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Female sexual function in urological practice

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CHAPTER 4

How reliable is a self administered questionnaire in detecting sexual abuse: a retrospective study in patients with pelvic floor complaints and a review of literature

Based on:

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INTRODUCTION

Female Sexual Dysfunctions (FSDs) are very prevalent and multifaceted problems, but are under-recognized and under treated (1). Sexual abuse, a significant contributing factor to sexual dysfunction, may even be more difficult to discuss with patients than the sexual problem itself. It is of utmost importance to recognize sexual abuse because of its impact not only on gynaecological complaints but on pelvic floor complaints in general. However, there is little data available regarding the superiority of one method over another in detecting sexual abuse. We wondered if a self-administered questionnaire designed for pelvic floor complaints would be comparable in terms of suitability and reliability to a questionnaire administered by a dedicated clinician to detect sexual abuse in daily practice.

In a study of health care practitioners and gynaecologist routine screening for sexual abuse was mentioned to be rare (respectively 1,3 and 0,5%) (2;3).

The prevalence of sexual abuse depends on the underlying definition and research population. The incidence in general population of child sexual abuse is 8-32% (4-15), in gynaecological and obstetric care 10-20% (3;14;16-18) and 19,4-27,5% in pelvic pain patients (19-21). One of the major problems in studies on sexual abuse is the lack of agreement on the definition and description of sexual abuse, like child abuse, rape or intimate partner abuse. Child abuse can be defined as any activity with a child before the age of legal consent that is for the sexual gratification of an adult or a substantially older child (22). These activities include oral-genital, genital-genital, genital-rectal, hand-genital, hand-rectal, or hand-breast contact; exposure of sexual anatomy; forced viewing of sexual anatomy; and showing pornography to a child or using a child in the production of pornography. In a recent study of Banyard et al child sexual abuse victims reported a lifetime history of multiple exposures to various trauma and higher levels of mental health symptoms (23). The distress outcome may be diverse. Sexual violence is associated with lower rates of cervical cancer screening (24) and increased risk of posttraumatic stress disorder (PTSD) (25;26) and depression (27). Already in 1993 a good overview of the problems related to this subject was given by The Panel on Research on Child Abuse and Neglect (28).

The interest in sexual dysfunction also increases the focus on symptoms and patterns associated with sexual problems in relation to pelvic floor complaints. Klevan et al conclude that urinary tract symptoms following sexual abuse are common (29). In this study 20% of the victims of sexual abuse complained of one or more genitourinary symptoms. Davilla et al conclude that sexual abuse survivors have a significantly higher incidence of genitourinary dysfunction symptoms, including stress and urge incontinence, and voluntary urinary retention (30). In this study 72% of the survivors of abuse reported ever

experiencing urinary incontinence symptoms. Recently Jundt et al reported significantly more women (30.6%) with overactive bladder had been previously physically and/or sexually abused than women with stress urinary incontinence (17.8%) and of the control group (17.5%) (31). Also women with chronic pelvic pain were found to have a higher lifetime prevalence of sexual abuse (19;32-34). The influence of early sexual abuse on later adult sexual functioning has been found to pertain in particular to problems in desire, sexual arousal and orgasm (35-37). Sarwer et al, found that childhood abuse involving sexual penetration or the use of physical force, was related to adult sexual dysfunction (38). Meston et al showed that the relationship between child sexual abuse and negative sexual affect was independent from symptoms of depression and anxiety, suggesting that the impact of child sexual abuse on sexual self-schemas may be independent from the impact that the abuse may have in other areas of the survivor's life (39). In a review article on factors predisposing women to chronic pelvic pain by Latthe et al, sexual abuse was associated with dyspareunia and also to non-cyclical pelvic pain (40). The importance of discussing abuse before performing a gynaecological examination is clear. Survivors of sexual abuse rated the gynaecological care experience more negatively than the controls, experienced more intensely negative feelings, and reported being more uncomfortable during almost every stage of the gynaecological examination than the controls. Survivors also reported more trauma-like responses during the gynaecological examination, including overwhelming emotions, intrusive or unwanted thoughts, memories, body memories, and feelings of detachment from their bodies (41-45). In the study of Robohm et al, eighty-two percent of the survivors had never been asked about a history of sexual abuse or assault by the gynaecological care provider (41). The importance of asking about sexual abuse was clearly illustrated by Davy in relation to endoscopic procedures (46) and Schachter et al in relation to physical therapists (47). It should be pointed out that her work refers to general physiotherapy and not pelvic floor practice suggesting how much more relevant it is in pelvic floor physiotherapy practice.

Physicians should also consider that any kind of gynaecological examination in these women may trigger a flashback of the primary situation and retraumatize the concerned women (48).

Our institute has recently developed and validated the Pelvic Floor Leiden Inventories (PelFIs), a 144 items new condition-specific pelvic floor assessment questionnaire, in an attempt to increase the quality of care and to get more uniformity in pelvic floor physiotherapy practice. During the validation of the PelFIs in the total population with and without pelvic floor complaints a high percentage (13,3%) of sexual abuse was reported .

A selection of patients has been evaluated in our Pelvic Floor Center. This outpatient Pelvic Floor Center is a specialized part of our Urological department

and consist a surgeon, gynecologist, urologist and a pelvic floor physiotherapist. Routinely all new patients were sent in advance a voiding diary and a questionnaire on pelvic floor complaints to be completed at home and discussed at the first visit of our Pelvic Floor Center. This questionnaire contains questions on defecation, lower urinary tract symptoms, obstetric information and also sexual complaints. One of the questions is about sexual abuse. We were interested how reliable this standard self-administered questionnaire is in detecting the number of patients admitting sexual abuse.

MATERIALS AND METHODS

From June 2005 to August 2006 during the validation of a new administered questionnaire (PelFIs) by a pelvic floor physiotherapist 26 out of 81 patients (32%) admitted sexual abuse.

We retrospectively evaluated if these patients had visited our Pelvic Floor Center in an earlier phase. In this center a self-administered pelvic floor questionnaire is standard of care before visiting our Pelvic Floor Center. The questionnaire is sent by mail and returned by the patient on its first visit. It appeared that 20 out of 26 patients had completed this standard self-administered pelvic floor questionnaire. The other 6 abused female patients that had completed the PelFIs were excluded because they had not been evaluated at the Pelvic Floor Center before, but had been evaluated at the department of Urology.

This self-administered questionnaire is not a validated pelvic floor questionnaire, but is used for efficiency and consists out of five parts. Part 1 contains nine questions on lower urinary tract symptoms (urgency, frequency, incontinence, urinary tract infections), part 2 four questions on gynecological complaints (prolaps, abdominal pain, delivery), part 3 two questions on defecation, part 4 questions on medical and surgical history related to pelvic floor complaints and part 5 four questions on sexual function (Table 1).

The PelFIs is a 144 item questionnaire administered by a pelvic floor physiotherapist and consists of 6 parts. Part 1 contains thirty-seven questions on general health, part 2 thirty-seven questions on lower urinary tract symptoms, part 3 thirty-three questions on defecation, part 4 nineteen questions on gynaecological complaints, part 5 nine questions on pelvic pain and part 6 nine questions on sexual function (Table 1).

Table 1: summary of described questions

Domain	self-administered questionnaire	PeLFIs
Questionnaire Time	5-10 min	20-30 min
General Health	7	37
LUTS	9	37
Gynecology/ prolaps	3	19
Defecation	2	33
Pain	3	9
Sex	1. Do you have a sexual partner? (Male, Female, None) 2. Do you have sexual complaints? (Yes, No) 3. If yes, - do you experience urine lost during intercourse? (Yes, No) - do you experience pain during intercourse? (Yes, No) 4. Did you have negative sexual experience in the past? - if you would like to give a comment, you can write it underneath	1. Do you have sexual intercourse? (Yes, No) 2. Pain during intercourse? (Yes, No) 3. If yes, - during introduction of the penis - deep penetration of penis 4. Do you have sexual problems because of your pelvic floor complaint? (Yes, No) 5. If yes, - urine lost during intercourse - urine lost during orgasm - stools during intercourse 6. Did you have negative sexual experience in the past? (Yes, No) 7. If yes, did you have therapy for it? (Yes, No) 8. Can you deal with it now? (Yes, No) 9. If not, do you want therapy? (Yes, No)
Total	28	144

PeLFIs = Pelvic Floor inventories Leiden; LUTS = Lower Urinary Tract Symptoms

At our Pelvic Floor Center one single physiotherapist with almost two decades of experience on pelvic floor treatment and skills in recognizing sexual abuse has been administering the PelFIs. We reviewed the self-administered questionnaires of all patients who admitted sexual abuse during the PelFIs by the pelvic floor physiotherapist. Patients with sexual abuse were offered sexual treatment by an urologist with a sexual education.

We tried to evaluate the reliability of the self-administered questionnaire in detecting sexual abuse using the PelFIs as “gold standard”. Because both questionnaires are used routinely in our clinic we did not need institutional review board approval for this evaluation.

RESULTS

20 Patients admitting sexual abuse during administration of the PelFIs had visited our Pelvic floor Center in earlier phase and completed a self-administered questionnaire. At first consultation the mean age of these 20 patients was 44,5 year (range 19-68 years). Only 6 of them (30%) with a mean age of 50,2 year (range 38-68 years) noted in the self-administered questionnaire they did not have a history of sexual abuse, but later on admitted sexual abuse during administration of the PelFIs. Sexual child abuse was reported in 13 out of the 20 patients, 6 patients reported a history of rape and 1 intimate partner abuse. 13 Out of the 14 patients, with a mean age 42,1 year (range 19-63years), who completed the self-administered questionnaire described the type of sexual abuse: sexual child abuse (8), rape (4) or intimate partner abuse (1). The only patient who did not describe the kind of sexual abuse later admitted she had been the victim of sexual child abuse.

DISCUSSION

A history of sexual abuse is a common problem in pelvic floor practice (18;29-31;49-56). The pelvic floor not only contains pelvic visceral organs within the pelvic cavity; it also controls individual and integrated functions, sustains proper anatomic relationships, and shares the basic mechanism with various visceral organs that control their function. The pelvic floor is the binding element between these organs. Although pelvic floor dysfunction has long been related to the lower urinary tract and, more recently to lower gastrointestinal symptoms also, it is now considered to be an influential factor in the normal function and behavior of the genital system in both men and women (57). Devroede described the pelvic floor as a muscular structure, pierced by the urological, genital and

distal intestinal tract (58). Normal function can be replaced by dysfunctions of several kinds, overlapping voiding, sexual, genital and defecatory behaviour. He already mentioned that if the pelvic floor was not considered as an integrated muscular structure, unsuspected pathology would lie outside the spectrum of activities of the given speciality. Thus, in relation to pelvic floor complaints, it is important to evaluate sexual function in general (59), including abuse. Bachmann (60) recently published a study to obtain pilot data on physicians' knowledge, perceptions, and practices regarding FSDs, which may help uncover means of facilitating future dialog between physicians and patients. A total of 1,946 survey physicians and other health professionals used a self-administered reply questionnaire. Most respondents (60%) estimated that one- to three-quarters of their patients had FSDs. Low sexual desire was the most prevalent FSD observed. A total of 58% of participants reported initiating the first discussion of FSDs in one-quarter or less of patients. Obstacles to discuss sexual health included limited time and training, embarrassment, and absence of effective treatment options. She concluded that healthcare professionals are aware of the high prevalence of FSDs but infrequently initiate a discussion of sexual function with their female patients or fail to conduct a comprehensive evaluation for FSDs. In discussing sexual dysfunction sexual abuse is probably a more delicate topic to address.

A study of MacMillan et al about a maltreatment history in childhood using a self-administered questionnaire, concluded that child abuse may be more prevalent in younger women compared with older women, or there may be a greater willingness among younger women to report abuse (12). The women in our study who admitted abuse in the self-administered questionnaire had a mean age of 42,1 year. The patients who did not report sexual abuse in the questionnaire had a mean age of 50,2 year. Although the number of patients (n=20) is too small to make conclusions on age difference between the two groups. It might indicate the older the patient the less sexual abuse is reported in a self-administered questionnaire. Marital status (in both groups 50% was married), history of psychological counseling in the past did not influence the women's decision to fill in the self-administered questionnaire.

"Did you have negative sexual experiences in the past" used in the questionnaire is of course not equal to "did you experience sexual abuse in the past" but in the Dutch language it is considered to be almost similar. This is confirmed by the responses of patients: all patients admitted abuse and 13 out of 14 patients described the type of negative sexual experience as sexual abuse.

How forthcoming a patient is about his or her medical, sexual, and sexual abuse history may strongly be influenced by the level of comfort created by the physician taking the history. Particularly, discussing a history of sexual abuse or sexual assault with a patient is usually emotionally very difficult. This raises the question whether patients are more forthcoming when completing a self-

administered questionnaire or talking to a physician. In this study 20 patients reported sexual abuse during administration of the PeLFIs by a physiotherapist. 14 Out of these 20 patients (70%), completed the sexual abuse question admitting sexual abuse in the routine questionnaire before visiting our outpatient Pelvic Floor Center and talking to a physician. This high percentage of patients admitting sexual abuse during the self-administered “screening” questionnaire raises the question: “is a concerned physician needed in detecting abuse?” Or is the anonymous self-administered questionnaire avoiding a face to face contact with a physician “safer” and less embarrassing for the patient reporting sexual abuse.

This is in contrast to the conclusion of the study of Nusbaum et al describing women to be more prone to discuss sexual issues with physicians who appear to be concerned, comfortable, and informed about FSDs (61). The rate of women reporting sexual abuse to a physician varies between less than 2% (62) to 28% (63). Although the response to the question on sexual abuse was 70% in the self-administered questionnaire compared to the administered questionnaire by a female physiotherapist, it still may be very helpful in daily practice in order to detect sexual abuse.

This raises the question if gender of the therapist influences the outcome of the study. In literature regarding this subject “the sex of the therapist” the gender of the therapist was not a major problem (64-66). Kaplan stated that: “the question of therapist gender and its effect on therapy with women highlights an issue of therapist self-awareness and growth rather than one of the patient’s selection process” (64). Probably, the therapist’ sensitivity and value system regarding the sexual abuse issue, is the most important factor.

In general physicians cite many barriers to ask women about sexual abuse, including lack of time and resources of support, fear of offending women, lack of training, fear of opening the “Box of Pandora”.

It is clear considering the impact of sexual abuse on the pelvic floor; sexual abuse is an import issue in routine pelvic floor care. However, the practice of a universal screening warrants further investigation. As Garcia-Moreno indicated it is not feasible in certain settings and may even be dangerous if caregivers lack sufficient training to ensure women’s safety during and after disclosure (67).

Physicians that are uncomfortable with this topic and do not feel qualified enough to deal with the responses they might receive or observe ongoing distress in there patients should refer these women to clinicians that are familiar with these issues (68).

Essential is appropriate medical education and training in order to improve in women the identification and management of FSDs including sexual abuse, realizing we still have a long way ahead of us (60;69-73).

We acknowledge several limitations of our study. This study relies exclusively

on data of women evaluated in an outpatient Pelvic Floor Center. Moreover, it is unclear if our sample is representative for other Pelvic Floor Centers. We know that the percentage of 32% of sexual abuse is higher than was seen at our Department of Gynaecology. In a study of 325 patients at our outpatient Gynaecology Department in 1996, 15.4% reported sexual abuse and 7.4% physical molestation (74).

Also is important to mention the cultural context in which the study took place. Only patients who were able to understand and read the Dutch language could be included. This excludes a part of the not Dutch-speaking immigrants. In that matter we need more questionnaires in different language to optimizing the likelihood of disclosure.

How forthcoming a patient is about his or her medical history, history of sexual and sexual abuse may strongly be influenced by the level of comfort provided by the physician taking the history. Our physiotherapist with almost two decades of experience on pelvic floor treatment and skills in recognizing sexual abuse has been administering the PelFIs. This could have had a positive impact on the level of detection. Also the impact of screening needs to be addressed. Screening is only possible in a setting with caregivers with sufficient sexual training. Although screening may be a helpful tool in detecting abuse and may give both patients and physicians comfort as illustrated in the studies of Brown et al describing abuse screening in the family practice setting (75;76).

Further research is needed to confirm our findings in other patient groups and to determine the threshold for admitting sexual abuse during interviews or self-administered questionnaires. Another important issue that needs to be addressed is the explanation of the relationship between sexual abuse and pelvic floor complaints.

CONCLUSION

In our opinion the interaction of a patient and clinician during the administration of a questionnaire is essential in order to gain the patients' trust and thus acquire a true perspective of past or prevalent sexual abuse and FSDs. We believe that a questionnaire administered by a clinician should be preferred to a self-administered questionnaire. However, in order to recognize sexual abuse a self-administered questionnaire can still be helpful and thus may offer healthcare physicians a helping hand in dealing with sexual abuse of their female patients in daily practice.

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