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Sexual trauma in women

The importance of identifying a history of sexual violence

Background

One in three women in Australia will experience sexual violence at some time in their life. Although these women use health services more than nonvictimized women, they may not receive the holistic care they need if their sexual trauma history is not known.

Objective

This article discusses the importance of opportunistically identifying a history of sexual violence in women presenting to general practice in order to provide optimal healthcare and avoid iatrogenic retraumatisation.

Discussion

A history of sexual violence is associated with an increased incidence of long term physical and psychological health problems, psychosocial difficulties, risk taking behaviours and premature death. Most survivors do not disclose a history of sexual violence to their doctors. Without this context, their ongoing health issues may not be fully understood, leading to suboptimal care. A safe environment is vital to support disclosure. General practitioners are well placed to identify, support and treat and/or appropriately refer women with a history of sexual violence. Priorities in management include addressing the pervasive long term consequences of sexual violence, encouraging preventive care and avoiding inadvertent retraumatisation.

Keywords

women's health; violence; sex offences; patient care management; general practice

after the birth of her first child. She was treated with antidepressants for 12 months, but stopped taking these as they made her feel nauseous and robotic. She was not offered any counselling at this time.

Medical procedures that required intimate contact sometimes triggered unexpected and unwanted responses. For example, Jennifer remembered having had two painful Pap tests in her 20s that had resulted in flashbacks, so she had avoided having Pap tests since. She was terrified of injections and avoided going to the dentist. She also felt guilty about the effects of her symptoms on her husband and children.

Just before disclosing her history of sexual violence she had watched a documentary about child abuse and realised that her ongoing physical and emotional problems were identical to those experienced by other victims. Jennifer attended a general practitioner who asked her when she had last had a Pap test. When Jennifer told the GP that it had been 10 years before, the GP asked if there was a particular reason for this. Jennifer then disclosed her history of sexual violence.

Talking about her experiences of sexual violence for the first time caused Jennifer to experience further anxiety and panic attacks in the ensuing days after disclosure. The GP arranged a longer appointment at which they discussed treatment options. The GP told Jennifer that she was suffering from a form of post-traumatic stress. Having kept the history of sexual violence hidden for so long led to Jennifer experiencing physical symptoms as well as emotional pain. She and her GP worked together to deal with the painful aftermath of disclosure, and scheduled regular appointments to facilitate Jennifer receiving optimal healthcare.

Case study

Jennifer, a scientist and married mother of three, was 38 years of age when she first disclosed a history of sexual violence: 'Disclosing the fact that I had been sexually violated, not by strangers, but by people closely linked to my family was so shameful it made me stay silent for over 30 years.'

Up until this time, no healthcare professional had asked Jennifer if she had ever experienced sexual violence. Over a period of many years she had presented with a range of symptoms including abdominal pains, headaches, menorrhagia and episodic depression, including postnatal depression

Sexual violence (SV) includes all forms of sexual assault, rape, attempted rape, contact and noncontact sexual violence and childhood sexual assault. It refers to unwanted and nonconsenting sexual activity in childhood, adolescence and adulthood. Sexual trauma encompasses both the event and its impact on the individual.

One in three women in Australia in 2002–03 reported experiencing SV over their lifetime and 29% experienced physical and/or SV before the age of 16 years.¹

It is also estimated that one in 6 men have a history of SV, predominantly as childhood sexual abuse or SV in early adolescence.² However, unlike women, there is a low incidence of SV for males in adulthood.

General practitioners will inevitably see patients for the health problems associated with sexual trauma,^{3,4} many without being aware of the SV, because most survivors do not disclose their experiences to health professionals.^{1,5–7} Additionally, some GPs may not broach this sensitive subject with their patients.⁸ It is important that GPs are aware of the long term physical and psychosocial sequelae of SV and the relevant intervention skills required to treat these patients holistically to avoid inadvertent retraumatisation.⁹

Although this article provides an overview of the evidence, issues and implications of sexual trauma in women, some of the findings are also relevant to male survivors of sexual trauma.

Long term health sequelae of sexual trauma

Over the past 3 decades, most English language research on the long term health sequelae of SV in women has reported on cross-sectional studies of community residents, college students and military personnel in the United States, relying mainly on self reported data. As such, a causal relationship between SV and health problems cannot be confirmed and more research is needed in this area. Researchers have often reported aggregated data for physical and/or SV, rather than SV in isolation, and have often included data on intimate partner violence. Nonetheless, the evidence across a number of studies using large, representative samples suggests that SV in women is associated with long term physical and psychological health problems. Those seeking health

services may present with a range of symptoms and medical conditions that diminish their quality of life. These may be comparable to chronic diseases such as diabetes and heart disease,¹⁰ impair daily functioning and disrupt the strength and quality of social relationships.^{7,11}

The adult health sequelae of childhood sexual abuse alone may present as psychosomatic symptoms, which may confound both survivors and health professionals, resulting in underdetection, misdiagnosis and ineffective treatment.¹² Sexual trauma is associated with a range of physical health problems,^{13,14} persistent urogynaecological and obstetric problems,^{6,15,16} mental health problems^{10,12,17–21} and health risk behaviours,²² as well as avoidance of preventive health examinations.^{13,23,24} Table 1 lists the long term health problems associated with sexual trauma in women.

Considerations for GPs

Women with a lifetime history of SV use health services more than nonvictimised women,^{3,15} but are often reluctant to disclose their experiences of SV to health professionals, including GPs.^{1,5–7} As a result, these women may not receive timely and appropriate intervention to detect, treat and/or prevent health problems.

In particular, women with a lifetime history of sexual trauma tend to avoid preventive healthcare such as Pap smears and early antenatal care.^{13,23,24} This is concerning as women with a lifetime history of SV, including childhood sexual abuse, rape and sexual intimate partner violence, have an increased risk for sexually transmissible infections, cervical dysplasia and an increased prevalence of invasive cervical cancer.²⁵

The evaluation of common gynaecological problems also places these women at risk for retraumatisation (eg. triggered memories or dissociation) during gynaecological and breast examinations.^{6,26,27} Retraumatisation may also occur in the context of perinatal care of women and/or their babies.²⁸

The ongoing impact of sexual trauma on mental health is an important consideration for GPs. Depression, anxiety, stress and post-traumatic stress disorder (PTSD) may also increase the risk for alcohol abuse,²⁹ binge drinking^{30,31} and substance abuse.^{20,31} Moreover, PTSD is a risk factor for revictimisation,²⁰ as is childhood sexual abuse,^{1,32,33}

and substance abuse and/or heavy alcohol consumption in specific populations, including female adolescents and college students.^{34–37} Compared to the general population, childhood sexual abuse victim-survivors also have a greater risk for suicide and accidental fatal drug overdose.³⁸

What can GPs do?

General practitioners need to be aware of the long term health sequelae of SV. However, to date, undergraduate and graduate entry medical programs

Table 1. Long term health problems associated with a history of sexual trauma in women

Physical health problems^{13,14}

- Irritable bowel syndrome
- Abdominal pain
- Vaginal pain
- Breast pain
- Headaches
- Musculoskeletal pain

Urogynaecological and obstetric problems^{6,15,16}

- Pelvic pain and pelvic inflammatory disease
- Dysmenorrhoea
- Menorrhagia
- Sexual dysfunction
- Nonmenstrual vaginal bleeding or discharge
- Rectal bleeding
- Bladder infection
- Dysuria

Mental health problems^{10,12,17–21}

- Anxiety
- Depressive symptoms
- Major depressive episodes
- Post-traumatic stress disorder

Health risk behaviours associated with childhood sexual abuse²²

- Smoking
- Alcohol use
- Drug use
- Obesity and inactivity
- Early intercourse and multiple partners

Avoidance of preventive healthcare^{13,23,24}

- Pap tests
- Breast examinations

in Australia have focused mainly on recent sexual assault and/or sexual abuse.³⁹ Both the health impact and the community costs of sexual trauma in women could potentially be reduced by early identification, allowing for timely and appropriate intervention to treat and prevent health problems.⁴⁰ Importantly, the overwhelming majority of women with a past history of SV do not tell their doctors what happened to them unless they are specifically asked. Instead, they present over time with a range of physical and/or psychological symptoms, as outlined in *Table 1*. Therefore, GPs who connect a woman's symptoms to historical SV are better placed to provide holistic treatment to the woman.⁷

The Royal Australian College of General Practitioners *Guidelines for preventive activities in general practice*⁴¹ (section on identification of psychosocial problems), and consensus guidelines for primary care physicians managing the family unit in the presence of intimate partner violence,⁴² advocate personal and professional attributes similar to those required to care for women with historical SV.

In terms of when to ask about SV, questioning is indicated if the patient presents with multiple or chronic health problems, expresses feelings of helplessness, shame or guilt, or avoids or has difficulty with medical examinations or procedures.⁴³ Before asking about a history of SV however, GPs should establish rapport and trust with their patient; monitor their own personal and professional attitudes and beliefs; be nonjudgemental and open to discussing sexual trauma; be prepared to acknowledge and validate the disclosure; make the patient feel safe and protected; ensure confidentiality; provide sufficient consultation time for discussion; and be able to refer the patient to culturally appropriate, affordable treatment, and psychological or specialist services when needed.^{7,42–44} Staff training, confidentiality of patient records and clinic protocols for monitoring patient safety are also important.

Summary

Women with a lifetime history of SV can be opportunistically identified by GPs, as they are likely to present more frequently than other patients with multiple or chronic health problems, have poor health status or display health risk behaviours. Many of these women will be

reluctant to disclose their experiences unless they already feel comfortable with their doctor.

As one in three women are affected by a history of SV, there is a pressing need to improve GP knowledge of the long term physical, psychological, behavioural and social sequelae in victim-survivors in order to build practitioners' capacity to sensitively, safely and effectively meet the needs of these women over their lifetime.

Evidence for the health impacts of a lifetime history of SV and skills in the sensitive and appropriate management of these issues should be included in both undergraduate and postgraduate medical curricula.

Guidelines for preventive activities in general practice should cover the identification of a history of SV and the appropriate interventions and counselling techniques and referral options.

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