

Recognizing sexual trauma in women with chronic pelvic pain

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ABSTRACT Chronic pelvic pain is a common presenting complaint among women in the primary care setting. Attempts to identify the source of this pain are often difficult and may result in frustration for both the physician and the patient. Extensive medical work-up frequently reveals no clear organic cause for the pain. In these women, a history of sexual trauma is common, but the patient may not volunteer this information unless specific questions are asked when taking the history. A sensitive but direct assessment of sexual trauma early in the evaluation may save the patient many unnecessary tests, preserve your relationship with your patient, and lead to a better outcome than any medical intervention alone.

Susan is a 37-year-old woman who reported vague and diffuse pain in the pelvic area. Despite a thorough and time-consuming evaluation, no specific organic cause was found. As the pain persisted during the ensuing months, Susan became more distressed and her physician became more frustrated. To solve the problem, her physician ordered more invasive tests and procedures. When nothing was found and the pain continued, the physician suggested a hysterectomy, and Susan quickly consented. The hysterectomy provided temporary relief, but within a few months the pain was back to presurgery intensity.

Does this scenario seem familiar? It is quite common. Chronic pelvic pain, defined as noncyclic pelvic pain lasting more than 6 months, accounts for more than 10% of gynecologic visits.¹ Evaluation of such complaints typically includes a detailed history and a complete physical examination, and may include laboratory tests (eg, urinalysis and culture, gonorrhea and chlamydia cultures, and wet mount of vaginal fluid) and laparoscopy for selected patients in which no organic cause of pain can be found.² However, laboratory tests are often not helpful,² and results of laparoscopies vary widely, with pathology uncovered in 8% to 83% of these procedures (Table 1).³ In addition, women without chronic pelvic pain are just as likely as women with pelvic pain to show abnormalities on laparoscopy.¹

When these procedures fail to reveal an organic cause, many physicians will order more extensive diagnostic tests such as bowel radiographs, urethrocytostcopy, intravenous pyelography, and tests to elicit trigonal or urethral tenderness, abdominal wall myofascial pain, or “trigger points.”¹ Evidence shows that 52% of women with this condition continue to have no

Practice Tips

- | When assessing women with chronic pelvic pain, be sure to screen for a history of sexual abuse or trauma.
- | Consider psychological factors before completing the gynecological evaluation; don't wait for the patient to volunteer sexual abuse information without direct questioning.
- | If a patient has been sexually abused, consider your limitations and know when to make the appropriate referrals for psychological care.

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TABLE 1 Disturbing facts about chronic pelvic pain

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| <p>More than 10% of visits to OB/GYN practices are for chronic pelvic pain.¹</p> <p>25% of diagnostic laparoscopies are for chronic pelvic pain.¹</p> <p>Up to 83% of laparoscopies for chronic pelvic pain reveal no organic abnormality.³</p> <p>65,000 to 123,500 hysterectomies are performed annually for chronic pelvic pain.¹</p> <p>38% to 50% of women with no organic abnormality continue to experience chronic pelvic pain following hysterectomy.⁴</p> <p>63% of women undergoing laparoscopy for chronic pelvic pain report childhood sexual abuse.⁶</p> <p>48% of women undergoing laparoscopy for chronic pelvic pain report sexual trauma as an adult.⁶</p> |
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identifiable somatic abnormality following such extensive, costly, and time-consuming procedures.¹

Although many cases have no clear organic cause, chronic pelvic pain leads to between 10% and 19% (65,000–123,500) of the 650,000 hysterectomies performed each year in the United States.¹ When hysterectomies are performed for chronic pelvic pain with no organic abnormality, 38% of women continue to report significant pain.⁴ Other surgical interventions may also be performed in an effort to alleviate the pain. Our patient Susan had originally presented to the emergency room in such severe pain that she underwent emergency appendectomy. The appendix revealed healthy tissue and, in spite of a reduction in pain while in the hospital, the pain quickly returned when she was discharged home.

Nonorganic explanations

Clearly, identifying the cause of chronic pelvic pain and alleviating symptoms are complex and difficult processes. Therefore, a multidisciplinary approach, including psychological assessment and intervention, is recommended from initial assessment through treatment. When specific organic abnormalities are detected (Table 2) during the clinical evaluation, traditional medical interventions (eg, hysterectomy, surgical correction of adhesions or endometriosis, or treatment of genitourinary infections including pelvic inflammatory disease, irritable bowel syndrome, or peptic ulcer disease) are often effective and appropriate. However, when organic causes of the pain are

not identified, traditional treatments may not suffice. Consideration of nonorganic factors, in addition to organic causes, may be necessary in these cases.

Women with chronic pelvic pain share a number of psychological characteristics, including higher than normal rates of depression, phobias, sexual dysfunction, and anxiety.^{3,5} But the most commonly cited characteristic in this patient population is a history of sexual trauma. A recent study showed that among women who had undergone laparoscopic procedures for pelvic pain, 63% had a history of sexual abuse during childhood and 48% were victims of rape or sexual assault as an adult.⁶ Although studies such as this do not necessarily prove a causal relationship between sexual trauma and chronic pelvic pain, they do provide sufficient evidence for the need to pay careful attention to a possible history of sexual trauma in the evaluation and treatment of pelvic pain.

In Susan's case, the initial evaluation did not include any attempt to elicit a history of sexual abuse or recent victimization, and none was volunteered by her. It was not until she returned to the office with injuries consistent with a sexual assault that her physician finally asked specifically about sexual trauma. Susan admitted that her live-in boyfriend had assaulted her. The physician did not feel comfortable asking further about present sexual victimization or past sexual abuse, but he did ask his nurse to talk with her. Upon talking to Susan, the nurse determined that this was not an isolated occurrence, and referred her to the local battered women's shelter.

Sexual trauma and somatization

One process through which sexual trauma may contribute to chronic pelvic pain is somatization—the manifestation of physical symptoms that normally suggest disease and cause clinically significant distress or impairment but cannot be fully explained in terms of physical disease.⁷ This process involves the transformation of emotional and psychological distress into physical ailments.⁸ Patients who somatize do not exhibit psychological distress through emotional expression; instead, they experience this distress through physical symptoms. Since the underlying psychological distress is often not addressed, the physical symptoms persist. Patients may undergo numerous tests and invasive procedures, and are often viewed as difficult and frustrating by their physicians. Patients who somatize may indeed take up a disproportionate amount of a physician's time.

Somatization, however, should not be confused with malingering (faking a disorder for external incentive) or with a factitious disorder (deliberate feigning of an illness because of a psychological need to be a patient).⁷

The explanations for somatization after sexual trauma vary considerably. Perhaps the most common is chronic emotional stress, which results in a lower resistance to disease. Another theory suggests that coping strategies instituted to overcome the sequelae of sexual trauma contribute to health complications. For example, a woman may abuse alcohol to blunt the chronically heightened arousal associated with posttraumatic stress disorder^{9,10}—a common consequence of sexual victimization.

Undocumented physical injury secondary to the trauma is another explanation, as is the dysfunction of various organ systems related to the chronic overarousal of posttraumatic stress disorder. Emotional pain not only may be experienced as physical pain but also may exacerbate existing physical pain.¹¹

We must remember that the somatizing person truly experiences pain. Although the patient is aware of her physical discomfort, she has generally not connected it to her psychological turmoil. Without psychological intervention, she is fairly helpless to do anything about them.

Patient screening

When screening a patient affected by chronic pelvic pain, it is necessary to obtain a detailed description of the pain, including its relationship to the menstrual cycle, its onset, quality, radiation, and any exacerbating or ameliorating factors. Obtain a detailed menstrual and obstetric history before you resume any other type of screening.

RECOGNIZING PSYCHOLOGICAL CAUSES

Women with chronic pelvic pain rarely report a history of sexual trauma, perhaps because they do not associate their pain with underlying psychological distress. Therefore, the physician should routinely screen for a history of sexual violence in women with chronic pelvic pain. The time saved in treatment will make up for the small amount of time spent in screening. By identifying psychological issues early, you are less likely to request unwarranted, costly, and time-consuming tests and procedures. Although screening does not eliminate the option of performing interventional tests and procedures in the future, it does decrease the likelihood that these procedures will be performed unnecessarily.

Many women are willing to talk about their sexual abuse if asked.

TABLE 2 Organic causes of chronic pelvic pain

| GYNECOLOGIC | GASTROINTESTINAL |
|-----------------------------------|-------------------------------|
| Extrauterine | Constipation/impaction |
| Adhesions | Hernias |
| Ectopic pregnancy | Inflammatory bowel disease |
| Chronic pelvic infection | Irritable bowel syndrome |
| Ovarian cysts | Intestinal parasites |
| Endometriosis | Partial bowel obstruction |
| Uterine | Peptic ulcer |
| Chronic endometritis | Colon cancer |
| Fibroids | Diverticulosis |
| Adenomyosis | MUSCULOSKELETAL |
| Intrauterine contraceptive device | Degenerative joint disease |
| Pelvic congestive syndrome | Herniated intervertebral disc |
| Pelvic relaxation | Fibromyalgia |
| Polyyps | Shingles |
| UROLOGIC | |
| Chronic urinary tract infection | |
| Interstitial cystitis | |
| Kidney stone | |
| Uninhibited bladder contractions | |

Adapted from Smith RP.²

Better outcomes are achieved when psychological factors are assessed initially, rather than after the completion of gynecologic evaluations.¹² Therefore, completing a psychological screening as soon as possible could produce a better result for your patient. Also, disclosing a history of trauma may be associated with positive changes in the patient's immune response—even without subsequent psychological treatment.¹³ Improved immune response, in turn, may result in improved health status.

Early recognition of psychological factors allows for appropriate treatment referrals. Once referrals are offered, the patient may be more likely to obtain these services—either immediately or in the future. Psychological treatment coupled with trauma disclosure in chronic pelvic pain is associated with increased positive outcomes.¹³ At the same time, taking a psychosocial history results in an improved physician-patient relationship and eases communication in other aspects of care. As a result, treatment may be made easier.

The holistic approach to pelvic pain

Practical tips

- Use a holistic approach in which medical care is not limited to the body and its systems; consider the “big picture,” as it saves time and cost.
- Look for psychological origins of physical symptoms early in the exam. Integrate this with screening for sexual trauma and other forms of violence.
- Explain to the patient that her symptoms and psychological issues are important; she will feel she is being listened to and will be more receptive to referrals.

The benefits of this approach

When the patient feels that she is being taken seriously, her attitude will be better; it will open the door to further discussion of psychological problems. It also enhances the patient-physician relationship. The practitioner is viewed as someone who cares about the patient’s physical and emotional welfare and who is open to discussing these issues. Finally, it prevents the patient from living with the physical discomfort and/or “doctor shopping” to find a physician who will take her seriously.

Perhaps most important, routine screening and early recognition of psychological issues will substantially reduce the clinician’s level of frustration in managing chronic pelvic pain that has no clear organic cause.

BE DIRECT

Women may be more likely to respond positively if screening is done as an interview (Table 3), but, given time constraints, this may not be possible.¹⁴ In such cases, a printed screening form can be used (Table 4). It may be helpful to include questions regarding physical abuse as well as specific questions regarding sexual abuse.¹⁵

Whichever screening tool you choose, try to normalize the woman’s experience by using an introductory statement such as, “Many of my patients have had unpleasant experiences in their lives that continue to affect them in some way.”¹⁶ You might then ask questions using simple words that describe the behavior, such as, “Has anyone ever touched you in a way you did not wish to be touched?” or, “Have you ever been forced into sexual activity against your will?”

Women seldom use words like *rape*, *incest*, *wife beating*, or *domestic violence* to describe their painful experiences. Be sure to avoid the use of jargon or emotionally charged questions such as, “Does your husband beat

TABLE 3 Screening for sexual trauma in women with chronic pelvic pain

- Ask direct questions during the initial evaluation
- Use a written form (see Table 4) if time is limited
- Include such screening early in the assessment
- Follow up any affirmative responses during the office visit
- Briefly question the patients at each visit concerning any changes in their sexual trauma history
- Use simple, nonderogatory language
- Respond in a nonjudgmental, supportive manner
- Refer to a qualified mental health professional when needed

you?” or, “Have you ever been raped?” These could provoke strong negative reactions.

INITIATE DISCUSSION

Many women are willing to talk about their sexual abuse if asked. Those who do not initially report abuse or who give misleading answers may do so for a number of reasons. Embarrassment, shame, or fear of stigmatization often prevents them from coming forward. At times, a woman may report an incident previously denied through simple forgetfulness, or perhaps, repression.

Sometimes a woman’s history of trauma is dynamic; what might not have been true at a previous visit may now be true—an assault may have occurred since the last examination. It is also possible that a woman’s perception of her experience has changed. Something she once thought “happened to everyone” may now be acknowledged as abuse.

Another common reason that women do not divulge histories of sexual trauma could simply be that they do not yet trust their physician. This is why it is important to form a trusting relationship with your patient by being understanding and nonjudgmental.

REPEAT BRIEF SCREENING EVERY VISIT

For these reasons, it is necessary to administer a brief verbal or written screening each time a patient is seen. An introductory statement can be used, such as, “I know we went over this matter before, but I would like to follow up to see if anything has changed or if there is anything you would like to tell me now.”

Many women who were victimized as children or adolescents are revictimized as adults.¹⁵ Therefore, assessments for past sexual trauma, as well as for more recent or ongoing trauma such as domestic violence,

are appropriate. It is possible that some abusers may accompany their victims on visits to the doctor's office. Because the abuser's presence will not allow the patient to provide forthright answers, it is imperative that the screening process is done privately and confidentially.¹³

Managing pelvic pain caused by sexual trauma

PHYSICAL EXAMINATION

Knowledge of a patient's history should influence how the physical examination is conducted. However, because a woman may not initially report a history of sexual trauma, it is wise to treat all women with chronic pelvic pain with the sensitivity you would use in treating a victim of abuse. Before performing pelvic, rectal, and/or breast exams on women with a history of abuse, describe the examination in detail. It may be helpful to continue a verbal description during the examination and to occasionally make eye contact to observe facial or other responses. Proceed gently and slowly. Women who appear excessively tense can be verbally encouraged to "let your legs loosen up" or "let your muscles go soft." It is crucial, however, to avoid language that an abuser might have used, such as "open your legs," "spread your legs," or "just relax."¹⁵

When performing the pelvic exam, look for adnexal thickening, cervical discharge, uterine masses, fixation of any structures, ovarian masses, and localized tenderness. If a mass is felt, ultrasonography (possibly using a transvaginal transducer probe) is indicated.

USE A SIMPLE RESPONSE

You may not feel adequately trained to respond to a disclosure of sexual trauma. However, the simplest of responses—such as, "I'm sorry that happened to you"—may be very therapeutic. This communicates that you believe the patient, do not blame her, and are open to explore the issue. Should the patient want to talk about the trauma, consider your limitations and when to make a referral. Under no circumstance should a woman be forced to discuss sexual abuse.

THE APPROACH TO TREATMENT

Initially a woman with a long history of somatization, in which pelvic pain is only one of many complaints, may not be receptive to psychological intervention. She may require more time with her own physician before she would benefit from a referral. Therefore, to encourage her to start searching for the real cause of her symptoms, gently ask questions such as, "What do you think caused

TABLE 4 Sexual abuse screening form

Many persons have had unpleasant experiences in their lives that continue to affect them in some way. Your answers to the following questions will assist your health-care provider in being helpful to you. If you would rather discuss these questions with your physician in private, please ask to do so.

1. When you were a child or adolescent, did anyone ever touch you in a way that you did not wish to be touched or force you into sexual activity against your will?
 Yes No
2. As an adult, were you ever forced into sexual activity against your will?
 Yes No
3. Since your last visit, has anyone forced you into sexual activity against your will?
 Yes No
4. When you and your partner argue, does either of you scream, yell, or use name calling?
 Yes No
5. Have you ever been hit, slapped, kicked, or shoved by your partner or by someone else?
 Yes No

your problem?" "Why do you think it started when it did?" or, "What do you think your sickness does to you?"⁸ Questions such as, "Do your symptoms seem to follow any kind of pattern?" or, "When are your symptoms worse, when are they better?" also help the patient connect her emotional and physical well-being.

Successful management of pelvic pain with underlying psychological causes should take the "long" view. For many patients, especially those with lengthy histories of somatization, we should not expect a cure. Rather, our goal should be a reduction in symptoms or in symptom severity. Sharing with the patient that a cure may not be a realistic goal can reduce her frustration and improve adherence. Successful management will continue to include regular inquiries about all aspects of the patient's life.

When to refer

Make an effort to normalize psychological treatment and refer the patient when needed. It can be helpful to use a statement such as, "Many patients find that talking with a professional about stressful experiences can reduce the

severity of their symptoms.” However, be careful to refer the patient to a qualified therapist, since an untrained or insensitive therapist may retraumatize the patient.¹⁴

In our case example, the physician was not comfortable discussing the sexual assault, and made the appropriate referral. At the women’s shelter, Susan acknowledged the current sexual abuse, as well as current physical abuse and a past history of sexual victimization; she was referred for group counseling and individual counseling even though she remained in the abusive relationship. While initially active in therapy, Susan soon found reasons not to attend as her boyfriend resumed his domination and control of her life. It was not until years later, when Susan managed to escape from this abusive relationship, that her pelvic pain began to resolve.

Conclusion

Many of us know patients whose chronic pelvic pain does not respond to conventional treatment. By obtaining a history that includes questions about sexual assault and other forms of violence, clinicians may be better able to effectively diagnose and treat symptoms. Violence against women is rampant, and sexual trauma often results in long-term psychological and somatic consequences. ♀

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