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Indicators of childhood sexual abuse in gynaecological patients in a general practice

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Objective – To find indicators of a history of childhood sexual abuse in patients consulting for a gynaecological examination in a general practice.

Design – Semistructured interview after a consultation.

Setting – General practice in the city of Oslo, Norway.

Participants – Of 117 women aged 20–49 with a gynaecological problem, 85 were interviewed.

Main outcome measure – History of childhood sexual abuse.

Results – 24 (28%) of 85 women interviewed by their female GP when consulting for a gynaecological problem reported childhood sexual abuse. In total they reported 32 abusive events, quite different as to the type of assault, the relation to the offender, and the duration. A history of pelvic pain or gynaecological surgery showed a significant association with reported childhood sexual abuse with odds ratios of 4.0 (CI 1.0–15.8) and 4.1 (CI 1.0–17.0), respectively. As adverse sexual experiences may lead to somatization as a coping strategy, certain findings might be indicators of unknown childhood sexual abuse in patients presenting for gynaecological disorders.

Conclusion – A history of pelvic pain and gynaecological surgery may be indicators of sexual abuse in childhood.

Key words: general practice, childhood sexual abuse, pelvic pain, gynaecological surgery.

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During the last two decades childhood sexual abuse has become a topic of multiprofessional interest concerning its short- and longterm impact. Its mental impact has mainly been studied to date. Depression, anxiety disorders, suicidal and self-destructive behaviour, dissociation disorders, drug abuse, and victimization by either accident, crime, or sexual violence are associated with a history of childhood sexual abuse (1). Several studies have revealed a high occurrence of somatization in the abused, interpreted as a possible consequence of post traumatic stress disorder (1).

Recent research has dealt with the longterm impact of childhood sexual abuse on general somatic health, and on gynaecological or gastrointestinal illness in patients in clinical settings. There are significant associations between sexual abuse in childhood or adolescence and pelvic pain (2), dysmenorrhoea, sexual problems, dyspareunia, vaginal discharge (3),

number of operations undergone (4), and functional gastrointestinal disorders (5). All the above mentioned studies were based on populations of women in specialist care. General practitioners (GPs) are confronted with a fundamentally different pattern of complaints and disorders. They are consulted by their patients for a variety of conditions for varying periods, so that, compared with specialists, they meet more cases of unspecified somatic problems. Consequently, a general practice may be an appropriate setting for the study of the somatic impact of sexual abuse in female patients.

Increasing awareness of the overall impact of abuse, and the recognition that addressing the topic is still difficult for both doctors and patients, demand careful consideration about whom and when to ask. Gynaecological consultations may be appropriate frames for anamnestic questions about adverse sexual experiences in general and sexual abuse in

childhood or adolescence in particular. By introducing these difficult topics, the GP shows concern and awareness of their impact, thereby facilitating a disclosure of hidden experiences. This allows the patient to talk openly and give possible clues about her problem, should she so wish.

The aim of our study was to find indicators of a history of childhood sexual abuse in a group of patients who consulted their GP for a gynaecological examination, and to describe the types of reported abuse.

Material and method

The patients were recruited in a single general practice run by the author ALK in the city of Oslo, Norway. 85% of the patients in the practice are women. 150 women aged between 20–49 years were originally registered in the study during six months in 1989/90; they were consecutive attenders for a gynaecological problem other than scheduled checks during pregnancy, or following an abortion or a delivery. 24 of them came on emergency days, and it would have been difficult to meet their possible adverse reactions to the interview. They, and nine women with a poor knowledge of Norwegian, were therefore excluded, leaving 117 women who met the criteria for inclusion and who were asked to participate. Whenever a woman called with a gynaecological problem, a secretary checked whether the inclusion criteria of our study were met. If so, she cited a standardized invitation to an interview of at least one hour's duration about gynaecological health, partnership, and former sexual experiences, and asked the patient for her consent to participate. Most of the interviews followed the consultation. A few were postponed due to the woman's wish, thus not causing any delay for the examination.

ALK interviewed all the participating women with structured questions about marital status, years of education, mental and somatic health, gynaecological, reproductive and sexual conditions, and about possible sexual abuse before the age of 18 years. The model for the interview was taken from a study of the relations between gynaecological complaints and abuse by partners (6). The introductory question to the topic of abuse was: «Were you ever approached against your will in a way you felt had sexual meaning in a wider sense before you were 18 years old?» If the answer was yes, the person involved was registered, and the event(s) categorized as either an un-

wanted sexual episode, or as less severe, severe, or very severe abuse (7).

The chi-square or Fisher's exact test were used for the comparison of frequencies. P-values ≤ 0.05 were regarded as significant. The multivariate statistics used were the multiple logistic regression model from the statistical program SPSS (8). Factors with bivariate association to a history of childhood sexual abuse with a p-value ≤ 0.05 were chosen as independent variables in the multiple logistic regression analyses, together with patient age and parity.

Results

85 women were interviewed. 32 (27%) refused to participate. There was no difference in age between participants and non-participants. 24 (28%) of the women reported events or long-time relations defined as sexual abuse. They did not differ in age, marital status, or years of education from the non-abused women. Table I shows reported abuse, classified according to the most severe event experienced. Several had been exposed to more than one abusive event. 32 very different abusive situations were reported. The «No sexual abuse» category includes nine women who reported indecent exposure or verbal advances.

All the offenders were males, and all were above 18 years of age, apart from two, both of whom were more than five years older than their victim. In 23 (72%) of the 32 cases the women knew the attacker. Ten were relatives: five fathers, one stepfather, two

Table I. A history of childhood sexual abuse in 85 gynaecological patients in a general practice.

Severity	Patients	
	n	(%)
No sexual abuse	61	(72)
Least severe (touch experienced as sexual) (forced to look at somebody's genitals)	4	(5)
Severe (forced to expose own genitals) (genital touch) (forced to touch the other's genitals)	12	(14)
Very severe (attempted or simulated coitus) (completed coitus)	8	(9)
Total	85	(100)

grandfathers, one uncle, and one cousin, responsible for rape in two, and long-time abuse in five cases. 13 of the attackers were acquaintances, such as friends, fathers of friends, friends of parents, a neighbour, and a teacher. They were responsible for one rape, four attempted rapes, and four cases of long-time abuse. Nine men were strangers, responsible for one rape and one attempted rape. Only one assault involved a group of males.

Table II shows symptoms and elements from the clinical history which in bivariate analysis were significantly associated with a history of childhood sexual abuse. There were no differences between the groups concerning mean age of menarche, use of contraception, amenorrhoea, irregular bleeding, and sexually transmitted diseases. The groups differed significantly with regard to numbers of pregnancies, in total 39 in the 24 abused, and 52 in the 61 non-abused women ($p=0.03$). The number of spontaneous and legal abortions did not differ. Table III shows the adjusted odds ratios of a history of childhood sexual abuse by various symptoms and clinical history by means of a multiple logistic regression. When controlled for age, parity, and the other independent variables, pelvic pain and gynaecological surgery remained significant indicators of a history of childhood sexual abuse. This was accentuated when both factors were present in the clinical history: of eight women with both factors, five re-

ported abuse, while both factors were absent in only four (17%) of the 24 abused, but in 43 (70%) of the 61 non-abused.

Discussion

This study describes findings from one single general practice with a female practitioner, which limits their interpretation. Norwegian studies have shown that female GPs may have from 75% to 92% female patients, while male GPs on average have 15% fewer female patients than their female colleagues, regardless of location in the country (9). Women prefer female GPs, especially when it is a question of gynaecological problems. If it is not possible to consult a female GP, the patient may possibly avoid a consultation (9). In one of three consultations with female GPs, women seek help for gynaecological complaints (9). Female patients who attend female GPs for gynaecological problems may therefore be selected to a certain extent. This reduces the general comparability of our findings.

The results of our study may be based on under-reporting concerning the number of events or degree of severity due to memory repression (7,10). Guilt and shame are both strong motives for keeping sexual abuse a secret (1,7,10). Feelings of responsibility for the parent's reputation may prohibit the disclosure (11). On the other hand, the women's eager-

Table II. Number (%) of patients with and without a history of childhood sexual abuse by symptoms and clinical history.*

		History of childhood sexual abuse n = 24	No history of childhood sexual abuse n = 61	p-value
Symptoms and clinical history		no (%)	no (%)	
Impaired physical health	no	13 (54)	51 (84)	<0.01
	yes	11 (46)	10 (16)	
Impaired mental health	no	9 (37)	41 (67)	0.01
	yes	15 (63)	20 (33)	
Pre-menstrual syndrome	no	7 (29)	33 (54)	0.04
	yes	17 (71)	28 (46)	
Vaginal discharge	no	3 (12)	21 (34)	0.04
	yes	21 (88)	40 (66)	
Pelvic pain	no	11 (46)	52 (85)	<0.01
	yes	13 (54)	9 (15)	
Gynaecological surgery	no	13 (54)	50 (82)	0.01
	yes	11 (46)	11 (18)	
Sexual problems	no	4 (17)	31 (51)	<0.01
	yes	20 (83)	30 (49)	

* A history of childhood sexual abuse consists of events as described in table I from least severe to very severe abuse.

Table III. Adjusted odds ratios of childhood sexual abuse histories in 85 gynaecological patients by age, health estimate, number of pregnancies, gynaecological disorders and surgery, and sexual problems.

Data and symptoms	No. of patients	Adjusted odds ratio	(95% CI)
* Age (20–49 years)		0.9	(0.8–1.9)
* No. of pregnancies (0–8)		2.1	(1.1–4.1)
Impaired physical health	no 64	1	
	yes 21	2.6	(0.5–12.8)
Impaired mental health	no 50	1	
	yes 35	1.4	(0.3–5.9)
Pre-menstrual syndrome	no 40	1	
	yes 45	2.3	(0.6–8.5)
Vaginal discharge	no 24	1	
	yes 61	2.4	(0.5–11.5)
Pelvic pain	no 63	1	
	yes 22	4.0	(1.0–15.8)
Gynaecological surgery	no 63	1	
	yes 22	4.1	(1.0–17.0)
Sexual problems	no 35	1	
	yes 50	3.2	(0.7–14.5)

* These variables are continuous, and odds ratios are presented for a 1 unit change (years, pregnancies)

ness to please the GP, and the interviewer's eagerness to uncover such histories, may contribute to an over-reporting. However, face-to-face interviews offer advantages for disclosure of adverse sexual experiences in women (7,13,14). Additionally, female interviewers probably receive more information about sexual abuse, interpreted as gender influence (1,7,12).

Estimates of childhood sexual abuse vary from 15% to 38% due to varying definitions, materials and methods, making a direct comparison of our findings with those of other authors difficult (12–15). But comparison of our results with some of the most important sociological studies from the USA (7,15), and with clinical studies (2,3), suggests that the prevalence in our general practice population is no lower than in those studies.

The next important finding, that almost three out of four women knew their attacker, is consistent with other studies (1,7,15). Four out of five women reported severe or very severe abuse, classified according to Russell (7). The 32 abusive situations mentioned showed different combinations of event, attacker, age and duration. Nine of the women experienced long-lasting abuse by close relatives or acquaintances, sometimes for years.

It is considered problematic to range events in severity concerning their probable health impact (1,2,14,16,17). Closeness of relationship to the attacker, repeated abuse, the experience of force, threat or conspiracy, disgusting or painful invasive

or penetrating acts, and young age at the onset of the abuse seem to have a deleterious impact on mental and physical health (1,2,16). Many other factors respecting the persons involved modify the individual outcome (15–17).

The two indicators, pelvic pain and gynaecological surgery, have been found in previous studies (2–4,17), but not in relation to patients in a general practice. They offer the possibility of selecting female patients with gynaecological problems who might have been sexually abused in childhood or adolescence. Nonsomatic pelvic pain is an important indicator of sexual abuse (2,17). Chronic pelvic pain accounts for 10% of outpatient gynaecologic consultations, 25% of diagnostic laparoscopies, and almost 15% of the indications for hysterectomy. It is consequently paramount to elicit those sources of pain that are grounded in hidden sexual violence (17).

A history of childhood sexual abuse is associated in several studies with a high somatization score (1,17), which is supposed to be the background for findings of above average numbers of operations during the lifetime of abused women (4,5,17). Somatization as a coping strategy for or a long-term impact of sexual assault is reported in many studies (1–5,17–20). Somatization contributes heavily to medical indications for invasive and penetrating diagnostic and therapeutic interventions (4,5,17).

The proportion of women who reported severe and very severe abuse in this study was higher than in the only age-comparative random sample from the

general population in another Norwegian city (6). Women with a history of sexual abuse more often have gynaecological complaints and consult their GP more frequently both for those complaints and for a large variety of other somatic disorders (2,3,5,16,20). Clinical samples based on gynaecological consultations may heighten the probability of finding histories of childhood sexual abuse. GPs need valid indicators of adverse sexual experiences. Nevertheless, our results have to be interpreted cautiously because the groups were small. We do not know why the 32 women refused to participate, nor what kind of experiences they may have undergone.

All the abused women knew the interviewing GP before, many of them for years. Only one of them had previously told her about her childhood sexual abuse. Most had never mentioned their experiences to anybody else, a phenomenon confirmed by previous studies (5,7,10) and related to cultural, social, and individual criteria. As any violation of a taboo creates both anxiety and rejection, one might argue that victims of sexual assaults have good reasons to keep the experience hidden, and that any attempt to facilitate a disclosure might represent an intrusion. But if the trauma of sexual assault, like other events which threaten life or integrity, contributes to the development of somatization and chronic pain, women with a history of sexual trauma are at risk of being misunderstood in a medical setting. GPs should be open to any possibility that the patients might talk about these matters, while at the same time being very sensitive to signs of discomfort in their patients. To respect any direct or indirect refusal is crucial.

The complexities of somatization are still poorly understood, and the problem of how to introduce certain questions in medical settings is still debatable. Our findings might increase the awareness of the meaning of gender in complex health problems in general, and in primary care with its well-known and very problematic overload of female patients with multiple disorders and unspecified somatic illness in particular. The experience of childhood sexual trauma may enter general practice in a somatic disguise much more often than is believed.

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