

Review

# Sexual and gynecological health in women with a history of sexual violence: the role of the gynecologist

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## Abstract

**Objectives:** Sexual violence is defined as any sexual act, attempt to commit a sexual act or unwanted sexual comment or action which, by means of force or coercion, is directed against a person's sexuality, regardless of the relationship with the victim. The global prevalence of sexual violence all over the world is 35.6%; 30% partner-related and 7.2% non-partner sexual violence, being the prevalence of sufferers from both types of sexual violence 1.6%. Sexual violence against girls and women is a global public health problem of epidemic proportions. As a violence free life constitutes a basic human right, actions to prevent sexual violence and to treat and follow-up its victims have to be undertaken. **Mechanism:** A multidisciplinary approach on these cases should be mandatory to help women in all the potential short-, mid- and long-term consequences, which need to be evaluated. **Finding in brief:** Consequences after sexual violence can be both physical and psychological, including a potential impact on gynecological, reproductive, obstetric and sexual issues of the individual. For this reason, gynecologists should play an important role in the follow-up of girls and women who have suffered sexual violence. **Conclusions:** Gynecologists have to participate in both the immediate attention and the follow-up of patients who have suffered sexual violence. Gynecologists have the gold opportunity to introduce sexual health care in their clinical practice and their visits should be the place where the discussion of sexual concerns is permitted and also where the identification, support and treatment of women with sexual violence is provided.

**Keywords:** Sexual violence; Sexual function; Sexuality; Gynecological health; Gynecological assessment

## 1. Introduction

According to the World Health Organization (WHO) sexual violence is defined as any sexual act, attempt to commit a sexual act or unwanted sexual comment or action which, by means of force or coercion, is directed against a person's sexuality, regardless of the relationship with the victim, in any environment, such as the workplace and home [1]. This type of violence encompasses physical force intimidation, psychological bullying, extortion and threat [1]. Sexual violence also occurs if there is no ability to consent, as it happens under the influence of drugs or alcohol, during sleep or with mentally incapacitated individuals [1,2]. There are some patients at higher risk of sexual violence; illicit drugs users and alcohol consumers, the youth, the homeless, the poor, the disabled, sex workers, survivors of childhood sexual or physical abuse and persons living in prisons, institutions or areas of military conflict [3–5].

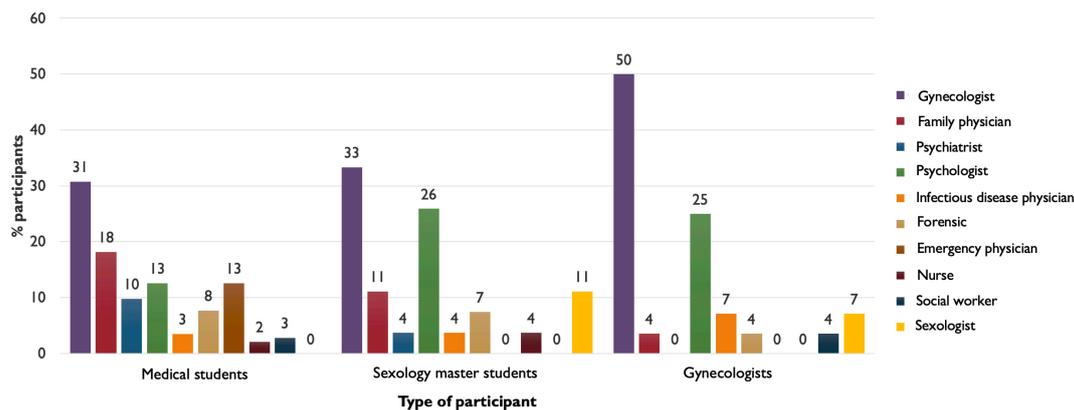
The global prevalence of sexual violence all over the world is 35.6%. However, this prevalence varies depending on whether the violence is non-partner sexual violence or sexual violence performed by a partner. Mostly, sexual violence is partner-related as the global prevalence of sexual

violence among all ever-partnered women is 30.0% and this prevalence is highest in African, Eastern Mediterranean and Southeast Asian regions [1]. Moreover, 7.2% of women from all over the world reported ever having experienced non-partner sexual violence. However, there were variations across the countries and the highest lifetime prevalence of non-partner sexual violence was reported in high income and African regions [1]. In addition, the prevalence of the two types of sexual violence, being both the partner-related and the non-partner suffered all together, is 1.6%.

Finally, it is important to highlight that around 120 million girls around the world, which approximately represents 1 out of 10, have experienced forced sexual acts at some point in their lives [6]. However, this risk varies according to the part of the world where girls live.

Sexual violence against girls and women is a global public health problem of epidemic proportions. As a violence free life constitutes a basic human right which every child and woman deserves, actions to prevent sexual violence and to treat and follow-up its victims have to be undertaken [1].





**Fig. 1. Role of each health care provider in a recent sexual violence episode according to medical students, sexology master students and gynecologists.**

## 2. Management in sexual violence

Women who have experienced sexual violence mandatorily require a multidisciplinary approach. Patients will be evaluated by a multidisciplinary team integrated by multiple health care providers: a social worker, a nurse, a gynecologist, a forensic doctor, an infectious diseases physician, a psychiatrist, a psychologist, a family physician and also the police. Patients receive a very complete evaluation and care in order to help them in all the aspects that may have been affected. Regarding immediate assessment, the gynecologist should evaluate both the psychological and general state of the patient, recognize and stabilize any emergency and conduct and document a medical interview (general history, gynecological and obstetric history and details of the sexual violence episode). Patient's informed consent is required during each step of the medical investigation. In the second place, the gynecologist should perform a physical examination, frequently simultaneous with a forensic doctor, to describe the potential lesions and collect evidence [7,8]. The gynecologist should also treat acute physical injuries, offer counseling for the prevention of sexually transmitted diseases and emergency contraception for pregnancy prophylaxis. The report to the authorities, as required by law, and the schedule of follow-up visits is also important [7–9]. The physician should provide psychological support to the victim of sexual violence, being the availability and immediate intervention of a clinical psychologist or psychiatrist the ideal solution [8]. The existence of a standard protocol on this topic in all the emergency departments is highly recommended.

Patients who have suffered sexual violence require not only an immediate multidisciplinary evaluation but also a multidisciplinary follow-up for as long as they need it. Sexual violence could constitute a scourge for these women and be the cause of clear consequences that must be evaluated in the short-, mid- and long-term.

The role of each health care provider might be different depending on the lapse between the sexual violence

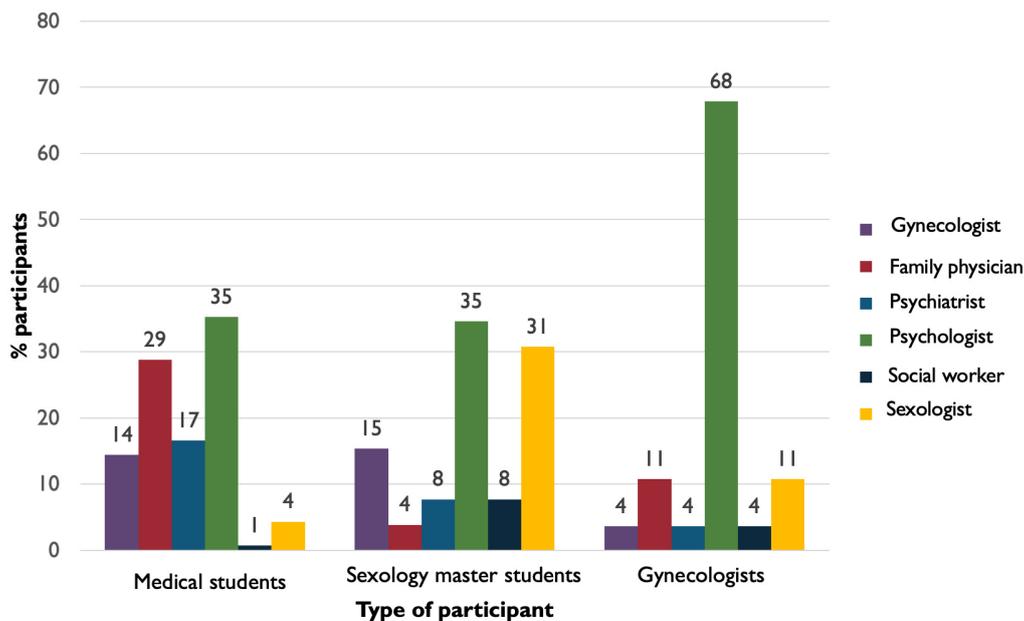
episode and the health evaluation, that is, if it is a recent or a past episode in the personal history. Administering surveys, we analyzed the preferred health provider to seek help after a recent sexual violence episode (Fig. 1) and a past one (Fig. 2) by three different populations (medical students, sexology master students and gynecologists). According to our data, 30–50% of the participants believed patients who had suffered a recent episode of sexual violence should attend a gynecologist (Fig. 1).

However, if such episode was referred to have occurred in the past, the psychologist was the most recommended professional, among others such as the family physician and the sexologist (Fig. 2).

Although immediate gynecological assessment is well established in a sexual violence situation, we believe in some cases is not enough. Consequences which derive from a sexual violence episode may be physical (sequelae of injuries such as bone and teeth fractures, chronic pain syndrome and infections, among others), psychological (low self-esteem, depression and anxiety, among others), gynecological, reproductive, obstetric and sexual for the individual potentially affected [5]. For this reason, gynecologists should play an important role in the follow-up of girls and women who have suffered sexual violence [10] and their response to these women demands sensitivity and expertise [11].

## 3. Gynecological, reproductive, obstetric and sexual consequences of sexual violence

Strong associations between a history of sexual assault and gynecological morbidity have been described. Concretely, a systematic review and meta-analysis showed that assaulted females are at 42% higher risk of developing overall gynecological morbidity [3]. This systematic review, which focused on 38 publications ranging from 1993 to 2018, included women aged more than 25 with a history of sexual violence and compared them with controls who had not suffered it to analyze gynecological morbidity out-



**Fig. 2.** Role of each health care provider in a past sexual violence episode according to medical students, sexology master students and gynecologists.

comes [3]. A statistically significant increase in the risk of pelvic pain, dyspareunia, vulvovaginal pain, dysmenorrhea, abnormal menstrual bleeding and urinary incontinence was found in the assaulted group in comparison to the one without such history [3].

A cross-sectional study in which 1838 women between 15–49 years old were interviewed in their homes in Brazil showed a statistically significant association between the history of sexual violence and the report of gynecological complaints and sexual dysfunctions [1]. Among all the interviewed women, 38.1% did not report a history of sexual violence. Considering women with a history of sexual violence, 54.8% of them reported having had sexual intercourse against their will at least once in their lifetime, without being forced to, while 23% explained some kind of coercion and 7.1% reported having been forced to have sex [12].

Another gynecological consequence derived from sexual violence are sexually transmitted diseases, with an increased risk of infection by the human immunodeficiency virus, syphilis and bacterial infection due to Chlamydia trachomatis and gonorrhea in these patients (Odds ratio 1.52, 1.61 and 1.81, respectively) [1]. Physically violent assaults and those committed by strangers were the most strongly related to gynecological health problems such as sexually transmitted diseases that remain dormant for long periods, resulting in later reproductive or sexual symptoms [13].

Women involved in violent relations report more adverse reproductive health outcomes which could be explained by the sexual violence and coercion. These women have more unintended pregnancies and the Odds ratio of un-

dergoing an induced abortion is 2.16 [1,14]. In some cases, this higher rate of unintended pregnancies is accompanied by unsafe abortions which can result in serious complications or even death.

A comprehensive review of the literature performed by Gazmararian *et al.* [15] concluded that the prevalence of intimate partner violence in pregnant women ranged from 1%–20%, depending on the way by means of which the intimate partner violence is assessed and the population studied. Sexual violence also has consequences in the obstetric field as women who suffer it are at higher risk of having small for gestational age fetuses, babies with a low weight at birth and premature deliveries [1]. It has been suggested that women who suffer abuse during pregnancy are more likely to delay and/or receive an inadequate prenatal care [16].

Moreover, a recent observational retrospective study which included 210 women, 114 of whom had suffered sexual violence, evaluated sexual violence, posttraumatic stress and postpartum depression with validated questionnaires. It showed a significant association between the existence of a sexual violence history and neglected gynecological care and postpartum depression [17]. These associations were confirmed in the multivariate analysis, in which sexual violence history was found to be independently and significantly associated with a negative relationship with the gynecologist, avoidance of gynecological care, sub-optimal routine gynecological follow-up, gynecological consultations only for acute symptoms and an increased risk of postpartum depression [17]. Sleep and appetite disturbances were commonly reported by the victims of sexual violence during

their follow-up [18,19]. They may also have an increased risk of social adjustment difficulties and impaired family functioning [20]. In patients with a history of sexual violence, long-term follow-up care and psychological support are necessary to make the transition from victim to survivor [11].

During the follow-up of patients with a history of sexual violence, a sexual dysfunction may be found. It consists of an altered ability to experience sexual pleasure which is a cause of discomfort. A significant association between rape and multiple aspects of female sexuality has been described, including sexual and reproductive health, sexual functioning and sexual behavior [21]. According to the classification of female sexual dysfunctions of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), disorders of sexual interest/arousal, orgasm and genito pelvic pain/penetration are the most prevalent [22]. These sexuality domains may be affected in women who have suffered sexual violence. Despite the direct effect of sexual violence on desire, arousal, orgasm and pain, sexuality is a broader concept. Furthermore, it includes global aspects of reproduction, identity, femininity, body and genital image, intimacy and personal relations, many of which can also be altered in women who have suffered sexual violence. In fact, according to Hawton and Catalan [23], a history of sexual violence may constitute either a predisposing, a precipitating or a maintaining factor for a sexual dysfunction. Some predictive factors of sexual problems have been described, such as a young age, a known offender, penetration during the assault and emotions felt during and immediately after it (e.g., anger, shame or guilt towards oneself) [18]. Sex avoidance also appears to be related to the development of sexual problems whereas a loving and comprehensive partner seems to be a protective factor [18].

In a study about the impact of rape on women's sexual health risk behavior, which included 102 adult rape survivors, an ecological model predicting cluster membership was performed and revealed that individual-level and contextual factors predict patterns of risk behavior [24]. This study used a cluster analysis to identify three patterns of sexual health risk behavior. Among women from the first cluster (high risk) significant increases in their frequency of sexual activity, number of sexual partners, infrequency of condom use and frequency of alcohol and/or drug consumption during sex were found when the after rape situation was compared to the pre-rape. The second cluster (moderate risk) showed an increased frequency of sexual activity and number of partners but mitigated that sexual health risk with an increase in the condom use. Finally, the third cluster (low risk) reported that their sexual health behavior had become much less risky after the rape [24].

Moreover, and contrary to what many people assume, the passage of time does not appear to heal sexual fears and desire or arousal dysfunctions following the assault [25]. Health care providers treating patients with sexual dysfunc-

tions should be aware of the severity and chronicity of sexual dysfunctions which follow sexual assaults.

Therefore, an enhanced awareness of this association may increase, in a gynecological consultation, the early detection of women who experience sexual violence. Moreover, it is important to remember that gynecological, reproductive, obstetric and sexual consequences of sexual violence may appear in the short-, mid- or long-term, go unnoticed and remain unattended due to a potentially altered relationship between these women and their gynecologist.

#### **4. The role of the gynecologist in sexual violence**

An important part of the society is unaware of the real prevalence of sexual violence [26]. Victims of sexual violence often suffer in silence, a fact which worsens the effects of the episode and puts victims at increased risk of further violence [27].

Gynecologists–obstetricians are usually not better informed than other society members [26]. Contrarily, gynecologists appear to be rather unfamiliar with intimate partner violence and may underestimate the prevalence of the problem. A survey performed to 249 members of the Flemish College of Obstetricians showed that only 8.4% of the gynecologists performed some kind of intimate partner violence evaluation to patients on a regular basis and only 6.8% of them had ever received any kind of education in intimate partner violence [28]. Moreover, surveyed gynecologists in this study felt insufficiently skilled to deal with intimate partner violence, while sufficiently capable of recognizing this type of violence among their patients. The believe that screening for intimate partner violence might be an effective way to counteract abusive behavior was manifested by all the doctors [28]. Another study showed that women preferred healthcare providers to play an active role in relation to intimate partner violence [29]. For the reasons which have been mentioned above, the awareness of intimate partner violence is a matter of major importance among all health care providers.

It is well known sexual violence is an underdiagnosed problem, of which we only detect the tip of the iceberg [4]. As it has been previously mentioned, an impairment of the relationship between women with a history of sexual violence and their gynecologist may be one of the multiple explanations. Nonetheless, patients may have other barriers such as shame, lack of support, difficulty in attending to health care consultations (in some regions or due to complicated social context) or unwillingness to relive the assault. Fear is a strong feeling which might be referred by patients who avoid help-seeking [30]. Not only have they fear of being guilty, not believed or incorrectly treated, but also social marginalization is a matter of preoccupation, as sexual violence still implies a social stigma in many cultures. Embarrassment and shame towards intimate partner violence and a sense of responsibility for the abuse are responsi-

ble for its hiding in many cases [16]. Moreover, sexual violence adolescent victims request help later than adults [20]. Health care providers, especially gynecologists, need to help women overcome some of these barriers providing them with a confident and non-judgmental environment that makes them feel safe and free to seek help. It is also common for women who have suffered sexual violence, to have difficulties in identifying it, usually minimizing the facts, or lack of knowledge of where to ask for help [30]. The role of gynecologists in these two barriers is key, as they accompany women along their lives, not only during gynecological diseases, but also through healthy conditions such as routine care, pregnancy and menopause. Therefore, they have the gold opportunity to introduce sexual health care in their daily clinical practice, which would enhance women to find a place where the discussion of sexual concerns is permitted. Moreover, it is the gynecologist's responsibility to center the sexual health care on positive sexuality, focusing on female sexual pleasure. Surely, a woman who identifies her pleasurable sexual experience may easier detect any sexual conduct which attempts to violate it.

Not only patients, but also gynecologists and other health care providers may have barriers. An article published by Uribe *et al.* [31] with the aim to assess the awareness of gynecologists and obstetricians regarding sexual violence was based on a survey designed by the Mexican Federation of Gynecology and Obstetrics. 334 patients answered the survey, 73% of whom were men. Only 56.7% considered sexual violence a medical problem while 94.5% considered it a social issue [31]. Therefore, a possible unawareness of the sexual, gynecological, reproductive and obstetrical consequences may explain the lack of proper gynecological information in consultations on this topic. This study also evaluated the personal opinion of gynecologists and obstetricians on their ability to handle sexual violence cases. Only two out of five (39.8%) considered themselves qualified and two out of three (66.9%) admitted having limitations [31]. Noteworthy, from a strictly medical point of view, 39.2% considered their medical training on sexual violence to be appropriate for clinically evaluating women who have suffered this condition [31]. This fact further explains why certain sexual, reproductive, gynecological and obstetric consequences may often not be taken into account in consultations.

Moreover, in a Canadian study performed in Quebec which consisted of an anonymous mail survey that 241 gynecologists completed, the doctor's experience did not determine differences in the anamnesis of the patients regarding sexual violence screening. Both the sexual history and counseling are still not well-integrated into clinical practice by either recent graduates or their older colleagues [32]. Therefore, an increased training in counseling techniques for clinical situations related to sexual health is needed, since physicians' preventive practices in these areas are still deficient, being similarly assessed by patients with a history

of sexual abuse or domestic violence regardless of whether they are recent graduates or senior specialists [32].

On the other hand, 84.3% of the doctors reported being interested in participating in prevention programs and 73.3% would be willing to take part in programs or organizations for the treatment and guidance of women who have experienced sexual violence [31]. However, these results contrast with the answers to the topics of choice for their continuous training. Three out of four participants reported a preference of learning for high technology or latest knowledge, while only 11% of them answered they would choose the sociomedical aspects of their profession [31].

In relation to this, the International Federation of Gynecology and Obstetrics (FIGO) has developed a program to face sexual violence. The main aims of this program are: educate society members (gynecologists) to be able to recognize sexual violence, make policymakers and the general public aware of sexual violence and its consequences, educate medical students to understand the implications of sexual violence, sensitize and train doctors and midwives in this topic and also develop projects to address sexual violence and integrate its assessment and care into their health services [27].

All in all, taking the above information into consideration, the importance of promoting sexual violence care programs to health care providers, especially gynecologists to ensure their correct training on this field has been seen.

As women's health care providers, gynecologists are in a unique position to identify, support and treat women with sexual violence. Hence, gynecologists should periodically screen women for sexual violence, even at routine visits, during pregnancy and at new-patients visits [9,33].

## 5. Conclusions

One out of three women suffers sexual violence, being partner related sexual violence more prevalent. These women mandatorily require a multidisciplinary approach and a standard protocol in this topic in all the emergency departments is highly recommended.

Gynecologists have to participate in both the immediate attention and the follow-up of patients who have suffered sexual violence. Regarding the immediate attention, and considering the spontaneous gynecological follow-up of these patients is low, it is very important to inform patients about the possible sexual, reproductive, obstetric and gynecological consequences of sexual violence. Gynecological morbidity is higher in women who suffered sexual violence, including pelvic pain, dyspareunia, dysmenorrhea, abnormal menstrual bleeding, urinary incontinence, sexually transmitted diseases, induced abortion, premature deliveries, postpartum depression, sexual dysfunctions and sexual health risk behaviors.

Moreover, gynecologists should incorporate this topic into their continuous training in order to acquire better skills that could help patients overcome communication barriers.

This would be a way to increase the detection of the un-noticed and unattended women with a history of sexual violence, by means of which their sexual and gynecological health could be improved.

Gynecologists have the gold opportunity to introduce sexual health care in their clinical practice and they should periodically screen women for sexual violence, even at routine visits, during pregnancy and at new-patient visits. The gynecological visit should be the place where the discussion of sexual concerns is permitted and also where the identification, support and treatment of women with sexual violence is provided.

### Author contributions

SE and SAA designed the research study, performed the research, analyzed the data and wrote the manuscript. LRT and CCB provided advice on manuscript editing. All authors contributed to editorial changes in the manuscript. All authors read and approved the final manuscript.

### Ethics approval and consent to participate

Not applicable.

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