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Dealing with patients facing a history of sexual abuse: A cross-sectional survey among Dutch general practitioners

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KEY MESSAGES

- General practitioners reported a need for a clinical practice guideline and a need for additional education on how to counsel for sexual abuse.
- Nurse practitioners perform most of the cervical screening smears in general practices, but the majority never or rarely asks about sexual abuse in advance.

ABSTRACT

Background: Sexual abuse (SA) is a common problem. As the primary confidant, the general practitioner (GP) has a valuable role in identifying a history of abuse, specifically with regard to the commonly performed pelvic examination for cervical cancer screening.

Objectives: This study focused on GPs' practice patterns, knowledge, training need and barriers concerning asking patients about SA. Furthermore, it was investigated who performs the cervical smear within the practice and if SA is taken into consideration.

Methods: The authors constructed a 31-item questionnaire, which was sent to a group of 730 Dutch GPs in September 2012.

Results: The response rate was 49.3%. Half of the 357 responding GPs asked their patients about SA sometimes. The majority (76.2%) stated they had some knowledge of SA. The most important barriers for not asking were 'no angle or motive for asking' (81.6%), 'presence of third parties' (73.1%), and 'not enough training' (54.1%). In most practices (84.3%), the nurse practitioner (NP) was assigned to perform the cervical smears, of which 34.8% presumably never ask about SA in advance. Additional training was in need according to 68.6%. GPs desired a clinical practice guideline regarding the counselling of SA (83.5%).

Conclusion: This study showed SA is an under-evaluated problem in general practice, yet GPs are motivated to improve knowledge and counselling skills. NPs perform most of the cervical smears, but the majority never or rarely asked about SA in advance. Educational training and a clinical guideline regarding SA would be appreciated and hence recommended.

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Introduction

Despite the UN Declaration on the Elimination of Violence Against Women adopted in 1993,[1] sexual abuse (SA) remains a common problem, the consequences of which affect both psychological and physical well-being.[2,3] Nonetheless, an event not only strikes women but also happens to men. In a recent survey among 9710 Dutch women and men aged 12–25 years, 40.6% of women and 20.4% of men reported having

experienced any non-volitional sex.[4] However, forced sex by penetration was reported by one in five women and by one in 20 men. In the instance of penetration (88.5%) or assault (72.5%), the perpetrator was known to the victim as an intimate partner, family member, good friend or other acquaintance.[4] This inordinate prevalence of sexual abuse is not exclusively a Dutch problem, as high prevalence of abuse has also been reported in the American,[5] Canadian,[6] Australian [7] and Nordic populations.[8] Due to different abuse definitions and

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sample characteristics being investigated, the prevalence rates are varying. When forced sex is distinctly defined as any vaginal, oral or anal penetration or intercourse in a situation against the will including situations where someone was unable to give consent, the lifetime prevalence is 10.6% for women and 2.1% for males.[9]

Patients with a history of sexual abuse are likely to experience and report various complaints, such as functional gastrointestinal disorders, chronic nonspecific pain and multiple psychiatric disorders.[2,3] Moreover, a history of sexual and physical abuse is associated with increased healthcare utilization including a greater risk for lifetime surgeries.[10] Alternatively, victims of emotional, physical and sexual abuse are often not identified by their healthcare providers, in this case, gynaecologists and gastroenterologists.[10,11]

In general practice, several situations are conceivable, in which a possible history of abuse should be taken into consideration. Potential situations include inexplicable or indistinct somatic complaints (often chronic or recurrent abdominal pain, pelvic pain and multiple somatic symptoms);[10] consultation on at first non-related psycho-emotional problems, consultations on insoluble urogenital tract problems and in advance of routinely performed preventive cytological examination of the cervix.

Concerning the cervical smear examinations, in the Netherlands the government provides a voluntary screening programme for cervical cancer. Every five years all women aged 30–60 years are invited for a cervical smear for cytological examination. This intimate procedure is usually taken in a general practice by using a speculum. The general practitioner (GP), the nurse practitioner (NP) or a medical intern may perform the procedure. It is a well-known fact that women with a history of SA report significantly more distress and pain during the pelvic examination.[12,13] Moreover, they tend to avoid the examination completely due to the additional distress.[14] The emotional contact between patient and examiner is of great importance as it leads to less discomfort for the patient during the gynaecological examination.[12,13]

Patients who have experienced SA may find it difficult to raise this delicate subject during a consultation. As the primary confidant often over a longer period, the GP is in a suitable position to raise the topic. This appropriate position is emphasized by three-quarters of the patients indicating a desire for professional care after having experienced SA, specifically including care from the GP.[15] In spite of this, little is known about the GPs' knowledge of prevalence and attitude in current practice towards asking about SA. This study focused on two aims:

- (1) To determine the attitude of Dutch GPs towards the provision of care for both male and female victims of sexual abuse and to evaluate their knowledge regarding SA.
- (2) To evaluate by which healthcare provider the cervical screening smear is performed within the practices and if specific attention is paid to SA in advance of performing a cervical smear.

Methods

Study design

Data for this cross-sectional survey were collected using a questionnaire (Supplementary material available online). The questionnaires were sent to two groups, together forming 730 Dutch GPs. At the time the study was conducted (September to December 2012), 8879 GPs were actively employed within a general practice throughout the Netherlands.[16]

Selection of participants

Participants were approached by two procedures; this was done to obtain a large, representative sample of all practicing GPs in the Netherlands. The addresses of the first group GPs were obtained from the website <http://www.zorgkaartnederland.nl> during September 2012. This website contained all the addresses of Dutch GPs and it was designed for patients to assess GPs. From 9278 Dutch GPs, 622 general practices were selected that had not been rated by patients, excluding those from the district of Leiden (Group 1). The second sample, 108 GPs and residents practicing in the district of Leiden received the questionnaire accompanied by an invitation to a training course in urology (Group 2). This was a convenient way to increase the total group of GPs, as the organizers of the training course agreed to send the questionnaire to the course attendees.

Survey procedure

After the initial mailing, reminders were sent to non-responders of the first group of 622 participants, after one and three months. It was not possible to send a reminder to the group from the district of Leiden, as only the organizers of the training course knew the addresses.

Questionnaire design

The authors designed the questionnaire based on a concise review of the literature (Supplementary material

available online). SA was introduced by the definition: 'Sexual abuse includes either forced commitment of any sexual contact or being forced to be a spectator of sexual acts of any kind, at any age'. Three GPs performed a pilot study; adjustments were made according to their comments.

The questionnaire consisted of 31 questions focusing on:

- (1) Demographic data including age, gender, function, experience, type of practice, Marital status and creed; seven items.
- (2) Practice, level of knowledge and awareness regarding SA; 20 questions.
- (3) Which procedure the practice follows regarding the cervical smear examination; three questions.
- (4) One question including 20 possible barriers towards addressing SA during a consultation.

With regard to the question on level of knowledge (question 25, Supplementary material available online), the responders were asked to rate on a scale from 1–10 what they knew about assisting patients with issues of sexual abuse. According to the Dutch educational rating system (high school and university), 1–5 was considered insufficient and 6–10 sufficient.

Analysis

Quantitative data were analysed by SPSS 20 (SPSS Inc., USA). Means of demographic values and answers to the questions were analysed using frequency distributions. Bivariate associations between demographic information and categorical data were calculated using the Pearson chi-square procedure. Associations between numerical data and demographics of the responders were analysed with independent sample *t*-tests and Cochran–Armitage test for trend. Comparison between the demographic characteristics of Group 1 and Group 2 was performed using Pearson chi-square procedure and independent *t*-test, depending on the type of data. Two-sided *P*-values <0.05 were considered statistically significant.

RESULTS

Response and participants

From 730 GPs, 524 responded to the mailing (71.8%) and six GPs moved to another address. Of these 524 replies, 357 GPs completed the questionnaire (response rate $357/724 = 49.3\%$), and 167 GPs reported they were not willing to participate. Reasons reported for not participating were lack of interest ($n = 30$, 18%), lack of time ($n = 127$, 76%), lack of experience ($n = 19$, 11.4%), currently not practicing as GP ($n = 8$, 4.8%). Four general

practitioners did not state a reason; some stated multiple reasons as multiple answers were possible. Two questionnaires were incomplete (<90%) and one was not included as it was not understandable due to illegible writing.

Demographic data of participants from the training course and participants from the postal survey were compared. Participants from the training course were significantly more often residents; for extensive information on responders' characteristics and participants (Table 1 and Figure 1).

Knowledge

In response to the question: 'How much knowledge do you have about sexual abuse?' most responders ($n = 269$, 76.2%) answered 'some knowledge,' 6% ($n = 23$) had considerable knowledge, and 17% ($n = 60$) said they did not have much knowledge. Sixty per cent ($n = 215$, 60.7%) thought that their knowledge was sufficient to be able to assist patients with issues of sexual abuse. Differences in age, gender, religion, time or experience as GP, did not affect the answers to any of the questions on knowledge. Sixty-nine per cent ($n = 244$) of the responders would like to improve their skills and knowledge. In response to the statement 'Estimate how much of your female and your male patients have a history of sexual abuse', the mean estimate for male patients was 4.5% (SD: 3.5), for female patients 10.6% (SD: 7.3). The majority of the GPs (83.6%) were aware of possible physical symptoms caused by sexual abuse. Most GPs (83.5%) expressed a wish to have a NHG (The Dutch College of General Practitioners) clinical practice guideline about sexual abuse and its physical and mental consequences.

Counselling and inquiry

To the question, 'How often do you ask about sexual abuse?' 0.6% ($n = 2$) answered never, 36.0% ($n = 129$) rarely, 52.2% sometimes ($n = 184$), 10.2% ($n = 36$) regularly and 0.8% ($n = 3$) said often. Responders' characteristics about the reported frequency of discussing SA are shown in Table 2. Responders who believed they had sufficient knowledge asked about sexual abuse more often (linear-by-linear association, $P = 0.002$). During the year before the questionnaire was sent, an estimation of 2.7% (SD: 4.0) of the female and 0.8% (SD: 1.8) of the male patients were asked about SA. Female responders and responders who thought their knowledge about SA was sufficient discussed SA more often with female patients. ($P = 0.041$ and $P = 0.019$, respectively). The most common reason for asking about sexual abuse in

Table 1. Responders' characteristics.

	Group 1 ^a (n = 297)	Group 2 ^b (n = 60)	Total ^c (n = 357)	Comparison Groups 1 and 2
Age in years—mean (range)	46.7 (26–72)	46.5 (25–67)	46.7 (25–72)	NS
Gender, female n (%)	169 (57.1)	30 (50)	199 (55.9)	NS
Function n (%)				P = 0.049
GP	289 (97.3)	55 (91.7)	344 (96.4)	
Resident (GP)	8 (2.7)	5 (8.3)	13 (3.6)	
Type of practice n (%)				NS
Single-handed practice	58 (19.5)	13 (21.7)	71 (19.9)	
Group practice	188 (63.3)	30 (50.0)	218 (61.1)	
Other ^d	51 (17.2)	17 (28.3)	68 (19.0)	
Time of experience in general practice n (%)				NS
0–11 months	4 (1.4)	1 (1.9)	5 (1.5)	
1–2 years	16 (5.5)	2 (3.7)	18 (5.2)	
3–5 years	34 (11.8)	6 (11.1)	40 (11.7)	
6–10 years	58 (20.1)	9 (16.7)	67 (19.5)	
11–15 years	51 (17.6)	8 (14.8)	59 (17.2)	
15 years or longer	126 (43.6)	28 (51.9)	154 (44.9)	
Religious, Yes n (%)	112 (38.5)	23 (40.4)	135 (38.8)	NS

^aRandomly selected GPs, excluding those from the district Leiden.

^bGPs practicing in the district Leiden.

^cn total differs, not all questions were answered consistently.

^dOther types of practice included multiple shared practices, teaching practices, hospital emergency clinics and other healthcare facilities. NS, not significant.

female patients was sexual problems; other reasons are presented in Figure 2.

Barriers

The three most agreed reasons that keep GPs from asking about SA were 'no angle or motive for asking' (81.6%), 'presence of third parties' (73.0%), and 'not enough training' (54.4%). Responders younger than 47 years old agreed more often with 'presence of third parties' and 'afraid to offend the patient' (linear-by-linear association, $P < 0.001$, $P = 0.025$). Responders older than 46 years agreed more often with: 'sex is a private matter' (linear-by-linear association, $P = 0.001$). GPs with 10 years of experience or less agreed more often to the barrier 'presence of third parties' ($P = < 0.001$). For the agreeability on all barriers, see Table 3. Reasons for not asking about SA in relation to the reported frequency of discussing SA are presented in Table 4.

Follow-up of the SA patient

In response to the question, 'If you are aware of your patient having a history of sexual abuse, what is your next step?' (multiple answers possible), most responders answered: 'I ask if the patient wants to talk about it' (57.0%, $n = 204$), followed by 'I wait until there is a reason to initiate a discussion about it' (32.7%, $n = 117$). Hardly any of the responders provided information if they were familiar with a patient's history of SA ($n = 6$, 1.7%). More than half of the responders ($n = 182$, 52.0%) indicated the wish for a referral system for patients who have a history of sexual abuse.

Cervical smear

In most practices (84.3%), the NP is assigned to perform the cervical smears. Female GPs performed the cervical smear significantly more often than their male colleagues did ($P = 0.030$). The responders estimated that 34.5% of their NPs never asked, 21.3% rarely asked, and 12.9% sometimes asked about SA before performing the cervical smear. Three per cent of the NPs are estimated to ask always, often or regularly in advance of a cervical smear and 28.1% of the responders did not know if their NPs asked about SA ($n = 310$).

Discussion

Main findings

When GPs were aware of a patient having a history of sexual abuse, 60% reported asking if a patient wants to talk about it. Only one-tenth of the responders stated to ask 'often' or 'always' about sexual abuse. The majority of the responders reported they possessed some knowledge about sexual abuse and wished to improve their knowledge. The two main reasons that keep GPs from asking about SA were 'no angle or motive for asking' and 'presence of a third party.' Most of the cervical smears are performed by NPs; half of them were trained during a course instructing them how to perform the procedure. According to the GPs' estimation, one-third of the NPs never ask about negative sexual experiences in advance of a cervical smear. Approximately one-third of the GPs did not know if their assistant asks about SA in advance of a cervical smear.

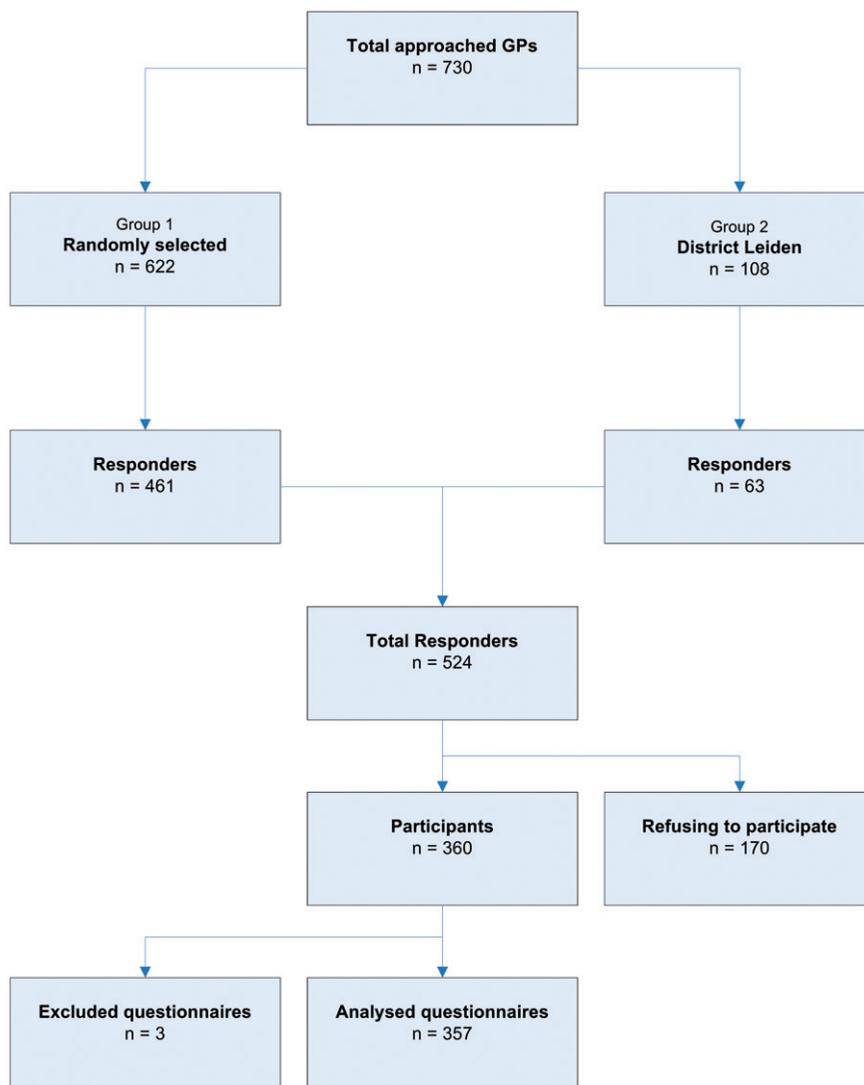


Figure 1. Flow chart participants.

Barriers towards discussing SA in practice

It is well known that most women find it difficult to raise the topic of SA themselves, and believe it would be easier if health professionals initiate a dialogue. Women considered it natural and relevant in the context of a gynaecological examination to answer questions about sexual abuse.[17] Only 0.4–1.1% patients told their gynaecologist spontaneously about abuse during a visit to the clinic.[11] Incomplete knowledge together with little disclosure from patients might lead to an underestimation and restricted discussion of SA by GPs. The same barriers that inhibit from asking patients about sexual function were found in Dutch cardiologists.[18] Although asking patients about sexual function disease is different from asking about sexual abuse, the same barriers were found: 'I do not have an angle or motive' and 'presence of a third party'.[18]

Gynaecological examination

In accordance with this study, clinical staff taking cervical screening samples in primary care underestimated the frequency of SA.[20] Also, similar to the current study, SA was not frequently raised during a visit to the doctor or prior to the cervical smear. A cross-sectional, multicentre Scandinavian study showed that 96–98% of gynaecological patients did not talk to their gynaecologist about abuse at their latest visit to the clinic.[12] However, the self-confidence required to raise a topic such as SA during or before a cervical smear is not always present. A research study concerning childhood SA and adult cervical screening by GPs and nurses found that 50% of the responders felt confident, and 66% felt competent to undertake the cervical smear procedure in childhood SA survivors.[20] A history of sexual abuse is associated with discomfort during gynaecological examinations

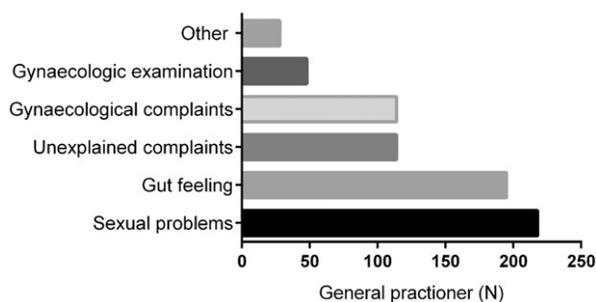
Table 2. Responders characteristics in relation to the frequency of discussing SA.

Responders characteristics	Routinely discussing SA ^b n (%)	Infrequently discussing SA ^b n (%)	P ^a
Gender			0.033
Male	11 (7.1)	144 (92.9)	
Female	28 (14.3)	168 (85.7)	
Age			NS
46 years and under	17 (9.9)	154 (90.1)	
Over 46 years	22 (12.2)	158 (87.8)	
Function			NS
GP	39 (11.5)	300 (88.5)	
Resident (GP)	0 (0)	13 (100)	
General practice experience			NS
≤10 years of experience	13 (10.1)	116 (89.9)	
> 11 years of experience	26 (12.3)	186 (87.7)	
Religious			NS
Yes	16 (12.1)	116 (87.9)	
No	21 (9.9)	192 (90.1)	

^aP value of chi-squared test between frequency of discussing SA and the presented items.

^bRoutinely was defined as the answers 'regularly,' 'often,' 'always' to the question 'How often do you ask about sexual abuse?,' infrequently was defined as the answers 'never,' 'rarely' and 'sometimes.'

NS, not significant.

**Figure 2.** The most common motive for asking a patient about SA (multiple answers possible).

and negative emotional contact with the examiner.[12] Those who experience such discomfort may even be at risk of re-traumatization during the gynaecological examination.[19] For this reason, it is important that GPs and NPs pay attention to the patient's experience before embarking on the gynaecological examination and collect confidence in doing so.

Knowledge and training need

In a survey of patient preferences and physician practices, almost 90% of the patients favoured inquiry about sexual abuse and believed that physicians could help them with the related problems.[21] These results enhance the importance of GPs possessing knowledge regarding prevalence and implications of SA to be able to inquire about it. Several studies indicate that training about care for sexual assault victims significantly improves clinicians' knowledge and facilitates inquiry.[22] Concerning children, it has been shown that an interdisciplinary team,

Table 3. Reasons for not asking about SA.

	Agree ^a n (%)	n ^b
No angle or motive for asking	288 (81.6)	353
Presence of a third party	257 (73.0)	352
Not enough training	192 (54.4)	353
Language or ethnicity reasons	169 (47.9)	353
Patient does not ask about it	160 (45.1)	355
Cultural or religious reasons	124 (35.2)	352
Afraid to offend the patient	122 (34.6)	353
Not enough knowledge	121 (34.5)	351
I feel uncomfortable with it	115 (33.0)	348
Patient is not ready to introduce SA	113 (32.2)	351
Not enough time	100 (28.2)	355
No connection with the patient	86 (24.5)	351
Feelings of shame	74 (20.8)	356
Advanced age of the patient	60 (16.9)	355
Sex is a private matter	52 (14.8)	352
Young age of the patient	48 (13.5)	355
Patient has a different gender	37 (10.5)	354
Age difference	17 (4.8)	354
It's someone else's task	9 (2.5)	355
Patient has the same gender	7 (2.0)	355

^aFor ease of presentation, results in response categories 'Strongly agree' and 'agree' have been merged, as have 'strongly disagree' and 'disagree.'

^bn total differs, not all questions were answered consistently.

using patient care exposure, will increase the physician's knowledge on evaluating children who have experienced SA.[23] Concordantly, results in this study show GPs' knowledge regarding SA needs to be improved and that extra attention to this aspect in GPs' education would be appreciated. Educational training might be of help in diminishing inhibitions and thus increasing the chance of SA being routinely addressed.

Strengths and limitations

This study has a few limitations. We used a non-validated questionnaire. Validated instruments, which evaluate GPs practices and beliefs about SA, do not exist. There might be a reporting bias as it is likely that non-responders are less interested in evaluating SA or already familiar with evaluating SA. Moreover, it is plausible that responders gave socially acceptable answers. Attempts were made to reduce such bias by conducting the survey anonymously. Two groups were approached which might have induced contrasting samples; however, the comparison showed that except for the number of residents, the groups were equivalent. Also, the varying number of residents is hardly a contributing and relevant detail as this calculation concerns a very small number of residents.

Another limitation of this survey is that GPs were asked to estimate how often the NPs counsel for SA concerning performance of the cervical smear, which is an exploration of a colleague's account. According to the authors' point of view, an accurate exploration of practice pattern is possible in most cases as GPs have intensive contact with their NPs. Differences in

Table 4. Reasons for not asking about SA in relation to the frequency of discussing SA.

Reasons for not asking about SA ^a	Routinely discussing SA ^c n (%)	Infrequently discussing SA ^c n (%)	P ^b
No angle or motive for asking +	27 (9.5)	257 (90.5)	0.039
No angle or motive for asking -	12 (18.5)	53 (81.5)	
Presence of a third party +	30 (11.9)	223 (88.1)	NS
Presence of a third party -	8 (8.4)	87 (91.6)	
Not enough training +	14 (7.4)	174 (92.6)	0.026
Not enough training -	24 (14.9)	137 (85.1)	
Language or ethnicity reasons +	21 (12.7)	145 (87.3)	NS
Language or ethnicity reasons -	16 (8.7)	167 (91.3)	
Patient does not ask about it +	6(3.8)	152 (96.2)	<0.001
Patient does not ask about it -	33 (17.1)	160 (82.9)	
Cultural or religious reasons +	15 (12.3)	107 (87.7)	NS
Cultural or religious reasons -	22 (9.7)	204 (90.3)	
Afraid to offend the patient +	11 (9.3)	107 (90.7)	NS
Afraid to offend the patient -	27 (11.7)	204 (88.3)	
Not enough knowledge +	6 (5.0)	113 (95.0)	0.011
Not enough knowledge -	32 (14.0)	196 (86.0)	
I feel uncomfortable with it +	7 (6.2)	106 (93.8)	0.035
I feel uncomfortable with it -	32 (13.9)	199 (86.1)	
Patient is not ready to introduce SA +	13 (11.5)	100 (88.5)	NS
Patient is not ready to introduce SA -	24 (10.3)	210 (89.7)	
Not enough time +	11 (11.3)	86 (88.7)	NS
Not enough time -	27 (10.6)	227 (89.4)	
No connection with the patient +	7 (8.1)	79 (91.9)	NS
No connection with the patient -	31 (11.9)	230 (88.1)	
Feelings of shame +	5 (6.8)	68 (93.2)	NS
Feelings of shame -	34 (12.2)	245 (87.8)	
Advanced age of the patient +	5 (8.5)	54 (91.5)	NS
Advanced age of the patient -	34 (11.6)	258 (88.4)	
Sex is a private matter +	4 (8.2)	45 (91.8)	NS
Sex is a private matter -	35 (11.7)	264 (88.3)	
Young age of the patient +	1 (2.1)	46 (97.9)	0.035
Young age of the patient -	38 (12.5)	266 (87.5)	
Patient has a different gender +	1 (2.8)	35 (97.2)	NS
Patient has a different gender -	38 (12.1)	276 (87.9)	
Age difference +	0 (0)	16 (100)	NS
Age difference -	39 (11.7)	295 (88.3)	
It's someone else's task +	1 (11.1)	8 (88.9)	NS
It's someone else's task -	38 (11.1)	304 (88.9)	
Patient has the same gender +	0 (0)	7 (100)	NS
Patient has the same gender -	39 (11.3)	305 (88.7)	

^a+ meaning the reason was agreed; - meaning the reason was disagreed by the general practitioners.

^bP value of chi-squared test between frequency of discussing SA and the presented items.

^cRoutinely was defined as the answers 'regularly,' 'often,' 'always' to the question 'How often do you ask about sexual abuse?,' infrequently was defined as the answers 'never,' 'rarely' and 'sometimes.'

NS, not significant.

prevalence rates occur as a result of variance in definitions of SA and criteria for age. Religion and civil status of participants were obtained, and the demographics of the responders were taken into account and compared with practice patterns. To the best of our knowledge, this report reflects an extensive study about the way GPs deal with SA in their daily practice.

Implications for clinical practice and education

This study indicates that it might be necessary to raise awareness among GPs regarding the special needs of patients with an SA history. Additional attention for SA may contribute positively to the quality of patients'

experiences and the patient-physician relationship. Educational training and NHG clinical practice guidelines on SA could assist GPs in acquiring knowledge about SA. GPs are advised to implement a protocol together with their clinical staff to ask about SA before performing a cervical smear.

Conclusion

This evaluation among GPs showed that SA is an under-evaluated problem in general practice. Nevertheless, the participating GPs were motivated to enhance their knowledge on how to counsel for SA. NPs perform most of the cervical smears in general practice, but according to the GPs the majority of NPs never or rarely informs about SA in advance of the examination. Educational training on counselling about SA and a clinical guideline regarding SA and counselling for SA with respect to the cervical screening smears are recommended.

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Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

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