Silent Survivors

Elizabeth R. Volkmann, MD, MS

Department of Medicine, Division of Rheumatology, University of California, David Geffen School of Medicine, Los Angeles, California

ABSTRACT

Early in my medical training, I cared for a patient who survived a brutal sexual assault necessitating ICU level care. Months later, I was raped. This essay is a reflection on my experience as a survivor of sexual violence and as a provider for patients whose wounds from these traumas have flourished in atmospheres of shame and stigma. In this essay, I further explore how physicians and other health care providers can play a central role in restoring the health of individuals who silently suffer after these unspeakable events.

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Nearly every physician I know can recall at least one career-defining patient encounter during residency.

For me, that patient was Katie.

Early in my internal medicine internship, I admitted Katie to the ICU after she had been found in her boyfriend's apartment, raped and beaten unconscious.

While my team and I examined her battered body laced with wounds from being bound with rope, we were silent. Katie also could not speak, but her tortured body told us her story.

As we wrote her orders for intravenous fluids and electrolyte replacement, an unspoken grief overtook us. Permeating this unspoken grief, however, were emerging, unanswered questions.

"How did this happen?"

"Why was she dating this guy?"

"Had she been under the influence of alcohol or illicit drugs?"

While some of these questions may have had clinical relevance, all of them helped us to rationalize this atrocity. As physicians, much like patients, we instinctively seek to discover explanations for human suffering, when often no explanation exists. As human beings, we involuntarily seek to establish blame in the face of a tragedy.

At that moment, I admittedly and most regrettably asked myself, "Was Katie somewhat responsible for what had occurred?"

Five months later, I asked myself the same question, except this time, the patient was me.

In the early morning hours on my day off from the hospital, a stranger who worked in my apartment complex sexually assaulted and raped me. Immediately following the incident, the man, about whom I would later learn had a prior criminal conviction for sexual assault, was arrested and incarcerated. An ambulance brought me to my training hospital, and henceforth my journey as victim of sexual violence began.

Upon my entry to the Emergency Department, a nurse advised me to use an alias to protect my identity. From that point forward, my suffering would be private. My experience as a patient and as a victim in the criminal justice system was known only to my parents, my program director, and a small group of close friends. Although I deemed my co-residents among the most compassionate individuals I knew, I feared both their judgments and their pity. I thought of Katie. I recalled the look on my

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CORRESPONDING AUTHOR

Elizabeth R. Volkmann, MD, MS
1000 Veteran Avenue, Suite 32-59
Los Angeles, CA 90095
evolkmann@mednet.ucla.edu

co-residents' faces when Katie awoke taunted by paralyzing memories. No, they could not know about me.

As I silently struggled to care for my patients, I attempted to juggle court hearings and counseling sessions on top of my 80+ hour work week. Each month, I received a subpoena to appear in court and had to request coverage for my inpatient duties. My absences from work made me feel like I was letting down both my patients and my team. After overhearing one of my co-residents complain about having to cover for me without any explanation (when I was due in court), I felt marginalized and voiceless.

During a pivotal training year, in which most physicians begin to cultivate their medical intuition, I lost all confidence in myself and in my ability to trust my instincts. My committed relationship also dissolved in the months following the rape, and when my trepidations about my offender seeking revenge intensified, I took refuge in the call rooms on nights when I was not on duty. The hospital was the only place where I felt safe.

I came to realize, however, that my experience was not unique. Sexual violence affects the lives of numerous individuals in the United States; an estimated 23 million (1 in 5) women and nearly 2 million men have been raped during their lifetime.[1] I also discovered that the criminal justice system largely discriminates against rape victims. While my character and profession made me an "ideal witness," according to the district attorney, at times, I felt as if I was on trial. To cope with the misogynist assumptions perpetuated by the defense council, I immersed myself in the care of my patients. Their suffering helped me to see the world in its proper proportions. Surely if my 18-year-old male patient suffering from leukemia could conjure up the strength to endure another round of chemotherapy, I could find the will to resist succumbing to the defense's intimidation and defamation strategies.

However, in doing so, I unconsciously adopted a pattern of ignoring my feelings and needs. As physicians often do, I put my patient's concerns before my own. I stopped going to counseling so I could work longer hours in the hospital. Instead of confronting my own fears that arose when I left the hospital, I diverted my attention to the management of my patients, frequently at the expense of getting adequate rest and nourishment. It was far easier for me to worry about the management of a patient with lupus than the troubling thoughts I faced at home and in the courtroom.

In hindsight, I appreciate that the medical consequences of sexual assault are enduring, especially for silent survivors. Although I received prompt medical attention following the incident, I was unaware of how this adverse life experience can affect long-term physical and emotional well-being. Consequences include not only pregnancy and sexually transmitted diseases, but also feelings of helplessness, depression, fears of intimacy, post-traumatic stress disorder, and even suicide.

For many survivors, the narrative of the traumatic event presents not as a dialogue, but as a physical malady, such as chronic pelvic pain or a functional gastrointestinal disorder. In recent years, I have cared for several patients with fibromyalgia who describe a sexual assault as the inciting event for their intractable pain. Often these patients suffer for years with chronic pain, eventually completely dissociating the assault event from their physical symptoms. For many, healing cannot commence until the connection between the patient's emotional experience is linked to their ongoing physical experience. Acknowledging that the majority of survivors do not readily disclose their history of rape, these survivors are uniquely susceptible to developing serious and chronic health conditions and receiving inadequate care for these conditions.

Indeed, an analysis of 2010 NISVS data illustrated that nearly one-half of female victims of sexual violence and approximately two-thirds of male victims who indicated a need for services, such as medical care, did not receive the needed services.[2] These statistics illuminated an important question for me: Are physicians properly trained to recognize victims of sexual violence and provide appropriate care and treatment?

The answer is no. Although numerous studies have demonstrated that health care providers are more likely to engage in a dialogue with patients about sexual violence if they have received training on the subject,[3] both the American Board of Internal Medicine and the American Board of Family Medicine require no formal training in sexual violence patient assessment and/or treatment. Outside of my personal experience, my internal medicine residency curriculum did not include didactics for sexual violence–related screening, physical assessment, or follow-up care.

Given the unfortunate pervasiveness of sexual violence and the fact that many survivors suffer in silence and do not seek medical attention immediately like Katie and I did, physicians and other health care providers are in a unique position to unearth a history of sexual violence in a safe and confidential environment. We can help reduce the burden of secrecy and shame that keeps so many survivors silent.

Yet in the years following my rape, none of my providers has solicited a sexual violence history from me. When I recently asked a colleague why she thought this might be, she told me that I "do not look like a victim of sexual violence." My journey, however, has taught me that all members of society are susceptible to sexual violence, regardless of age, sex, race, or social

standing. During the criminal proceedings, which spanned my entire residency and most of my fellowship, I learned that my offender had sexually assaulted several other women in the past. After his successful conviction, I discovered that his victims were individuals from all walks of life; some were even his superiors at work. One of the victims reported an assault that had occurred 30 years prior. Advanced patient age should not deter us from initiating a dialogue with our patients on this topic. No one is immune to this crime.

My initial reluctance to share my experience with my peers is now tempered by a growing sense of responsibility within me to ensure that all survivors of sexual violence receive timely evaluation and competent and compassionate medical care. One potential strategy for improving our care of these vulnerable patients is through the development of a national training model in sexual assault education for postgraduate medical education programs. At my own institution, we are developing a formal sexual violence curriculum for 3rd-year medical students within their longitudinal doctoring course.

In addition to initiating educational programs for young doctors, as a practicing rheumatologist and rape survivor, I now embrace a healthier and more fulfilling work-life balance. I have realized the essentialness of nurturing my needs along with the needs of my patients.

And of this I am now certain: Katie was not to blame. And neither was I.

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