Use of a Screening Instrument in Women's Health Care: Detecting Relationships Among Victimization History, Psychological Distress, and Medical Complaints

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ABSTRACT. The interactive relationship between psychological distress and physical health is a particularly salient one for women. Routine screening for abuse history and current psychological disturbance is essential in providing comprehensive patient care. The present study examines the utility of a brief screening measure in detecting psychological factors in female patients at a primary care facility. Sixty-nine percent of 108 women screened at a women's health clinic reported a history of trauma and almost half (49%) reported having been sexually harassed. Women presenting to treatment for gynecological problems were more likely to be victims of sexual assault and were more likely to report a history of childhood sexual abuse. In addition, women seeking specialized health care also reported increased rates of stress. Relationships among victimization histories, substance use, and eating disturbances were also found. These data suggest the importance of assessing psychological disturbances and trauma histories as part of a comprehensive medical evaluation. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: getinfo@haworth.com]*

INTRODUCTION

The interactive relationship between psychological and physical health has been well documented (Cohen & Williamson, 1991). Persons suffering from various forms of psychological distress are likely to experience somatic and psychophysiological responses to these events (Kimerling & Calhoun, 1994), some of which mirror a variety of medical syndromes. When undetected or untreated, these responses can confound accurate diagnosis and treatment of medical disorders (Wolfe, Mori, & Krygeris, 1994), resulting in increased use of medical services, extended hospitalization periods (Levenson, Hamer, & Rossiter, 1992), and an unnecessary drain of increasingly limited medical resources (Manning & Wells, 1992; Van Heimert, Bakker, Vandenbrouke, & Valkenburg, 1993). The purpose of the present study is to examine the utility of a brief screening instrument in identifying trauma and psychological comorbidities in women presenting for medical care.

The issues of psychological distress and accompanying medical problems and health care utilization are particularly salient for women. Studies have indicated that women are more likely than men to label psychological symptoms as physical illness (Cleary, Mechanic, & Greenley, 1982; Kessler, Brown, & Broman, 1981; Verbrugge, 1985) and thus may be more likely to present in medical settings with significant psychological distress attributed to medical causes. In particular, violence and victimization have

been shown to significantly affect perceived health and health care utilization in female patient populations. Female survivors of physical and sexual assault report significantly more physical health complaints, particularly gynecological symptoms and sexual dysfunction, than nonvictims (Koss, Woodruff, & Koss, 1991), and generally view themselves as being in poorer health than nonvictims (Koss et al., 1991; Waigandt, Wallace, Phelps, & Miller, 1990).

Addictive disorders such as substance abuse and eating disorders may also affect health care symptoms and utilization. Women with eating disorders report substantially more somatic complaints such as migraine headaches (Brewerton & George, 1993), asthma, and ulcers (Ghadirian, Englesmann, Leichner, & Marshall, 1993) than non-eating disordered women. Women with substance use problems experience high rates of alcohol related medical problems such as liver and gastrointestinal disease (Alexander, 1996), and it has been estimated that as much as 20% of the U.S. total national health expenditure is spent on alcohol-related illness and injuries (Cyr & Wartman, 1988). Thus, women with any of these psychological comorbidities are at increased risk for presenting components of psychological distress in the form of health complaints.

Additionally, psychosocial stressors such as job pressure, financial worries, and health concerns have been implicated in a number of health problems (Billings & Moos, 1982; DeLongis, Coyne, Dakof, Folkman, & Lazarus, 1982; Krause, 1988; Pilisuk, Boylan, & Acredolo, 1987). Still, research suggests that the impact of such stress is often overlooked by many healthcare utilization models (DeLongis et al., 1982; Krause, 1988).

Psychological disturbances rarely occur in isolation. Relationships among comorbidities such as substance abuse, eating problems, stress, and victimization sequelae have been well documented (Alexander, 1996; Connors & Morse, 1993; Glass, Prigerson, Kasl, & Medes de Leon, 1995; Holderness, Brooks-Gunn, & Warren, 1994). For example, researchers have suggested that persons with trauma histories are more likely to develop substance abuse problems than persons without such histories (Goodman, Koss, & Russo, 1993; Winfield, George, Swartz, & Blazer, 1990) and, conversely, that women who abuse substances run a greater risk of sexual victimization (Alexander, 1996). Hence, detection of even a single psychological symptom can facilitate the detection of other symptoms.

In an era of medical care cutbacks and shrinking hospital budgets, there is an increasing need for early detection of psychosocial phenomena that are likely to be associated with presenting medical symptoms (Magruder-Habib, Zung, & Feussner, 1990). Early identification would expedite the process of accurate medical diagnosis and could guide the course of ap-

propriate treatment without the use of unwarranted or scarce resources. Efforts in recent years to implement mental health screens in primary care settings have yielded promising results, suggesting that both patients and health practitioners are in favor of such screens. Further, use of such screens appears to elicit critical information that otherwise might not be disclosed by the patient in the course of a medical visit (Friedman, Samet, Roberts, Hudlin, & Hans, 1992; Springs & Friedrich, 1992).

Despite this evidence, only a few standardized screening procedures have been implemented within primary care settings (Cyr & Wartman, 1988; Hase & Luger, 1988). Furthermore, extant studies on screening instruments are limited with regard to the content of the assessment. Measures used in primary care facilities have generally focused on a singular identified form of psychological distress such as alcohol and other drug use, and depression (Bradley, 1992; Greenwood, Tangalos, & Maruta, 1990; Magruder-Habib et al., 1990; Seng & Peterson, 1995). To date, more comprehensive psychological inventories screening a variety of symptoms and behaviors have not been widely employed. Moreover, newer screening measures such as the SDDS-PC (Broadhead et al., 1995) and the PRIME-MD (Spitzer et al., 1994) do not probe for the presence of trauma history, a factor prevalent in female treatment-seeking populations and associated with numerous psychiatric and physical concomitants (Koss et al., 1991; Goodman et al., 1993).

The lack of instruments designed to assess victimization history in the context of a broader mental health screen served as the impetus for the present pilot project. This project had two goals: to preliminarily test the viability of a psychological screening survey for women seen in a primary care setting and to examine relationships between victimization histories and medical complaints. Descriptive analyses of victimization histories and psychological difficulties such as substance use disturbances, stress, and eating disturbances are presented. We anticipated that this preliminary investigation would help identify the incidence of victimization histories of women in a primary care setting and determine the viability of probing for this information through a brief screening procedure. The results of this study are exploratory and are intended to guide future development of a brief comprehensive screen that can be readily used in a primary care setting.

METHOD

Participants

A total of one hundred female veterans and eight service eligible non-veterans at one of two outpatient women's health clinics completed a

routine screening for history of sexual assault and lifestyle experiences and events between October 1994 and November 1995. All new female patients (whether new or returning) who visited a women's health facility at a Veterans Affairs Medical Center or outpatient clinic were approached for this screening. Because women were being screened while waiting for their medical appointments, some women who began the screening process were not able to complete the questionnaire battery before being seen by their primary care provider. For this reason, approximately 13% of the 124 women who began the screening interview were unable to complete the questionnaires.

Participants' mean age was 54 years old, with a range of 22 to 91. Approximately 18% of the sample were less than 35 years old, 45% were between the ages of 35 and 64, and 37% were 65 years old and older. Although data on race were not available for approximately 28% of the sample, 67% (n = 72) of the sample were white, 2.8% (n = 3) were African Americans, and another 2.8% (n = 3) were Hispanic. Approximately 34% of the sample were married (n = 36), 25% (n = 26) were single, another 28% (n = 29) were divorced or separated, and approximately 13% (n = 13) were widowed. Four individuals did not provide information regarding marital status. Thirty-four women (35.4%) reported working outside the home at the time of interview. Ninety-three percent of all participants were veterans.

Measures

Participants completed a short battery of self-report questionnaires, developed by mental health professionals with formal behavioral health expertise. The battery included: (a) a demographic inventory, (b) a trauma screen, and (c) a 12-item "Lifestyle" questionnaire comprised of open-ended questions designed to probe for a variety of psychological disturbances.

The Women Veterans' Demographic Inventory (WVDI) (Rosenheck & Fontana, 1994). The WVDI is a 30-item questionnaire which assessed demographic variables such as age, race, employment, service-connected status, and military history. Also included were questions regarding current psychological treatment, use of psychiatric medications, and the patient's reason for visiting the medical clinic that day. In addition, the respondents' presenting medical problem upon their first visit to the Women's Health Center was recorded. Medical complaints were coded and broken down into the following categories: (1) routine care/checkup, (2) gynecology, (3) cardiology, (4) respiratory, (5) chronic pain, (6) seizures/brain disorders, (7) breast problems, (8) sleep disorders, and (9) other.

All categories were collapsed into two groups: routine care/checkup and specialized care. A subset of specialized care including female-specific problems (gynecological and breast) were analyzed separately.

The Women Veterans Trauma Screen (WVTS). The WVTS is a 28-item yes/no answer questionnaire intended to measure a lifetime history of experiencing different traumatic events. Such events include automotive accidents, domestic violence, sexual harassment, and sexual trauma (e.g., "Have you ever been involved in a major accident or disaster?"; "Have you ever had an experience where someone used force or the threat of force to have sexual relations with you against your will?"). Follow-up questions probed as to whether the traumatic event occurred during military service. Questions on this measure were a compilation of other brief stressor exposure checklists that have been used in both military (Wolfe, Brown, Furey, & Levin, 1993) and civilian populations (Norris, 1992).

Lifestyle Questionnaire (LQ). The LQ consists of 12 open-ended questions examining substance use patterns, eating and body image disturbances, and stress and coping responses. Questions addressing substance abuse were modeled after items from the Psychoactive Substance Use Disorders section of the Structured Clinical Interview for DSM III-R (SCID) (Spitzer, Williams, Gibbon, & First, 1990), and the CAGE, a well-validated screening measure to detect alcohol abuse (Ewing, 1984). Questions designed to assess eating disturbance were modeled after the Eating Disorders section of the SCID (Spitzer et al., 1990) and the Eating Attitudes Test (Garner & Garfinkle, 1979). Three other items were included to assess the extent to which a woman might experience highly stressful events in her work or personal life.

Individual items from the Lifestyle Questionnaire were coded and grouped into subcategories reflecting substance use problems, eating disturbances, and psychosocial stress. Respondents who positively endorsed at least one of three questions concerning substance abuse (i.e., "Has your drinking or drug use ever caused you any difficulties in your work or social life?"; "Have friends or family members ever objected to either your alcohol or drug use?"; "Have you ever felt that you might have a problem with alcohol or drugs?") or reported having more than two drinks per day or being intoxicated more than once a week were classified as having some indication of a substance use disturbance. Respondents who answered positively to at least one of three questions measuring an eating problem (i.e., "Would you say that you are more concerned about your weight and/or body shape than most people?"; "Have you ever eaten well past the point of feeling full and is this something that has happened regularly for you in the past or happens regularly now?"; "Has there ever

been an ongoing period of time when you were depriving yourself of food, even though you were hungry?") were regarded as having some indication of an eating disturbance. Endorsements of anxiousness, feeling overwhelmed, or "stressed out," or reports of ineffective coping strategies to manage stress were considered to be an indication of a stress problem.

Procedure

Master's and Doctoral level mental health clinicians from the hospital's psychology division administered screening packets during weekly shifts at women's health clinics. Women were approached in the waiting rooms of the clinics and asked if they would be willing to participate in a brief screening interview prior to their medical appointment. Women were told that the screening information would be confidential and would be used only to provide information about the female veteran population as a whole. Interviews were conducted in private mental health rooms housed in the women's clinics.

The Trauma Screen and Lifestyle Questionnaire were self-administered and information from the demographic questionnaire (e.g., date of birth, branch of military, current psychological treatment) was obtained by the interviewer. Upon completion of the questionnaires, the interviewer reviewed the questionnaires and obtained further information regarding any positively endorsed symptoms of substance abuse, eating disturbance, or stress. After completing the interview, patients indicating such distress or any mental health symptoms were informed of mental health services available to female veterans and were provided with the name of a contact person at the mental health clinic. The total screening process took approximately 15 minutes.

RESULTS

Victimization Histories of Women Seeking Medical Care. A total of 69% of the women screened (n = 72) reported having at least one lifetime trauma experience. Of the total sample, 28% (n = 29) had been in a major accident or disaster; of these, 55% reported that this occurred while in the military. Approximately 26% (n = 26) had been physically assaulted or had been the victim of a violent crime and 42% of these indicated that this occurred while in the military. Another 25% (n = 25) had been hit or physically hurt by a spouse or partner; 24% of these women reported that this occurred during military service. Among 25% (n = 24) of the sample

who had been physically threatened by a spouse or partner, 33% indicated being threatened while in the military. Among 32% (n = 33) who had been sexually assaulted, approximately one-third (30%) revealed sexual assault during their military service. Of the total sample, 28% (n = 27) had been sexually abused before the age of thirteen. The majority of women with trauma histories had been multiply victimized (n = 54, 51.9%) with 14% of the women reporting five or more lifetime traumatic experiences.

Approximately 49% (n = 49) of all participants reported ever having received uninvited or unwanted sexual attention. Fifty-three percent of these reported this experience occurred during their military service. Victims of sexual harassment stated that this behavior often happened at work (49%) and particularly while in the military (79%). Approximately 23% of all participants reported that they were currently bothered by feelings of these past traumatic events (see Table 1).

TABLE 1. Incidence of Trauma Histories and Psychological Comorbidities

Variable	Frequency (%)	N
Types of trauma		
Accident/disaster	28	29
In military	55	16
Physically assault	26	26
In military	42	11
Physically hurt	25	25
In military	24	6
Physically threatened	25	24
In military	33	8
Sexual assault	32	33
In military	30	10
Sexual harassment	49	49
In military	53	26
Sexual harassment at work	49	24
In military	79	19
Child sexual assault	28	27
Psychological comorbidities		
Substance use	19	18
Eating disturbance	40	38
Stress	55	52

Incidence of Psychological Symptoms in Women Seeking Medical Care. Nineteen percent (n = 18) of the women had symptoms associated with substance use disturbances. Rates of stress and anxiety were higher, with more than half (55%, n = 52) of the sample endorsing high levels of stress and/or ineffective coping strategies for its management. Forty percent (n = 38) of study participants reported symptoms linked to noteworthy eating or body image disturbances.

Psychological Symptoms Reported by Women in Specialized vs. Routine Medical Care. Women seeking treatment for specialized medical care were more likely to positively endorse stress symptoms than their counterparts presenting to treatment for routine care (62.5% versus 38.7%, respectively) [(2(1, N = 95) = 4.77, $p < .05$]. Women with gynecological problems were more likely to be victims of sexual assault (53.3% versus 23.5%, respectively) [(2(1, N = 49) = 4.2, $p < .05$] and childhood sexual assault (53.3%) than women presenting for routine care (22.6%) [(2(1, N = 46) = 4.35, $p < .05$]. These women were also more likely to exhibit higher stress symptoms than those seeking routine care (75% versus 38.7%, respectively) [(2(1, N = 43) = 4.55, $p < .05$]. No other results were significant; however, the following patterns emerged: Women with sexual assault histories including rape, sexual harassment, and childhood sexual abuse were consistently more heavily represented at specialized care visits than at routine exams. The same was true for women who reported eating difficulties (see Table 2).

Upon examining factors associated with routine care in comparison to breast problems and gynecological complaints, women with gynecological and/or breast problems were more likely to be victims of sexual assault (48% versus 23.5%, respectively) [(2(1, N = 59) = 3.85, $p < .05$] than those seeking routine care. While not statistically significant, two interesting patterns were identified: Women who reported sexual harassment and childhood sexual abuse histories were more likely to present to medical treatment with breast and/or gynecological complaints in contrast to routine care. No other comparisons between these groups were significant.

Associations Between Victimization History, Demographic Characteristics, and Psychological Symptoms. In secondary analyses, relationships among victimization history, demographic characteristics, and psychological symptoms were examined. Women with substance use symptoms reported more traumatic experiences (m = 3.89, SD = 2.22) than those without substance use symptoms (m = 1.64, SD = 1.69)[t(89) = 4.72, $p < .001$]. Women endorsing eating disturbance symptoms reported higher rates of trauma (m = 2.66, SD = 2.13) than did those who did not endorse these symptoms (m = 1.71, SD = 1.84)[t (89) = 2.27, $p < .05$]. Women who

TABLE 2. Associations Between Psychological and Medical Variables

			Specialized Care							
	Routine (n = 35)		Total Group[a] (n = 73)		Breast (n = 10)		GYN (n = 16)		Breast & GYN (n = 26)	
Psychological Variables	n	%	n	%	n	%	n	%	n	%
Sexual harassment	12	35.3	37	55.2	5	50.0	9	64.3	14	58.3
Sexual assault	8	23.5	25	36.2	4	40.0	8*	53.3	12*	48.0
Physically threatened	8	24.2	16	25.0	3	30.0	5	33.3	8	32.0
Physically hurt	8	25.0	17	25.4	3	33.3	5	33.3	8	33.3
Physical assault	8	24.2	18	26.5	3	30.0	5	33.3	8	32.0
Child sexual assault	7	22.6	20	31.3	3	30.0	8*	53.3	11	44.0
Accident/disaster	9	25.7	20	29.4	4	40.0	4	26.7	8	32.0
Stress	12	38.7	40*	62.5	4	44.4	9*	75.0	13	61.9
Substance use	5	16.1	13	20.6	1	11.1	4	33.3	5	23.8
Eating disturbance	10	32.3	28	44.4	4	44.4	5	41.7	9	42.9

Note. Comparisons are between Routine and each Specialized care subgroup.
[a]Includes gynecology, cardiology, respiratory, chronic pain, breast, sleep and other medical problems.
*$p < .05$.

endorsed symptoms of general stress reported experiencing more lifetime traumatic stressors (m = 2.97, SD = 1.98) than those not currently endorsing stress (m = 1.07, SD = 1.47) [t (90) = 5.18, p < .001]. Age differences were found between substance users and nonusers with users being younger (m = 43.8, SD = 14.5) than nonusers (m = 57.3, SD = 17.4) [t(92) = 3.04, p < .01]. In addition, those who reported stress were younger (m = 51.5 1.5, SD = 16.4) than those who did not reveal symptoms of stress (m = 59.2, SD = 18.5) [t(93) = 2.07, p < .05]. Women with symptoms of an eating disturbance were also younger (m = 49.6, SD = 19.2) than those who did not reveal symptoms of an eating disturbance (m = 58.2, SD = 15.8) [t(92) = 2.36, p < .05].

Treatment Seeking Patterns. Women who reported being in psychological treatment (82.4%) were more likely to report stress than those not in treatment (48.6%) [(2(1, N = 91) = 6.34, p < .05]. Also, women receiving treatment were more likely to report childhood sexual assault (52.6%) than those not currently receiving psychological services (20.5%) [(2(1, N = 92) = 7.84, p < .01]. In addition, women receiving psychological treatment were more apt to report feeling bothered by thoughts and feelings regarding past traumatic events (44.4%) than those not currently receiving psychiatric services (14.7%) [(2(1, N = 86) = 7.60, p < .01].

DISCUSSION

The present study sought to examine the utility of a brief screening measure to identify the incidence of victimization history and other psychological factors in female patients at a women's medical facility. The study also sought to explore the relationship between these variables and medical treatment seeking and medical diagnoses.

Our experience with this study suggests that the use of a psychological screen in a primary care setting is both viable and useful. Screens were administered expeditiously and referrals were offered if follow-up or psychological treatment seemed indicated. As a result, the screening process was quick and did not interfere with patient medical care. Moreover, patient reactions to the screen were positive. Some of the women who reported an abuse history or other psychological symptoms stated that this screening was the first time they had ever had the opportunity to discuss any of these issues. Many women indicated that they were appreciative that some of their concerns and experiences were at last being addressed by primary care personnel.

The number of women screened at this center with a victimization history of any kind was striking: Women who reported a history of sexual

trauma or assault (32%) were particularly high compared with other health care seeking samples in the literature. These studies report rates of 14-25% (Greenwood et al., 1990; Springs & Friedrich, 1992). Although military service in particular appears to be a risk factor, our finding is likely to be important in terms of health care utilization in general, since sexual assault histories have been empirically linked to substantially increased use of medical care services (Golding et al., 1988; Koss et al., 1991). Moreover, other connections have been suggested to exist between childhood and adulthood victimization and health care usage (Alexander, 1996). Consonant with this research is our finding that women with trauma histories are more heavily represented among those seeking gynecological care and other specialized services.

Previous studies have shown that sexual harassment is not an uncommon part of the work environment for many women (Charney & Russell, 1994; Fitzgerald, 1993). Our findings were consistent with this body of literature, with almost half of the women screened reporting some form of sexual harassment in their lifetimes, and of these, almost half reporting that the harassment occurred within the work environment.

Consistent with the findings of Golding (1994), women seeking treatment for gender-specific services (i.e., gynecological services or breast health services) were more likely to report sexual trauma backgrounds. While this is compelling, it is important to note that research has suggested that female veterans in general have substantially higher lifetime prevalence of gender-based illnesses (e.g., breast cancer) than their civilian counterparts (LeDonne, 1988; Thomas, Kang, & Dalager, 1991). Hence, etiologic linkages cannot be determined.

The number of women who positively endorsed symptoms of eating disturbances was notably elevated and substance use disturbances were similar when compared to rates in the general population. Lifetime prevalence of eating disorders in the female population, for example, has been estimated to be 11% (Pope, Hudson, & Yurgelun-Todd, 1984), while substance abuse in women is approximately 18% (Kessler et al., 1994). Results of a 1986 study suggest that rates of alcohol abuse may be even higher for women seen in primary care settings (e.g., 16%, Blume, 1990). While it is important to note that not all of the women endorsing symptoms of eating/body image or substance problems would meet DSM-IV criteria for actual diagnosis (Spitzer et al., 1994), rapid and early detection of these symptoms is likely to be useful in enabling the provider to implement early interventions.

The overlap of trauma, substance use, and eating disturbances was corroborated by the large body of literature showing associations among

these components. The number of trauma experiences was a consistent thread in reports of substance misuse as well as eating and body image disturbances and stress, with repeated victimization playing a particularly salient role in the manifestation of weight/eating problems. To date, there has been some controversy in the literature regarding the relationship between trauma history, particularly sexual trauma, and disturbed eating patterns. This study provides support for a relationship between these two factors. Our finding that over half of the women queried had experienced some form of psychosocial stress is supported by the growing body of literature on the widespread problem of psychosocial stress and its relationship to physical health (Billings & Moos, 1982; Krause, 1994; Verbrugge, 1985).

A limitation of this study was the number of psychological and behavioral variables that were not explored. We did not, for example, evaluate depression–a pervasive problem in women–particularly for those with victimization histories (BunceWalker, Katon, Hansom, Harrop-Griffiths et al., 1992). Still, we were concerned at this stage with identifying victimization histories more widely associated with medical and psychological sequelae, and the screen was largely tailored to psychological specialty services being offered at the facility. Future studies should target depressive and anxiety symptoms. Similarly, more precise delineation of Posttraumatic Stress Disorder symptomatology is also indicated, given this disorder's prevalence in women.

Implications for treatment professionals in primary care clinics include the necessity and ease of implementing a screen as part of an overall health evaluation as well as the need for proper follow-up with psychoeducational materials and mental health referrals. Our data suggest that a comprehensive screen which assesses women for victimization history and psychological comorbidities is expeditious and provides useful information for health care providers. In situations where time allowed for a screen is limited, practitioners may choose to screen only specialty care patients and younger women, since our data suggest that it is these women who are at greatest risk for victimization history and psychological comorbidities.

With regard to follow-up, it is noteworthy that only 40% of the women who reported being bothered by past physical or sexual abuse or harassment were in treatment at the time of the screening. This suggests that there may be a substantial number of women who experience psychological distress but do not seek the psychological treatment that they may need. To address this potential need, detection of psychological symptomatology should be followed up with a mental health referral. To this end, primary care providers should work to develop ties with counseling ser-

vices and other mental health providers to ensure smooth integration of services. Additionally, health care centers may wish to provide relevant psychoeducational materials (e.g., brochures, pamphlets) on a variety of mental health issues.

The present study served to identify victimization histories and psychological comorbidities seen in women at our primary care facility. This information is being used to develop a comprehensive screening instrument that will include more detailed inquiry of victimization history and its impact. When psychometric properties are derived, such an instrument could be used in a range of health care facilities for women.

While our data are preliminary, they suggest that psychosocial stressors and psychological disturbances should be assessed and taken into account as part of a comprehensive medical evaluation for women, especially within primary care. Inclusive screening measures such as the one used in this study seem to provide critical background information and are efficient. Our experience and other research support that patients do not find these questions intrusive. Some, in fact, may welcome such inquiries as the response of a concerned professional or part of a more comprehensive approach to health care (Felitti, 1991; Friedman, 1992). In the long run, integrated and preventive health services can positively impact the psychological well-being of women who may be at high risk for medical problems associated with psychological distress. Such services may also streamline health care use by addressing the psychological issues which underlie them.

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