7 The Trauma-Informed Examination

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A note about terminology: Wherever possible, we have tried in this chapter to avoid gendered pronouns. The recommendations in this chapter come from experience in the EMPOWER Clinic, which is an OB-GYN clinic, and therefore when necessary, she and her pronouns are used to describe the patient and s/he to describe the provider. However, we encourage providers to be cognizant that not all patients in need of contraception or abortion identify as women and that an individual patient's gender identity and pronouns should be respected.

Introduction

Examination of a patient with sexual trauma can be daunting, as most obstetrician- gynecologists are not explicitly taught how to manage patients with sexual trauma. The author of this chapter is the founder and director of the EMPOWER Clinic for Survivors of Sex Trafficking and Sexual Violence; therefore, the advice offered includes methods used by the EMPOWER Clinic, as well as potential alternatives to meet the needs of clinics that are structured differently. There is very little evidence to demonstrate

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many of the best practices described in this chapter; where little evidence exists, recommendations are made based on experience.

Making Appointments, Checking In, and Registration Process

The patient visit starts with the process of scheduling an appointment. The scheduling, check-in, and registration process alone can be barriers to care. When a patient calls to schedule an appointment, the first attempt may be unsuccessful or frustrating because of a phone tree, reaching an incorrect department and being rerouted, or a number of other reasons. A typical patient may experience frustration but try again. However, patients with trauma may be more ambivalent about the care they are seeking and may be less persistent in seeking an appointment.

Office Workflow

Careful consideration should be taken toward designing the office workflow and selecting office personnel to interact with survivors. For example, while the scheduling process for a typical patient may involve a centralized scheduling mechanism that can distribute patients to many providers and allow for flexibility of time and date, it may be more useful to route scheduling for survivors through a single staff member or through the provider directly. Or, rather than an appointment-based system, the facility could consider a walk-in appointment system for both new and follow-up visits, if feasible. This process depends on the workflow of the facility itself and the feasibility of arranging this. Furthermore, some patients, especially those with language barriers or severe trauma, may have their appointments scheduled by case managers or social workers. This can be of benefit to providers as well, since those case managers are usually then responsible for ensuring the patient's attendance at the visit, and can be a resource for follow-up.

Training of Office Staff

While individual providers may be trained in trauma-specific care or may be aware of the impact of trauma, office staff rarely have access to resources or training in trauma-informed care. Therefore, it may be valuable to train office staff on trauma and provide specific procedures and parameters around interacting with patients identified as trauma survivors. Furthermore, the same trained office staff could offer sensitivity to all patients, even those not previously identified as having trauma, as many survivors exist in the general population.

Safety is a major concern for abused populations and especially for survivors of human trafficking. If patients may be vulnerable to revictimization by abusers or traffickers, it may be helpful to have an office that allows patients to be brought inside the clinic out of the main waiting room and have a more secure place to wait for their appointment. This may also be helpful to individuals who struggle with crowds, noise, and other overstimulation due to trauma.

Accepting Patients by Referral Versus Self-Referral

The EMPOWER Clinic is dedicated to serving traumatized patients of the highest need: those who otherwise do not have access to care, have previously been too traumatized to seek care, or have had negative experiences in healthcare due to their trauma. For this reason, patients are accepted only by referral. These referrals can be made by a social service organization (i.e., an organization that provides social and/or legal services), case managers, lawyers, or therapists. This is helpful in triaging patients, confirming their appropriateness for enrollment in EMPOWER, and assisting with follow-up after the visits. These patients have high social service needs that would overwhelm a medical provider, so having contact with a referring source is invaluable.

However, this limits the access of other patients to trauma-informed services, and so this model may not be appropriate for

every provider or clinic. In deciding on a referral system for a clinic devoted to trauma, providers should consider their target population, their capacity to accommodate a specific volume of patients, and the need to follow up with a referring source. Allowing self-referral improves access to care for patients who do not need or do not have a connection to a social service organization, but risks overwhelming providers with requests for appointments. Providers who choose to accept self-referral may want to create a triage system in order to screen the appropriateness of patients enrolling in their services (i.e., need for trauma-specific services) and consider which staff would be the most appropriate to receive and process referrals and make decisions regarding scheduling.

Resources for New Identification of Trauma

Many patients with trauma have never disclosed their trauma to anyone or are not aware of social services available to them. Providers may encounter patients with trauma in the course of their typical practice and may not have the benefit of being able to contact a referring organization or individual. For this reason, it can be useful to be aware of the referring mechanisms within one's own practice and in the local community. Some practices may have a social worker on-site who can counsel patients and provide resources. In the community, there may be organizations that address domestic violence, legal services (such as legal aid), trafficking, and sexual violence. The appendix to this chapter lists national Web-based resources that may be valuable in helping providers identify local resources.

Scheduling

It may be helpful to consider an alternate method of scheduling patients with trauma. There are several reasons for this: (1) patients with severe trauma may require longer visits than traditionally scheduled in routine outpatient care; (2) it is essential that

patients disclosing or discussing trauma do not feel rushed during their visit and are confident that they have the provider's undivided attention; (3) scheduling can be better individualized to the needs of the patient prior to the visit, based on the anticipated trauma issues and clinical concerns. If patients with trauma are being seen in a specialized clinic, this can facilitate alternate scheduling methods, whereas this may be more difficult when patients with trauma are incorporated into routine panels.

The EMPOWER Clinic found, through trial and error, that the ideal visit duration is 1 hour for intake (new) visits and 30 minutes for repeat visits, with little to no overbooking if it can be avoided (though there are exceptions). While some intake visits require more than 1 hour, missed visits are common, and the extra room in the schedule allows some flexibility in timing. Duration of intake visits can also be varied depending on the information provided by the referring organization; based on the patient's trauma history, clinical needs (e.g., both exam and affidavit), or previous experiences with healthcare, the provider may decide to lengthen the intake duration to 90 minutes if needed.

Registration Process

Registration processes can vary between outpatient facilities. Some have patients register in the same area in which they are to be seen, while others have a separate registration area or office. Providers who plan to see patients with trauma should be aware of their facility's registration process and consider which aspects of the process may present a barrier to care. For example, if registration is done in a separate area from the care services, patients may be turned away if they lack specific paperwork and registration personnel are not aware of the vulnerability of these patients. Therefore, it can be helpful to communicate a contingency plan and contact person if patients are turned away. For facilities in which registration takes place at the location of care delivery, this process may be easier to facilitate; nonetheless, patients may still encounter obstacles to registration that may need to be triaged by providers or clinic personnel who are familiar with trauma.

A patient with trauma who is turned away, especially if the encounter is adversarial, may be disinclined to return or seek care in the future, as the experience can reinforce their sense of disempowerment.

Insurance Issues

Patients with trauma may or may not have health insurance. Access to health insurance varies greatly depending on location, and so providers should be aware of insurance eligibility in their area. Some patients, especially those who have experienced sex trafficking, may be undocumented and therefore ineligible for Medicaid or other health insurance options. Some facilities may have processes for providing care to uninsured populations, and these processes should be made explicit to referring personnel and/or patients prior to scheduling appointments.

Obtaining Patient History

Providers who are aware of their patient's trauma history prior to the appointment may want to modify their history-taking in the ways illustrated below. Patients may also disclose previously unreported trauma in the course of a routine visit; this is addressed at the end of this section.

Privacy

Patients should always be seen alone. Some patients may be accompanied by family members, friends, or case managers. Many of these accompanying individuals may help to comfort the patient and may be an overall beneficial influence; however, there is no way to verify this prior to the visit. Patients with a history of trauma are uniquely vulnerable to revictimization, and therefore, the provider must initiate the visit and take the history without any accompanying personnel. The presence of another

individual in the room may also make it more difficult for patients to disclose elements of their trauma history that the survivor feels ashamed of.

Furthermore, patients may not want to disclose any or all of the trauma to the provider, but may feel obligated to do so. In order to avoid this awkwardness, seeing the patient alone and allowing her to disclose only what she is comfortable disclosing help to empower the patient to make this decision for herself. The presence of case managers may especially make patients feel that they have to disclose everything, or case managers may feel obligated to correct the information given by the patient.

Introduction to the Patient

A formal introduction to the patient by the provider can help to create a sense of respect and welcome. In a clinic or setting specifically dedicated to seeing patients with trauma, the provider can ask the patient what the referring organization told the patient about what kind of medical care to anticipate and introduce herself or himself as a specialist in sexual trauma (or the specific trauma that the patient has experienced). This can help in two ways: (1) the provider is the first person to openly state the type of trauma, relieving the patient of this responsibility; (2) it acknowledges that this type of trauma is important and deserving of specialized attention and care.

Modifications to Routine History-Taking

The typical history includes a history of present illness, past medical and surgical history, past obstetric and gynecological history (for obstetrician-gynecologists), current medications, allergies, social history, and family history. We recommend starting the visit with the routine history; this helps to give time to form a trust bond with the patient prior to initiating a discussion of trauma, which may be stressful. Once the full history is taken, the provider can then broach the subject of the trauma.

Taking a Social History

The social history typically includes exposure to toxic substances (tobacco, alcohol, drugs). In addition, it can be helpful to ask where the patient lives (e.g., shelter vs. apartment), who the patient lives with, and whether there is any ongoing domestic or intimate partner violence (IPV) (patients with prior trauma are vulnerable to future IPV). In addition, asking about current employment or enrollment in school can help to assess the patient's economic vulnerability and engagement with the workforce, which may be a resilience factor.

Discussion of Trauma

We recommend providing an opportunity to disclose trauma but specifying that it is not required or necessary. Having the patient recount the narrative or provide too many details runs the risk of re-traumatizing her, creating flooding (excessive emotional and psychological reaction to recounting her history) and/or solidifying the memory. The provider can ask specific questions that are necessary to assess safety, for example:

- When did the trauma occur?
- When did the traumatic experience end?
- How did the patient escape or stop the traumatic experience?
- Who was the abuser, and is the patient still in contact with the person/people?
- Is the patient at risk of revictimization by the abuser (e.g., reentry into trafficking)?

If the patient chooses to narrate the history of trauma, the provider should carefully monitor her emotional status for signs of flooding. This can include pressured speech, uncontrolled crying, hyperventilation, and dissociation. If flooding seems to be occurring, the provider should intervene to calm the patient and redirect the discussion away from the more psychologically difficult aspects of the trauma. In order to reassure the patient that the

interruption is for her own benefit, the provider can openly note that the patient seems upset and that it may be helpful to calm a little or talk about something else for the time being. This can help reassure the patient that a discussion of trauma is not being rejected by the provider, but that the provider is looking out for the patient's best interests.

While taking a trauma history, it is important that the provider is not typing or otherwise distracted. The provider should appear calm, should make eye contact, and should try not to divert attention from the patient's narrative. The provider can interrupt to guide the narrative, or to express sympathy or concern, but should allow the trauma discussion to be relatively open-ended.

The trauma history can be recorded later in narrative form, or whatever is most helpful to the provider. The only exception is when a trauma history is being taken for the purpose of providing an affidavit. In this case, it is important to record the history in real time as accurately as possible and some of the patient's wording verbatim. The provider can explain that s/he needs to type as the patient speaks in order to record directly for accuracy, so that the patient understands the reason for potentially diverted attention.

Standardized Assessments

Certain assessments may be of value in ascertaining current psychological status or assessing for other traumas. These assessments can be completed by patients independently prior to the visit, or they can be administered verbally by the provider or clinic staff. A more complete description of these assessments can be found in Chap. 8.

- The Adverse Childhood Experiences (ACE) questionnaire assesses for childhood traumas that occurred before the age of 18.
- The Patient Health Questionnaire-9 (PHQ-9) is used to screen for depression.
- The PTSD module of the Mini-International Neuropsychiatric Interview (MINI) can be used to screen for PTSD.

The Role of the Clinician

A clinician caring for patients with sexual trauma has multiple roles. First, the clinician provides medical care, as expected. But the clinician also has a powerful role to play in a patient's recovery. Many people ascribe to doctors (and other clinical care providers) a high degree of authority and respect. This is a double-edged sword; providers' status can be intimidating, but it can also be wielded to reinforce positive messages regarding trauma and encourage psychological healing. When a doctor addresses a patient's trauma, the doctor is usually reinforcing many of the messages communicated by a therapist or case manager, but the fact of the message being reinforced by someone in a position of authority in the patient's mind can make it especially powerful. A clinician who takes the time to listen to a patient's trauma narrative, and who frames the trauma within the context of clinical care, can help the patient confront and grapple with the trauma in a way that may hopefully seem less shameful or insurmountable.

This also means that a clinician can do damage by transmitting the wrong messages. Many survivors are struggling with negative stereotypes and assumptions from society and from their own shame. A clinician who seems impatient or brusque and who belittles or dismisses a patient's trauma will reinforce these negative messages. This will, in turn, limit the ability to build rapport and could interfere with the patient's willingness to seek care in the future.

The role of the clinician is not to be a social worker or therapist, and this should remain explicitly clear. Clinicians are limited in time and must attend to multiple patients in a short amount of time. Patients with sexual trauma may have a high number of social and psychological needs. The clinician should express concern for these issues and attempt to harness resources to help but risks becoming occupied with time-consuming nonclinical tasks if s/he does not delegate the handling of these needs to other individuals.

Helpful Tips and Phrases

If the trauma is already known to the clinician at the beginning of the encounter (e.g., if the patient was referred for this purpose), it can be helpful for the clinician to broach the subject first, relieving the patient of the burden of disclosure. If the clinician has experience with sexual trauma or the specific issue that the patient is presenting with (e.g., female genital cutting), explicitly stating that expertise at the beginning of the visit can help reassure the patient that the care will be trauma-informed.

Patients may feel too tense at the beginning of an encounter to discuss their trauma, and therefore, it is usually helpful to take a full medical history before inquiring about the trauma. This sets the tone, establishes that the patient's medical concerns will be taken seriously, and gives the patient time to decide that she has sufficient rapport with the clinician to discuss a difficult subject in detail.

Many patients with trauma carry a burden of shame and often blame themselves for their own victimization. They may use terminology that implies this self-blame, such as "I am ruined" or "I am worthless." The clinician should point out this terminology and try to reframe the narrative. It can be helpful to talk about trauma and specifically about PTSD, as a common response to trauma. The clinician can focus on the internal strength required by the patient to survive their trauma and reframe the narrative as one of strength and survival, rather than weakness or self-condemnation.

When taking a trauma narrative, it is imperative to demonstrate empathy, but not exaggerated horror or shock. Many patients' stories can be upsetting, but the patient should not feel that theirs is particularly unnerving, nor should the patient be in the position of comforting the clinician or managing the clinician's emotions.

The use of the ACE questionnaire, as well as a thorough trauma narrative, can help the clinician to broach the subject of trauma and discuss with the patient what impact the patient feels trauma has had on her life and medical care. The clinician can also

discuss the augmenting impact of multiple traumas, which is a phenomenon often instinctively recognized by patients but rarely openly acknowledged.

Previously Undisclosed Trauma

In some cases, the clinician may not be aware of the patient's trauma in advance of the visit, but it is disclosed during history-taking. In this situation, it is important for the clinician to show that her or his full attention is on the patient. If the clinician is typing or otherwise distracted when the trauma is disclosed, it is important to stop and calmly focus on the patient and offer the opportunity to provide more information. Long silences are common while the patient summons the courage to elaborate. The clinician can offer tissues if the patient starts to cry and can reassure the patient that it is OK and normal to be upset and can encourage her to disclose if she feels ready. The clinician can also emphasize that many people have experienced sexual trauma and that the patient is not alone.

Once the patient has disclosed trauma, she may be upset. The clinician should ask if she is ready to move forward with the exam (if one is indicated) or if she prefers to return another day. This decision can be entirely up to the patient, and making the decision is often empowering.

The Physical Examination

Pace of the Exam

A typical routine exam is fairly quick and efficient. However, individuals with trauma may exhibit anxiety or jumpiness when it comes time for the exam and may need a slower pace. The clinician should ensure that the patient is fully covered by a gown and/or sheets (if the patient needed to change). When uncovering body parts, the clinician should try to uncover only one body part at a time, with as little exposure as possible. The clinician should

briefly explain each element of the exam and the purpose, pausing slightly to allow the patient to process. Often patients exhibit a fight-or-flight response that makes it difficult to listen to instruction and explanation, so a calm, slow pace can be helpful in providing time for the patient to listen.

Presence of Other Personnel

It is helpful to limit the number of people in the room. Many clinicians, especially gynecologists, have an assistant in the room to handle materials and instruments. This can be helpful, as the assistant can monitor for signs of distress or dissociation and can hold the patient's hand if needed. The assistant should be positioned so that she cannot see the patient's perineum, and the assistant can explain the purpose for her presence in the room. Having observers (e.g., students) in the room can be detrimental, as many survivors already feel self-conscious.

Patients may request to have a friend or family member accompany them for the exam; this request should be accommodated as long as the accompanying person would likely be helpful as per the judgement of the clinician. This person should also be positioned at the patient's head so that the perineum is not visible. If a procedure is expected to be painful, the clinician can explain this to the accompanying person so that s/he is prepared.

Tips on Conducting Exam

Each aspect of the exam should be explained to the patient, as described above. The breast and pelvic exams tend to be the most stressful elements. During the breast exam, the clinician can explain what she is feeling for and how the patient can conduct a breast self-exam.

To prepare for the pelvic exam, the clinician can ask if the patient has had a pelvic exam before and, if so, whether there are any modifications she has noted to be helpful in tolerating the exam. For patients who have never or rarely had a pelvic exam,

the clinician can explain the exam in advance and reassure the patient that she will go slowly and walk her through it.

The patient is asked to place her feet in the footrests (never "stirrups") and how to position herself on the table. Many survivors will tightly close their knees and need encouragement to open the legs for the exam. The clinician should avoid using her hands to position the legs but instead explain to the patient how to open her knees and why it can be helpful in tolerating the exam to open the legs further. The clinician can demonstrate with her hands where she would like the patient's knees to be when in the proper position. The process of opening their legs may be slow and require patience, but it is important to take time to do this without showing irritation as it sets the tone for the rest of the exam.

Once the patient is properly positioned, the clinician can prepare her for the speculum exam by first gently touching the leg, then the thigh, and then the labia majora, while explaining what s/he is doing. Patients with trauma may jump or react during this process, so it can be helpful to calmly repeat until she is desensitized to the touch sensation.

In order to broach the speculum and bimanual examinations, the clinician should explain involuntary and voluntary muscle control of perineal muscles. The clinician can touch the perineum in the approximate location of the perineal muscles and explain that the patient will have an involuntary reaction to contract the muscles, but she can consciously overcome the instinctive response and relax the muscles.

The clinician should then slowly introduce the speculum. If she encounters constriction of the perineal muscles, it is important not to continue inserting the speculum, but to stop and explain again the muscle control. The clinician can also touch the perineal muscles with one finger and help the patient to locate the muscle she needs to consciously relax. This part of the exam can also take a long time but should be slow and deliberate. Once the patient is able to relax the perineal muscle, the clinician can proceed with insertion of the speculum. It can be helpful to insert only the tip of the speculum and pause to detect further perineal muscle contraction and allow for relaxation. Once the tip of the speculum is

beyond the perineum, insertion can be conducted more smoothly, but should still be at a gentle pace. The clinician should offer encouragement and then warn the patient that opening the speculum will create a sensation of pressure but not pain. If adjustment of the speculum is required, this should be explained to the patient, and the clinician should avoid jerky or rapid movements. Once the cervix is visualized, the visual inspection and taking of samples should be conducted efficiently, but gently, and explained throughout. The speculum can be gently removed and encouragement provided to the patient for tolerating it. The bimanual exam can be explained. Most patients can tolerate two fingers for the bimanual examination, but for patients with a small perineum, who are menopausal, or still intolerant of the exam, one finger can be used. The pace should be the same as for the speculum exam, so as to avoid startling the patient.

Discussion of Examination Findings

Once both examinations are complete, if all findings are normal, it is important that the clinician verbalizes this and not assume the patient will realize it. Many patients with trauma suspect that their trauma is reflected physically and are anticipating some kind of abnormality to be detected on examination. The clinician's explicit statement to the contrary can be highly reassuring.

If the patient has specific symptoms that are explained by the examination (e.g., fibroids or pelvic mass), the clinician can explain and normalize this; specifically, she should address that these problems have nothing to do with the patient's trauma experience and can be present in women who have never experienced trauma.

Planning for Follow-Up

Follow-up plans should be explicitly discussed and may require reiteration. In patients for whom the pelvic examination was unusually stressful, they may need a few minutes to regroup

before they can absorb further instruction. Writing or drawing findings (if present) may be helpful.

If the patient came with a case manager, family member, or friend, the clinician can offer to explain all findings to the patient and then repeat with the accompanying person if the patient wants. However, this should be framed as strictly up to the patient, and she can decide to limit the information transmitted to others. Patients with trauma may be unusually concerned with privacy and disclosure, so privacy standards and laws (such as HIPAA) should be explicitly discussed to help the patient understand her privacy rights and reassure her of confidentiality.

Cultural Considerations

Patients from developing countries may be unfamiliar with standards and expectations of the American healthcare system. For example, some individuals may come from places where primary care is uncommon, and the norm is to present for care only in the context of illness. Therefore, it can be helpful to discuss the expectations of primary care and care-seeking behavior. For example, annual wellness visits, Pap smears, and routine testing can be explained. In addition, the clinician can specify that the patient herself is expected to present for these visits and may or may not receive reminders, depending on the practices of the facility.

Additionally, it is helpful to keep in mind cultural differences in approaching doctors. Some patients may view doctors as having exceptional authority and may be reluctant to ask questions or indicate that they did not understand the instructions. It can be helpful to solicit verbal confirmation or ask the patient to explain the findings and instructions to confirm their understanding. The clinician can also specify that the patient can feel comfortable asking questions and that it is important that she understands the instructions.

Follow-Up and Communication

Many patients with sexual trauma are grappling with many ongoing challenges, including poverty, food insecurity, therapy, work or work-seeking, child care, and legal issues. These demands on their time and attention can overshadow medical follow-up, and therefore, a plan for follow-up should be made, especially in cases where specific findings or conditions need to be managed. Follow-up appointments can be scheduled before the patient leaves the office, and patients can be provided with a mechanism for reaching the clinician, either through their case manager or through the office or both, to reduce the likelihood of loss to follow-up. Additionally, many low-income patients have variable access to cellular telephone service, as they have transient phone plans and may not be able to pay their bill for stretches of time. It can be helpful to have alternate contacts, whether through a case manager, family member, or email address. Facilitation of communication should be carefully considered and tailored to the patient population of the clinician.

Summary

This chapter discusses the various considerations needed in order to design an outpatient visit for a patient with sexual trauma. Modifications should be made to the process of examining a patient to be sensitive to the survivor's trauma and potential for triggering. Similarly, the office experience should be considered from a trauma-informed perspective to reduce stress and minimize obstacles to care. Everything from the office workflow, scheduling systems, and insurance and billing must be considered in terms of how they could potentially affect the patient experience. This chapter offers the EMPOWER Clinic as a model; not all clinics for populations with trauma must follow this formula. Different clinics should consider their own set-

tings and patient population to determine an optimal workflow process. Nonetheless, the impact of trauma should be considered at each step.

Additional Resources

Ades V, Goddard B, Pearson Ayala S, Greene JA. Caring for long term health needs in women with a history of sexual trauma. BMJ. 2019;367:l5825.

Ades, et al. An integrated, trauma-informed care model for female survivors of sexual violence: The Engage, Motivate, Protect, Organize, Self-Worth, Educate, Respect (EMPOWER) Clinic. Obstet Gynecol. 2019; 133(4):803–9.

CDC website on Adverse Childhood Experiences (ACE) Study. https://www.integration.samhsa.gov/clinical-practice/trauma-informed.

SAMHSA-HRSA Center for Integrated Health Solutions website on trauma and trauma-informed approaches. https://www.integration.samhsa.gov/clinical-practice/trauma-informed.

SAMHSA's Concept of trauma and guidance for a trauma-informed approach. https://store.samhsa.gov/system/files/sma14-4884.pdf.