Cases illustrating the benefit of the IPM consultation and a trauma informed approach when working with survivors of sexual violence

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Introduction

Survivors of sexual trauma report that helpful therapy relies on choice, autonomy and the freedom to choose when to speak and what to speak on(1). The IPM-based approach, which prioritises a respectful curiosity of that which the patient brings to the consultation, aims to empower the patient to uncover their unconscious processes at their own pace. This approach has at its core a respect for the autonomy of the patient, necessitating embodied listening by the clinician, not just to the patient's words but to body language, tone, and to the unspoken between the patient and practitioner.

The principles of trauma-informed care are: safety, trustworthiness, choice, collaboration, empowerment, and cultural consideration(3). These principles are elaborated on in Fig. 1. The IPM-based consultation can be used to compliment a trauma-informed practice and may therefore be suited to working with a patient group who have experienced sexual trauma.

Summary of cases

Case 1 – woman in her 50s, who spoke about her history of sexual abuse and became tearful on the couch after examination because "nobody has ever asked me before touching me". She was later able to reflect on the fact that even though the examination was uncomfortable, she was able to say when she wanted the examination to stop.

Case 2 – woman late 20s who had brought a history non-consensual sex, and fear of smear tests, with a negative experience of an examination abroad. The doctor had 'yelled' according to the patient "don't keep your muscles so tense! Just relax!". The patient's anxiety on the couch was initially extreme, holding her breath, hands clutching the sheet. With a careful and slow examination, led by the patient, she was surprised to find it pain-free.

Case 3 – woman in her mid-30s who spoke about her sexual assault as a teenager, and negative experience of medical examination "nurse slapped my leg and told me to keep my knees apart" and then experienced pain during sex following caesarean delivery of first child. She enquired if everything was normal after the exam, and when informed that it was, she reflected "I thought it might be. Something about you examining me and asking me when you could start made me think of how different it was.."

Discussion

These three cases where there was a traumatic sexual experience and in two cases a prior medical examination or experience which may have led to some degree of re-traumatisation.

Giving a patient the opportunity to decline, defer, stop, or move the examination forward at a pace that suits them in all these cases provided the opportunity for the patient to reflect on the differences in experiences. This opportunity allowed for reflection of the patient and observation of the practitioner and built on the rapport developed in the patient-practitioner interaction.

Fig 1: What is Trauma Informed Care?

The six key principles of trauma-informed practice:

Safety - can be prioritised by asking what the patient needs to feel safe, attempting to prevent re-traumatisation

Trustworthiness - as a practitioner, explaining what we are doing and why, having clear expectations and not overpromising, doing what we say we will do

Choice - supporting patients in shared decision-making, goal setting and explaining options clearly. Acknowledging that people who have experienced trauma may perceive a lack of safety and this can impact development of trusting relationships.

Collaboration - using formal and informal peer support, involving service users in what they need in the delivery of services.

Empowerment - aiming to share power, listening to what an individual wants and needs and supporting decision making and action.

Cultural consideration - move beyond cultural biases based on demographics, by offering access to gender responsive services, incorporating processes that are responsive to the needs of individuals.

Adapted from Gov.uk(4)

Phrases and questions that may be useful in a trauma-informed IPM consultation:

'Is there anything we/I can do to help you feel safe during this consultation?'
'What is important to you today?'
'What do you want to get out of today/ this consultation?'
'Let me know if and when you are ready for me to start examining you.'
'How do you want to let me know if you want to stop the examination?'

Conclusions

The psychosexual examination, when *offered to* rather than *inflicted on* the patient, is be a useful tool for observation and reflection for both patient and practitioner. Use of the IPM approach in a trauma-informed way during physical examination, can be a helpful tool for therapy in survivors of sexual violence. Giving a patient the autonomy over examination and allowing the patient the power to agree to, to start and to stop the examination is central to this approach.

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