Sexual abuse and female sexual disorders: Clinical implications

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ABSTRACT. Patients that are seeking gynecological treatments for sexual dysfunctions are often likely to be sexual abuse survivors; it is therefore important for clinicians to conduct a thorough assessment that includes questions about sexual abuse history. Clinicians may not feel comfortable asking questions about sexual abuse history because of lack of experience and training on how to handle the difficult feelings associated with the topic. This paper aims at reviewing some of the most common health problems of women survivors of sexual abuse and provides a list of suggestions on how to handle disclosure of sexual abuse during the clinical interview.

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INTRODUCTION

Sexual abuse (SA) is a common problem often underestimated by clinicians. Although SA has a strong impact on the sexual functioning of survivors, questions about abuse are often not asked during assessment because health care providers may feel inadequately trained on the subject. This article aims at:

- providing suggestions on how to conduct interviews and assessments with women with a history of SA;
- providing information on psychosomatic, psychological and gynecological factors that may impact survivors' sexual functioning.

BACKGROUND

Women with a history of SA are more likely to utilize medical care than non-abused women (1, 2) and to report stress-related somatic and psychophysiological disturbances (3) including sexual dysfunctions. Becker et al. (4) found that in 371 assault survivors,

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sexual arousal dysfunction was highly prevalent in women with a history of rape and childhood SA, while low sexual desire affected women with a history of rape. Several factors make it difficult or uncomfortable for untrained clinicians to ask about past SA experiences: a) not knowing how to react to the patient's intimate disclosure, b) fear of invading the patient's privacy, c) confusion about what to do with the information given, and d) concern that talking about the event will make the patient feel worse. Studies in the area of trauma help address the answers to some of these concerns. For the clinician who is uncertain on how to react to a patient disclosing a history of SA, the best response is a warm and nonjudgmental one. At times the clinician may be tempted to investigate the accuracy of the patient's memories. Controversy surrounds the accuracy of SA recovered memories, which are defined as memories that have not been accessible to the patient for a period of time and begin resurfacing suddenly and often unexpectedly (5). Although researchers have not been able to determine the accuracy of these memories, from a clinical point of view this matter is of little importance (4). Treating all of the reported memories as valuable and reliable is the suggested approach taken by most therapists and clinicians who are conducting assessment and treatment interventions. Assuming an investigative role can create a hostile therapeutic environment and re-traumatization could occur if the patient were to feel doubted. At the same time, to prevent the formation of false memories, it is important not to imply or suggest that the patient may have been sexually abused.

When empathizing with a patient, the clinician should keep in mind that women vary in their responses to past SA. Some women have been able to cope effectively and although the memories of the abuse are still upsetting, they are no longer terrifying. For other women, the memories continue to be so disturbing that they are not ready to admit fear or anger toward the perpetrator. Reflecting the feelings expressed by the patient is a safe way to respond with empathy without making an assumption about the patient's current emotional state. The important message to convey in the initial moments of disclosure is complete acceptance with no judgment attached to what happened, and a genuine concern for the patient's safety and her feelings. Sympathy for the feelings of loss or for her anger towards the injustice of the situation can also be powerful tools for the development of a good relationship with the patient. Unless absolutely necessary for the assessment, it is not recommended that a clinician probe about details of the event. The patient may not be ready to disclose or focus on facts that could force them to delve into deeper feelings that they do not yet have the resources to control.

Clinicians often express concern that such questions may violate the patient's privacy, but survivors often report a sense of relief from disclosing a secret that was a source of guilt and shame. Additionally, including questions about a history of SA in the routine assessment helps dispel the myth held by some SA survivors that they are alone in their experiences. Clinicians should also keep in mind that the patient may have years of experience talking to therapists about the event and, consequently, talking about it may create little or no distress. Some clinicians may feel uncomfortable with the disclosure of the SA history because there is no immediate solution to the problem. These are feelings clinicians need to acknowledge, and this discomfort should not prevent them from including a useful and necessary part of the assessment.

Helpful procedures and recommendations for clinicians to offer patients who have disclosed a history of SA include assessing the patient's current safety, making a referral to a mental health professional when indicated, and ensuring the patient is not becoming overwhelmed with the memories. If the clinician suspects potential reoccurrence of the SA, the

patient needs to be referred to a mental care provider. It is important to keep in mind that the most intuitive advice (e.g., "leave your partner") may not be the safest or best solution for the patient. Clinicians should abstain from giving personal suggestions on what to do and should comply strictly with the ethical and legal guidelines of their affiliations. For those cultures in which therapy is not a common practice, the client may express some resistance to the referral. It can be useful to normalize the idea of therapy by explaining that often women report finding relief from being able to share these memories and feelings with someone who can help them work through the difficult emotions attached to these past events.

Conducting an invasive gynecological examination with SA survivors can be challenging. Patients' feelings of mistrust, anger, and pain may negatively interfere with the visit to the extent that they may not pursue further visits. Attention to key details can minimize the discomfort of the visit and increase the likelihood that the patient will return. First, conducting the interview prior to any physical examination can be helpful in establishing rapport. Second, the clinician should be cognizant of the patient's sensitivity to feeling out of control during assessment and invasive procedures. During the SA event, the survivor was deprived of the right to control what was happening, and this can be mirrored during the gynecological visit. The clinician should inform the client that she should feel free at any point to ask to stop or take a break. Giving the patient privacy when she undresses, asking for a female nurse to be in the room during the visit, and explaining the clinician's actions step by step are standardized procedures used in the United States that can be particularly useful with SA survivors.

CLINICAL APPROACH

Below are the three major areas of concern that would be helpful for the clinician to consider when assessing women with a history of SA:

1. Psychosomatic

Women with a history of SA often report having frequent headaches, weight change, and back pain. Weight change can have an impact on sexual functioning by making women feel unattractive (6). Often, a sense of nausea and gagging may be reported during sexual activity, particularly in women who were forced to perform oral sex. Cardiac arrhythmia and menstrual symptoms are also frequently reported.

2. Psychological

Because of the high comorbidity between psychological disturbances and SA, it is important to collect information regarding common psychological syndromes such as depression, post-traumatic stress disorder (PTSD), general anxiety, and dissociation. SA survivors may report a lack of interest in fun activities (sex may be one of the activities), lack of energy, and decreased self-worth. Feeling too tired to engage in previously enjoyable activities or feeling unattractive and unlovable are aspects of depression that can indirectly impact the patient's sexual functioning.

PTSD symptoms such as intrusive and unwanted memories, hypervigilance, or exaggerated startle reaction, and a sense of numbness or isolation from people may also negatively impact sexual functioning. Women often try to deal with these symptoms by avoiding situations that trigger memories, which sometimes means avoiding sex-related thoughts and behaviors (2). Women with PTSD often use drugs and alcohol to self medicate. This could put the woman at risk to engage in unwanted sexual behavior.

Dissociation (e.g., feeling like floating above one's body during sexual activity) is also a common experience among SA women who find sexual activity upsetting (7). Although the dissociation may have been an adaptive behavior during the SA experience since it allowed the woman to block out the pain and anguish,

Table 1 - Practical Message: psychosomatic, psychological and gynecological consequences of sexual abuse that may impact female sexual functioning.

Psychosomatic	Psychological	Gynecological
Headaches	Depression	Urinary tract infections
Nausea	Post traumatic stress disorder	STDs
Back pain	General anxiety	Pruritis
Cardiac arrhythmia	Difficulties trusting partner	Abdominal pain
Menstrual symptoms	Anger	Skin lesions and trauma
Weight change	Dissociation	Yeast infection
Gagging – Vomiting	Avoidance/Fear sex	Scars in posterior forchette, hymen, vagina

continuing to dissociate during consensual sexual activities may prevent the development of any type of sexual pleasure or sense of closeness. Feelings of anger towards sex in general, men, or one's partner, or a lack of trust in others (8) are often associated with a history of SA and can affect sexual functioning.

3. Gynecological

Lesions or sexually transmitted diseases that may have occurred as part of the SA can impact the survivor's current sexual functioning. In particular, physicians should pay attention to potential lesions and scar tissue in the hymen, posterior forchette, and inside and outside the vagina (9). Yeast infections are also common among women who have been sexually abused.

CONCLUSIONS

In summary, it is advisable for the clinician to question about a history of SA. If the patient starts disclosing a history of SA it is important to show empathy, assess for current safety, and make a referral in cases where the patient looks distressed or reports having difficulties dealing with the memories. To effectively assess sexual functioning, the clinician is advised to assess the potential psychosomatic, psychological and gynecological consequences of SA listed in Table 1.

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