggers

“Feeling like I was not in control. It reminded me of the experience of being molested as a child and not being in control of the situation.”

(Schnur, J. B. (2018*) Palliat Support Care*)

Fears & Triggers

Anesthesia

- Examined/operated upon while unconscious, unable to defend themselves

(Schnur, J. B. (2018*) Palliat Support Care*
Sharkansky, E. (2014) *US Dept of Veterans Affairs website*
Raja, S. (2015). *Fam Community Health*
)

Anesthesia

“The most difficult part was having to give up control to be put under anesthesia. It made me feel really scared and vulnerable, like someone could do anything to me and I would be unable to do anything about it.”

(Schnur, J. B. (2018*) Palliat Support Care*)

Triggers

“The radiation, I had to lay there naked and have people touch my pelvic area, I was not allowed to move or I might be greatly injured and I would have to start with the procedure all over again.”

(Schnur, J. B. (2018*) Palliat Support Care*)

Provider-Related Triggers

- Provider gender; male providers, particularly older males
  - Physicians, nurses, radiation therapists
- New providers and providers who are perceived as "strangers"

(ACOG # 796 (2020) *Obstet Gynecol*
Schnur, J. B. (2018*) Palliat Support Care*)

Triggers

- *“Every exam with an older male physician, I’ve been healing for a while and it brought it back.”*
- *“I felt that my oncologist was treating me in the same manner as my abusers… as a piece of meat, and something to be conquered before they could move on and conquer the next person.”*

(Schnur, J. B. (2018*) Palliat Support Care*)

Triggers

“Trusting people, strangers, in positions of authority. Allowing them to do unknown things to my body because it was supposed to “be good for me” and “help” me…trusting strangers is still pretty scary for me.”

(Schnur, J. B. (2018*) Palliat Support Care*)

Silence

- Patients may not express discomfort or fear and may silently experience distress

- 45% of survivors (38% of controls) reported not revealing distress to physician, despite intensity

(ACOG (2019)
Sharkansky E. (2014) National Center for PTSD.
Robohm, J. S. (1996) *Women Health*)

The Smile Spectrum

Figure 1. *The Smile Spectrum*, by Anita Ravi

(Ravi, A. (2018) *AMA J Ethics*)

Adherence

Impact of Sexual Violence on Adherence

- Avoidance of health care providers; reluctance to seek preventive health care
- Repeated
  - Poor adherence to treatment plans
  - cancellations
  - Postponements

(Ades, V. (2019) *Obstet Gynecol*
Schnur, J. B. (2018) *Palliat Support Care*
Raja, S. (2015). *Fam Community Health*
Cuevas, K. M. (2018) *J Am Osteopath Assoc*.
Brooks, M (2018) *Australian Journal of General Practice*
Sharkansky E. (2104) *National Center for PTSD.*
Schachter, C.L. (2008). *Public Health Agency of Canada*.)

Cervical Screening

- National Health Service in the last 5 years:
  - 78.6% screening overall
  - <50% in survivors of sexual violence
- In Australia
  - Avoidance behavior reported by 26% of survivors
- In the US within the past 2 years
  - 50.4% overall
  - 36.0% in survivors

(Farley, M. (2002) *J Fam Pract*
Cadman, L.(2012) *J Fam Plann Reprod Health Care*
Harsanyi, A.(2003) Aust Fam Physician)

Sexual Minority

- Trauma is a “persistent backdrop” for members of LGBT communities
- Sexual minorities report avoiding preventative health care visits and exams as self-protective strategies to avoid re-traumatization

(Searle, J. (2017) *J Clin Nurs.*
Quiros L. (2015) Journal of Loss & Trauma)

Reasons

- Belief that the exam was unnecessary or unsafe or not useful
- Negative past experiences with screening or exams
- Some patients report that these experiences had been caused by the providers conducting the screening

(Weitlauf, J. C.(2010). *J Womens Health Larchmt.*
Harsanyi, A. (2003). *Aust Fam Physician*.)

The Four "R's" of Trauma Informed Care

- **Realizing** the widespread impact of trauma
- **Recognizing** signs and symptoms of trauma, (including in staff and clinical team members)
- **Responding** by fully integrating knowledge about trauma into policies, procedures, and practice
- **Resist** (actively) re-traumatization

(Ravi, A. (2017) *Am Fam Physician*
SAMHSA (2014) HHS Publication No. (SMA) 14-4884)

Resilience

- Provides a buffer between the person and the traumatic event, mitigating the negative effects
- Resilience is utilizing protective factors for support to navigate successfully through a stressful situation to return to “baseline”
- A key component of being trauma-informed is promotion of resilience

(Earls, M. F. (2018) *N C Med Journal*
Leitch, L. (2017) *Health Justice*)

Themes heard in survivor interviews

"...the framing of health care as caring for oneself."

(Gesink, D (2015) *BMJ Open*)

Strategies Patients Employ

To prepare for, navigate and recover after healthcare encounters:

- Select providers (gender, continuity, rapport)
- Bring
  - support persons to appointments
  - lists of questions/concerns

(Reeves, E. A (2018) *J Clin Nurs*)

Disempowerment; A Fundamental Experience of Abuse

- Even the most benevolent paternalism (often inherent in the medical system) recreates a cycle of helplessness
- Believe in the patient's strength and resilience
- Support their evolution from passive victim to active, motivated participant

(Purkey, E.(2018) *Can Fam Physician*)

Trauma Informed Practice

- Examine and assess every aspect of care and potentially modify practices
- Incorporate understanding of how trauma affects a person's life and reaction to care
- Recognize that patients can be traumatized and re-traumatized by well meaning providers

(Leitch, L. (2017) *Health Justice*
Earls, M. F. (2018) *N C Med Journal*
Raja, S. (2015). Fam Community Health
Purkey, E.(2018) *Can Fam Physician*
Cuevas, K. M. (2018) *J Am Osteopath Assoc*.)

Adherence

- Stress safety & trust
- Avoid taking away control; use a Shared Decision-Making model
- Avoid saying *must* and *should*
- Focus on rapport and communication
- Convey empathy

(Gesink, D (2015) *BMJ Open*
Brooks, M (2018) Australian Journal of General Practice
Schachter, C.L. (2008). Ottawa: Public Health Agency of Canada)

Adherence; Patient Education

- Explain the rationale for the recommendations in plain language; written & verbal information
- Check for understanding
  - *"I want to be sure I've been clear, can you tell me…"*
- Ask questions:
  - *"Do you feel able (willing) to follow this plan?"*
  - *"How do you see yourself managing this?"*
  - *"Can you tell me more about that?"*
  - *"How would that be for you?"*

(Brooks, M (2018) Australian Journal General Practice
Schachter, C.L. (2008). Public Health Agency of Canada.)

Inclusive Policies & Practices

Sensitive to:

- Personal and social identity
- Culture and ethnicity
- Gender identity
- Sexual orientation

Screening

Universal Trauma Precautions

- Requires changes to practice --for use with all patients
- Universal precautions do not require screening patients for a trauma history or knowledge of an individual's trauma history (or lack of it)
- TIC may be particularly beneficial for establishing trust and rapport with trauma survivors

Raja, S. (2015). *Fam Community Health*

Decide Whether or Not to Screen

- Examine your specialty, setting, and level of long-term interaction with patients
- Decide if you will screen for current trauma (eg, current IPV) or a history of traumatic events

Raja, S. (2015). *Fam Community Health*

If Screening

- Use a framing statement prior to the trauma screen
- Provide all staff with communication skills training about how to discuss a positive trauma screening with a patient
- Have referrals in place
- Know your mandated reporting laws

(Raja, S. (2015). *Fam Community Health* Davies, J. A. (2017) *Am J Lifestyle Med* McGregor, K. (2013) *J Child Sex Abus.)*

"I told the provider about my history of abuse. She didn't acknowledge it, she just kept right on going with what she was doing ... Oh boy! If somebody says it, then you've got to acknowledge it. Because then what that says to me is that it's not valid, it's not important"

Schachter, C.L. (2008). Ottawa: Public Health Agency of Canada.

A Framing Statement

"Because abuse and violence are common and can affect a person's health, I make a point to ask patients if they have ever had these experiences."

(Ravi, A. (2017) *Am Fam Physician*)

Trauma Informed Universal Precautions

A New Standard of Care for All

Universal trauma precautions for all patients & trauma-specific strategies if a known trauma history

(McGregor, K. (2013) *J Child Sex Abus.)*

Themes heard in survivor interviews

“Sadly, it may be safe to assume that at least some patients will have a trauma history with anxiety around physical issues and medical visits”

(Gesink, D (2015) *BMJ Open*)

Theme from Survivor Interviews

"I think they should have that same regard for everybody. Then they wouldn't have to worry about making exceptions or treating us differently. They would have that regard and respect for everyone…If it's good for people who've been abused, it's good for everyone. It's a win-win situation."

(Gesink, D (2015) *BMJ Open*)

Consider One's Own History & Reactions

- Reflect on your own trauma history (if applicable) and how it may influence patient interactions
- Address potential signs of professional burnout and vicarious traumatization

Raja, S. (2015). *Fam Community Health*

Theme from Survivor Interviews

"A heater in the room. I have a feeling probably won't be. Probably not that warm. They have clothes on. I wouldn't feel cold. It's a huge trigger. How many times as a kid lying naked in a cold place. I don't want people touching me when I'm cold."

(Gesink, D (2015) *BMJ Open*)

Suggestions for Best Practices in TIC

Language

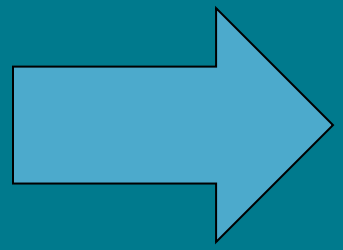
“Person-First” Language

- A patient is not defined by a potentially stigmatizing condition or coping-related behavior
- Avoid using terms such as “difficult” or “noncompliant” which gloss over the multifactorial issues

(Ravi, A. (2017) *Am Fam Physician*)

Person-First Language

- A cancer patient



- Someone with cancer

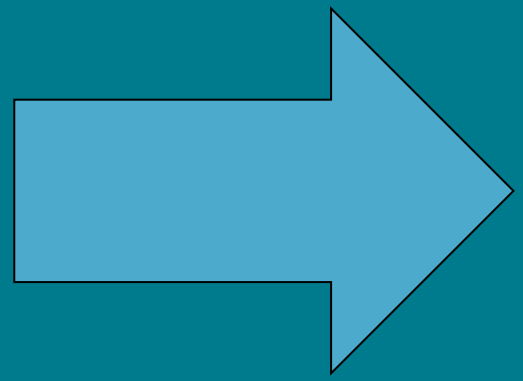
- An addict

- A person with a substance use disorder

Adapted from: Reproductive Health AccessProject

Examples of TIC Language

- Panties
- Bed
- Stirrups
- Spread
- Insert/ Insertion

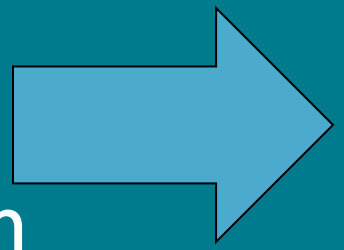


- Underwear
- Table
- Footrests
- Separate
- Place/ Placement

Adapted from: Reproductive Health AccessProject: Contraceptive Pearl: Trauma- Informed Pelvic Exams https://www.reproductiveaccess.org/resource/trauma-informed-pelvic-exams/

Avoid Words an Abuser May Have Used

- Open your legs
- Relax/ just relax
- Relax your bottom
- Relax it won't hurt as much

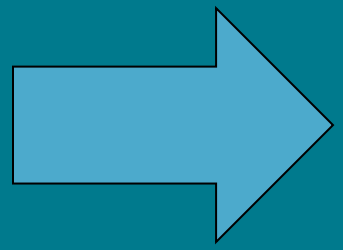


- Let your knees move out to the side as much as is comfortable for you
- Think about your muscles being heavy

(Adapted from: Reproductive Health Access Project
Sobel, L. (2018). *Obstet Gynecol)*

Language: Less Directive More Consent

- Take a deep breath and relax



- Some people find it helpful to take a deep breath during this part of the examination

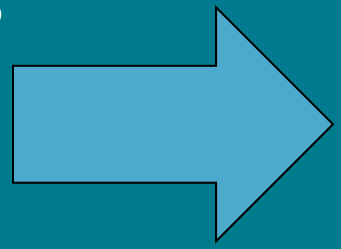
- Now you are going to feel my touch

- May I proceed?

(Adapted from: Reproductive Health Access Project Sobel, L. (2018). *Obstet Gynecol)*

Language “Do’s and Don’ts”:

The more still you are, the sooner this will be over



Imagine you head and shoulders dropping into the pillow

(Adapted from: Reproductive Health Access Project
Sobel, L. (2018). *Obstet Gynecol)*

Before Exam or Procedure

Previsit

(.

- Present opportunities for disclosure of sexual violence
  - Place relevant posters or pamphlets to indicate an awareness and a willingness to discuss
- Have referral resources available in the waiting room
- Display educational material

(Raja, S. (2015). *Fam Community Health*
ACOG 796 (2020) *Obstet Gynecol*
Ravi, A. (2017) *Am Fam Physician*
Sobel, L. (2018) *Obstet Gynecol*)
Harsanyi, A.(2003) *Aust Fam Physician*
Schachter, C.L. (2008). *Public Health Agency of Canada*

Futures Without Violence

Previsit

Review patient's chart for trauma-related documentation to avoid asking the patient to repeat this history and to improve visit preparation

(ACOG 796 (2020) *Obstet Gynecol*
Ravi, A. (2017) *Am Fam Physician*
Sobel, L. (2018) *Obstet Gynecol*)

Neurobiology of Sexual Violence

- Survivors of sexual violence may experience chronic hypervigilant states
- Minimize potentially fearful stimuli in the environment that might trigger a defensive response

(Cuevas, K. M. (2018) *J Am Osteopath Assoc*.)

What Can Providers Do?

- The goal is for the patient to have as much control and choice as possible in care planning
- Reduce the power differential between provider and patient
- Greet the patient while still fully dressed
- Focus on building rapport

(Gesink, D (2015) *BMJ Open*
Sharkansky E. National Center for PTSD. 2014.
ACOG 796 (2020). *Obstet Gynecol*)

Negative Emotional Contact With the Examiner

"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'
'And I didn't even buy you a nice dinner.'"

(Gallo-Silver, L.(2014) *Permanente Journal*
Hilden, M. (2003) Acta Obstet Gynecol Scand)

Confidentiality

- Emphasize confidentiality as the encounter begins
- Let the patient know that you may be taking notes during the encounter to ensure thoroughness in addressing all questions and concerns

(Ravi, A. (2017) *Am Fam Physician*)

Taking a History

- Explain the rationale for sensitive questions, such as when eliciting substance use and sexual history
- If a language interpreter is being used: ask if the patient has a gender preference for the interpreter

(Ravi, A. (2017) *Am Fam Physician*)

Who is in the Room and Where are They?

- Be seated at or below patient's eye level to decrease the existing power differential
- Encourage other staff or students to be seated as well
- Offer options for staff to care for accompanying children
- Ask if they would like a support person

(Ravi, A. (2017) *Am Fam Physician*)

Who is in Control?

"We have all had times when we are not in control of our bodies":

- This is not one of those times
- You are in control
- You are doing this for you

Adapted from: Reproductive Health Access Project

Addressing Fear:

Proactively let the patient know:

- It is OK to have fear
- It is a normal reaction
- Fear causes shallow breathing and tensing
- Ask how you can to increase feelings of safety

(Adapted from: Reproductive Health Access Project
Gallo-Silver, L. (2014). *Perm J*.)

To Distinguish the Clinical Experience From Sexual Violence

- Discuss in advance that the patient can dictate the pace of the examination and can signal to you (through agreed upon verbal or nonverbal signals) if there is discomfort or a break is needed
- “If you want me to stop, you only have to say stop”

(Brooks, M (2018) *Australian Journal of General Practice*
Ravi, A. (2017) *Am Fam Physician*
ACOG (2020). *Obstet Gynecol*)

Avoid Visual Triggers & Be Prepared

- Set up the appropriate equipment (e.g., swabs, specimen containers, and apply lubrication on scopes or speculums) before the patient removes clothing
- Cover instruments and solutions (monsels, iodine, tenaculum, biopsy forceps)
- Have postprocedure supplies ready: (tissues or wipes following speculum or anoscope exam)

(Ravi, A. (2017) *Am Fam Physician*)

Encourage Questions

- Encourage the patient to ask questions before during and after appointment.
- “What questions do you have for me about____?”

(ACOG (2020). *Obstet Gynecol*
Raja, S. (2015). *Fam Community Health)*

Patients Are Experts on Themselves

- Prior to physical examination, briefly describe what parts of the body will be involved
- Offer to explain both in advance and as you do it; history, examination, and any procedures
- Use task-specific inquiry before the exam to address anticipated difficulties and collaborate to minimize discomfort
- Note body language

(Gesink, D (2015) *BMJ Open*
Sharkansky E. *National Center for PTSD. 2014.*
Schachter, C.L. (2008). Ottawa: Public Health Agency of Canada.
Raja, S. (2015). Fam Community Health)

Patients Are Experts on Themselves

- *"What do you think might be the toughest part of _____procedure for you?"*
- *"Is there anything you have done in the past that helps make things like this that are hard for you, easier?"*
- *"What might help reduce stress/discomfort during the exam (make you more comfortable)?"*

(Ravi, A. (2107) *Am Fam Physician*
Schachter, C.L. (2008). Public Health Agency of Canada.
Sharkansky E. National Center for PTSD. 2014.)

During Exam or Procedure

Patient Apologies

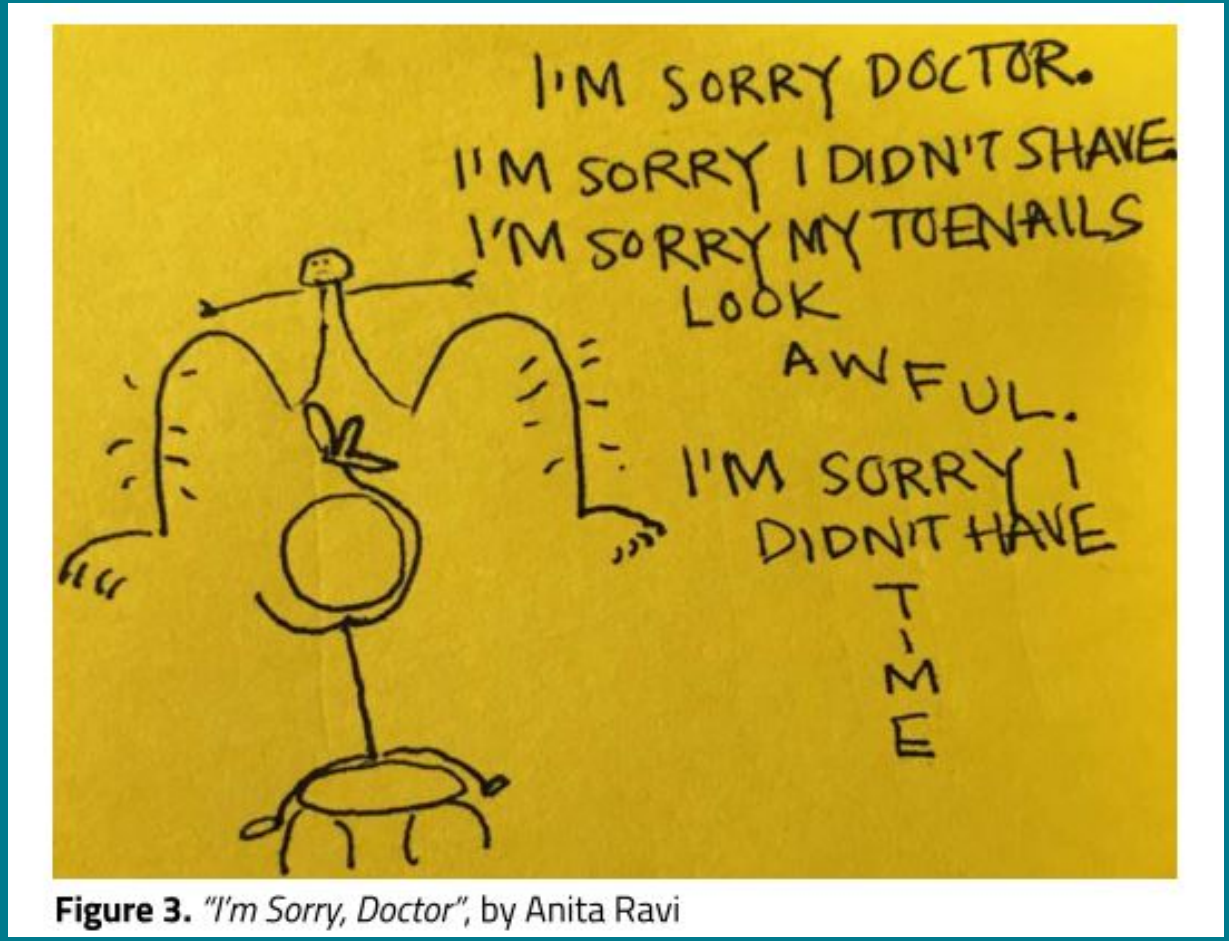


Figure 3. *"I'm Sorry, Doctor"*, by Anita Ravi

(Ravi, A. (2018) *AMA J Ethics*)

Chaperone

- It is recommended to have a chaperone present for exams, tests, and procedures involving breasts, pelvis, genitalia, or rectum
- Exams characterized by intense emotion and vulnerability
- Regardless of the gender of the examiner or patient
- Reassures patient about the professional context
- Protects patient and examiner

(ACOG #796 (2020) *Obstet Gynecol*
Royal College of Obstetricians and Gynaecologists. #6 (2016)
Veterans Health Administration. (2018) VHA directive 1330.01)

Consent

- We can’t assume that just because a patient made an appointment that day, they are giving consent
- Patients disagree strongly with the assumption that they must allow any touch during an exam that the provider thinks is necessary
- People want to be:
  - informed about the need for the intimate touch
  - part of the decision-making about when the exam takes place and who performs it

(Keller, J. M. (2019) *J Sex Med*)

Physical Exam and Testing: Consent

Ask the patient for permission before conducting each section of physical examination (e.g., when moving from speculum to bimanual examination)

(Gallo-Silver, L.(2014) *Permanente Journal*
Keller, J. M. (2019) *J Sex Med*
Schachter, C.L. (2008). *Public Health Agency of Canada*.
Raja, S. (2015). *Fam Community Health.*
Ravi, A. (2107) Am Fam Physician
ACOG Committee Opinion 796 (2020))

Survivor's Preference

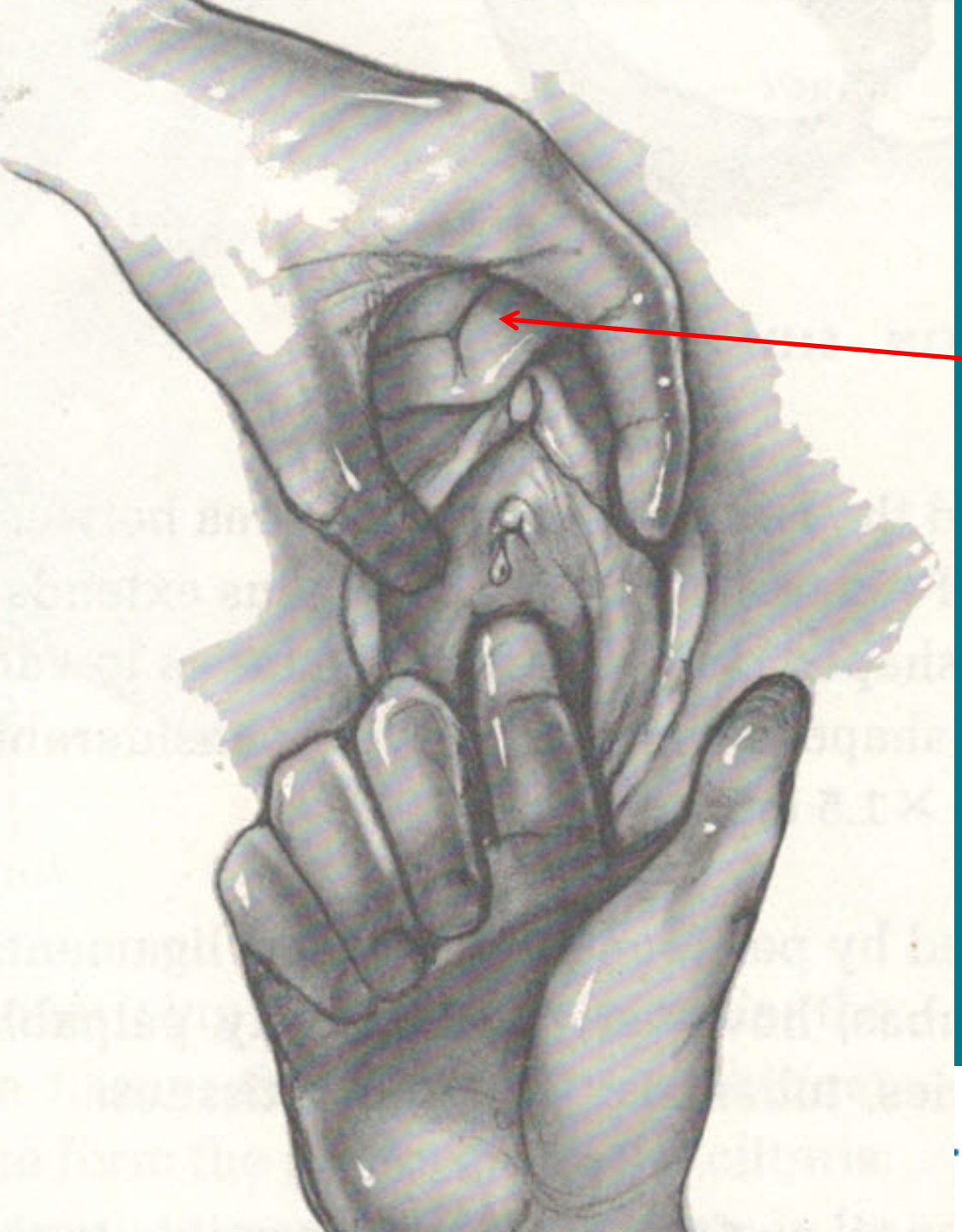
"It would be even better if, rather than just telling me what she is about to do, if she would ask me 'Is it okay for me to do X now?' 'I am about to do Y, is that okay?' It's a subtle difference but can be important, it would keep reminding me that I have some control with this."

(Gesink, D (2015) *BMJ Open*)

Choose the Less Invasive Option
More Control for Patient

- Offer a mirror with which to watch the examination or treatment
- Offer self-insertion of swabs instead of speculum examination

(Ravi, A. (2017) *Am Fam Physician*
Raja, S. (2015). *Fam Community Health*
Schachter, C.L. (2008). *Ottawa: Public Health Agency of Canada*.)



Note the examiners finger resting on the glans of the clitoris

Bates, B (1979) A guide to physical examination

Pelvic Exam: Draping

- Don’t ask patient to remove clothing on parts of the body not involved in the examination (e.g., chest, arms, feet, etc.)
- Drape parts of the body not being examined
- Give the option of shifting clothing out of the way rather than putting on a gown (patient can shift clothing)

(ACOG (2020) *Obstet Gynecol, 135*
Schachter, C.L. (2008). *Public Health Agency of Canada*.
Raja, S. (2015). *Fam Community Health.*
Ravi, A. (2107) Am Fam Physician)

Pelvic Exam: Positioning

- When possible, offer to raise the head & upper body during the pelvic exam; offer a pillow for their back
- Minimize the time a patient remains in a subordinate position
- Avoid leaning over the patient

(ACOG # 796 (2020)
Schachter, C.L. (2008). Ottawa: Public Health Agency of Canada.
Raja, S. (2015). *Fam Community Health)*

Positioning

"My family physician kept bringing it up until I finally told her that I was frightened of laying flat on my back in a paper gown. She told me that it would not be a problem for me to be partially sitting up throughout the whole examination including the pelvic exam. Now she tells all of her patients that that is an option. She told me that it had been an important conversation for her."

Schachter, C.L. (2008). Ottawa: Public Health Agency of Canada.

Vaginal Speculum Exams without Footrests

- Routine in the UK, Australia, New Zealand
- Easy to learn, simple to perform
- Does not affect the adequacy of examinations
- Reduces feelings of vulnerability
- Less discomfort; free to adjust the position of their feet and hips to most comfortable position

(Seehusen, D. A. (2006). *BMJ*.
Barr, W. B. (2006). *BMJ*
Schachter, C.L. (2008). *Public Health Agency of Canada.*
Raja, S. *(2015). Fam Community Health)*

Communication

Communicate about specific things the patient may feel or hear

“You may hear clicks when the speculum is opened”

“The lubrication on the speculum/anoscope may feel cool”

(Ravi, A. (2017) *Am Fam Physician*)

Speculum Self Placement

- Data suggest that speculum placement may be the most physically uncomfortable part of the pelvic examination for some
- Offering self-placement of the speculum has emerged as a best practice

(Ravi, A. (2017) *Am Fam Physician*
Sperlich, M. (2017) *Midwifery Womens Health*
Wright,D. (2005) *J Clin Nurs)*

Speculum Self Placement: Patient Feedback

- "…feel more comfortable returning for future pap smears"
- Privacy
- "could do it myself"; "easier"; "better"; "nicer";
- "I had more control… I could position (the speculum) where it was comfortable"
- Contrasted with being subject to an "invasive procedure"

(Wright,D. (2005) *J Clin Nurs.)*

Self Placement of Speculum: A guide

1. Let them know that only the blades are placed into the vagina and the handle is for the clinician's use only
2. Reassure that self-inserting the speculum will not cause harm
3. Warm speculum

(Wright,D. (2005) *J Clin Nurs.)*

Self Placement of Speculum: A guide

4. Hand the speculum to the patient with the handle facing down
5. Consider moving away from the table during self-placement, to allow privacy

(Wright,D. (2005) *J Clin Nurs.)*

Consider *in Some Cases*

- Perform the bimanual exam first in order to relax the vaginal muscles
- Demonstrate which muscles need to be relaxed by palpating the perineal muscles from inside the vagina

(Ades, V. (2019) Obstet Gynecol)

Distraction

- Engage in dialogue throughout exam
- Ask the patient about their life, job, or family in order to keep them engaged and help them to distract from the exam

Sharkansky E. Sexual Trauma: Information for Women's Medical Providers. National Center for PTSD. 2014.

Themes heard in survivor interviews

"During a pap test, what helps me the most is she asks me about my work, I think she knows that grounds me the most."

(Gesink, D (2015) *BMJ Open*)

Stop if Necessary

- Be ready to take a break during the exam or procedure if necessary
- Be prepared and willing to reschedule if necessary

Sharkansky E. Sexual Trauma: Information for Women's Medical Providers. National Center for PTSD. 2014.

After Exam or Procedure

Interprofessional Collaboration

- Maintain a list of referral sources across disciplines
- Notify referrals in advance regarding relevant trauma history so colleagues are appropriately prepared

(Ravi, A. (2017) *Am Fam Physician*
Raja, S. (2015). *Fam Community Health)*

“The office never called my primary doctor to explain what happened.”

(Gallo-Silver, L.(2014) *Permanente Journal*)

Recognizing when Outside Help is Needed

"Clinicians don't have to handle the whole crisis, but they do need to know how to recognize it. And how to make a referral in a nice way "Is there someone you can talk to?" . . . They wouldn't need to go beyond their scope of practice, but it is helpful if they can recognize it"

Schachter, C.L. (2008). Ottawa: Public Health Agency of Canada.

Anticipatory Guidance: Imaging Procedures

Let the patient know in advance when referring them for imaging if it may be:

- invasive (e.g., transvaginal or scrotal ultrasonography)
- constrictive (e.g., magnetic resonance imaging)
- weighted (e.g., lead aprons for chest radiography)

(Ravi, A. (2017) *Am Fam Physician*)

TIC Actions for Physicians: Post Visit

- Provide written after-care instructions and follow-up plan in case patients experience dissociation or distracting anxiety during the visit
- Use plain language in written instructions
- Choose sensitive language for gender & diagnoses in visit summaries that are provided to patients and in documentation

(Ravi, A. (2017) *Am Fam Physician*)

Validated Assessment tool about TIC

Assess Health Professionals' Knowledge, Attitude and Practice Download survey tool:

open.library.ubc.ca › media › download › pdf

(King, S. (2019) *Pediatr Qual Saf*.)

Resources

- JBS International, Inc. and Georgetown University National Technical Assistance Center for Children's Mental Health: Trauma Informed Care: Perspectives and Resourceshttp://trauma.jbsinternational.com/traumatool/
- National Center for Trauma-Informed Care: https://www.samhsa.gov/nctic
- National Child Traumatic Stress Network: http://www.nctsn.org/
- National Council for Behavioral Health: Trauma-Informed Primary Care Initiative https://www.thenationalcouncil.org/trauma-informed-primary-care-initiative-learning-community
- U.S. Department of Veterans Affairs National Center for PTSD: Sexual Trauma: Information for Women's Medical Providers: https://www.ptsd.va.gov/professional/treatment/women/ptsd-womens-providers.asp

(Ravi, A. (2017) *Am Fam Physician*)