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Editorial

The role of the physiotherapist in treating survivors of sexual assault

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In memory of India Eve Chipchase

The *Me Too Movement* has facilitated an international conversation on sexual harassment and sexual assault, paving the way for change.[1] This topic – once shrouded in secrecy, silence and shame – is currently under the spotlight, challenging society in a new and dynamic way. With open dialogue and readily accessible information, the need for healthcare professionals to know more and do more is compelling. Thus, it is time to reflect on the role that physiotherapists may play, either explicitly or implicitly, in the management of people who have undergone sexual assault. The intent of this editorial is to raise awareness and demonstrate a need for specific skills and training to meet the complex needs of women who are survivors of sexual assault trauma. The primary focus is on women's experiences; men, however, may be similarly impacted.

In Australia, a population survey conducted in 2016 found that one in every two women experienced sexual harassment.[2] Sexual harassment includes a range of unwanted behaviours such as touching, kissing, fondling and showing or sending sexually offensive material via text, email or social media.[2,3] Sexual assault, on the other hand, is an act of a sexual nature that involves threat, intimidation and physical force, carried out against a person's will and includes rape, attempted rape and/or indecent assault.[3] One in six women have experienced a sexual assault in Australia, although if childhood sexual abuse is included, this ratio becomes one in four women.[2,3] The terms sexual assault and sexual abuse (often associated with behaviour toward children, not adults) are often used interchangeably in the literature. For the purposes of this paper, the term sexual assault is used and encompasses rape, sexual abuse and assault.

Sexual assault impacts on a person's physical, social, emotional and psychological health. A systematic review of international papers, including over three million participants, reported that sexual assault had a significant association with a lifetime diagnosis of depression, post-traumatic stress disorder, anxiety, eating disorders, sleep disorders and suicide attempts.[4] Similarly, Paras et al[5] found a statistically significant association between women with a history of rape and a subsequent diagnosis of fibromyalgia, chronic pelvic pain and gastrointestinal disorders. Indeed, any exposure to trauma – be it psychological, emotional, physical or sexual in nature – results in an individual being 2.7 times more likely to experience a somatic syndrome than if they had no exposure to trauma.[6] These last two studies were systematic reviews and meta-analyses of studies conducted internationally.[5,6]

Physiotherapists who work in the Women's, Men's and Pelvic Health subdiscipline of the profession have a role to play with women who are survivors of sexual assault because they are more likely to have multiple pelvic floor complaints compared with those without a history of sexual assault.[7] Similarly, women who have been sexually assaulted have been found to perceive symptoms of incontinence or constipation as more severe and life impacting than those without a sexual assault history.[8] While suitably qualified physiotherapists in the Women's, Men's and Pelvic Health subdiscipline play a fundamental role in the management of these pelvic floor conditions, there are two aspects that require further consideration.

First, given that one in four women have experienced sexual assault, we must consider how this knowledge can be used in practice to achieve the best possible outcome for women seeking treatment. This may require physiotherapists, in the process of taking a history, to use screening tools that address aspects of sexual wellbeing. Sexual trauma impacts a person's psychological and physical health, and treatment effectiveness relies on treating the underlying issues as well as focusing on presenting symptoms.[9] Thus, one could argue that it is an ethical duty to screen for sexual trauma and to obtain as much clinically relevant information as possible to support assessment, treatment and referral.[9] There are different ways to obtain this information, either through subjective questioning, or through the use of more structured assessment tools. For example, the Adverse Childhood Experience Questionnaire for Adults[10] is a 10-question tick box tool that can identify exposure to sexual, emotional and physical adversity in childhood (Box 1). Alternatively, the American College of Obstetricians and Gynecologists suggests five screening questions that can be asked to screen women for sexual assault (Box 2).[11] The American College of Obstetricians and Gynecologists suggests that healthcare practitioners screen those presenting with pelvic pain, sexual dysfunction or dysmenorrhoea.[11] The numerous health implications associated with sexual assault means that it is highly probable that all physiotherapists will encounter patients with a history of sexual assault in their practice, whether explicitly identified or not. Training in conducting a subjective assessment and use of the aforementioned assessment tools is important to ensure that physiotherapists are competent in dealing with the possible responses to the screening questions, while remaining sensitive to the needs of the patient throughout the process.[12]

A second aspect for physiotherapists to consider when treating a patient presenting with a history of sexual assault is the survival response and sequelae. Approximately 70% of women report tonic immobility during a sexual assault.[13] Tonic immobility is a profound, global motor inhibition where the skeletal muscles tense rigidly and are unable to be moved voluntarily.[13,14] Not only is voluntary movement affected, but vocal capacity is also diminished.[14,15] These motor inhibitions mean that key survival-based actions of screaming and movements of fighting or running away, which ordinarily protect the body during a sympathetic response to threat, are not available.[15] Women who experience tonic immobility during sexual assault are

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Box 1. Adverse Childhood Experience Questionnaire for Adults.[10]

- Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?
- Did you lose a parent through divorce, abandonment, death, or other reason?
- Did you live with anyone who was depressed, mentally ill, or attempted suicide?
- Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?
- Did your parents or adults in your home ever hit, punch, beat or threaten to harm each other?
- Did you live with anyone who went to jail or prison?
- Did a parent or adult in your home ever swear at you, insult you, or put you down?
- Did a parent or adult in your home ever hit, beat, kick or physically hurt you in any way?
- Did you feel that no one in your family loved you or thought you were special?
- Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?

Box 2. American College of Obstetricians and Gynecologists sexual assault screening questions.[11]

- Has anyone ever touched you against your will or without your consent?
- Have you ever been forced or pressured to engage in sexual activities when you did not want to?
- Have you ever had unwanted sex while under the influence of alcohol or drugs?
- Do you feel that you have control over your sexual relationships and will be listened to if you say 'no' to sexual activities?
- Is your visit today because of a sexual experience you did not want to happen?

Floyd S, Anderson J. American College of Obstetricians and Gynecologists Committee Opinion Number 777: Sexual Assault. *Obstet Gynecol.* 2019;133:e296– e301.

twice as likely to develop post-traumatic stress disorder and are three times more likely to have severe depression 6 months after sexual assault.[13] Women describe the experience of tonic immobility as leaving them vulnerable to the feeling that immobility may occur in other stressful life situations that involve sexual contact, or when they feel afraid, out of control, angry or disregarded.[15] It is plausible that when physiotherapists treat women with a history of sexual assault that involuntary reflexive responses relating to the assault may be elicited during the course of treatment. This is particularly likely if a woman is seeking help for a distressing pelvic condition that requires an internal examination and related treatment.

To date, one case study has been published addressing how a patient who received physiotherapy management of lower back pain later developed symptoms associated with a prior history of sexual assault.[16] In this case study, a number of physiological signs and symptoms were observed in the patient after 10 weeks of treatment, including sweating, shaking, suppressed breathing, freezing, hypervigilance, an inability to focus, and outbursts of anger.[16] The patient then disclosed experiencing flashbacks of her sexual assault 40 years prior and was subsequently diagnosed with post-traumatic stress disorder. This report of delayed-onset post-traumatic stress disorder during physiotherapy sessions draws into focus a number of key questions that require investigation. For example, how many women experience similar somatic symptoms during visits to physiotherapists? Are physiotherapists equipped to detect and manage these uncomfortable somatic experiences? To what degree does a fear of uncomfortable somatic experiences interfere with a woman's willingness to access physiotherapy services? If a patient does access physiotherapy and vestiges of the survival response arise, what conditions are necessary to promote a positive treatment outcome?

A trauma-informed approach is recommended when treating a patient who presents with a history of any type of trauma.[17] The five core principles of trauma-informed care include: providing emotional and physical safety by attuning to a patient's needs; being trustworthy; offering choices to patients; collaborating with them; and empowering them.[10,17] In a qualitative study involving 27 survivors of childhood sexual abuse who received or were referred to physiotherapy, a need for safety was considered the prevailing theme when discussing how health professionals can practise with more sensitivity to their needs.[18] Safety was impacted if patients perceived a lack of control. They valued accepting environments where the physiotherapist respected them, was informed about how trauma impacts the body and was attentive to their personal boundaries. Survivors also expressed a need to work in partnership with a healthcare team consisting of a physiotherapist, psychotherapist and general practitioner.[18] A similar approach was documented by Dunleavy and Slowik in the physiotherapy management of a patient with low back pain and a history of sexual assault 40 years prior.[16] With collaborative identification of stress responses and triggers, management of hyperarousal, and a slow, graded exposure to triggering stimuli, the patient reported positive outcomes in her back pain after 2 years and an improvement in post-traumatic stress disorder symptoms over 4 years.[16]

With very little available research to address how physiotherapists can work with women who have been sexually assaulted, we must consider how to build capacity within the profession to ensure that women who are survivors of sexual assault receive the care and support they require. This editorial is a first step that has aimed to highlight gaps in research and in clinical practice. There is a strong need for: good screening of sexual assault history and subsequent psychological illness in women; a requirement for future research to provide more detailed approaches to delivering trauma-informed pelvic healthcare to women who are survivors of sexual assault; and competency-based training for physiotherapists so that they can deal with the issues that may arise from screening. This is a call to action to further our profession's capacity to help the one in four women who have experienced sexual assault.

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References

1. Lore G, et al. *Policy Options Politiques*. 2020. https://policyoptions.irpp.org/magazines/february-2020/support-services-still-lacking-for-survivors-of-sexual-assault/. Accessed 9 September, 2020.
2. Australian Bureau of Statistics. Personal Safety. Canberra: ABS; 2017. https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4906.0~2016~Main%20Features~About%20the%20Personal%20Safety%20Survey%20~2. Accessed 9 September, 2020.
3. Australian Bureau of Statistics. Personal Safety. Canberra: ABS; 2012. https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4906.0Chapter5002012. Accessed 9 September, 2020.
4. Chen LP, et al. *Mayo Clin Proc*. 2010;85:618–629.
5. Paras ML, et al. *JAMA*. 2009;302:550–561.
6. Afari N, et al. *Psychosom Med*. 2014;76:2–11.
7. Beck JJ, et al. *J Sexual Med*. 2009;6:193–198.
8. Imhoff LR, et al. *Arch Surg*. 2012;147:1123–1129.
9. Probst DR, et al. *J Aggress Maltreatment Trauma*. 2011;20:199–226.
10. Provider Toolkit. Screening and Responding to the Impact of ACE's and Toxic Stress. May 2020. https://www.acesaware.org/wp-content/uploads/2020/05/ACEs-Aware-Provider-Toolkit-5.21.20.pdf. Accessed 9 September, 2020.
11. Floyd S, Anderson J. *Obstet Gynecol*. 2019;133:e296–e301.
12. Frawley HC, et al. *Physiother Theory Pract*. 2019;35:1117–1130.
13. Moller A, et al. *Acta Obstet Gynecol Scand*. 2017;96:932–938.
14. de Kleine RA, et al. *Psychiatry Res*. 2018;270:1105–1109.
15. TeBockhorst SF, et al. *Psychol Trauma*. 2015;7:171–178.
16. Dunleavy K, Slowik AK. *Phys Ther*. 2012;92:339–351.
17. Kezelman C, Stavropoulos P. *Blue Knot Foundation*. 2018;1–147.
18. Schachter CL, et al. *Can Fam Physician*. 2004;50:405–412.