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Committee on Health Care for Underserved Women
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Adult Manifestations of Childhood Sexual Abuse

ABSTRACT: Long-term effects of childhood sexual abuse are varied, complex, and often devastating. Many obstetrician–gynecologists knowingly or unknowingly provide care to abuse survivors and should screen all women for a history of such abuse. Depression, anxiety, and anger are the most commonly reported emotional responses to childhood sexual abuse. Gynecologic problems, including chronic pelvic pain, dyspareunia, vaginismus, nonspecific vaginitis, and gastrointestinal disorders are common diagnoses among survivors. Survivors may be less likely to have regular Pap tests and may seek little or no prenatal care. Obstetrician–gynecologists can offer support to abuse survivors by giving them empowering messages, counseling referrals, and empathic care during sensitive examinations.

Women who are survivors of childhood sexual abuse often present with a wide array of symptoms. Frequently, the underlying cause of these symptoms is unrecognized by both the physician and patient. The obstetrician–gynecologist should have the knowledge to screen for childhood sexual abuse, diagnose disorders that are a result of abuse, and provide support with interventions. Adult childhood sexual abuse survivors disproportionately use health care services and incur greater health care costs compared with adults who did not experience abuse (1).

Definitions

Child sexual abuse is defined as any sexual activity with a child where consent is not or cannot be given. This includes sexual contact that is accomplished by force or threat of force, regardless of the age of the participants, and all sexual contact between an adult and a child, regardless of whether there is deception or the child understands the sexual nature of the activity. Sexual contact between an older child and a younger child also can be abusive if there is a significant disparity in age, development, or size, rendering the younger child incapable of giving informed consent. The sexually abusive acts may include sexual penetration, sexual touching, or noncontact sexual acts such as exposure or voyeurism (2). Legal definitions vary by state; however, state guidelines are available by using the Child Welfare Information Gateway (www.childwelfare.gov/systemwide/laws_policies/state).

Prevalence

Although the exact prevalence is unknown, it is estimated that 12–40% of children in the United States experience some form of childhood sexual abuse. Shame and stigma prevent many survivors from disclosing abuse. Incest, once thought to be rare, occurs with alarming frequency (3). Survivors come from all cultural, racial, and economic groups (4). Approximately one in five women has experienced childhood sexual abuse (4). From 2006 to 2008, among females aged 18–24 years who had sex for the first time before age 20 years, 7% experienced nonvoluntary first sex (5). Twelve percent of girls in grades 9–12 reported they had been sexually abused; 7% of girls in grades 5–8 reported sexual abuse. Of all girls who experienced sexual abuse, 65% reported that the abuse occurred more than once, 57% reported that the abuser was a family member, and 53% reported that the abuse occurred at home (6).

Sequelae

Symptoms or behavioral sequelae are common and varied. More extreme symptoms can be associated with abuse onset at an early age, extended or frequent abuse, incest by a parent, or use of force. Common life events,

like death, birth, marriage, or divorce may trigger the return of symptoms for a childhood sexual abuse survivor. The primary aftereffects of childhood sexual abuse include the following:

- Emotional reactions
  Emotions such as fear, shame, humiliation, guilt, and self–blame are common and lead to depression and anxiety.
- Symptoms of posttraumatic stress
  Survivors may experience intrusive or recurring thoughts of the abuse as well as nightmares or flashbacks.
- Distorted self-perception
  Survivors often develop a belief that they caused the sexual abuse and that they deserved it. These beliefs may result in self-destructive relationships.

Physical Effects

Chronic and diffuse pain, especially abdominal or pelvic pain (1), lower pain threshold (7), anxiety and depression, self-neglect, and eating disorders have been attributed to childhood sexual abuse. Adults abused as children are four to five times more likely to have abused alcohol and illicit drugs (8). They are also twice as likely to smoke, be physically inactive, and be severely obese (8).

Sexual Effects

Disturbances of desire, arousal, and orgasm may result from the association between sexual activity, violation, and pain. Survivors are more likely to have had 50 or more intercourse partners, have had a sexually transmitted infection, and engage in risk-taking behaviors that place them at risk of contracting human immunodeficiency virus (HIV) (8, 9). Early adolescent or unintended pregnancy and prostitution are associated with sexual abuse (10, 11). Gynecologic problems, including chronic pelvic pain, dyspareunia, vaginismus, and nonspecific vaginitis, are common diagnoses among survivors (12–14). Survivors may be less likely to have regular Pap tests and may seek little or no prenatal care (15).

Interpersonal Effects

Adult survivors of sexual abuse may be less skilled at self-protection. They are more apt to accept being victimized by others (15, 16). This tendency to be victimized repeatedly may be the result of general vulnerability in dangerous situations and exploitation by untrustworthy people.

Obstetrician–Gynecologist Screening for Sexual Violence

With recognition of the extent of family violence, it is strongly recommended that all women be screened for a history of sexual abuse (15, 17). Patients overwhelmingly favor universal inquiry about sexual assault because they report a reluctance to initiate a discussion of this subject (18). Following are some guidelines:

- Make the question "natural." When physicians routinely incorporate questions about possible sexual abuse, they will develop increased comfort (19).
- Normalize the experience. Physicians may offer explanatory statements, such as: "About one woman in five was sexually abused as a child. Because these experiences can affect health, I ask all my patients about unwanted sexual experiences in childhood" (19).
- Give the patient control over disclosure. Ask every patient about childhood abuse and rape trauma, but let her control what she says and when she says it in order to keep her emotional defenses intact (19).
- If the patient reports childhood sexual abuse, ask whether she has disclosed this in the past or sought professional help. Revelations may be traumatic for the patient. Listening attentively is important because excessive reassurance may negate the patient's pain. The obstetrician–gynecologist should consider referral to a therapist.
- The examination may be postponed until another visit. Once the patient is ready for an examination, questions about whether any parts of the breast or pelvic examination cause emotional or physical discomfort should be asked.

If the physician suspects abuse, but the patient does not disclose it, the obstetrician–gynecologist should remain open and reassuring. Patients may bring up the subject at a later visit if they have developed trust in the obstetrician–gynecologist. Not asking about sexual abuse may give tacit support to the survivor's belief that abuse does not matter or does not have medical relevance and the opportunity for intervention is lost (20).

Obstetrician–Gynecologist Intervention for Sexual Violence

Once identified, there are a number of ways that the obstetrician–gynecologists can offer support. These include sensitivity with the gynecologic or obstetric visit and examination in abuse survivors, the use of empowering messages, and counseling referrals.

Obstetric and Gynecologic Visits and Examinations in Abuse Survivors

Pelvic examinations may be associated with terror and pain for survivors. Feelings of vulnerability in the lithotomy position and being examined by relative strangers may cause the survivor to re-experience past feelings of powerlessness, violation, and fear. Many survivors may be traumatized by the visit and pelvic examination, but may not express discomfort or fear and may silently experience distress (20). All procedures should be explained in advance, and whenever possible, the patient

should be allowed to suggest ways to lessen her fear. For example, the patient may desire the presence of friends or family during the examination and she has the right to stop the examination at any time. Techniques to increase the patient's comfort include talking her through the steps, maintaining eye contact, allowing her to control the pace, allowing her to see more (eg, use of a mirror in pelvic examinations), or having her assist during her examination (eg, putting her hand over the physician's to guide the examination) (20). It is important to ask permission to touch the patient.

Pregnancy and childbirth may be an especially difficult time for survivors. The physical pain of labor and delivery may trigger memories of past abuse (21–23). Women with no prior conscious memories of their abuse may begin to experience emotions, dreams, or partial memories. Pregnant women who are abuse survivors are significantly more likely to report suicidal ideation and depression (7, 24). There are no consistent data regarding adverse pregnancy outcomes for women with histories of childhood sexual abuse.

Positive Messages

Some positive and healing responses to the disclosure of abuse include discussing with the patient that she is the victim of abuse and is not to blame. She should be reassured that it took courage for her to disclose the abuse, and she has been heard and believed (19, 20).

Counseling Referrals

Traumatized patients generally benefit from mental health care. The obstetrician–gynecologist can be a powerful ally in the patient's healing by offering support and referral. Efforts should be made to refer survivors to professionals with significant experience in abuse-related issues.

Physicians should compile a list of experts with experience in abuse and have a list of appropriate crisis hotlines that operate in their communities. Contacting state boards of psychology or medicine can be beneficial in locating therapists who are skilled in treating victims of such trauma. Veterans' centers, battered women's shelters, and rape crisis centers often are familiar with therapists and programs that treat various types of trauma, as are many university-based counseling programs. Because of the relationship between trauma histories and alcohol and drug abuse, therapists should be skilled in working with individuals who have dual diagnoses (25).

When discussing with a patient referral to a mental health professional, it is helpful to identify a specific purpose for the referral. For example, "I would like Dr. Hill to assess you to determine if your past abuse is contributing to your current health problems" is more effective than telling the survivor that her symptoms are all psychological and that she should see a therapist (26). It is important to secure the patient's express authorization before referring her to a mental health specialist, as well as helping the patient to not feel abandoned or rejected when a counseling referral is made.

Conclusion

For some survivors of childhood sexual abuse, there is minimal compromise to their adult functioning. Others will experience psychologic, physical, and behavioral symptoms as a result of their abuse. An understanding of the magnitude and effects of childhood sexual abuse, along with knowledge about screening and intervention methods, can help obstetrician–gynecologists offer appropriate care and support to patients with such histories.

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