


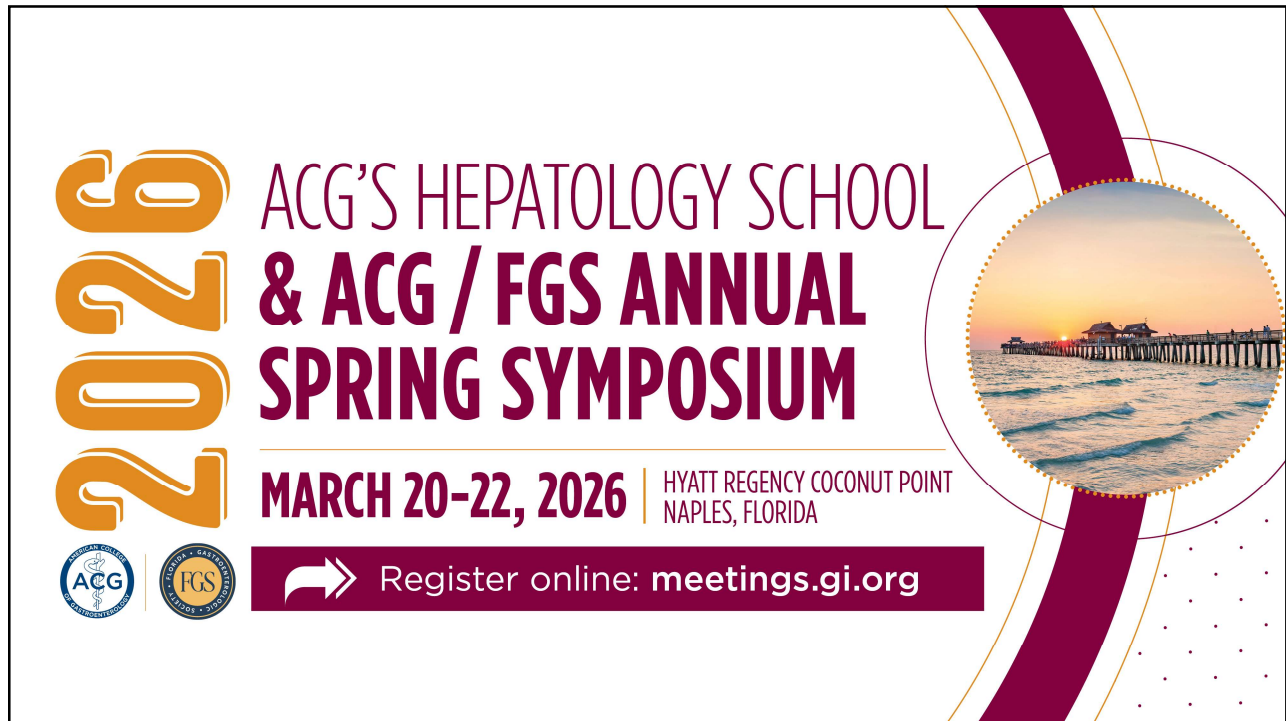


2026 ACG'S ENDOSCOPY SCHOOL
& ACG / LGS REGIONAL POSTGRADUATE COURSE

MARCH 6-8, 2026 | HILTON NEW ORLEANS RIVERSIDE
 NEW ORLEANS, LOUISIANA




   Register online: meetings.gi.org

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2026 ACG'S HEPATOLOGY SCHOOL
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MARCH 20-22, 2026 | HYATT REGENCY COCONUT POINT
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Participating in the Webinar




Moderators:
Christina N. Awad, MD

All attendees will be muted and will remain in "Listen Only Mode"

Type your questions here so that the moderator can see them.
Not all questions will be answered but we will get to as many as possible.

A handout with the slides and room to take notes can be downloaded from your control panel.



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Week 07 – Thursday, February 12, 2026
 GI Nutrition Care Series: Nutrition Strategies for Patients with Mucosal Diseases;
 From Celiac, to IBD and Eosinophilic Disorders
 Faculty: Laura Manning, RD, and Stephanie L. Gold, MD
At Noon and 8pm Eastern




Week 08 – Thursday, February 19, 2026
 Mental Health Care in IBD
 Faculty: Chung Sang (CS) Tse, MD
 Moderator: Shirly Cohen-Mekelburg, MD, MS
At Noon and 8pm Eastern

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Disclosures



Christina N. Awad, MD:
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The Impact of Violence and Trauma on Patient Care: What the Gastroenterologist Needs to Know

By
Christina Awad, MD
Mark Hubner, MD



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Objectives

<p>GI</p> <ul style="list-style-type: none">• The global impact of the violence and why we should talk about it• How it may present in the Gi clinic• How to care for survivors in clinic and the endoscopy suite	<p>Mental Health</p> <ul style="list-style-type: none">• Identify the principles of Trauma Informed Care• Understand how create a safe and supportive environment• Recognize the issues of counter transference and importance of self care
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Case 1

- You are working in an open access rural clinic where primary care providers can refer patients to you for screening colonoscopies. The clinic offers moderate sedation 4 days a week and moderate anesthesia care 1 day a week which is reserved for ASA 3-4 patients
- You are sedating a 45-year-old male with history of IBS-C. When you insert the scope into the rectum, he become agitated and asks you to stop the procedure. He reports it brought back “bad memories”. You immediately stop... what do you do next?

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Case 2

- You have received a referral for 32-year-old immigrant woman to evaluated nonspecific abdominal pain. As you review the EHR, you notice multiple visits for headaches, trouble concentrating, body aches and fatigue. You also notice a pattern of “no shows”.
- As you review the EHR, what emotional response do YOU have? What bigger picture might this constellations of somatic complaints and “no shows” point to? How might you prepare yourself and your staff for the appointment?

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Introduction

- Patients with history of abuse have more functional disability, physical symptoms, higher healthcare utilization and costs (1)
- Patients with history of abuse are 1.5-2 times more likely to experience Gi complaints compared to those without such history

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Global statistics on violence

Type of Experience	Women (Global Estimates)	Men (Global Estimates)
Lifetime physical and/or sexual violence	≈30% worldwide (~840 million women)	Lower and less systematically measured globally
Childhood sexual violence	≈650 million girls/women	≈410–530 million boys/men (~1 in 7)
Intimate partner violence	≈27–31% of ever-partnered women	Reported at lower rates; limited global data

Sources: World Health Organization (WHO); UNICEF; Sardinha et al., *The Lancet* 2021. Global estimates reflect underreporting, especially among men.

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Interpretation and Key Implications

- Violence affects both men and women globally, but prevalence is consistently higher in women across most datasets.
- Men experience substantial levels of violence, particularly sexual violence during childhood, yet remain underrepresented in global reporting.
- Underreporting among men is driven by stigma, gender norms, and limited inclusion in national surveys.
- Women are more likely to experience severe and repeated intimate partner and sexual violence, with greater documented health consequences.
- Global surveillance systems prioritize violence against women, contributing to more robust data compared with men.

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Umbrella of “Gender based violence” (GBV)

- Intimate partner/domestic violence
- Physical or emotional abuse
- Sexual harassment or actual violence (including rape)
- Financial or economic maltreatment
- Online or cyber abuse or harassment
- Female genital mutilation

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Human trafficking

- A growing global issue worldwide and in the US
- Approximately 40.3 million people (equal to the population of **California**) are estimated to be current victims of human trafficking globally
 - Est. 81% are trapped in forced labor
 - 75% are female
 - 29% are children.
- The National Human Trafficking Hotline reported over 11,500 cases of human trafficking in 2020, with many cases involving minors and young adults.

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Intimate partner violence (IPV)

- Behaviors by an intimate partner or ex-partner that causes physical, sexual or psychological harm including physical aggression, sexual coercion, psychological abuse or controlling behaviors (4)
- Growing body of literature emphasizing the effect of IPV on disorders of the gut-brain interaction (DGBIs) (3)

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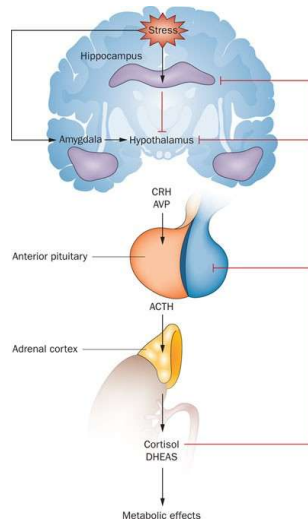
GI complaints

- Abdominal pain was the most common symptom reported by women who experience sexual violence in marriage (3)
- Women experiencing psychological, emotional abuse, and/or coercive control are 1.7 times more likely to report digestive problems (5).

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Hypothalamic-pituitary-adrenal Axis

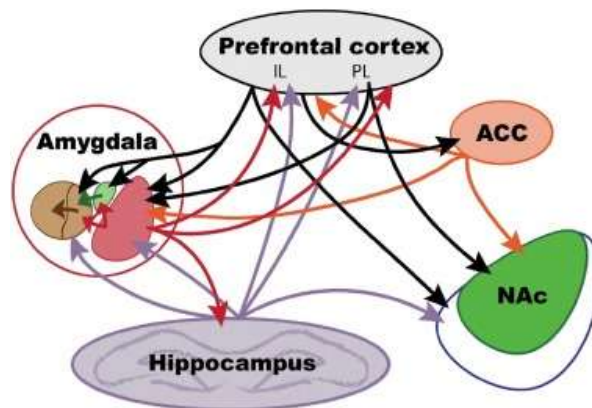


Papadopoulos, A., Cleare, A. Hypothalamic-pituitary-adrenal axis dysfunction in chronic fatigue syndrome. *Nat Rev Endocrinol* 8, 22-32 (2012). <https://doi.org/10.1038/nrendo.2011.153>

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Corticolimbic Pain Modulatory Systems



Jeremy M. Thompson, Volker Neugebauer, Cortico-limbic pain mechanisms, *Neuroscience Letters*, Volume 702, 2019, Pages 15-23,

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IBS/Stress/Abuse

- The brain areas involved in irritable bowel syndrome are also areas that are linked and activated by stress and abuse
- Studies have linked strong emotions or fear with visceral pain in patients with irritable bowel syndrome

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The Question

- Based on the association of digestive symptoms with trauma, abuse, and IPV:

Should we, as gastroenterologist, be asking about trauma and abuse history?

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HOW GBV/IPV MAY PRESENT TO THE GI CLINIC AND WHY

- Abuse is one of the most stressful lifetime events
- Most women who report domestic violence to the police have chronic digestive discomfort consistent with DGBIs (6)

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Non-physical violence

- Understand that psychological abuse, not just physical and sexual abuse, is associated with DGBIs (3, 7)
- This goes against the thought that physical or sexual violence has more impact than nonphysical, verbal, or emotional abuse

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Vulnerable populations to gender-based violence

- Women
- Minors
- Marginalized populations (cultural, religious, and gender/sexual minorities)
- Economically and educationally disadvantages
- Current or past drug addiction/abuse

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Vulnerable populations to gender-based violence Cont.

- Displaced populations (war, natural disasters, food insecurity)
- Immigrants, especially those who not speaking the prevailing language of the area
- People with disabilities
- Veterans
- Those who have been previously victimized or traumatized
- Homeless or those with housing insecurities

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MENTAL HEALTH IMPACT OF GBV/IPV (11)

- Frequent Symptoms
 - Somatization
 - Triggers
 - Flashbacks / Re experiencing
 - Ambivalence
- Impact of TBI

(95% lifetime prevalence of head injury in commercial sex workers)

 - Headaches
 - Slower cognitive processing
 - Memory issues
 - Irritable, depressed mood
- Provider Preparation
 - Recognize constellation of symptoms
 - Focus on quality of interaction
 - Trust
 - Dignity
 - Provide hope
 - Slow down the interaction
 - Give concrete instructions, choices
 - Share control
 - Point out the patient's strengths

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Impact of GBV/IPV and Trauma on the Provider (11)

- Counter transference
 - Skepticism
 - Over protection
 - Distancing
 - Activation of your own issues
 - Loss of objectivity
- Secondary trauma
- How to respond
 - Be aware of your emotions
 - Recognize your counter transference
 - Take a break
 - Create a pattern of good self care
 - Talk it out with a colleague
 - Don't ignore the impact on you

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Trauma Informed Care in the GI clinic ⁽⁸⁾

- Trauma Informed Care developed in the 2001 to shift away from “What is wrong with you?” to “What happened to you?”
- It is based on the 4 R’s:
 - Realization (understanding the wide spread impact of trauma)
 - Recognition (the possibility of trauma in individuals)
 - Respond (by providing supporting environments)
 - Resist re-traumatization

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Giving the Patient Control Sharing in the Decisions

- Victims often feel loss of control
- It is important to give the patient maximum appropriate control and self determination as well as shared decision making
- History taking should not pressure them to share information or details that they are not ready to share

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Finding the Balance

- Practitioners must take complaints and pain seriously and not simply attribute the symptoms to the trauma history
- **Although trauma is part of someone's history, it should not be their identity (either by them or you)**
- We must do our “due diligence” in working up symptoms before we determine it is secondary to their trauma
- Even if it is from trauma, we still treat them with a holistic approach

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A Word About Substance Abuse

- According to the American Society of Addiction Medicine, IPV has been identified as a predictor in developing substance abuse and/or addiction
- Substance abuse could be a dysfunctional coping mechanism (10).
- As specialists, we should consider screening such patients for both IPV and substance abuse in a nonjudgmental manner

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Be Informed as a Provider

- The prevalence of GBV is shockingly high and often unrecognized
- Victims of GBV are present in every GI office and procedure suite
- Awareness, sensitivity, and a stance of trauma informed care will aid the GI practitioner in helping these patients find support and proper treatment for their situation

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How to Apply this in Clinic

1.Be

Self-aware of your own baseline and how you are doing on any given day
Be respectful, open, and nonjudging

2.Do

Approach each person with compassion, learn their story
Help them on their journey

3.Create (with staff)

A place of safety
A sense of autonomy, self-determination, and dignity

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Care in the Endoscopy Suite

- Both sedation and endoscopy can be triggers for patients to reexperience past or present trauma
- Some ways a practitioner may show respect and ease the stress of the situation are shown as the 4 Ps

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Procedure Suite: The 4 Ps

- Provide anticipatory guidance
- Present support
- Protocols for reactions
- Process and reassure afterwards

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Consent, Sharing Information and Control

- Provide detailed anticipatory guidance as to what will be done:
 - Why it is necessary
 - What the patient may experience
 - Other alternatives, if there are any

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Be Prepared

- Endoscopy and colonoscopy may
 - Provoke flashbacks of sexual assault and be very stressful for the patient
- It would be appropriate to discuss this risk with the patient beforehand
 - Be prepared to help them process it (in a reassuring and supportive way) following the procedure

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Creating a Sense of Safety

- Always treat the patient with compassion, dignity and respect
- Slow thing down so the patient can process
- Periodically ask the patient how they are doing and if there are questions
- Explain each activity beforehand giving reasons and alternatives (if possible)
- Provide a chaperone
 - Consider allowing the patient to bring a trusted friend as chaperone



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Adjusting “Normal Practice”

- Have a prepared protocol on how to deal with a patient who under sedation:
 - May have disinhibition
 - May decompensate or struggle emotionally with uncomfortable memories
 - May have flashbacks or a reaction out of proportion to the situation

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Ways Forward

- GI practitioners should have a plan of action when a patient reports on going abuse and wants change
- If a patient is currently in an abusive relationship but is not ready to get help, practitioners should have helpful contact numbers ready to give to patients
- One idea is to have contact numbers on the discharge paperwork for all patients

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Our Role

- It is not our role to provide professional mental health care, but we should always be prepared to refer them to the appropriate services
- Aware and sensitive GI practitioners can play a critical role in helping suffering patients.

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Back to Case 1

- You did the right thing by stopping immediately and gently reassuring the patient
- Post-procedure, while patient is recovering from sedation and while in the endoscopy suite is not the right place to dig the history of trauma and abuse placing no judgement on the patient
- A good time to set up a follow up appointment in clinic to re-establish clinical history

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Back to Case 2

- Does this constellation of symptoms and ambivalence raise any “red flags”?
- How can you prepare your staff to facilitate a positive experience for this woman?
- How many patients like this should you see before considering provider “self care”?

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Summary 1

- The prevalence of GBV is shockingly high and often un-recognized Victims of GBV are present in every GI office and procedure suite
- Awareness, sensitivity, and a stance of trauma-informed care will aid the GI practitioner in helping these patients find support and proper treatment for their situation
- GI practitioners should have a plan of action when a patient reports ongoing abuse and wants change

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Summary 2

- If a patient is in an abusive relationship and is not ready to get help, practitioners should have helpful contact numbers ready to give to patients. One idea is to have them on the discharge paperwork for all patients
- It is not our role to provide professional mental health care, but we should always be prepared to refer them to the appropriate services
- Aware and sensitive GI practitioners can play a critical role in helping suffering patients

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Questions



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