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The Sexually Abused Man's Relationship with his Physician

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Abstract

Background: One in six men are survivors of childhood sexual abuse. There is mounting evidence that childhood sexual abuse can lead to greater susceptibility to lifelong physical and mental health problems.

Methods: Consenting male patients were identified as having a history of sexual abuse while attempting to resolve medical issues involving oral, anal or genital care, and consulting with a urologist, a dentist or a gastroenterologist.

Results: Childhood maltreatment poses a substantial risk for long-term health. The results show that non-abusive relationships with a healthcare provider fosters mutual trust and promotes long-term health success by allowing a survivor to feel taken care of in an adult relationship with his physician, based on that trust.

Conclusion: Healthcare providers must learn to identify survivors of childhood sexual abuse, because most survivors will not divulge this information readily. Once a history of abuse has been established, it is imperative for physicians to alter their clinical practice to accommodate survivors so their patients feel safe, empowered, and heard.

Keywords: Survivors of sexual abuse; Post traumatic stress disorder; Child sexual abuse; Sexual trauma; Male victimization

Case Report

This article represents my work as a physician, a survivor of sexual abuse, and an advocate for sexually abused men. It is written especially for healthcare providers and focuses on key aspects of healthcare that pose a problem for sexual abuse survivors, particularly oral, genital, and anal care, and consulting with a urologist, a dentist or a gastroenterologist. I will discuss some of the most common obstacles male sexual abuse survivors face and what healthcare professionals can do to, first, recognize the clues suggesting their patient may have a history of sexual abuse and, second, specific ways to help them deal with their fears.

Case 1

Sexual betrayal

Lewis avoided going to the doctor nearly his entire adult life. At forty-two, he seemed like an overgrown child, impishly smiling when asked why. Molested for years by his older brother, Lewis was unable to gain any real insight as to why this happened. He internalized his confusion and pretended the abuse never took place. In his early twenties, he was hit by a car and taken to the emergency room. As the male physician examined his leg, Lewis developed an erection. This involuntary reaction forced him to consider that the encounters he had with his older brother might have made him gay, and Lewis did not want to be. To avoid this prospect, he retreated from medical care for decades and adopted an asexual existence. After a recent visit to an urgent care center for a sinus infection, Lewis was found to have high blood pressure [1-10].

At our initial visit, he explained his reluctance for comprehensive medical care, prefacing the upcoming physical exam by saying, "I sometimes get erections but I can't help it. I'm not gay!"

"One in six men are survivors of childhood sexual abuse". Furthermore, "In the United States, 1 in 71 men reports having been raped, with 27.8% of these men indicating their first experience of rape by age ten years or younger". There is mounting evidence that childhood sexual abuse can lead to greater susceptibility to lifelong physical and mental health problems, including cardiovascular disease, hypertension, diabetes, anxiety disorders, depression, substance abuse, and perpetration of future violence.

And finally, "Childhood maltreatment is defined as any act or series of acts of commission or omission by a parent or other caregiver, in the context of a relationship of responsibility, trust, or power, that results in harm, potential for harm, or threat of harm to a child's health, survival, development, or dignity".

Childhood maltreatment poses a substantial risk for long-term health for many reasons. First, frequent exposure to the stress associated with maltreatment can lead to potentially irreversible changes in the interrelated brain circuits and hormonal systems that regulate stress. Changes in these brain systems can lead to a premature physiological aging of the body that increases vulnerability to disease over time. Childhood maltreatment increases the risk of behavioral problems such as smoking, substance abuse, obesity, and sexual promiscuity [11-13]. A related body of evidence indicates that early adverse childhood experiences have a profound effect on a range of cognitive, social, and emotional competencies that lay the foundation for successful learning, coping, and subsequent economic productivity [14,15].

While many studies and reviews have concluded that survivors of childhood sexual abuse are highly likely to experience several adverse effects, strongly implying a causal relationship between child sexual abuse and the later development of psychopathology, others have been more cautious, arguing that outcomes are variable, rather than being consistently and intensely negative.

The New York Times published an article entitled, Let's (Not) Get Physicals, in which Elizabeth Rosenthal listed the pointless and dangerous reasons why a routine physical exam and many of the screening tests that routinely accompany them-are useless. I wrote a rebuttal for the Huffington Post entitled, "In Support of the Annual Physical Exam", emphasizing the need to focus on preventative healthcare [16-20].

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Many healthcare providers utilize the annual physical exam as a time to delve deeper into psychosocial issues. Beyond the textbook questions about smoking, alcohol consumption, and recreational drug use, this is an opportunity to review a patient's mood and family interactions as well as have a thorough discussion about sexual practices and childhood traumas. No healthcare provider could be expected to cover the breadth of this information in a routine 15-minute visit. I have always encouraged patients to schedule an annual physical exam around their birthday. I allot 45-minutes to have a discussion before performing the exam.

But most patients are reluctant or ashamed to talk about sexuality and sexual traumas. The question, then, is how do you broach the topic of sexual abuse without asking the question directly? My advice is to ask your patient about his childhood. "Did anything traumatic happen to you when you were a child?" This question could be interpreted many different ways and initiates a conversation. I would avoid asking, "Did you have a normal childhood?" "Normal" is hard to define, and who, really, has had a "normal" childhood? Even the best childhood experiences are interpreted as having abnormal periods at some point during those formative years.

Lewis may not have divulged his history of sexual abuse had it not been for his full physical. It was in the context of a longer appointment and after careful probing that I was able to gain this information. It is amazing how responsive patients can be once their healthcare provider encourages them to speak freely, filling in those uncomfortable silences while the provider waits for the patient to respond. As a result of our conversation, Lewis agreed to enter talk therapy and was encouraged to attend a support group for male sexual abuse survivors [21-25].

Dental Health

Adam

Adam is a thirty-year-old gay male who hadn't been to a dentist in over ten years. When asked why, he shook his head and shrugged. Since most people avoid the dentist out of fear, Adam was referred to a dentist who had received sensitivity training to deal with anxious patients [26-30].

Following Adam's appointment, the dentist reported to the healthcare provider that while in the dentist's chair, Adam experienced symptoms of acute anxiety: sweating, labored breathing, and involuntary retching at the onset of the exam. The dentist thought Adam was having a seizure because he was staring blankly into space, appearing suddenly startled and unable to explain what he was feeling. After several minutes, Adam calmed down. He was able to sit up, drink water and verbalize that he did not know what was happening to him. The dentist began to ask Adam about his childhood, and it was then that Adam revealed he had been sexually abused as a boy [31-33].

A number of aspects of dental treatment symbolically represent sexual abuse for many male survivors:

- Being alone with a male or, if the abuser was female, a woman
- Being placed in a horizontal position
- Feeling restrained
- Having someone touch him
- Having someone put objects in his mouth
- Being unable to talk or swallow
- Experiencing or anticipating pain.

Given the high numbers of boys affected by sexual abuse, it seems likely that many are unaware of the long-term consequences of abuse and consequently fail to associate difficulties in receiving dental treatment with their abuse. As a result, dental treatment is avoided without a clear understanding of why. Even if they are aware, they may not disclose the information readily [34-37].

Also, adult survivors can find it difficult to tolerate dental treatments and may repeatedly cancel appointments. Many avoid dental treatment entirely. Multiple factors play a role in the establishment and maintenance of dental fear, but a history of childhood sexual trauma is often associated with elevated dental fear.

As noted, there are parallels between some aspects of childhood sexual abuse experiences and dental care. Patients are expected to lie in a chair while someone touches them and penetrates their mouth. Patients are supposed to trust the dentist, who may assure them that while the experience may be uncomfortable in the end, it is for their good. But this is similar to how abusers often groom victims, beginning initially with harmless activities and reassurances that the discomfort is minor and/or the experience is for the child's own good. In addition, sexual abuse frequently involves the child's mouth [38-42].

Adult survivors often do not disclose their history of abuse to their dentist. Instead, they may just tell their dentist they are anxious. It's vital that healthcare providers probe further into why their patient feels anxious. If a history of child sexual abuse is uncovered, it is important for the dentist to address this issue directly.

Survivors report that having an empathic and understanding dentist who was patient and willing to listen to their concerns was critical in reducing their anxiety. Before the initial dental exam, the examiner should describe to the patient what is about to take place so the patient can feel he is involved in the process instead of being a reluctant participant. Agreeing on non-verbal cues to indicate increasing anxiety may alleviate some of that anxiety. When patients feel, they have some control, it tends to put them more at ease. Often, listening to relaxing music via headphones during a procedure can soothe the patient. If possible, allow a friend or family member to stay in the room during the appointment. During the procedure, offer to let the patient hold the suction device and provide regular reassurance and explanations throughout the procedure, particularly when the procedure is nearly complete, to give your patient a sense that the light at the end of the tunnel is nearing.

Adult survivors are likely to communicate poorly, especially when anxious or when trying to talk or trying not to talk about their needs based on their trauma and triggers. It is important for the dentist to pay close attention and to recognize non-verbal signs of anxiety: cringing at your touch, gagging when instruments are inserted into their mouths, and/or lying still and silently screaming.

In addition, survivors of sexual abuse often exhibit avoidance of stimuli associated with eliciting such intense emotional reactions. Many studies report that survivors will deliberately avoid healthcare services where some aspect of the treatment has previously resulted or is likely to result, in the abrupt emergence of fear, anger, terror, or grief. Common triggers include:

- Body position discomfort
- Sense or loss of control
- Latex gloves
- Cologne or aftershave
- Instruments in the mouth

Reclining, in particularly, has been reported as being most threatening to survivors of sexual abuse. Strategies to avoid triggering patients include offering them a sheet or cover, such as a blanket, so they feel less exposed. If possible, allow the patient to have one foot on the floor to provide him with a sense of control. Control can also be gained by allowing him to hold a mirror so he can see what the dentist is doing inside his mouth.

The smell of latex gloves can remind survivors of condoms, which may have been used during the abuse. Vinyl gloves are an alternative. Moreover, the smell of cologne or after-shave by healthcare providers may also trigger memories of the past perpetrator. Try to avoid wearing cologne or after-shave, or ask your patient if the scent bothers him. And, whenever possible, patients should be encouraged to invite chaperones to escort or accompany them to their appointment.

Survivors note that when the dental assistant is empathically engaged the experience is further enhanced. It is therefore important that dental assistants be familiar with the patient's history so they too can look for signs the patient is experiencing anxiety and offer comfort. Of course, the healthcare provider needs to get the patient's permission first before disclosing sensitive information to the assistant. A simple gesture like offering to hold the patient's hand, placing a hand on the patient's shoulder, or speaking in a soft, reassuring voice, can be very soothing for a male survivor of sexual abuse. But make sure you check in with the patient and ask their permission first. Remember even a gentle touch or a soft reassuring voice may act as a trigger for sexual abuse survivors. Words of encouragement like, "You're doing great," and "We're nearly done," are helpful, and routinely check in with the patient throughout the procedure, "Are you okay?"

Prostate and Colorectal Care

John

John was a sixty-year-old male who had moved to New York recently from Los Angeles. During an initial visit, he complained of having to get up from bed several times during the night to urinate. When the physician asked if he could perform a digital rectal exam, John adamantly refused.

As a sixty-year-old man, John should have had a rectal exam, a PSA, and a colonoscopy. When asked why he wouldn't allow the physician to perform a rectal exam, John immediately said, "I wasn't molested or anything if that's what you're insinuating."

Since this was his first visit, the physician deferred the rectal exam but drew a PSA and encouraged John to consult with a gastroenterologist for a screening colonoscopy. When his blood work came back, John's PSA was 12 ng/mL, or three times the upper limit of normal. At his follow-up visit, the physician explained the results could be due to an inflammation of the prostate called prostatitis, which is often caused by a bacterial infection, but firmly expressed concern that the elevated PSA could be a sign that something more serious could be going on. At this point, the physician again asked John to allow him to perform a digital rectal exam. Again, John refused. As a result, they agreed that John should see a urologist as part of a workup to rule out prostate cancer. John agreed, but he never went to the urologist or the gastroenterologist and canceled his follow up appointment with the primary care physician. When the receptionist finally got in touch with John, he explained that he had returned to Los Angeles and would follow up with a physician there.

Three years later, John returned to New York. He said he went to a urologist in Los Angeles, but the experience was awful. "After I explained the results of my PSA," said John, "the urologist told me to stand up and assume the position, meaning I had to bend over the exam table. Then, as he examined my prostate, my anus began clenching involuntarily. The doctor joked, 'Hey, I'm going to need that finger back.' I was so humiliated that I left right then and there."

The primary care physician strongly suspected that John may have been sexually violated as a child even though, unasked, John volunteered at his first visit that he had never been abused. Still, the primary care doctor brought up the topic again. This time, John admitted that he was molested for years by his father, who spoke to him almost the same way the urologist had, ordering him around like a child and mocking him. The primary care doctor explained that it was his choice whether to get examined again, but that there was a sense of urgency, particularly since three years had passed. The physician recommended a female urologist and a psychologist. John agreed with this plan. Unfortunately, he was diagnosed with stage III prostate cancer. John underwent surgery to remove his prostate followed by radiation therapy. Although the likelihood of his surviving for at least five years is over 90%, he has issues with urinary incontinence and impotence [43-45].

Richard

In contrast to John's experience, Richard was referred to a gastroenterologist for a colonoscopy because he complained of blood in his stool. Before the procedure, Richard told the doctor he was an incest survivor.

The doctor explained that a scope was going to be inserted into his anus but that Richard would be sedated. Later, Richard told the referring physician that initially he refused the colonoscopy. "I couldn't imagine letting anyone put something inside me," but the gastroenterologist explained it was completely Richard's decision and promised he would not feel any discomfort during the procedure. So, Richard agreed. Afterward, Richard said that the gastroenterologist asked him how he felt and that he was brave for allowing him to perform the procedure.

The rectal exam is performed for multiple reasons. It is part of the annual physical exam in both men and women. The rectal exam provides information about the physical state of the rectum, but in men, the prostate is palpable through the rectal wall.

Typically, the prostate feels firm, smooth, and about the size of the base of your thumb. During a digital rectal exam, the examiner also collects a minuscule amount of stool to test for fecal occult blood used to screen for colon cancer called the guaiac test for all men and women beginning at age 50.

Reasons to perform a rectal exam:

- Palpate the rectum
- Palpate the prostate in men
- Perform a fecal occult blood test or guaiac test

In 1994, the Food and Drug Administration (FDA) approved the use of the prostate-specific antigen (PSA) test in conjunction with a digital rectal exam to test asymptomatic men for prostate cancer. Currently, the American Cancer Society recommends screening men for colon cancer and prostate cancer at age 50 with a colonoscopy and a testing of the man's PSA, a protein produced by cells of the prostate gland. This test measures the level of PSA in a man's blood. It requires a blood sample, which is sent to a laboratory for analysis. Most healthcare providers consider PSA levels of 4.0 ng/mL and lower as normal.

Although (PSA) screening has improved the detection of prostate cancer, the precise mortality benefit of early detection is unclear. This is in part due to a discrepancy between the two large randomized controlled trials comparing PSA screening to usual care. The European randomized study of screening for prostate cancer (ERSPC) found a survival benefit to screening, while the US prostate, lung, colorectal, and ovarian (PLCO) cancer screening trial did not.

Sexual Abuse History Disclosure and Physician Empathy

The significant difference between John's and Richard's experiences was that one chose to disclose his history while the other did not. Disclosure altered the relationship between Richard and his gastroenterologist.

The decision to reveal a history of sexual abuse relates to "triggering" discomfort/distress caused by intensified sensitivity to stimuli in the examination setting. The success of the changed relationship requires an empathic physician who recognizes the importance of the shared information for the patient and the patient's distress.

Unfortunately, it would be incorrect to assume that disclosing a history of abuse to a health care provider always results in a positive outcome. I have known many healthcare providers who would rather not engage in such a discussion, concerned it would take up too much time, leave the patient feeling emotionally unstable or because they themselves are uncomfortable discussing sexual trauma. Still, if healthcare providers ignore the warning signs or refuse to educate themselves to identify signs of abuse, they are indirectly reinforcing a survivor's unwillingness to seek appropriate medical help.

My suggestion is to ask about a patient's history in an empathic way to encourage disclosure. Realize that once he admits to being sexually abused, it is not your responsibility to resolve it at that moment. Make a plan with the patient to bring up this topic again at your next visit, suggest a therapist if he is not already seeing one, and probe him about where he is emotionally regarding his history of sexual abuse. Just because you've uncovered something big doesn't mean you have to unpack it all upon discovery. Your patient will appreciate your concern and respect you as a healthcare provider for including it in his plan along with his other medical issues.

Dermatologic Care

Rodney

Rodney is a twenty-three-year-old male of Jamaican descent who presents with darkening of his cheeks, forehead, and neck. His primary care physician referred him to a dermatologist. On exam, the dermatologist noted the hyperpigmentation but also that Rodney's facial complexion was significantly lighter than the skin on his arms. Rodney admitted to using various skin bleaching products to lighten his skin. When the dermatologist asked Rodney to disrobe for a complete skin assessment, he adamantly refused. The dermatologist did not push Rodney. He warned him to stop using the bleaching products immediately. Otherwise, the hyperpigmented areas would become permanent, and he could develop long-term health issues. Rodney was given an appointment in one month and referred to his primary care physician. After reviewing the dermatologist's consultation, the primary care physician asked Rodney why he refused the full skin assessment. Rodney stated that he doesn't like to see himself nude or have anyone see him without any clothes. When asked if he had been abused as a child, Rodney disclosed that his mother's boyfriend sexually abused him from age ten to thirteen. After he told his mother, she accused him of seducing her boyfriend because Rodney was gay. Rodney was sent to live with his aunt in New York City. He began bleaching his skin in high school, thinking people with lighter skin were given more opportunities in life. The primary care physician concurred with the dermatologist's plan, and Rodney was referred to a psychiatrist.

Skin depigmentation/bleaching, the practice of using toxic cosmetic chemical agents to lighten the complexion of one's skin, poses grave health consequences including but not limited to irreversible skin damage, skin cancer, and kidney failure. The hyperpigmented areas on Rodney's face and neck were diagnosed as exogenous ochronosis. The condition is most often associated with alkaptonuria but can occur after the topical application of hydroquinone and is limited to sites of application. The hyperpigmentation may fade slightly after discontinuing the agent, but the discoloration is usually permanent. Exogenous ochronosis is an avoidable dermatitis that can be caused by the topical application of compounds such as hydroquinone or phenols, though mercury, picric acid, and anti-malarials have also been implicated.

Majority of the explanations that seek to describe the root causes of skin bleaching predominantly fall within a psychosocial paradigm, where having lighter skin (a proxy for European ideals of beauty) is equated with greater attraction or higher social status. This theory, however, does not explain the desire to engage in skin bleaching despite its harmful effects. The experience of negative physical health outcomes of skin bleaching and its continued use implies that self-preservation may be in question, leaving researchers to hypothesize that the underlying motivation must be related to self-hate, as measured by low self-esteem.

The presence of trauma symptoms and childhood physical and sexual abuse may increase the likelihood of skin bleaching (James et al. 2016). Skin bleaching can be considered similar to other forms of harmful body modification behaviors like Body Dysmorphic Disorder and Eating Disorders. Childhood trauma historically has been linked to extreme self-harm behaviors such as self-mutilation.

But it was Rodney's refusal to disrobe that piqued his primary care physician's curiosity. Had he not asked about childhood trauma, Rodney might not have disclosed his history of childhood sexual abuse. Research has shown that although only a small fraction of physicians routinely inquiries about historical traumatic incidents, most patients report that they would actually favor such inquiries. Nevertheless, the power differential between Rodney and the dermatologist once he was asked to disrobe triggered feelings of powerlessness. The only way for Rodney to cope with these feelings was to refuse to get undressed.

Because of the obvious intimate nature of medical care, any number of triggers exists, among them the request to undress, physical contact, and positioning the patient's body. A patient's refusal to undress should prompt the physician to inquire why. The decision to disclose by a male survivor of childhood sexual abuse relates to the "triggering" discomfort/distress caused by the increased sensitivity/reactivity to stimuli. The success of the changed relationship requires an empathic physician response that recognizes the importance of the shared information for the patient and the patient's distress.

If your patient indicates he is fearful, ask him how to increase his feelings of safety. For a full skin assessment, review the evaluation with your patient before he undresses and ask for permission before you touch him. Taking off all your clothes can make anyone feel vulnerable. If you sense your patient is uncomfortable, perform the skin assessment in stages so that the patient can remain partially clothed. This will allow him to retain a sense of control. During the exam, look for signs of self-mutilation: scars from cutting, burning, or skin picking.

Best clinical practices with male survivors of childhood sexual abuse include physicians considering changes in the way they initially identify this patient population, communicate, respond, listen to, involve, examine, and plan for effective and empowering interactions with them.

Substance Abuse, Smoking, High-Risk Sexual Behavior, and STDs

Michael

Michael is a twenty-year-old unemployed actor with a long history of substance abuse. Upon being discharged for the third time from an in-patient drug rehabilitation program for crystal methamphetamine use, he was referred to a primary care physician. At the initial visit, Michael was overly friendly, making jokes about his addiction failures and lack of career. "This time things are different," he said, cheerfully, but when asked what made this time around different, he got quiet, staring down at the floor. Upon further questioning, Michael readily admitted that while in rehab he engaged in condom-less sex with some of the other patients, and that they often used drugs. "It's very common," he said. "Put a bunch of gay guys in a group and, believe me, they'll find ways to have sex and do drugs."

The US Department of Veterans Affairs (2016) states on its website, "Men who have been sexually assaulted have a high incidence of alcohol and drug use. The probability for alcohol problems in adulthood is about 80% for men who have experienced sexual abuse, as compared to 11% for men who have never been sexually abused." Similarly, survivors of child sexual abuse are more likely to engage in many harmful activities. Therefore, adult survivors are at increased risk of abusing alcohol and drugs, of smoking, and of risky sexual behavior.

In the adverse childhood experiences (ACE) study, subjects who had experienced four or more adverse childhood events (psychological, physical, or sexual abuse; violence against mother; or living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned), compared to those who had experienced none, had 4- to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt. In another primary-care sample, those with a history of victimization were more likely to use recreational and intravenous drugs. Similarly, in a study of gay and bisexual men, sexual abuse survivors were more likely to use psychoactive drugs.

Healthcare providers play an important role in screening patients for substance abuse, providing interventions, referring them for treatment, and providing ongoing monitoring. Screening and assessment to detect drug use can be administered during annual routine visit by asking direct questions:

1. How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?

2. Have you ever had blackout or flashbacks as a result of drug use?

3. Do you ever feel bad or guilty about your drug use?

4. Does your partner, spouse, or family ever complain about your involvement with drugs?

5. Have you engaged in illegal activities to obtain drugs?

Patients who report using drugs can be counseled to reduce their drug use and other risky behaviors. Specifically, they should be educated about how continued drug use may harm their brains, their overall health, and other areas of their life, including family relationships and work. Screening and interventions do not have to be time-consuming and can be integrated into general medical settings. In patients with positive screening results, substance use should be categorized into hazardous use, substance abuse, or substance dependence. For most substances, even infrequent use is considered hazardous because of potential health consequences, the risk of dependence, and the risk of legal repercussions. However, not all substance use is equally hazardous. Evidence suggests that the use of heroin, methamphetamine, and crack cocaine is associated with an intrinsically high risk of harm to self and others.

Brief counseling is indicated for patients with hazardous substance use or substance abuse. Patients with substance dependence require more intensive treatment. Physician judgment is important in determining the appropriate intervention or advice regarding hazardous substance use. Patients with substance abuse issues should be referred for substance abuse treatment, and for those patients in treatment, healthcare providers can provide ongoing support to stay in treatment and abstain from drugs during their follow up appointments. Closely monitor your patients and if you suspect a relapse or if they show signs of continued drug use, refer them back to treatment.

Cigarette smoking is another common addictive behavior, and a leading cause of mortality and morbidity in the US. Sexual abuse among men and women that occurred by 14 years of age and antedated age of smoking initiation was associated with a 4-fold increase in smoking initiation. Moreover, survivors who are also formerly drug or alcohol dependent may continue to smoke tobacco to alleviate anxiety even though some studies suggest that nicotine use and withdrawal can actually increase anxiety.

Although there is a vast literature suggesting that smoking is linked to heart disease and stroke, smoking remains the last vestige of control for many survivors. "All I have is my cigarette," said Michael, stuffing it behind his ear. "And it's my choice when to smoke it." Having this small sense of control feels comforting for the survivor but does not circumvent the deleterious and atrocious effects of cigarettes. Still, it is important for healthcare professionals to monitor and provide treatment interventions for those patients who are most at risk for nicotine dependence.

Risky sexual behavior is the most highly documented form of harmful behavior in abuse survivors. This finding holds true for males and females and is consistent across the range of sexual orientations. And, of course, risky sexual behavior leads to a greater likelihood of contracting a sexually transmitted disease (STD).

In one study, gay and bisexual men with a history of childhood sexual abuse were more likely to have unprotected anal intercourse and had a two-fold increase in the prevalence of HIV infection compared with gay and bisexual men who had not been sexually abused. Those who had been sexually abused before age 13 were more likely to participate in anal intercourse without protection compared with men in their sample who had not been sexually abused by that age.

A history of child abuse or neglect can increase the risk for STDs in adulthood, according to a study partly funded by the National Institute of Mental Health. The researchers found that people who experienced abuse or neglect 30 years before the study were more likely than controls to have had an STD. In some cases, abuse survivors were three times more likely to have had more than one type of STD. Childhood sexual abuse appeared to increase the risk for STDs in women even more than in men, and in white participants more than in participants of color. Overall, however, survivors of sexual abuse are clearly at greater risk for sexually transmitted diseases.

Screening adult survivors for STDs is one of the most important things you can do for any patient, but especially for survivors of sexual abuse. These are the STD testing recommendations for men by the Centers for Disease Control and Prevention:

- All adults and adolescents from ages 13 to 64 should be tested at least once for HIV
- Screening at least once a year for syphilis, chlamydia, and gonorrhea for all sexually active gay, bisexual, and other men who have sex with men (MSM). MSM who have multiple or anonymous partners should be screened more frequently for STDs (i.e. at 3-to-6 month intervals)
- Anyone who has unsafe sex or shares injection drug equipment should get tested for HIV at least once a year. Sexually active gay and bisexual men may benefit from more frequent testing (e.g. every 3 to 6 months)

Obesity and Eating Disorders

Jamie

Jamie is a thirty-three-year-old male with Type II Diabetes. His body mass index (BMI) is 39.5. Body mass index is a measure of body fat based on height and weight. Obesity equals having a BMI greater than 29. Being very self-conscious of his size, Jamie repeatedly apologizes as he maneuvers his way through the waiting room. Once inside the exam room, he sits on the table, wringing his hands. His blood sugar that day is over 200, and his hemoglobin A1C is 9.

Jamie is a known diabetic and is currently on oral medication to help control his diabetes, but he is non-compliant with a low sugar diet. As a result, his A1C is higher than it should be. If he lost weight, he could lower his A1C, but instead his healthcare provider has to increase the dose of his current diabetic regimen. When asked why it's so hard for Jamie to control the amount of sugar he eats, Jamie becomes flushed, wringing his hands so that his knuckles blanch.

Over the course of several months, Jamie reveals that his uncle and older brother sexually abused him as a child. Worse still, Jamie suspects his parents knew about it but did nothing to prevent it. As a teenager, Jamie gained weight, finding comfort in food, and perhaps in some subconscious way he wore his obesity as an armor to protect him from further abuse.

Obesity is quite common among adult survivors of childhood abuse. In a study of 131 patients with a history of incest, 60% of these patients were more than 50 lbs. overweight, compared with 28% of the control group. Twenty-five percent were more than 100 pounds overweight, compared with 6% of the control group. Many survivors are prone to binge eating while others put on weight to desexualize themselves, trying to avoid future abuse.

Men with a history of sexual abuse may not fully recover from an eating disorder, or may experience chronic relapses, if they don't address the underlying trauma. Identifying patients with an eating disorder is the first step. Knowing there is a strong correlation between early childhood sexual trauma and eating disorders, it's important to ask your patients about their childhood if they haven't already disclosed a history of childhood sexual abuse. Treatment often involves an integrative approach. Some suggestions include cognitive-behavioral therapy, a nutritional consultation, support groups, and exercising. In addition to cognitive-behavioral therapy there are several other interventions, including:

1. Eye movement desensitization and reprocessing (EMDR)
2. Somatic experiencing
3. Coping skills training
4. Movement or art therapy

Sleep Disorders

Jacob

Jacob is a forty-eight-year-old stockbroker who began having nightmares when he was notified his father was admitted to a hospice for terminal cancer. Jacob's wife accompanied him to his doctor's appointment and described episodes in which Jacob appeared to be choking or trying to scream while still asleep. Several times she was awakened by these awful sounds and had to wake Jacob up.

His father began molesting Jacob by age nine. It wasn't until Jacob attempted suicide in his early twenties that he entered therapy and was able to move past this traumatic event by confronting it. The recent news of his father's failing health triggered the nightmares. Memory fragments that Jacob had filed into a closed container somewhere in his mind returned to him while asleep, and, even though Jacob's father was no longer a threat to him, the news about his father's health brought back memories of events when he was nine. During the day, he could fend off anxiety, but at night he found it difficult to fall asleep. When he did, he dreamt of his father breaking into his room.

Adequate sleep is essential for good health. Sleep occurs in every animal species and is necessary for survival. During childhood and adolescence, sleep is vital for brain maturation. The consequences of insufficient sleep have particular implications for the cognitive and emotional functioning of adolescents.

Lack of sufficient sleep affects health in various ways. People who are chronically short on sleep are more prone to infections and illnesses and are more likely to have accidents.

Safety promotes sleep; sleep naturally occurs in times and places that feel safe. Therefore, threats to safety-as is often the case with child sexual abuse-frequently result in extended periods of sleep disruption. Post-traumatic stress disorder resulting from sexual abuse may be characterized by sleep disturbances and nightmares. Also, poor sleep quality has been linked to depression.

In addition to accessing adult mental and physical health status, clinicians should be aware that there are a variety of other pathways through which childhood abuse might impair an adult's sleep:

1. Chronic stress
2. Depression
3. Post-traumatic stress disorder (PTSD)

Overall Health Perception

Sexual abuse survivors often express less overall satisfaction with their health than non-survivors. In a study of primary-care patients, only 80% of patients who had been sexually abused described themselves as healthy, compared with 97% of the non-abused control group who were matched for age and sex.

Overall health is a complex interplay of psychosocial, physiologic, and mental wellbeing, which influence each other. Abuse influences these interconnections, and the outcomes vary for each. To improve health outcomes for adult survivors, healthcare providers first must

identify patients as survivors of sexual abuse. Only when survivors confront their past are they able to move forward as active participants in their overall health.

Second, discuss a healthcare plan appropriate for your patient's age and family history, paying close attention to preventative health care measures as well as reducing modifiable risk factors with suggestions like smoking cessation, monitoring alcohol intake, and avoiding recreational drugs.

Remember, simply counseling a survivor to "quit smoking" or "lose weight" will not be helpful if the survivor does not believe that anything he does can make a difference in his life. Healthcare providers must acknowledge the complex forces that lead to good health, and help their patients confront the years of negative influences-the shame and guilt-with which their past history of sexual abuse has left them. Only then, by recognizing and addressing all these underlying influences, can we hope to improve the health of an adult survivor.

Best clinical practice for providing healthcare to male survivors of childhood sexual abuse cluster around issues of communication, control, and permission:

The communication cluster focuses on disclosure of sexual abuse to the health care provider. Most survivors will not disclose a history of abuse at the initial visit, but if and when they do, they will view this as a test. How will my health care provider respond? Survivors use this as an opportunity to see how open and willing their healthcare provider is to listening. But the disclosure equally offers opportunities for providers to begin conversations about possible triggers.

The control cluster involves the triggering aspects of the medical exam, tests, and treatments. Clinicians must not disregard the hubris involved in asking a patient to disrobe and disclose personal information after a brief introduction. We ask a lot from our patients. Respect their trust. Allow them to share the responsibility of control. Adopting these practices will help alleviate their stress. By employing your patient as a partner in his healthcare, you lay the foundation for a relationship as opposed to being an adult telling a child what to do. You reinforce that the two of you are now in an adult relationship based on mutual trust.

The permission cluster is the exchange between the healthcare provider and the patient before the actual intimate aspect of medical care begins. Consider this scenario: you meet a patient for the first time. He is sitting on the exam room table wearing only a paper gown and underwear. The average person feels quite vulnerable in this position. Imagine this person is a survivor of sexual abuse. How much more difficult would it be for him? Instead, what would it be like if you allowed your patients to remain fully dressed during the initial intake? If you explained the events that are to take place before having them undress for the physical exam?

Sometimes these events may have to take place in stages. For sexual abuse survivors, it might be prudent to take a history and then allow them to decide if they want to proceed with the exam, offering the option to come back in a week.

The typical busy medical practice poses a challenge to optimal communication. Now, with electronic medical records becoming the standard of care, templates can be very useful to keep your patients up to date with their preventative healthcare in an efficient manner. A potential downside to the electronic medical record, however, is that it's easier for a physician to gaze at the computer screen or the keyboard rather than facing and interacting with the patient. The physician must be aware of this to accomplish a crucial goal, an empathic response to the disclosure of a history of childhood sexual abuse. If your response doesn't meet with your patient's satisfaction, you may never see him again.

It is typical for male survivors of childhood sexual abuse to feel overwhelmed or intimidated during an interaction with their healthcare provider. For most survivors, healthcare providers represent authority figures. Often, the abuser was someone in a position of authority. It is critical for healthcare providers to remember that, even though their patient has agreed to an exam, procedure, or treatment, the patient may not feel empowered if he feels threatened. As a result, he may acquiesce even though he may have changed his mind. A good healthcare provider needs to reassess the patient regularly and look for visual cues that the patient may be uncomfortable. Maintain an ongoing dialogue with the patient about his experience and assess his coping ability at that moment.

Healthcare providers should be particularly careful to ask permission for invasive procedures like the digital rectal exam, testicular exam, or the retraction of the foreskin. Often health care providers assume patients have granted them permission to examine them fully because it's understood once they've made the appointment that an exam is part of the routine visit. By not specifically asking for permission, however, you imply the patient has no choice. This unfortunately replicates for some survivors their history of sexual abuse, in which the survivor's body ceased to be his own, with the abuser using it in various ways for the abuser's needs without regard for the needs of the survivor. If the survivor feels you are like his abuser, he is likely to flee from your medical care.

Conclusion

Childhood sexual abuse affects a significant number of men, making it necessary for health care providers who treat male health issues to alter their practice to meet the needs of these men. There is voluminous data to show that childhood sexual abuse has long-term effects on the overall physical and mental wellbeing of adult survivors. Since most perpetrators of abuse were authority figures, childhood sexual abuse survivors often develop intense feelings of mistrust, fear, and suspiciousness of later authority figures. Having a history of abuse can result in fear and avoidance of medical care, since many survivors see their healthcare providers as authority figures to be dreaded and avoided.

Healthcare providers must first learn to identify survivors of childhood sexual abuse, because most will not divulge this information readily. Once a history of abuse has been established, it is imperative for physicians to alter their clinical practice to accommodate survivors so their patients feel safe, empowered, and heard. When adults betray a relationship with a child, they destroy that child's future sense of trust. Since gaining survivors' trust can therefore take a long time, healthcare providers must remain patient and consistent.

Throughout their later lives, abused children will struggle to understand why abuse happened to them. Having a non-abusive relationship with a healthcare provider fosters mutual trust and promotes long-term health success by allowing a survivor to feel taken care of in an adult relationship with his physician, based on that trust.

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