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Handbook on Sensitive Practice for Health Professionals:

Lessons from Women Survivors of Childhood Sexual Abuse

Canada

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Handbook on Sensitive Practice for Health Professionals – Lessons from Women Survivors of Childhood Sexual Abuse
was prepared by **Candice Schachter, Carol Stalker and Eli Teram**
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I. The Handbook as a Tool for Clinical Practice

A. Who is this handbook for?

This handbook has been written for health professionals and students who are not trained as mental health professionals or psychotherapists and who have limited experience working with survivors of childhood sexual abuse. The handbook offers ideas and suggestions for ways to practise that are sensitive to the needs of survivors of childhood sexual abuse. We have termed these ideas and suggestions "sensitive practice".

B. How does this handbook pertain to my clinical practice?

At least 1 in 5 women and 1 in 10 men are survivors of childhood sexual abuse.[1] The high prevalence rates and research indicating that childhood trauma is associated with a greater risk of a wide variety of health problems suggests that **health professionals work, often unknowingly, with survivors.**

> Sensitive practice is not just for survivors of childhood sexual abuse. All clients need sensitive practitioners.[2]

Although this handbook focuses on female survivors of childhood sexual abuse, it captures essential features of clinical practice for **all clients**. Thus, the reader will find ideas in this handbook that can be applied to (or already reflect) his or her current practice. The handbook goes on to highlight specific practice suggestions for the clinician working with clients who have histories of abuse.

C. How can the information in this handbook benefit my clients?

The research on which this handbook is based has shown how important it is for survivors to feel safe. The survivor who does not feel safe may not be able to fully participate in or benefit from treatment. In some instances, the survivor may even stop treatment because he or she does not feel safe enough to continue. This handbook offers suggestions that can help the clinician facilitate the feeling of safety during treatment, thereby assisting the client to benefit more fully from treatment.

D. What is in the handbook?

This handbook is divided into three sections:

- **Background Information About Childhood Sexual Abuse.** This section will assist the clinician to understand more fully why sensitive practice is important for the client who is a survivor. The dynamics, long-term effects and types of feelings, experiences and behaviours that may interfere with treatment are described.
- **Principles of Sensitive Practice.** These principles underlie all interactions between health professionals and their clients.
- **Guidelines for Sensitive Practice.** These are practical suggestions that health professionals can incorporate into clinical practice.

E. Terminology used in the handbook

- The terms *survivor* and *client* are used interchangeably, both because the clinician may not be aware of a client's history of childhood sexual abuse and because this information is not required for a clinician to practise sensitively.

- The handbook uses the word *survivor* instead of *victim*. In using the term survivor, we celebrate the strength and resourcefulness of the person who developed ways of coping with her abuse.[3]

- The terms *abuse* and *violence* are used interchangeably throughout this handbook. Abuse may not always involve physical injury; however, it is a violation of the person and is usually experienced as traumatic.[4]

- This handbook uses the feminine pronoun because it is based on research with women survivors. While there appear to be some differences in the way that males and females respond to child sexual abuse, "outcome studies have actually had difficulty demonstrating consistent differences in symptomatology between abused boys and girls or men and women. It would appear, based on current research, that there are more similarities than differences in the impact of abuse [on males and females]."[1, p. 47] Although we believe that the Principles for sensitive practice (Section III) and Guidelines for sensitive practice (Section IV) may be helpful in working with all survivors, further research about the specific needs of men is required.

F. How the handbook was developed

This handbook is the product of a multidisciplinary research study designed to explore ways that health professionals can best address the health care needs of adult female survivors of childhood sexual abuse. The project initially focused on physical therapy, but as the reader will see, this handbook goes beyond the bounds of physical therapy practice to describe sensitive practice in all health professions.

The research was conducted in three phases. In the first phase, 27 adult female survivors of childhood sexual abuse in Saskatchewan and Ontario were interviewed. Following the conventions of qualitative research methods, recruitment of new participants was stopped when the researchers sensed a saturation of the data (that is, when themes continued to be repeated and no new themes emerged).

The survivors, who were predominantly Canadian-born Caucasian, ranged in age from 19 to 62 and had a broad range of educational backgrounds, professions and socio-economic status. All women had begun their journeys of healing from childhood sexual abuse. They had been referred to both in-patient and outpatient physical therapy for orthopaedic and cardiorespiratory problems. The women described their experiences in physical therapy, and how practitioners could be more sensitive to their needs. For a summary and analysis of the findings of the interviews, the reader is referred to Schachter, Stalker & Teram,[5] Teram, Schachter & Stalker[6] and Stalker, Schachter & Teram.[7]

The researchers chose to interview women initially because statistics suggest the prevalence of childhood sexual abuse is significantly higher in females than males.[1,8–11] This is not to suggest that the experience of male survivors is in any way less important than that of females. We subsequently sought to recruit male survivors but were unsuccessful. We hope that our work will lead to research investigation of sensitive practice specifically with male survivors.

In the second phase of the project, groups of physical therapists and survivors worked together to develop recommendations for the Guidelines for Sensitive Practice. Group members who were physical therapists applied the ideas in their clinical practices and offered feedback to the groups. The groups then used this feedback to refine their recommendations.

In the final phase of the project, the information from the interviews and working groups was used to draft the handbook. The words of survivors who were interviewed for the study are included throughout the handbook to provide powerful illustrations of their feelings and thoughts. In successive drafts, physical therapists, physical therapy students, survivors and counsellors across Canada offered their feedback. This broad consultative process was designed to ensure clinical applicability of the handbook.

G. Limitations of the handbook

It is important to point out that race, culture, class, sexual identity, stage of recovery from childhood trauma and other factors will affect a survivor's response to a health professional. Thus, this document does not capture every individual response nor does it inclusively describe every aspect of clinical practice that is sensitive to survivors. While acknowledging these limitations, we feel that the handbook offers health professionals both a useful framework and many broadly applicable suggestions for all types of practice.

H. What this handbook is NOT

The ideas described in this handbook are not intended to encourage health professionals to step outside their scope of practice and develop skills in the realm of psychotherapy. In addition, this handbook is not meant to be used as a tool to intentionally facilitate emotional release. Lastly, the handbook is *not* meant to help the clinician detect whether the client is a survivor of abuse.

I. How to use the handbook

We encourage the clinician and student to approach the handbook in the following ways.

- Reflect on the links among the background information about childhood sexual abuse, the principles of sensitive practice and the guidelines for sensitive practice.

- Discuss with others the ideas expressed here.
- Consider:
  - how the ideas and suggestions apply to you;
  - how you would actively implement the suggestions in your practice; and
  - what your responses would be in various situations described in the handbook.

You may initially feel that certain suggestions in the handbook do not apply to your practice. Before dismissing the suggestion, consider two questions:

1. Why does this suggestion not apply?
2. Is there another way to incorporate part of this suggestion or the essence of the suggestion into my practice?

II. Background Information About Childhood Sexual Abuse

A. What is childhood sexual abuse?

The sexual abuse of a child is a criminal act. "Child sexual abuse occurs when a child is used for the sexual gratification of an adult or adolescent. It involves the exposure of a child to sexual contact, activity or behaviour, and may include invitation to sexual touching, intercourse, or other forms of exploitation, such as juvenile prostitution or pornography."[4, p.1] The child's consent to such activity is a moot issue because "authority and power enable the perpetrator, implicitly or directly, to coerce the child into sexual compliance."[12, p.9] Children who are sexually abused are often also abused physically and emotionally.

B. What is ritual abuse?

Ritual or ritualistic abuse refers to abuse at the "extreme end of the spectrum of child sexual abuse."[13, p. 163] Individuals who have experienced ritual abuse often identify both as survivors of childhood sexual abuse and ritual abuse. Ritual abuse usually involves a combination of physical, sexual and emotional abuse, and frequently refers to abuse suffered by individuals as part of a group, and in the context of a powerful belief system. Finkelhor, Williams and Burns[14] describe three subtypes: 1) true cult-based in which sexual abuse is only one element of the child's involvement in cult rituals and beliefs, 2) pseudo-ritualistic, in which sexual abuse is the principal activity and cult rituals are secondly, and 3) psychopathological ritualism where mentally disturbed individuals abuse children while using idiosyncratic rituals. Ritual abuse is sometimes used synonymously with the term "satanic abuse," but this would be correct only when child abuse is combined with rites and practices by people who worship Satan.

Reports by children and adults of horrific abuse, torture and brainwashing have been repeatedly received from many parts of the world, and many of the reports are virtually identical in detail, even though the informants are unknown to each other. While police have been able to find physical evidence for some allegations, for many they have been unsuccessful. Consequently, there is controversy regarding the prevalence of this form of abuse. Since ritual abuse often involves sadistic acts and degradation of the victim, it can have very serious long-term effects.[13]

C. How prevalent is childhood sexual abuse?

The 1984 Royal Commission on Sexual Offences Against Children and Youth reported that 22% of women and 10% of men had experienced childhood sexual abuse before the age of 18 years in Canada.[8] While there is some variation in prevalence rates reported by different studies in the literature, most reviewers have concluded that **at least 20% of women and from 5% to 10% of men in North America have experienced sexual abuse during childhood**. The percentage

of adults reporting histories of childhood sexual abuse may vary in part because of the use of different ages to define the end of childhood, and whether experiences such as abuse by peers, witnessing exhibitionism, exposure to pornography, or receiving unwanted invitations to engage in sexual activities are included within the definition.

D. What should health professionals know about the dynamics of childhood sexual abuse?

Difficulties which survivors may experience when seeing health professionals can result from past abuse. While the clinician cannot change a survivor's history, an appreciation of the dynamics and long-term effects can provide a better understanding of the client's reactions during treatment. The following summary has been derived from mental health research, clinical literature and interviews with survivors.

1. Sexual abuse is traumatic

Many of the reactions of childhood sexual abuse survivors are similar to those experienced by survivors of other kinds of overwhelming life events such as military combat, sexual assault in adulthood, and natural disasters, and are included in the criteria for Post Traumatic Stress Disorder[4,15] (see Appendix A). While some adults who were sexually abused as children do not report long-term negative effects, most mental health professionals and researchers agree that a history of childhood sexual abuse is associated with a range of significant difficulties in adulthood.

Our society tends to place violent acts on a continuum: certain acts are judged to be "not as violent" as others. We then proceed to place trauma that results from violence and the victim's reactions to the violent acts on a similar continuum. Such judgements are harmful to those who have experienced violence. It is not the role of health professionals to make judgements about the relative severity of the violence, the resulting trauma or an individual's reactions to the experiences.

2. Sexual abuse is a violation of body, boundaries and trust[3]

The violations of body, boundaries and trust can affect the survivor's relationships with herself, her body and others. When a child is abused, she feels out of control and powerless. She is invalidated: her sense of reality is challenged and what she wants does not count. As a result, the child learns that her body does not belong to her and that she has no right to have any say over what happens to her body. She learns to disown and not care about her body. To live through the abusive episodes, she may have learned to disregard or ignore signals of pain, injury, alarm, danger or other sensations that her body generates, or to disconnect from her body. Thus, the survivor's relationship or connection with her body can be damaged.[3,4]

Childhood sexual abuse is, by definition, a violation of boundaries. Most children learn about boundaries early in life through day-to-day interactions. They internalize ideas about what is personal or private, and about what physical and emotional closeness and distance mean. When a child sees and experiences that others respect her boundaries and her

wishes for privacy and separateness, it reinforces the idea that she is a valuable person. She learns that she is separate from others, that she is a self, and that she has an identity of her own. But the child who is sexually abused learns that her body belongs to someone else. Her body is used to meet someone else's needs, and her feelings, wishes and needs are not important. Thus, her relationship or connection to her sense of self, and her sense of who she is, are damaged.[3,4]

Most sexual abuse is perpetrated by people known to the child – family members, baby sitters, friends of the family, teachers, coaches, clergy, etc. – people given responsibility for protecting and nurturing the child. The consequences of this experience can be profoundly devastating. When such people take advantage of her, the child is betrayed. The world becomes an unsafe place as she learns that people who say that they care, or are in care taking roles, cannot be trusted. Thus, her relationship with others (including health professionals) can be damaged.[3,4]

E. What are the long-term effects of childhood sexual abuse?

Numerous studies have documented that childhood sexual abuse is associated with mental, interpersonal and physical health problems in adulthood.[16] Long-term sequelae can affect many aspects of function, including cognitive, emotional, behavioural, interpersonal and physical. The following describes some types of difficulties that have been documented by researchers and health professionals.

Cognitive – Studies indicate that child abuse is often associated with distorted beliefs and perceptions about one's self, one's behaviour, and the intentions of others. These distortions can lead to guilt, self-blame and low self-esteem.[10] Perceptions of helplessness, chronic danger and consequent hypervigilence (extreme sensitivity and watchfulness for possible danger) are common.[10] Belief that one is powerless may present as passivity or, conversely, as behaviour that others experience as controlling.[10]

Emotional – Long-term correlates include depression, anxiety, anger, fear, dissociation (defined on page 10) and numbing of feelings.[10,17]

Behavioural – Studies reveal a number of actions used by survivors to cope with or avoid distress or emotional pain. These include substance abuse and addiction, self-harm, suicide attempts, eating disorders and health risk behaviours such as earlier onset of smoking, earlier sexual intercourse and multiple sexual partners.[18]

Interpersonal – Difficulties include reluctance to trust others, avoidance of intimacy and close relationships, sexual problems and fear of being alone.[10] Because survivors have had basic boundaries violated and have experienced a lack of sensitivity to their feelings and needs, some may have difficulty learning usual social behaviours that require sensitivity to the feelings and boundaries of others.

Physical – Studies repeatedly show that traumatic childhood experiences, including childhood sexual abuse, are

associated with higher rates of lower back pain,[19] chronic pelvic pain,[20–22] gastrointestinal disorders,[23] chronic headache[24,25] and general medical problems.[18,26]

Some painful conditions may be a direct result of past abuse which has left permanent structural damage and becomes more problematic as the individual ages.

The stress of traumatic incidences can have long-term adverse effects on normal physiological functioning.[15] "The growing fields of psychosomatic medicine, psychoendocrinology, and psychoimmunology are increasingly providing information about the relationship between external events, brain biochemistry, the body, and the way the mind interprets all these events."[27, p.21]

Research on traumatic memory supports the concept of "somatic" or "body memory." Traumatic memories may be encoded as part of the non-verbal "non-declarative" memory, independent of normal language-based memory. Such traumatic memories can be triggered by stress in the present that reminds the person of past trauma, and can be experienced as "somatic" or "body memory."[28]

F. What survivors bring to treatment

1. Feeling safe is crucial

A feeling or perception of safety is a crucial need for the survivor because of the violations she has experienced in the past. This need to feel safe is compelling in all aspects of the survivor's life, including her interactions with health professionals.

2. Transference and Counter-transference

Transference: When Past Experiences Interfere with Present Situations

The factors discussed in this section are related to the psychological phenomenon of **transference**. This term refers to the displacement of feelings and perceptions about past situations to experiences in the present.

A number of psychological theories propose that we all experience transference in our lives. While transference can be positive or neutral, it can also be negative and may interfere with healthy and adaptive functioning. For example, as a child, the survivor may have been frequently criticized by a parent or the person who abused her. She may then expect that the clinician (another authority figure) will also criticize her, and perceive a critical attitude where none is intended. Understanding the concept of transference may help the clinician to avoid taking these responses personally.

Counter-transference

Counter-transference occurs when a health professional transfers feelings and perceptions from past situations to the relationship with the client, or allows the client's transference response to evoke a non-therapeutic response. "Counter-transference may manifest as: needing to be liked or admired by one's clients; expecting to have one's opinions on any and all topics endorsed." [29, p.5]

Both transference and counter-transference responses are normal, but must be resolved ethically, so the client does not develop resistance to healing, and the care that the clinician provides is

not compromised through emotional over-involvement or exploitation of the therapeutic relationship.[29]

3. *Feelings, experiences and behaviours that may interfere with treatment*

Feelings and experiences commonly associated with childhood sexual abuse can impede the therapeutic process by compromising the survivor's sense of safety. It is not possible to present a complete list because feelings, experiences and behaviours can vary widely among individuals. This section outlines some of the common feelings, experiences and behaviours that survivors may bring to their relationships with health professionals. Clinicians who broaden their understanding of childhood sexual abuse will be better prepared to respond well to unusual reactions to treatment that may be related to past abuse. **The reader is cautioned, however, that these reactions and feelings are not limited to survivors. One cannot draw conclusions about a client's past solely on the basis of these feelings and behaviours.**

The Principles and Guidelines for Sensitive Practice that follow provide ideas for client-centred care that address the difficulties that are briefly outlined in this section.

a. Fear and distrust

> *…[sitting in the clinic waiting room, I felt] nervous, apprehensive, not exactly knowing what was going to happen…Just as far as clothing was concerned or...touch, just not knowing…*

Many survivors experience tremendous anxiety and fear of being hurt during treatment. The survivor may distrust the health care professional and therefore be hesitant to adhere to treatment.

b. Physical pain

For many, the experience of physical pain is cognitively associated with past abuse. This may be seen in various ways: some survivors have learned to numb their pain or dissociate from it; others may feel the full force of both current pain and the pain of the abuse.

> *I think sometimes when survivors are in pain, and coming for physiotherapy, it hooks us back into…our childhood where we were in pain and…no one responded. And if you did indicate you were in pain...the pain was trivialized or you were threatened [not to tell] anyone.*

c. The need to feel "in control"

The need to feel "in control" often arises from past violations in which the child had no control over what was done to her. As a result, a perceived lack of control will diminish the survivor's feeling of safety during treatment and may affect treatment adherence.

> *I'm learning that if I don't have a sense of control…I will walk away from [the situation].*

d. Discomfort with men

Perpetrators of childhood sexual abuse may be men or women; however, statistics suggest that the majority of perpetrators are men.[1] As a consequence, the female survivor may feel unsafe and uncomfortable in the presence of the male health professional.

[A male physical therapist and assistant were] in the room with me, and I had my pants off, and this guy's putting [ultrasound] gel on my leg. And I felt really uncomfortable…Even though... probably nothing could have happened, but I just didn't like the fact that I was in a room by myself with my pants off, with two men. That was really eerie.

Some survivors may also feel uncomfortable around male clients.

In one instance, I was beside a couple of men [who were also patients], and…I was lying down with my ankles on a cushion and I felt very vulnerable and I remember not being able to concentrate on what I wanted to do because I was worried about the two men beside me. And in fact, it probably was very detrimental to the physiotherapy I was trying to do. The men were harmless, but there's a certain vulnerability of lying down and not being able to flee…

e. Ambivalence about the body

Many survivors feel hate or shame about their bodies, and/or feel disconnected from their bodies. The conflict between a survivor's need to seek treatment for a physical problem and her difficulty in caring for her body may affect treatment. She may, for example, ignore symptoms that could offer valuable insight into diagnosis or response to treatment.

And [the amount of attention that I give to my body] ebbs and flows too, depending on where I'm at and how well I'm choosing to take care of my body. Which is a very difficult thing for me physically to do, because when you don't live there, it's just sort of a vehicle to get around.

f. Conditioning to be passive

Abuse often teaches children to avoid speaking up or questioning authority figures. As adults, survivors may have difficulty expressing their needs to the health care practitioner who is now the authority figure.

[The therapist did something and] I really freaked but…I didn't show her I was freaking, because our history is that you don't let on if things are a problem for you. You just deal with it however you can…by dissociating or what have you.

g. Triggers

A flashback is an experience of reliving something experienced in the past. Some survivors have a susceptibility to flashbacks and being overwhelmed by feelings related to the past. Examination and/or treatment may "trigger" or precipitate flashbacks or overwhelming emotions such as fear, anxiety, terror, grief or anger. This may occur momentarily or for a longer period. Such experiences are thought to involve a dissociative process.

And the goop that they put on me for the ultrasound gave me flashbacks, nightmares, insomnia, I just couldn't deal with it.

h. Dissociation

Dissociation has been described as "a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment."[30, p. 477] It may be sudden or gradual, transient or chronic. Dissociation "should not be considered inherently pathological and often does not lead to significant distress, impairment or help-seeking

behavior."[30, p. 477] One common experience of dissociation is highway hypnosis where an individual who has been driving a car suddenly realizes that he or she does not remember what happened during all or part of the trip.[31]

Dissociation can be viewed as a skill which the survivor used to alter her attention for adaptive purposes – as a child, she used this skill to cope with the abuse. When the survivor continues to use this coping strategy in adulthood, it can interfere with adaptive functioning.[28] Many survivors report that they are not able to have consistent control over this ability to "escape" from the current (usually stressful) situation and some report having been unaware of their tendency to dissociate for many years.

Some survivors describe experiencing themselves as being outside their bodies, watching the present situation from a distance, an experience which is thought to be the result of a dissociative process. Some find it painful and difficult to come back to the present.

> *[In a physical therapy session] I would just get that same dread feeling inside, and I would do the same coping that I would have done when I was abused...Just trying to not feel my arms and not really be there.*

Researchers continue to study dissociation, a phenomenon which has been said to be "devilishly complicated."[28, p. 287] Considerable empirical research supports the hypothesis that dissociation is a common response to a traumatic situation and a response which is not exclusive to survivors of childhood abuse.[32] For a further explanation of dissociation, see Appendix B.

i. Self-harm

Self-harm (such as scratching, cutting or burning the skin) is a method of coping for some survivors. Health professionals may see evidence of self-harm in the form of injuries or scars on the arms, legs or abdomen.

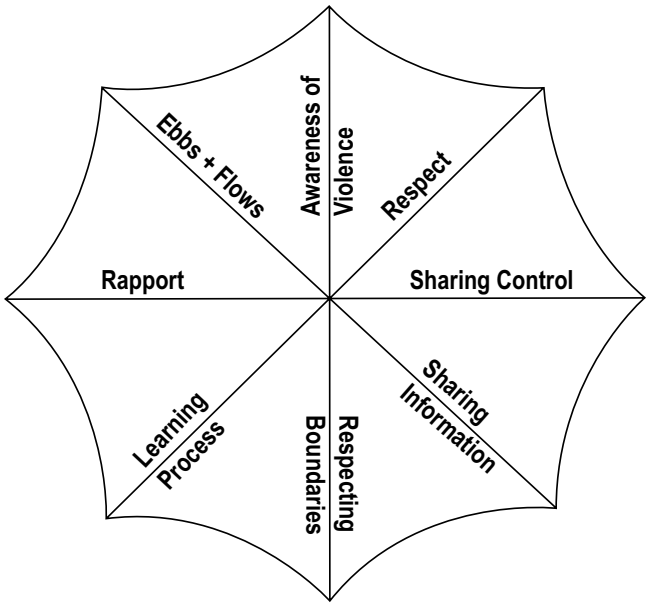
There are many reasons why survivors harm themselves. It may serve to distract or numb the survivor from her emotional pain; it may shift her feeling of pain to one concrete area; it may serve to end episodes of feeling numb. Others may seek to punish themselves because of a sense of self-blame for past abuse.

III. Principles of Sensitive Practice

The fundamental importance of helping the client to feel safe

> *…I now am beginning to understand that my physical wellness is really very connected to my emotional state, and if I'm not comfortable, if I'm feeling unsafe, then I'm not going to progress as quickly as a physiotherapist would want me to.*

One of the primary goals of treatment must be the development of feelings of safety for the client. Safety can be seen as a protective umbrella: when it is open, the survivor can participate in the treatment at hand. The spokes that keep the umbrella of safety open are the principles of sensitive practice.



1. Respect

Respect can be defined as realizing the individuality of the other person.[33] The survivor may be very sensitive to any hint of disrespect as a result of past abuse during which she was not respected in a fundamental way.

> *I find [physical therapists and other health professionals]… don't even consider the fact that maybe you might feel uncomfortable…A lot of them…say, "Oh, we just see you as a patient…we don't see you as a person"…part of me says, "No I don't think so! You're human, and I'm human, and [therapy] is a personal thing.…You're looking at* ***my*** *body, you're touching* ***my*** *body and you're asking me about* ***my*** *life."* ***That's personal****.*

2. Rapport

While establishment of rapport is important in every therapeutic relationship, it is an all-important component of facilitating feelings of safety for the survivor. Development of rapport must begin at the first moment of clinician-client interaction and must be given ongoing attention.

The balance of professionalism and friendliness that contributes to positive rapport is partly a function of individual style. But the clinician who is distant and cold in his or her professionalism is not likely to facilitate a positive connection with the client. Conversely, an overly familiar style can feel invasive and disrespectful. Developing a balance is

crucial, keeping in mind that effective professionals convey genuine caring while maintaining appropriate boundaries.

> *… I was just another name on a [referral]… She had no warmth…I didn't experience being safe with her because I didn't think that this was somebody I could talk to at all, about anything! She just was NOT interested…*

3. Sharing control

As a child, the survivor was not allowed control over her own body. Consequently, in adulthood, the sense of having control is of paramount importance in the establishment and maintenance of safety. By sharing control, the client can become a respected, active participant rather than a bystander during treatment. The clinician can act as a coach or facilitator, working **with**, rather than **on** the client.

> *…[the physical therapist] brings definite knowledge and expertise [into treatment]…So together with what I know and what I can tell her, I would hope that she would be able to…assess the situation and offer alternatives... So instead of her being the expert and me being the patient, us being co-communicators about my body. That's what I'd like to see…*

4. Sharing information

Sharing information with the client about the initial examination and about every component of treatment also helps the client to develop a sense of safety. Information sharing must be extended to the ways in which the client can best retain information about her body and her treatment when she leaves her appointment.

Information must flow both from clinician to client and from client to clinician. The onus for this two-way flow of information rests with the clinician: she or he should explain the examination and treatment and seek ongoing feedback about reactions to treatment as well as about the client's perceived progress.

5. Respecting boundaries

Respect of boundaries is a crucial safety issue.

> *As a survivor, I need to know that that person is not going to invade my space. Or do harm to me. Not necessarily physically, but emotionally.*

The word "boundaries" refers to the outer limit of the space we consider personal, in both physical and psychological terms. Boundaries define or delineate the areas of the body and the limits of information that we feel are appropriately under our control. Touching a person without consent breaches a physical boundary; asking very personal questions breaches a psychological or privacy boundary. When a breach occurs, the individual feels violated.

The concepts of power and responsibility in the therapeutic relationship factor prominently in any discussion of boundaries. "…[Boundaries] recognize the inherent power inequity of the [therapeutic] relationship and set limits

for the therapist's expression of power."[34, p. 50] In the position of power, health professionals are responsible for ensuring that, first and foremost, the therapeutic relationship serves the **client's** needs. In failing to set or respect boundaries, the clinician allows his or her needs to come before the needs and best interests of the client. For example, a boundary is violated if a practitioner, rushed for time, decides that she or he does not have time to ask for consent before beginning a procedure. In doing so, the clinician is addressing his or her need rather than the client's needs.

Boundaries can be confusing at times for both the client and clinician. Boundary violations are often inadvertent. It is up to the clinician to remain focused on maintaining appropriate boundaries for both the client and herself or himself. While less common, the clinician may also experience boundary violations. The survivor may sexualize authority figures because as a child she learned to relate to the abuser primarily in a sexual way. It is the clinician's responsibility to be alert to boundary violations and potential violations and to address both, should they arise. The onus is always on the clinician to clarify the situation and guard against violation of boundaries.

Some survivors who, by definition, experienced boundary violations as children, may have only just begun to appreciate the importance of boundaries. By demonstrating respect for and sensitivity to boundaries, the clinician may serve as a model for the survivor who is learning to establish healthy boundaries in her life.

6. Fostering a mutual learning process

The principles outlined above underpin ways of interacting that the survivor may not have experienced as a child and is only now learning as an adult. She may need encouragement in her journey to become a full, active participant in her health care. Concurrently, the clinician must discuss shared responsibility for the survivor's health with the client in a way that invites participation without creating unrealistic expectations of treatment outcomes.

> *…That assertiveness of [saying] "no" takes a long time to get...it was somebody else giving me permission that allowed me to say "no" until I could learn to give myself permission [to do so]…*

At the same time, the clinician is learning about working with survivors. The survivors who participated in this research reminded us that mistakes and uncomfortable situations are inevitable, but that two remedies are invaluable. First, the clinician needs to recognize his or her mistake and offer an apology. Second, the clinician should discuss the situation with the client to resolve the problem that has arisen.

7. Consideration of ebbs and flows

> *Parts of my body at different times might be untouchable. It's gonna change, depending on what I'm dealing with. So, you're not going to be able to make a list and count on that every time kinda thing: it's gonna be a check-in every session.*

Neither coping with the effects nor healing from childhood sexual abuse are linear processes. As a result, the survivor may vary in the degree to which she is able to tolerate and participate in treatment at various times. Such variations in the survivor's tolerance may occur rapidly (day-to-day) or may develop over longer periods of time. To address the possibility for such change, the clinician must repeatedly "check-in" with the client and be willing to adjust the treatment approach accordingly.

8. Demonstrating an awareness of the prevalence and sequelae of violence and childhood sexual abuse

Many survivors look for indicators of a clinician's awareness of issues of violence and abuse. Demonstrating this awareness can take a variety of forms. External indicators such as displaying posters and pamphlets from the local sexual assault centre offers a cue that health professionals have such an awareness of the prevalence of violence and abuse. Incorporating the Principles and Guidelines of Sensitive Practice into daily practice is a strong indicator of awareness of issues of violence and abuse.

> *…I'm way more interested in...how much awareness [the therapist has] around trauma. So, that holds a lot of weight with me.*

IV. Guidelines for Sensitive Practice

A. Introduction

All survivors are not the same. Some survivors experience few negative effects of past abuse. Some have learned to manage the long-term effects in ways that do not interfere with their daily functioning. Other survivors experience these effects in all aspects of their lives.

Concurrently, survivors are also at different points on the continuum of healing from past abuse. Some do not remember the abuse; others are aware of the abuse but have avoided thinking about it or seeing it as significant; still others have just begun or are well along in their journeys of healing from childhood sexual abuse.

Not all survivors will share the same perspective on the relationship between their physical and psychological health and past abuse. Some survivors feel that their physical health and reactions to treatment are intimately connected with their psychological state. Others have not made such connections. All of the women who participated in this research had begun their journeys of healing. They spoke about the strong links between their physical health and past abuse. Many described their interactions with health professionals at various times in their lives: before they had begun to remember past abuse, before they had begun to see connections between their health and past abuse, and during or after the development of this awareness.

Thus, the clinician may be working with survivors whose responses to their past abuse vary greatly.

> *[Survivors] may not link their health with the abuse or they're not at that sort of point in their life. I went a lot of years not knowing how the abuse affected my body, my life, my emotions, everything, and now looking back I think maybe if doctors or somebody would have known that, it would have made a difference.*

The Guidelines in all sections other than *Dealing with the client who is upset* and *Disclosure of childhood sexual abuse* **represent a respectful way to work with survivors and non-survivors alike**. The guidelines in these sections refer specifically to survivors of childhood sexual abuse.

Not every suggestion in the guidelines will apply to every health profession, to every clinical setting or to every survivor.

Readers are encouraged to develop ways to apply the guidelines in their own clinical practices.

Readers are also cautioned that the guidelines section of this handbook is not a "stand-alone" document but, rather, builds on the dynamics and long-term effects of childhood sexual abuse and on the Principles of sensitive practice.

B. Preparation for the initial appointment

1. The right to choose a clinician and a facility

The client has a right to make an informed choice about health professionals with whom she will work. She also has the right to request a referral to another clinician or facility if she is not comfortable with her current situation. **Such options may not be easy or even possible in every situation**; nonetheless, health professionals are encouraged to seek ways to support this principle.

As noted in the section on long-term effects of childhood sexual abuse, many survivors are uncomfortable working with men. It is important for male health professionals to recognize that the survivor's discomfort can stem from her past experiences. Frequently, the male clinician and client are able to build a good therapeutic relationship. But at times the survivor's discomfort is too great and cannot be overcome. How should the clinician proceed? We suggest that every clinician practise sensitively and be willing to refer to another practitioner if the client wishes.

2. Helping prepare the client for treatment

A written introduction to treatment may help the client to understand more about the therapeutic process to come. The **Suggestions for Clients at Out-Patient Physical Therapy Facilities** (Appendix C) is such an example. They provide a template which can be modified for use by health professionals in diverse clinical settings. In order to consider the literacy level of clients, these suggestions were drafted using a readability formula.[35]

This information can be sent to the client before her first appointment, given to her while she waits for her first appointment, and displayed in waiting rooms or treatment areas. The information can help to reduce anxiety at the outset and assist the clinician in beginning to address some of the survivor's needs from the first moment of interaction.

C. Initial evaluation

The following suggestions can be used during the initial clinical history taking and examination.

- Draft the initial written Informed Consent in "client-friendly" terms. Avoid technical terms and use language that assures the survivor that she/he is viewed as a whole individual (see Appendix D, Sample Consent Form).
- Make sure clients know they can have someone with them at all times during treatment.
  - Post this option on signs in the waiting room and on appointment cards.
  - Reinforce this option verbally.
- Provide the client with the option of a private room for the initial examination if possible.
- Let the client know what the subjective and objective evaluations involve **before** you proceed.
- Seek verbal consent for each segment of the evaluation.

- Complete the initial medical history **before** you ask the client to remove any clothing required for the physical examination.
- Allow enough time for answers during clinical history taking. Many survivors have learned to ignore their bodies and may require extra time to articulate a description of their symptoms.
- Seek a balance between offering descriptors of symptoms ("Would you describe the pain as sharp or dull, throbbing or aching?"), and encouraging the survivor to identify and therefore "own" her symptoms.
- If the client appears uncomfortable or is having difficulty responding to one aspect of the subjective assessment, it may be helpful to move on to another part of the assessment and return to your previous questions later.
- Ensure privacy for undressing and changing and confirm that the client is ready – knock, ask if the client is ready, and **wait for permission** – before entering.
- Before shifting the physical examination from one area of the body to another, let the client know that you would like to examine a different area of her/his body and explain why.
- Ensure that the client clearly understands that she/he can ask you to pause, slow down or stop during the physical exam.
- Ask the client if she/he is comfortable or ready to continue:
  - intermittently during the exam;
  - when shifting the exam from one part of the body to another; and
  - if her/his body language indicates discomfort.
- Emphasize that you are willing to be flexible during the evaluation and subsequent treatment to lessen her discomfort or anxiety.
- Offer explanations about the body and its many connections, especially when examining areas other than the site of symptoms. Reassure the client that locations of pain and other symptoms distant from the site of her concern are quite common.
- Ask the client about her best time of day for appointments before booking additional appointments. A survivor who has trouble sleeping may wish to choose a time of day that will maximize her ability to participate in treatment.
- See the client, at least briefly, in a fully dressed state **after** each session. This reinforces that the clinician sees the client as a whole person.
- Explain the clinician's and client's roles in treatment after examination but **before** treatment begins.

These suggestions may mean that an initial evaluation will take longer than anticipated. Taking this extra time may help establish rapport, trust and safety more quickly and thereby save time in the long run.

D. Other treatment considerations

The following discussion expands upon some of the suggestions for initial evaluation and presents additional ideas and suggestions for clinical practice.

1. Consent

Consent is a crucial issue for safety. Clinicians are advised to review the guidelines for consent established by their professional licensing bodies.

> *And [the physical therapist] would… tell me, "This is what I'm going to do," and she would … show on herself a little bit, and then she'd ask, "[Are you] comfortable with this?" And I'd say yes. And so she'd normally put an ice pack or a heat pack on me and then come back in 15 minutes. When she came back, right before she was going to [proceed with further treatment], she'd ask me again, "Are you comfortable with this? Is everything alright? And do you understand what I'm doing?" And that was so much easier, because one minute you can feel comfortable, and the next minute, you could feel uncomfortable...so she gave me an opportunity that, if I were to change my mind and feel uncomfortable, all of a sudden, for whatever reason, she would know, and I'd be able to say something. So I felt like I was in control, and I did have the say of what was going on.*

Consent must be an ongoing, interactive process. Do not assume that consent given today applies to all successive days: ask for consent in each successive day of treatment.

- Always ask and receive verbal permission before proceeding with each component of an examination or treatment each time you see the client.
- Seek the client's consent to allow students to observe or participate in treatment. This should be done as far ahead of time as possible and without the student present. Explain the role(s) of the student and whether the student will be present to observe, treat or both. Remind the client that she may withdraw her consent to the student's presence at any time.
- When using an electrophysical agent (such as ultrasound and TENS), describe the physiological effects and what it will feel like. Mention any gels, electrodes, etc., that will be used. Ensure that you have obtained verbal consent for use of the modality after giving the explanation.

2. Language and communication

Language can be used to amplify or minimize the power imbalance in the therapeutic relationship.

- Avoid overuse of medical terminology: seek with the client a common language that facilitates both a sense of safety for her and a sense of professionalism for you.
- Seek a balance in the amount of information offered at one time – offering too much information to the client may be just as counterproductive as not offering enough.
- Monitor the client's body language during treatment and address with her any apparent discrepancies between verbal and non-verbal responses.

> *…we send out signals…to people that we have been abused…I was sending signals out, and I don't think the people were listening really and picking up on them…[I would]cringe and move and I often said "what are you doing?"*

- Monitor your own body language. Does your body language convey the same message that your words deliver? Clients are very perceptive of your non-verbal cues.

- Show your client that you are listening to her. Active listening is one effective technique to clarify what the client is trying to say. Through the use of re-statement, reflection and clarification, you are "paraphrasing the speaker's words rather than reacting to them in order to clarify if you have caught the intended meaning."[36, p. 106]

- Consider offering a brief written summary of the treatment session. While this can be time consuming, the survivor may feel more involved in treatment as a result. Use of photo-copiers or carbon paper can reduce the time required.

3. Clothing

Having to undress to undergo treatment may leave the client feeling vulnerable. Explain the rationale for your preference in clothing and ask the client about her preference. Agreement on alternative clothing or providing gowns that do not gape open may increase the survivor's feeling of safety and comfort during treatment. Provide a variety of sizes of gowns and shorts for all body sizes and ask if your client is comfortable with the options.

Remember, too, that what you wear may also have effects – although a white lab coat generates a sense of professionalism, it may increase the perception of the power imbalance and intimidate some clients.

4. Touch

Touch may be associated with painful memories for survivors. As a result, many survivors may have difficulty tolerating touch by health professionals. For some survivors, this may change as trust develops; for others the discomfort does not decrease.

> *…[having to go to a physical therapist] kinda bothered me, because I don't like to go to a place where people are going to be touching me...Whether it's my head or my toe, I don't like that…[If I tell them about my discomfort] I don't want them looking at me like, "What are you, bonkers? I'm just touching your head or your foot! Like, no big deal!"….[At] the thought of going to see somebody that's going to be touching me, then I start thinking about my past. And then I really start stressing out.*

Your approach to touch must emphasize the principles of sharing control and sharing information.

- Describe the touch that is required during treatment.

- It is critical that you ask for consent to touch throughout a treatment session.
  - Some clients may want a step-by-step description.
  - Other clients may be comfortable giving consent after a description of the whole procedure.

> *But when somebody tells me what they're doing, and why they're doing it, as they're doing it, then I feel more comfortable. I'm still feeling a bit uncomfortable because someone's touching me.*

- Check with the client if her body language suggests a negative response to touch.
- Always be aware of the physical distance between the client and yourself during treatment. Avoid being in very close proximity except when treatment requires it.
- Avoid unnecessary physical contact. If treatment involves bracing part of the client's body against your own body, explain this, and seek consent before proceeding.

5. Privacy

Addressing privacy needs of the client is another important step in building and maintaining feelings of safety. The balance between safety and privacy is not the same for all survivors. Some clients will be more comfortable in a private room where no one can overhear them. Some may prefer a private room as long as they can have someone of their choice present during examination or treatment. Others will forego privacy because they feel safer in a larger, common space.

Not all clinical facilities can accommodate the client's need for a private room, and this issue should be addressed with her at the outset of treatment. If an agreeable solution cannot be found, the survivor's needs may be better served by referral to another clinician or facility.

> *…I felt...uncomfortable [in a curtained cubicle] 'cause I thought anybody could just open up those curtains at any time…I found when people would walk by…[and bump…the cubicle, the curtains would… move, and I didn't feel as safe or as if this was my space. I felt like at any time it could be invaded…I was really vulnerable…You hear everything around…It doesn't feel very personal, it doesn't feel private, it doesn't feel safe.*

- Post a notice in the reception area offering a private room to clients if they prefer one.
- Ask the client about her need for privacy. Discuss alternatives to meet her need for privacy.
- Ask the client to let you know if her need for privacy changes **and** check her need for privacy as treatment progresses.

Although options for privacy are more limited in acute care settings, clinicians are urged to address this issue with the client.

> *…for [personal parts of treatment]…I was in a real room with walls and stuff. And that…made me feel more comfortable…It felt like [the therapist] was acknowledging, "[This] shouldn't be shared with everybody…You should have privacy"…That was really nice.*

6. Other environmental considerations

Control over the environment is important for many survivors.

- Take the time to familiarize the client with the treatment area.
- Many survivors are most comfortable when they can see or be near the door.
- Knock or announce yourself – and await permission – before entering a client's space.
- Offer secure storage of clothing if disrobing is required and treatment is carried out at a distance from where the client has undressed.
- Some clients may feel more comfortable if they bring along a small familiar object that symbolizes safety and security. Avoid being judgemental about such a coping technique.
- Identify separate men's and women's washrooms, wherever possible.

Some survivors are strongly affected by lighting, floors and ceilings.

- Ask the client about her comfort level:
  - with the lighting available in your facility.
  - when she must assume a position facing the floor or ceiling.
- If problematic, explore alternatives with her.

If your facility does not offer the environment your client needs to feel safe, explain and give her the option of a referral to a clinician in another facility.

7. Issues related to pain

Pain is a complex issue that is often difficult for both the survivor and health professionals to sort out. Acute and/or chronic pain may be complicated by past abuse. While "psychological distress can find somatic expression,"[37, p. 143] researchers are also learning more about the long-term impact of trauma on the physiological responses to stress that can also contribute to the survivor's pain.

Remember that:

- Some survivors may respond to pain by ignoring it, not taking it seriously or dissociating when they experience pain.
- Some survivors may not feel pain.
- The survivor may experience pain associated with body (somatic) memories as part of, or in addition to, other problems for which she seeks your clinical expertise.
- The survivor may have had negative experiences with health professionals who discredited her pain because it did not seem to match test results or examination findings. Regardless of whether pain matches examination findings, the client's experience of pain is real.

It is the clinician's responsibility to address the client's pain, other symptoms and problems, in a systematic, non-judgemental and thorough manner. The clinician needs to set realistic goals with the client and work systematically toward these goals.

Despite thorough exploration of all the treatment options within a clinician's scope of practice, there will be clients whose pain the clinician is unable to resolve. If pain is not resolved satisfactorily, it is the clinician's responsibility to explain that treatment options have been exhausted and to discuss other options outside the clinician's scope of practice.

- Document what you and the client said during such a discussion. This record may be helpful if you see the client again at a later time.
- Leave options for further consultation open.
- Consider joining or creating a health care team that will work with the client to address the problem.

Consider referrals to clinicians or clinics that specialize in the management of chronic pain and to other professionals who may specialize in positioning, energy conservation, fitness, massage, etc. Under some circumstances, the clinician may suspect that the client's problem is related in part to psychosocial issues that are outside that clinician's scope of practice. The clinician can discuss this with the client and refer her for counselling.

Rehabilitation often follows a functional model rather than a symptomatic model of treatment. In rehab, the client is asked to disregard "reasonable symptoms in the absence of objective signs of harm" in order to develop the functional tolerances required to return to pre-injury employment and/or lifestyle. Survivors participating in rehabilitation may require additional education regarding the phases of tissue healing and assistance in interpreting the symptoms associated with "hurt" vs. "harm."

8. Time factors

There are many time pressures on health professionals in today's health care system. While it is challenging for the clinician to find the balance between time constraints and good care, it is important to recognize the potentially grave consequences for the survivor when the clinician is rushed. Treatment may feel very depersonalized, robbing the survivor of her sense of safety. Without this sense of safety, treatment is much less likely to be successful.

> *…[having enough time for the client]… doesn't happen very often with medical people. They gotta get on to the next appointment all the time. You're scheduled for your half-hour and that's it. And so maybe it means that the very first appointment [should be]…a longer appointment, so that someone can relate a bit before this person's touching your body…*

- Discuss time pressures with the client in order to plan how best to meet her needs.
- Because of ambivalence about her body, it may take longer for the survivor to develop the confidence to carry out an ongoing independent program of self-management. A number of follow-up appointments (scheduled, for example, at monthly intervals) may be helpful.

9. Control and adherence to treatment

> *There [were] some of the exercises…that they wanted me to do [after a total hip replacement]…And one of them that I still today cannot do…You lie on your side... it's a scissor…[Even when the physical therapist] had the sling…around my ankle and it had a handle and I could pull it and my leg would go up, I couldn't even do that. I'd get it so far, but I wouldn't go any further because I had to keep [my legs] so tight…[and the physical therapist] got frustrated, she really did.…she thought I wasn't trying, and that wasn't true at all because I was doing the other [exercises] very well…*

Difficulties with treatment adherence may be linked with past abuse. Some survivors may be out of touch with their bodies and have difficulty identifying signs of over-exertion or other body signals. Others may perform too many exercises, perhaps in an attempt to gain control over their bodies, to please the clinician or as a form of self-harm. Some may have difficulties with certain actions or body positions because of associations with past abuse. The following suggestions may help the client achieve a desired level of adherence.

- Include a daily check-in before each treatment.
- Respond to the feedback before you proceed with treatment: come up with alternatives together to avoid parts of treatment that she finds difficult to tolerate.
- Explain the rationale for treatment.
- Discuss adherence difficulties with the client. Do not use blame and guilt as tools to achieve adherence. Avoid using words such as **must** and **should**. Rephrase objectives using comments such as "do the best you can do."
- Problems with adherence are often very pressing in acute care settings. After surgery, for example, early mobilization can be critical to recovery, but pain may overshadow such goals. The clinician may be tempted to achieve adherence by using the language of "must" and "should." However, encouraging the client to refocus on her initial goals of treatment may be more effective in facilitating adherence.
- In out-patient or home care settings, the clinician may encourage adherence by working with the client to structure the treatment differently so that it fits the client's life and lifestyle better.

When incorporating exercise and activity into treatment:

- Offer clear and direct guidelines for exercise programs.
- Offer written and oral instructions that include what each exercise should feel like.
- Give upper and lower limits for the number of repetitions and sets to be done.
- Develop and progress through an exercise program slowly to allow the client to build the neuromuscular skill required.

- Describe signs and symptoms of overuse to the client and monitor the exercise prescription for signs of overuse.
- Encourage the client to keep an exercise or treatment log.
- Encourage the client to view the home treatment program as a tool she can use to care for herself.

10. Encouraging reconnection with the body

> *[One part of treatment is] how healthy it has been for me to start to get in touch with my body...I think that a physiotherapist can really affect that [by giving] that supportive invitation to…come back into their own body…I think it would make a big difference…*

Herman[4] suggests that part of a survivor's healing is reconnecting with her body. Health professionals may have a role in this process.

- Some survivors have difficulty recognizing or interpreting physical sensations and reactions to treatment. She may need to learn to recognize and interpret sensations such as muscle fatigue, stretching within reasonable limits, tension, relaxation, the reaction of a joint to over-exertion, etc.
- Incorporate visualization of the exercise and sensations expected during exercise. This may help the survivor develop the kinesthetic sense needed before she begins to actually perform the exercise.
- Use breathing exercises, yoga and relaxation techniques.
- If you know that you are working with a survivor who is seeing a counsellor, you may want to offer to work jointly with the client and her counsellor.

11. Encouraging and modelling self-care

Taking care of one's self – eating well, getting enough rest, performing regular physical activity, taking time to relax, etc. – can be challenging for many of us. Health professionals can model self-care and encourage the survivor to develop strategies for her own self-care. If the client has difficulty maintaining self-care behaviours, she may appreciate knowing that she is not alone!

12. Problem solving

When a client has difficulty with a treatment you suggest, explore different strategies to attain the therapeutic goals. Be respectful and non-judgemental when discussing alternatives to address the problem for which she sought your expertise.

If you feel that your authority has been challenged, engage in a dialogue instead of becoming defensive. Offer treatment options. These may include treatments that you recommend, and treatments for which you feel the goals will take longer to achieve or which are not as effective but might be more acceptable to the client.

13. Continuity of care

Switching clinicians without prior discussions with the client can result in a feeling of a violation of established trust and/or of the treatment contract.

- If you know that you are going to be away from work, give the client as much notice of your anticipated absence as possible.
- Discuss alternatives with the client; recommend a colleague who is informed about, and sensitive to, survivor issues.
- Introducing the client to the clinician who is covering your caseload would also be helpful.
- If you practise alone, discuss the practical aspects of your absence with the client.
- Whenever possible, for unexpected absences, the survivor should be notified and given a choice of whether to attend an appointment with an alternate clinician.

E. Dealing with the client who is upset

[On] the second visit, again, I had to lie on the table …[the therapist] didn't warn me and all of a sudden…I heard the whirring and he raised the table and [I found myself] coming toward the ceiling. I just felt attacked. But I kept it inside and didn't tell him what was happening. But I didn't go back. That was just too much.

Treatment may "trigger" the client to relive past abuse (flashback) or to experience an overwhelming emotional response. Such reactions may occur regardless of whether or not the survivor has disclosed past abuse to you or even remembers past abuse.

Thus, this section applies both to those survivors who have disclosed past abuse and to those who have not disclosed but appear very uncomfortable or upset during treatment.

1. Identifying triggers

There is no **complete**, predictable list of triggers for all survivors. Touch is frequently described as a trigger. Traction and electrophysical agents such as TENS, ultrasound and interferential current may also act as triggers.

Some survivors may be able to identify their triggers while others may be unaware of their triggers.

[During] my first experience [in physical therapy], they didn't have any Kleenex, and the minute [the therapist started] touching me I just started sobbing, without having any idea of… why…

2. Recognizing body language that may indicate discomfort, triggering, dissociation

Some survivors describe body language that communicates a high level of discomfort:

- stiffening
- cringing

- pulling away
- shaking
- startling
- muscle tension and inability to relax
- sudden strong emotional reactions (such as tears).

Survivors have described many different physical reactions to being triggered. Some of these may be understood as physiological reactions to stress:

- shallow, rapid breathing, breath holding or a change in breathing pattern
- rapid heart rate
- decreased concentration level.

A client who has been triggered may dissociate. If your client is in a dissociative state, she may seem:

- distant
- unable to focus
- uninvolved in the present.

Once present after she has dissociated, the client may ask questions, such as: "Where was I? What did I just say? What just happened?"

3. Managing triggers and dissociation

…now, [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…[by saying, for example] "Do you see your counsellor tomorrow?" or "Is there someone you can talk to?" They would definitely have their scope and they wouldn't need to go beyond that. But if they can recognize what can happen when a woman is going through a flashback…How to ground a person. It's not hard...You know, just basic humanity and reassurance. You know, "you're okay, it's safe here." Or [validating] the energy and the courage that it takes to go through physio…And "yes, [physical therapy] can trigger memories, and it can be really disturbing and distressful, and what you're feeling is normal."

The goals of this section are 1) to provide information that will help the clinician be a supportive ally and 2) provide the clinician with ways to ensure that the client does not leave the session feeling disoriented or embarrassed about her reactions to treatment. The information in this section is not intended as instruction in counselling techniques.

Regardless of whether you know that your client is a survivor or not, if she demonstrates body language that indicates great discomfort, stop immediately and inquire.

- If a client has been triggered, stop treatment immediately and try to help ground her in the present.
  - Let her know where she is.

  - Reassure her that she is in a safe place now.
  - Encourage her to take slow, deep breaths.
  - Encourage her to sit up and put her feet on the floor.
  - Ask her to look at you and keep you in focus.
  - Ask how she is feeling.
- Avoid touch.
- Continue to talk to her and reassure her, using a calm voice, but do not bombard her with questions.
- If the client has disclosed past abuse, let her know that treatment can sometimes trigger flashbacks or emotional responses and that this is not uncommon.
- If your client has experienced a strong emotional reaction, reassure her that it is okay to be angry, sad or afraid (or whatever she is feeling).
- If the client has dissociated:
  - Ask her to keep her eyes open and to look at you and around the room.
  - Pose questions calmly and slowly: For example: *Are you here? Are you with me? Are you following me? Do you have any techniques for staying present?*

Once your client appears less upset or more present, speak to her about what has just occurred:

- Give her the necessary time and space to recover from her experience. A quiet room may be helpful.
- Do not ask for details of her abuse that contributed to her being triggered.
- Acknowledge that people sometimes react to circumstances in the present that remind them of past experiences.
- Ask her what she needs right now: Does she want company, or to be left alone?
- Ask her whether she feels able to continue the treatment session.

Being triggered can be a frightening or bewildering experience. Your client may benefit from talking to someone within her circle of support about the experience.

- Remind her that her reaction is not uncommon and that it is understandable and okay.
- Ask whether she has someone with whom she feels comfortable talking about the experience after her appointment with you. This may be a friend, family member or counsellor.
- If she would like to explore what has happened further but has no one to talk with, refer her to a counsellor or other resources in your community (such as the sexual assault centre).
- You may want to remind her that you can be a good listener, but that you are not trained to be a counsellor.

If time constraints mean that you are unable to help an upset client as fully as you would like, explain this and ask if someone else can help. (This might be another staff member or a friend whom you could call for her.)

4. After the experience

The client may feel very vulnerable after being triggered. It is important to discuss the experience with the client the next time you see her to ensure that she is alright and reassure her that you are not judging her actions or responses.

- Work with your client to identify what you can avoid or modify in the future to avoid triggers. Focus your inquiries on treatment rather than on the flashback or emotions during the experience.
- Ask the client if she has any techniques for staying present and work with her to outline a strategy for the future.

Remember that while there will be instances in which your client is able to identify the trigger, there may also be times when she is unable to identify the cause of her reaction.

If you find that you are upset because of what has happened, reassure the client that she has done nothing wrong. At a later time, you may benefit from discussing your reactions to the events with someone within your support system. This can be done without breaching confidentiality (see *Taking Care of Yourself*, page 37).

5. Working with survivors who have Dissociative Identity Disorder

We recommend working with a multidisciplinary health care team to assist the client who has disclosed Dissociative Identity Disorder. If the client agrees, consult those practitioners with whom she is already working, to determine how you can work collaboratively.

F. Disclosure of childhood sexual abuse

1. Introduction

This discussion is based primarily on the experiences of survivors working with physical therapists who often see clients for relatively short periods of time and for specific problems. The components of this discussion of disclosure also apply to a broad range of health professionals who may see clients over longer periods of time.

2. What is disclosure?

In its broad sense, disclosure refers to the survivor's telling the clinician that she was sexually abused as a child. The identification of sensitivities and discomfort specific to treatment represents a more limited form of disclosure that we call "task-centred disclosure."

3. Clinician-initiated inquiries

a. Task-centred inquiries

The clinician should begin to inquire about the client's task-centred sensitivities and discomforts during the initial examination. The information that the survivor reveals (such as problems tolerating touch, certain body positions, etc.) is highly relevant to treatment. This information should be applied during subsequent examinations and treatment to facilitate feelings of safety. Such task-centred disclosure focuses on the client's sharing of specific information that is immediately pertinent to the treatment without revealing other personal information she is not prepared to share at that time.

Inquiries can take the form of a combination of close-ended and open-ended questions. An example of a close-ended question before beginning an examination of the lower limbs is, "I would like to examine your legs now. Do you have any sensitivity to having your legs touched?" Including an open-ended question at the end of the initial appointment such as, "Is there anything else you feel I should know before we begin?", may allow the client to share anything she considers relevant to the therapeutic relationship but has not been specifically asked about.

Inquiries about sensitivities and discomforts can also be made using questionnaires. Some survivors may be more comfortable with this written approach. If a questionnaire is used, the client can be given a choice about completing the questionnaire independently or with the clinician.

While the clinician should initiate such inquiries during the initial examination, she or he must be aware that the survivor may choose to reveal sensitivities and discomforts only as treatment progresses. The survivor may choose to disclose only after getting to know the clinician and making her own assessment about whether the clinician is a trustworthy person. Therefore, **the clinician cannot assume that the client has made all task-centred disclosures early in treatment and must continue to inquire about difficulties and follow up on non-verbal indicators of discomfort throughout treatment.**

b. Inquiries about past abuse

In some types of clinical practice, health professionals believe that knowing that the client has a history of abuse will enable them to better facilitate the client's safety and comfort and maximize treatment effects. If asked about past abuse, the survivor may choose to disclose or may take time to decide whether the clinician is trustworthy and whether she feels safe enough to disclose.

4. Survivor-initiated disclosure of past abuse

Some survivors feel that disclosing past abuse to the clinician is important because of the impact of the abuse on their health or their reactions to treatment. They may look for ways or times to disclose to the clinician. One of the things that may hold the survivor back is uncertainty about the clinician's response to a disclosure of childhood sexual abuse.

> *I didn't know how they were going to react or if they would shy away from it, or if that's something they wanted to hear. So I would tell them all the other stresses... that's one thing I got really frustrated about because I wanted to say something, but I wasn't sure on how or if that's what they wanted to hear.*

Previous experiences with disclosure may also play a major role in the assessment of whether the situation feels safe enough to disclose.

> *I wasn't feeling safe enough or I wasn't sure, because I've had experiences before where I have mentioned it, and someone has just freaked out or else they've looked at me like I'm from a different planet, like what am I doing even sharing this with them? So I'm really hesitant on mentioning it to people, especially in the health professions. I don't want to start talking about it or mention it, and get that rejection. Cause that's the worst.*

Thus, the clinician's response to disclosure is very important to the survivor.

5. What should I say when someone discloses?

> *Well, for one thing, it's really important [that the clinician tell the survivor]… that you believe them, because this might be the first person they've told. And also, it's really important to accept them as a person. You can say whatever your real feelings are…"I'm really sad to hear that."*

It is important to offer appropriate verbal and non-verbal responses to disclosure. The basic elements of appropriate responses are as follows.

- **Acceptance of the information** (that is, letting the survivor know that you heard her words)
  - Offer an expression of understanding and support. For example:
    - "I'm sorry that happened to you."
    - "Tell me how I can help you during your time with me."
- **Acknowledgement of the prevalence of abuse** Acknowledging your awareness of the prevalence of abuse has the effect of reducing shame. You might say:
  - "We know that at least 1 in 3 to 5 women (or 1 in 7 to 10 men) are survivors of childhood sexual abuse. It is a terrible thing that so many children have suffered in this way."
- **Validation of your belief in the survivor's words and the consequences of the abuse for her**
  - Validate the courage that it took to disclose.
  - If your client is visibly distressed, acknowledge it. "I see that this is painful (distressing, disturbing) for you right now. What can I do to help?"
  - Let her know that you do not think she was responsible for the abuse.

Allow the survivor control over the timing and extent of her disclosure. If you are under time constraints, find a way to inform the client of this so that she will not feel dismissed or think she has done something wrong by disclosing.

Canadian law in most provinces requires that suspected abuse of children (under the age of 16) be reported to child welfare officials. There is no legal obligation for you to report disclosure of past abuse by an adult survivor to child welfare officials unless the client also reveals current abuse of a child.

6. What should I NOT say or do when someone discloses?

> *[Sometimes] someone [will start] to disclose [and professionals will say] "you don't have to tell me this if you don't want to."…People who are really nervous about hearing [a disclosure] keep saying that, and it gives the message "I don't want to hear this."*

If a client discloses:

- do not remain silent, as you may be perceived as ignoring the client's words; and
- avoid an overwhelming response, loaded with a list of directive statements ("shoulds").

> *I told the physical therapist 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, it doesn't have anything to do with us.*

In addition, ***DO NOT:***

- offer pity (e.g., "Oh, you poor thing")
- offer insincere concern
- tell the client to "Look on the bright side"
- dwell on the negative
- smile (While you may think your smile conveys compassion, a neutral or concerned expression is more appropriate.)
- touch the person without permission even if you intend it as a soothing gesture
- interrupt (Let the client finish speaking.)
- try to say something that will "fix it"
- say anything that invalidates her decision to disclose or her experiences of abuse (e.g. "Don't tell anyone about it." "But don't you think your parents did the best they could?")
- tell the person to forget about it (e.g. "Put it behind you." "Get over it!" or "Don't dwell on the past.")
- minimize the potential impact of past abuse (e.g. "I know a woman that this happened to and she became an Olympic gold medalist." "Let's just concentrate on your back pain." "What's that got to do with your sprained ankle?")
- ask intrusive questions that are not pertinent to treatment
- talk about yourself, your experiences, or someone else's experiences
- disclose your own history of abuse
- give the impression that you know everything there is to know on the subject.

> *…don't push the person and be really aware not to use the "shoulds", like "you should call the crisis line"…or "are you seeing a therapist?"*

7. After a client has disclosed

The survivor may feel more vulnerable and exposed after disclosure. Reassure her that:

- disclosing was not wrong,
- you respect her,

- you respect her decision to disclose as well as the information that she revealed, and
- you will respect her confidentiality.

The client may still feel more vulnerable the next time you see her. It may help to repeat these points again briefly at her next appointment.

It is also important to talk with the client about how she feels her past abuse may affect her response to treatment. Explore practical issues within treatment. For example, "Is there anything about treatment that we should change to make you more comfortable?" and "As we proceed with treatment, please tell me if I am doing anything that doesn't feel right to you." You may have to balance the importance of taking time to discuss disclosure with the client versus either beginning or continuing treatment. Discussing the implications of disclosure on treatment will take additional time but is likely to increase a survivor's feeling of safety in future treatment.

After disclosure, it is important to clarify what the survivor's expectations of the clinician are. Some survivors hope for, or expect, a response that is beyond the clinician's ability or scope of practice. It is therefore important to delineate clearly what your scope of practice is, and identify your clinical abilities and limitations. If you feel the survivor requires help beyond your scope of practice, suggest additional resources (see page 36). Focusing on what treatment involves and can achieve and on how to best work with the survivor's sensitivities provides both the clinician and client a solid basis from which to proceed with treatment after disclosure.

G. Health care records

1. Confidentiality of records

While health professionals consider client charts confidential, it is important to recognize the meaning and limitations of confidentiality in each clinical setting. A client should be made aware of the level of confidentiality that applies to her health care record. She should be told:

- who has access to her chart within the health care setting both in the present and future;
- that her record(s) can be released to other individuals only with her consent; and
- that her records will be released when required by law.

When charting, the clinician should be mindful of the limits of the confidentiality of the health care record.

2. Some issues in documentation

If the client has an unexpected reaction to treatment or to the clinician, the clinician is advised to chart the events in as much detail and as objectively as possible, as soon after the incident as possible. Include the words and actions of the client, the clinician and any other staff involved. The same advice is appropriate when the client expresses discomfort with anything professionals do or do not do.

Task-centred disclosures can be documented in a way that allows for the identification of specific sensitivities or discomforts without revealing the abuse history. Charting in this manner allows

for communication of relevant information to other clinicians without revealing more than the survivor is comfortable with. In determining what and how much information to include in a client's record, the clinician should be guided by his or her assessment of what notes are needed in order to provide the best service to the client.

Documentation of abuse may have legal implications for the client who is (or may in the future be) involved in a court case. This may occur, for example, if the client chooses to proceed with criminal charges or a civil action against an abuser or in relation to civil litigation after a motor vehicle accident. These are a few of many possible instances when health records may be subpoenaed. In some instances, the records will be sought to support the client's case; in other instances, the records will be sought to try to challenge the client's credibility or the client's account of events.

An in-depth discussion of the legal implications of health records is beyond the scope of this handbook. The clinician is advised to seek legal advice in any situation in which a client's health records are requested by a third party in the absence of the client's consent. A clinician should not release confidential records at the request of the police or a lawyer without the client's consent. If records are subpoenaed, the clinician should seek the advice of a lawyer. Subpoenaed records should not be released until a court orders their release, usually following a hearing on this issue.

Health professionals are advised to familiarize themselves with current policies on maintenance of health care records issued by their professional licensing bodies and by organizations with whom they are affiliated.

H. Discharge

Many survivors have experienced feelings of abandonment, rejection and subsequent shame in childhood that are carried forward into adulthood. Under some circumstances, being discharged from treatment may leave a survivor feeling as though the clinician is rejecting her or minimizing her problem. The clinician can do several things to help the client with closure.

- Discuss discharge during the first appointment, as part of the introduction to treatment. As treatment progresses, raise the issue of discharge again to ensure that the client's needs are addressed.
- Plan the timing and other details of discharge with the survivor as far in advance as possible.
- Review initial goals with the client and ask about other goals that the client now has as the end of treatment draws nearer.
- Consider a follow-up appointment, telephone call or email exchange 6 to 8 weeks after regular treatment has stopped.
- Leave the door open for the client to return in the future if her condition worsens.

I. Other suggestions to assist both client and clinician

1. Community resources and counselling

It is important to reinforce that **clinicians need not be all things to all people**. In treating the whole person, the clinician should offer to assist the client to locate and access additional community resources.

- Get to know your community resources. You can start by contacting:
  - your local Sexual Assault Centre
  - women's centres
  - family service agencies
  - community mental health centres.
- There may be other useful agencies in your community. Ask your sexual assault centre or women's centre about other agencies that work with survivors.
- When you call such agencies or organizations to inquire about survivor services, ask:
  - What types of services does the agency offer to survivors (e.g. crisis intervention, individual counselling, group therapy, support groups)?
  - What do the services cost? Are services free or on a fee-per-service basis? Does the agency have a sliding fee scale in place?
  - Does the agency usually have a waiting list? If so, how long is the usual delay?
- Prominently display posters and brochures on abuse, with help-line numbers, such as:
  - sexual assault centres often staff a 24-hours-a-day crisis line
  - battered women's shelters, and
  - mobile crisis units.
- Locate and display good reference materials.
  - The local sexual assault centre may have a good bibliography of resource materials that you can make available to clients.
  - The National Clearinghouse on Family Violence has many resources.

    Telephone: 1 800 267-1291
    (613) 957-2938
    Fax: (613) 941-8930

    http://www.hc-sc.gc.ca/nc-cn
- Ask the staff of your local sexual assault centre if they maintain a current list of counsellors, doctors and other health professionals who deal sensitively with adult survivors of childhood sexual abuse. If they do, you will be able to suggest that your client contact the centre for such recommendations.
- Be careful not to give too much information about resources at one time.
- Inquiring about whether your client is seeing a counsellor is sometimes difficult. Your client may interpret this as silencing or as a message that you think she is "not okay." It may be easier and less offensive to ask whether the client has a support system that she can draw upon. This may also allow you to raise the issue of counselling with greater ease.

I think [physical therapists] have to know who the good [counsellors] are that are gonna believe [survivors]. I think that…medical people have to be very, very responsible in who they refer people to…[someone] who understands the role that violence plays in the lives of women and children. I think that's critical…

- Under some circumstances, the clinician may believe that it would be helpful to the client to work on psychosocial issues at the same time that she pursues treatment focused on the body. This can be raised in such a way that the client begins to consider that the physical condition may be compounded or exacerbated by past experiences.

2. Taking care of yourself

The understanding and compassion we have for our clients must be extended to ourselves. One cannot always be prepared for what happens during clinical practice! Every clinician needs to develop strategies to address difficult events that occur with clients. It is also crucial to remember that our comfort level for managing difficult situations is never constant, even for the experienced clinician.

You may benefit from the support of a colleague or counsellor to process your reactions to a disclosure or a client's emotional reaction in treatment. **This can and must be done without breaching confidentiality.** You can discuss your reactions to the event without disclosing details about the survivor. Ignoring your discomfort is not recommended. You may end up wanting to avoid the client, and this may leave her feeling that she has done something wrong.

You are not expected to be the survivor's primary source of support. Many sexual assault centres can offer in-person training or support if you need assistance in clarifying your roles and responsibilities.

3. Consultation with other health professionals

Your client may be willing to have you speak with a physician or counsellor with whom she is working. Such consultation can help you feel more comfortable in your work with the client and may be more effective than treating the client in isolation.

I think that we're talking about really long-term partnerships with a number of medical people...maybe a physiotherapist, a psychotherapist, a family doctor. We need these nuclei of support, and they need to be in touch with each other, and I have that, so I feel like I have a network of support.

J. The clinician's contribution to the survivor's healing

The violations of childhood sexual abuse can result in disempowerment for the survivor and disconnection from others.[4] Recovery, concludes Judith Herman (a psychiatrist and researcher), is based upon the survivor's empowerment and reconnection with herself and others.[4] **While you are not a psychotherapist**, you can make a significant contribution to a survivor's healing as an ally to her.

Health professionals can:

- help to establish a connection between the survivor and themselves through the creation of a safe, trusting therapeutic relationship;
- facilitate a reconnection between the survivor and her body; and
- facilitate her empowerment by encouraging the survivor to become an active participant in her health care.

So, what we have is a relationship of… mutual give and take… [the clinician] gives me a lot of responsibility, I give her a lot of information, we negotiate how best to work [together] to help me to fulfil my needs and to let me have power over my own life.

V. Concluding Comments

This handbook does not include **all** possible ways in which health professionals can be sensitive to survivors, nor does it include **all** of the ways that childhood sexual abuse may affect a client's experiences in treatment. We each bring different styles, personalities and life experiences to our work. There is no recipe for handling every set of circumstances. It is hoped that this handbook will provide health professionals with knowledge of childhood sexual abuse and ideas about how health professionals can work with survivors that are both sensitive and within the professional's scope of practice.

References

1 Finkelhor, D. (1994). Current information on the scope and nature of child sexual abuse. *Future of Children*, 4, 31–53.

2 Rothstein, J. M. (1999). The sensitive practitioner. *Physical Therapy*, 79, 246–247.

3 Blume, E. S. (1990). *Secret Survivors*. New York: Ballantine Books.

4 Herman, J. (1992). *Trauma and recovery*. New York: Basic Books.

5 Schachter, C. L., Stalker, C. A., & Teram, E. (1999). Toward sensitive practice: Issues for physical therapists working with survivors of childhood sexual abuse. *Physical Therapy*, 79, 248–261.

6 Teram, E., Schachter, C. L., & Stalker, C. A. (1999). Opening the doors to disclosure: Childhood sexual abuse survivors reflect on telling physical therapists about their trauma. *Physiotherapy*, 85, 88–97.

7 Stalker, C. A., Schachter, C. L., & Teram, E. (1999). Facilitating effective relationships between survivors of childhood sexual abuse and health professionals: Lessons from survivors who have received physical therapy. *Affilia: Journal of Women and Social Work*, 14, 176–198.

8 Badgley, R. (1984). *Report of the federal committee on sexual offenses against children and youth*. Ottawa: Canadian Government Publishing Centre.

9 Bagley, C. & Ramsay, R. (1985). Sexual abuse in childhood: Psychosocial outcomes and implications for social work practice. *Journal of Social Work and Human Sexuality*, 4, 33–47.

10 Briere, J. N. (1992). *Child abuse trauma: Theory and treatment of the lasting effects*. Newbury Park: Sage.

11 Finkelhor, D., Hotaling, G., Lewis, I. A., & Smith, C. (1990). Sexual abuse in a national survey of adult men and women: Prevalence, characteristics, and risk factors. *Child Abuse and Neglect*, 14, 19–28.

12 Sgroi, S., Blick, L. C., & Poter, F. S. (1982). A conceptual framework for child sexual abuse. In S. Sgroi (Ed.), *Handbook of Clinical Intervention on Child Sexual Abuse* (pp. 9–37). Massachusetts: Lexington Books.

13 Jones, D. P. H. (1991). Ritualism and child sexual abuse. *Child Abuse and Neglect*, 15, 163–170.

14 Finkelhor, D., Williams, L., & Burns, N. (1988). *Nursery Crimes: Sexual abuse in daycare*. London: Sage.

15 van der Kolk, B. A. (1996). The body keeps the score: Approaches to the psychobiology of posttraumatic stress disorder. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaith (Eds.), *Traumatic Stress. The Effects of Overwhelming Experiences on Mind, Body, and Society* (pp. 214–241). New York: The Guilford Press.

16 Finkelhor, D. (1990). Early and long-term effects of child sexual abuse: An update. *Professionals Psychology: Research and Practice*, 21, 5, 325–330.

17 Braun, B. G. (1988). The BASK model of dissociation. *Dissociation, 1*, 4–23.

18 Springs, F. E. & Friedrich, W. N. (1992). Health risk behaviors and medical sequelae of childhood sexual abuse. *Mayo Clinic Proceedings*, 67, 527–532.

19 Schofferman, J., Anderson, D., Hines, R., Smith, G., & Keane, G. (1993). Childhood psychological trauma and chronic refractory low-back pain. *Clinical Journal of Pain*, 9, 260–265.

20 Harrop-Griffiths, J., Katon, W., Walker, E., Holm, L., Russo, J., & Hickok, L. (1988). The association between chronic pelvic pain, psychiatric diagnoses, and childhood sexual abuse. *Obstetrics and Gynecology*, 71, 589–594.

21 Reiter, R. C. & Gambone, J. C. (1990). Demographic and historic variables in women with idiopathic chronic pelvic pain. *Obstetrics and Gynecology*, 75, 428–432.

22 Walker, E., Katon, W., Harrop, G. J., Holm, L., Russo, J., & Hickok, L. R. (1988). Relationship of chronic pelvic pain to psychiatric diagnoses and childhood sexual abuse. *American Journal of Psychiatry*, 145, 75–80.

23 Scarinci, I. C., McDonald, H. J., Bradley, L. A., & Richter, J. E. (1994). Altered pain perception and psychosocial features among women with gastrointestinal disorders and history of abuse: A preliminary model. *American Journal of Medicine*, 97, 108–118.

24 Domino, J. V. & Haber, J. D. (1987). Prior physical and sexual abuse in women with chronic headache: Clinical correlates. *Headache*, 27, 310–314.

25 Felitti, V. J. (1991). Long-term medical consequences of incest, rape, and molestation. *Southern Medical Journal*, 84, 328–331.

26 Golding, J. M. (1996). Sexual assault history and limitations in physical functioning in two general population samples. *Research in Nursing and Health*, 19, 33–44.

27 Bloom, S. L. (1997). *Creating Sanctuary: Toward the Evolution of Sane Societies*. New York: Routledge.

28 Allen, J. G. (1993). Dissociative processes: Theoretical underpinnings of a working model for clinician and patient. *Bulletin of the Menninger Clinic*, 57, 287–308.

29 College of Chiropractors of Ontario, College of Massage Therapists of Ontario, and College of Physiotherapists of Ontario. (1998). *Where's my line*.

30 American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders*. (4th ed.) Washington, D.C.: American Psychiatric Association.

31 Putnam, F. (1995). Dissociation as a response to extreme trauma. In R. Kluft (Ed.), *Childhood Antecedents of Multiple Personality* (pp. 66–97). Washington: American Psychiatric Press.

32 van der Kolk, B., van der Hart, O., & Marmar, C. R. (1996). Dissociation and information processing in Posttraumatic Stress Disorder. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaith (Eds.), Traumatic Stress. *The Effects of Overwhelming Experience on Mind, Body, and Society* (pp. 303–327). New York: The Guildford Press.

33 Fromm, E. (1962). *The Art of Loving*. New York: Harper & Row.

34 Lott, D. A. (1999). Drawing boundaries. *Psychology Today*, 32, 48–52.

35 National Institutes of Health. *The SMOG Readability Formula*. 1982. NIH Publication.

36 Davis, C. M. (1998). *Patient Practitioner Interaction: An Experimental Manual for Developing the Art of Health Care*. (3rd ed.) Thorofare, NJ: SLACK Incorporated.

37 Roy, R. (1998). *Childhood Abuse and Chronic Pain: A Curious Relationship?* Toronto: University of Toronto Press.

38 Frankel, F. H. (1990). Hypnotizability and dissociation. *American Journal of Psychiatry*, 147, 823–829.

39 Seltzer, A. (1994). Multiple personality: A psychiatric misadventure. *Canadian Journal of Psychiatry*, 39, 442–445.

Appendix A: Diagnostic Criteria for Post Traumatic Stress Disorder

Source: *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.),[2] pages 424–429.

According to the *Diagnostic and Statistical Manual for Mental Disorders* (4th ed.),[2] a person is experiencing Post Traumatic Stress Disorder when criteria in six categories are met. The first category involves exposure to an event in which the person experienced serious injury, threats of death or serious injury, witnessed actual or threats of death or serious injury to others, or experienced a threat to the "physical integrity of self or others."[30p427] In addition, the person responded to the traumatic event with intense fear, helplessness or horror.

The second category of criteria requires that the person have at least one of a number of possible indications that the trauma is persistently re-experienced. Examples include: 1) repeated and disturbing memories of the event that intrude into the person's awareness, including images, thoughts or perceptions; 2) repeated distressing dreams of the event; 3) behaving or feeling as if the event is happening again as in dissociative flashback episodes or hallucinations; 4) acute distress in response to exposure to things that remind the person of the traumatic event; and 5) physiological reactivity to things that remind the person of the traumatic event.

The third category requires several examples of attempts to avoid stimuli associated with the trauma and numbing of general responsiveness which was not present before the traumatic event. Examples are: attempts to avoid thoughts, feelings or talk associated with the trauma; attempts to avoid activities, places or people that remind the person of the trauma; difficulty remembering aspects of the trauma; significantly reduced interest or participation in important activities; feelings of detachment; reduced range of affect; or feeling that one will not have a normal future.

The fourth category of criteria involves at least two symptoms of increased arousal, such as difficulty sleeping, irritability or outbursts of anger, difficulty concentrating, hypervigilance or an exaggerated startle response.

In addition, the disturbing symptoms are required to have lasted more than one month (fifth criteria), and are resulting in significant difficulties in social, occupational or other important functioning (sixth criteria).

For more detailed information, please consult the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.).[30]

Appendix B: Dissociation

The literature lacks clarity regarding the concept of dissociation.[17] The DSM-IV states that "the essential feature of the Dissociative Disorders is a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment". [2, p.477] The DSM-IV also points out that dissociation should not be considered inherently pathological, and that a cross-cultural perspective is important "because dissociative states are a common and accepted expression of cultural activities or religious experiences in many societies". [2, p. 477]

Different forms of dissociation have been postulated to exist on a continuum[7], one end of which includes such relatively common experiences as "highway hypnosis", where a person who has been driving a car suddenly realizes that she does not remember what happened during all or part of the trip. The other end of such a continuum may include extreme forms of dissociation such as Dissociative Identity Disorder (that used to be termed Multiple Personality Disorder). Some authors argue that there is reason to question the idea of a continuum of dissociation. They state that some forms of experience termed dissociative are qualitatively different from others which therefore speaks against the idea of a continuum. They argue for caution in response to claims that do not acknowledge the limits of our knowledge of this phenomenon.[17]

Dissociative Identity Disorder (DID) is the diagnosis assigned to a relatively small proportion of survivors of childhood abuse. As adults, among other diagnostic criteria, they have distinct "identities" or "personality states" which recurrently take control of behavior, and these individuals demonstrate "an inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness".[2, p. 487] Researchers have concluded that DID is almost always associated with a history of severe child abuse.[26] Controversy also exists regarding the diagnosis of DID. Some psychiatrists argue that sociocultural influences and iatrogenicity have contributed to the frequency of the diagnosis of DID in recent years.[33]

Appendix C: Suggestions for Clients at Out-patient Physical Therapy Facilities

Welcome to physical therapy! We are glad to work with you. Physical therapy will include an assessment and treatment by the physical therapist. Direct and open communication between the client and the therapist is important. Below is a list of suggestions that may help you at physical therapy.

You have the right to choose a male or female physical therapist.

- If you know this is important for you, please tell us when you book your first appointment.
- If you decide later in treatment that you would rather work with a therapist of a different gender, you may tell us then too.
- If we are unable to book you with your choice of a male or female therapist, we may refer you to a facility that can.

You can choose to have someone accompany you during your physical therapy appointments.

This person can be:

- a family member or friend, or
- a staff member from the clinic.

Physical therapy works best when you and your therapist work as a team.

For example, your physical therapist will explain your treatment to you. Please tell your physical therapist if:

- you are not comfortable with the treatment,
- you do not understand the treatment or language your therapist is using, or
- you do not agree with the treatment.

Also, physical therapy works best when you talk to your physical therapist about how the treatment is working (or not working!) for you. The more you are able to tell your physical therapist, the better he or she will be able to help you.

We will do our best to ensure your privacy.

- Your physical therapist may need you to wear a gown for some treatments. If you would prefer to bring loose fitting clothing from home, please tell your physical therapist.
- In some cases, it is necessary to change your clothing for your treatment: you will have privacy to change your clothing.
- Please tell us if you would like the curtains drawn around your treatment table during any part of treatment.

Physical therapy involves touch and movement of your body.

Tell your physical therapist if:

- certain parts of your body are sensitive to touch or movement,
- you are nervous about touch, or
- there is something your physical therapist can do to make you more comfortable.

You have the right to stop treatment at any time, during or after a session.

Reasons for which people might stop treatment:

- discomfort during treatment, or
- deciding to try a different type of medical care.

If you decide to try a different type of care, your physical therapist may be able to give you the name of someone she or he thinks can help you.

Above all, we want you to notice an improvement in your health.

Readers are encouraged to copy this sheet or amend it for use in their practices.

Appendix D: Sample of Consent Form

I am about to be examined and treated by a physical therapist and her or his assistants.

In order for me to be properly examined or treated, I will need to wear shorts and a T-shirt. The physical therapist will need to observe my body while it is still and while it is moving. It will be necessary for the therapist to touch and move my body in assessment and treatment. Should I feel uncomfortable about the assessment and treatment process at any time, I can inform the physical therapist and request that assessment and/or treatment be stopped. I can have someone else in the room with me – either a friend or relative, or someone else from the clinic, if available. In the latter case, I can choose the gender of this person.

I will need to tell the physical therapist about my health problems, both past and present. The therapist will ask my permission to contact my doctor if he or she finds any new problems. I am aware that all information I disclose and all information that will be charted is confidential.

Physical therapy treatment may involve: _____ (plain language, be specific). Soreness after treatment is common because joints and muscles are stretched. If I have any other symptoms, I will tell my physical therapist.

My signature below indicates that I understand all of the above information.

Client Signature _____ Date _____

Witness Signature _____ Date _____

Appendix E: Recommended Reading

Bloom, S. L. (1997). *Creating Sanctuary: Toward the Evolution of Sane Societies*. New York: Routledge.

Blume, E. S. (1990). *Secret Survivors*. New York: Ballantine Books.

College of Chiropractors of Ontario, College of Massage Therapists of Ontario, and College of Physiotherapists of Ontario. Where's My Line. College of Physiotherapists of Ontario is located at: 230 Richmond Street West, 10th Floor, Toronto, ON M5V 1V6. Tel: (416) 591-3828. Fax: (416) 591-3834. E-mail: collegpt@worldchat.com. Http://www.worldchat.com/public/collegpt

Davis, C. M. (1998). *Patient Practitioner Interaction: An Experimental Manual for Developing the Art of Health Care* (3rd ed.). Thorofare, NJ: SLACK Incorporated.

Herman, J. (1992). *Trauma and Recovery*. New York: Basic Books.

Oksana, C. (1994). *Safe Passage to Healing: Guide for Survivors of Ritual Abuse*. New York: Harper Perennial.

Peterson, M. R. (1992). *At Personal Risk: Boundary Violations in Professional–Client Relationships*. New York: W.W. Norton & Company.

Radomsky, N. A. (1995). *Lost Voices: Women, Chronic Pain and Abuse*. New York: Harrington Park Press.

Rush, F. (1980). *The Best Kept Secret: Sexual Abuse of Children*. New York: McGraw Hill.

Smith, M. (1993). *Ritual Abuse. What It Is, Why It Happens, How to Help*. San Francisco: Harper.

van der Kolk, B. A. (1996). The body keeps the score: Approaches to the psychobiology of posttraumatic stress disorder. In B.A. van der Kolk, A. C. McFarlane, & L. Weisaith (Eds.), *Traumatic Stress. The Effects of Overwhelming Experiences on Mind, Body, and Society* (pp. 214–241). New York: The Guilford Press.

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