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Chapter 4:

Prevalence of sexual abuse among patients seeking general urological care

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Abstract

Introduction: Sexual abuse (SA) history can be found in the backgrounds of an important fraction of men (8-10%) and women (12-25%). Until now there are no data about this prevalence within a urological patient population.

Aim: To establish the prevalence of SA among men and women visiting a urological outpatient clinic and to assess their opinion on screening for SA by urologists.

Methods: A questionnaire to identify SA was translated into Dutch, English, and Turkish, and was adjusted for use in men. These questionnaires were anonymously distributed among 1,016 adult patients attending the urological outpatient clinic.

Main outcome measure: The self-reported prevalence of SA. Secondary outcome measures were data about the assailant, victim's age at the time of the abuse, if the abuse was disclosed to the urologist, if the urologist had asked for SA, and patient opinions on standard screening for SA in urological care.

Results: A total of 878 questionnaires were returned, giving a total response rate of 86.4% (878/1,016). Thirty-three patients refused to participate. This resulted in 845 filled-out questionnaires suited for analysis (845/1,016 = 83.2%). There were more male (75.7%) than female respondents (21.8%); 2.1% (13/624) and 13.0% (21/161) of the male and female respondents reported a history of SA, respectively. Almost 42% reported a stranger as assailant. In nearly 90%, the SA took place before adulthood: 56.2% in childhood and 31.2% in adolescence. Fifteen percent of the respondents with SA had it disclosed to their urologist. More than 70% of the abused respondents considered the idea to screen for SA in urological practice to be a good one.

Conclusions: The prevalence of SA in patients seeking urological care in the Netherlands is 2.1% for men and 13.0% for women.

Introduction

According to large population based surveys the prevalence rate of sexual abuse (SA) in western society range from 12 to 25 percent for females and from 8 to 10 percent for males^{1,2}. Several papers report about the association between a history of SA and specific urological complaints³⁻⁹. However, the prevalence of SA within a general urologic population never has been investigated. Noteworthy, Dutch urologist estimate the prevalence of SA in their female patient population to be less than 10%, which is lower than the percentages mentioned for the general population¹⁰.

Aims

The primary purpose was to determine the prevalence of a history of SA among male and female patients seeking general urological care. In addition, we investigated whether patients who had been forced to engage in unwanted sexual activities 1) had disclosed the SA to their urologist, 2) had been asked about SA by their urologist, 3) their own opinion with regard to standard screening for SA by urologists, 4) the identity of the assailant and 5) victim's age at which the SA occurred.

Methods:

A German questionnaire to measure the prevalence of SA among females seeking gynecological care was translated into Dutch, English and Turkish and also adjusted for males¹¹. From September 2008 to December 2008 these questionnaires were anonymously distributed among 1016 adult patients attending the urological outpatient clinic of the HagaHospital in The Hague, the Netherlands. A general practitioner and a psychiatrist were on call if a respondent became distressed completing the questionnaire. However, no distress was reported and emergency consultations were not necessary. The questionnaire was available in Dutch, Turkish and English. The last two were chosen while these are the most frequently spoken foreign languages in The Hague. Nine participants requested the Turkish and seven the English version. All attending patients received a letter explaining the goal of the study and the content of the questionnaire. Those who didn't want to participate marked "No, I don't want to participate". Part I included patient characteristics and two questions concerning a possible history of SA. The first "Have you ever been the subject of unwanted sexual attention such as having been propositioned, touched etc.?" was included to ensure that patients could differentiate between physical abuse and SA and the second "Have you ever been forced to have sexual activities that you did not want?" was intended to screen for SA. Possible answers to these two questions were "yes," "no," or "I don't know." Those who answered "yes" to the second question were asked to complete part II. This consisted out of five questions. The first was related to the first time of the SA: as a child (0-12 years), an adolescent (13-17 years), or as an adult (18+ years). The second question disclosed the identity of the assailant: parent, spouse, relative, friend, or stranger and the third revealed if the patient had ever talked to their urologist about SA. Response options were "yes," "no, because I did not consider the

information to be relevant to the urologist," and "no, because I was afraid to talk about the subject with the urologist." The fourth question was if their urologist had ever asked them for a history of SA and the fifth asked patients about their opinions with regards screening for SA by urologists. Throughout the study period the secretaries distributed the questionnaires every day to all patients visiting the outpatient clinic. A small mark was left on the patient identification card to prevent doubles. Patients were asked to fill in the questionnaire in the waiting room and to deposit it in a marked and secured box. The local Research Ethics Board gave approval.

Main Outcome Measure

The primary outcome measure was the self reported prevalence of SA. The data were entered into and analyzed with SPSS 16.0 (SPSS Inc., Chicago, IL). Descriptive statistics were used to estimate the prevalence of unwanted sexual attention and activities and to examine rates of disclosure and screening. Frequencies were calculated for categorical data, and means and standard deviations (SDs) for continuous ones. Secondary outcome measures were: the number of patients who had disclosed the SA to their urologist, the number of patients asked for SA by the attending urologist, their opinions about standard screening for SA abuse by urologists, age at which SA occurred and the identity of the assailant.

Results

A total of 878 questionnaires were returned, giving a total response rate of 86.4% (878/1016). Thirty-three patients notified not to participate. This resulted in 845 filled out questionnaires suited for analysis (845/1016=83.2%). In correspondence with the m/f ratio in Dutch urological patients, there were more male respondents (75.7%) than female ones (21.8%). Unfortunately 2.5% (21/845) did not depict their gender identity. Thirteen out of the 624 males (2.1%) reported a history of SA and 21 out of the 161 females (13.0%). When asked for a broader definition of abuse ("unwanted sexual attention") the prevalence was 4.1% (25/608) for the male respondents and 16.8% (26/155) for the female ones. The mean and median age of the participating males were respectively 63 and 66 years versus 59 and 57 for the females (not significant). Respondents younger than 60 reported more often a history of SA compared to those older than 60 (24 vs 10, $p < 0.05$). Two of the 34 who reported SA, did not fill out the rest of the form, so 32 completed forms (11 males and 21 females) could be used for further analysis. Two out of the 32 respondents (both females) reported more than one assailant (parent and friend, parent and stranger). Both respondents were placed in the group "parent". Most respondents with SA reported a stranger as assailant, namely 41.9%. Compared to older ones, males under 60 accounted more often a stranger as assailant (85.7%) ($p < 0.05$), while females above 60 reported more often a parent as assailant (Table 1). In nearly ninety percent the SA took place before adulthood: 56.2% in childhood (18/32) and 31.2% in adolescence (10/32), statistically not different for males/females or ages. Only 5 of

the 32 abused respondents (15.6%) had reported their SA history to their urologist. Half of them (16/32) had not given this information while they thought it was not relevant for their urologist. 25% (8/32) had not spoken about their SA, because it was their very first visit. Three respondents (9.4%) wrote that they were afraid to discuss the subject. Only one patient with a history of SA had ever been asked for it by her urologist. 71.9% of the abused respondents (23/32) supported the idea to screen for SA in urological practice. This did not differ neither with regards gender identity (72.7% of the males; 71.4% of the females), nor for age (73.9% for ≤ 60 and 66.7% for >60). Without any argument one female participant wrote that routine screening during urological work up was a bad idea (Table 2).

Table 1: Identity of the assailants

		Male ≤ 60	Male >60	Female ≤ 60	Female >60	Total
What is the identity of the assailant?	Parent	0	0	1	3	4
		0,0%	0,0%	6,2%	60,0%	12,9%
	Spouse	0	0	5	0	5
		0,0%	0,0%	31,2%	0,0%	16,1%
	Relative	1	2	6	0	9
		14,3%	66,7%	37,5%	0,0%	29,0%
	Stranger	6	1	4	2	13
		85,7%	33,3%	25,0%	40,0%	41,9%
	Total	7	3	16	5	31
		100,0%	100,0%	100,0%	100,0%	100,0%

Table 2: Opinion about standard screening for sexual abuse during routine urological care

		Male ≤ 60	Male >60	Female ≤ 60	Female >60	Total
What is your opinion about standard screening for sexual abuse during routine urological care?	Good idea	5	3	12	3	23
		71,4%	75,0%	75,0%	60,0%	71,9%
	Bad idea	0	0	0	1	1
		0,0%	0,0%	0,0%	20,0%	3,1%
	No opinion	1	0	3	1	5
		14,3%	0,0%	18,8%	20,0%	15,6%
	Missing	1	1	1	0	3
		14,3%	25,0%	6,2%	0,0%	9,4%
	Total	7	4	16	5	32
		100,0%	100,0%	100,0%	100,0%	100,0%

Discussion

This is the first report about the prevalence of a history of SA among males and females attending a general urologic outpatient clinic. The self-reported prevalence rate of SA by females visiting our urologic clinic (13.0%) corresponds to the data in other specific Dutch female populations (11-24%)¹²⁻¹⁶. See also Table 3. The prevalence of a history of SA (2.1%) in our male respondents is lower than reported in international literature (8-10%), but comparable to a Dutch prevalence rate of approximately 4%^{1,15,17}. Male patients in urological outpatient clinics are relatively old. It may be possible that they don't want to bring up their history of SA because of embarrassment due to the values of an earlier era. In addition, memory loss about events that happened a long time ago may play a role. Another reason can be that SA history is not recognised as being SA history. In a study by Holmes et al. 35% of the surveyed men did not self-define abusive childhood sexual experiences to be childhood sexual abuse¹⁸. According to MacMillan and co-workers there is a greater willingness in males and females under 60 years to report SA compared to people older than 60¹⁹. Also in our study there seems to be a greater willingness in males and females under 60 years to report SA compared to older respondents. If there was an accompanying partner, older male respondents may have been reluctant to bring up SA, because they never had discussed this with their partner. The same holds for the questionnaire. Although we created an anonymous setting, we noticed that some participants completed it in the presence of their partner. We also observed two partners reading the questionnaire aloud to the visually impaired respondent. One author even noticed a partner,

who wrote the answers of the respondent without asking for his opinions. Undoubtedly these observations distorted our study. Seventy percent of Dutch female patients are willing to fill in a questionnaire about possible SA at their first visit to a urologist and nearly 70% of the Dutch urologist asks their female patients for a history of SA, but how many urologists ask males for SA is unknown¹⁰. We suppose that urologists seldom ask their male patients for SA, but we have no data to support this hypothesis. While the prevalence of SA is low, one can argue that standard screening for SA is not necessary in male urological patients. However, this study shows that 70% of the urological patients with a history of SA support the idea to screen for it. SA victims report a lifetime history of multiple exposures to various trauma and higher levels of mental illness symptoms²⁰. Sexual violence is associated with lower rates of participation in cervical cancer screening and increased risk of posttraumatic stress disorder and depression²¹⁻²⁴. However, it is unknown if patients with a history of SA tend to avoid urological examinations including cystoscopy. We think it is commendable to screen for SA before urological examinations. The importance of discussing SA before performing a gynaecological examination is clear. Survivors of SA rate the gynaecologic care experience more negatively than the controls, experience more intensely negative feelings, and report being more uncomfortable during almost every stage of the gynaecological examination than controls²⁵. Survivors also report more traumatic responses during the gynaecological examination, including overwhelming emotions, intrusive or unwanted thoughts, memories, body memories, and feelings of detachment from their bodies²⁶⁻²⁹. In the study of Robohm et al., 82% of the survivors had never been asked about a history of SA or assault by the gynaecologic care provider²⁵. In our study only one of the 24 respondents was asked about a history of SA. How forthcoming patients are about their medical, sexual, and SA history may strongly be influenced by the level of comfort created by the physician taking the history. Discussing a history of SA or sexual assault with a patient can be very difficult³⁰. One of the major problems in studies on SA is the lack of agreement on the definition and description of SA, 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 for the sexual gratification of an adult or a substantially older child³¹. 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. A meta-analysis shows that a history of SA is associated with lifetime diagnosis of multiple disorders, like seizures, gastrointestinal problems and non-specific chronic pelvic pain³². Another recent meta-analysis demonstrates that SA is associated with multiple psychiatric problems, including lifetime diagnosis of anxiety disorders, depression, eating disorders, PTSD, sleep disorders, and attempted suicide³³. Voiding complaints like frequency, urinary incontinence and dysuria are also associated with SA, but a review on this topic is not available³⁻⁹. No literature is available about the perception of SA-victims with regard to urological examinations. It is reasonable to argue that genital and rectal exam or urethrocytoscopy can be more traumatic

to patients with a history of SA than to those without. However, further research is needed to examine the impact of SA on the patient's perception of urologic examinations. Our findings support the recommendation that urologists should routinely screen for the possibility of SA. By addressing the issue, treatment of the urological disorder may improve with an understanding of underlying psychological issues stemming from the abuse. Victims of SA would also benefit as screening would afford an opportunity to disclose abuse to a trusted medical professional, resulting in a referral for therapy if needed.

Conclusions

The prevalence of SA in patients seeking urological care in the Netherlands is 2.1% for males and 13.0% for females. 15% of the respondents with SA had it disclosed to their urologist. Only one patient with SA was asked for it by urologist. More than 70% of the sexually abused respondents supported the idea to screen for SA in urological practice. Almost 42% report a stranger as assailant. In nearly ninety percent the SA took place before adulthood: 56.2% in childhood and 31.2% in adolescence.

Table 3: Prevalence of sexual abuse among females in The Netherlands

Authors	Dutch research population	Sexual abused number	Total number	Prevalence	Year of publication
Draijer et al. ¹²	Females 20-40 years	248	1054	23.5%	1990
Lankveld et al. ¹³	Non-oncologic gynecological patients	50	325	15.4%	1996
Van der Hulst et al. ¹⁴	pregnant women (non-clinical) without co morbidity	70	625	11.2%	2006
Lamers-Winkelman ¹⁵	11-18 years old students	108 *	989 *	10.9% *	2007
Beck et al. ¹⁶	Female patients attending an university pelvic floor center	42	185	22.7%	2009
This report	Female urological patients	21	161	13.0%	2011

*7,9% (146/1845) for 872 boys and 989 girls combined. This survey mentions a three to four time higher prevalence among girls, but no gender specific data is given. Recalculation of a 3 times higher prevalence for 108 out of 989 girls versus 36 out of 872 boys gives an estimated prevalence of 10,9% for girls only.

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