GENERAL GYNECOLOGY

History of abuse and its relationship to pain experience and depression in women with chronic pelvic pain

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OBJECTIVE: We sought to determine the relationship among a history of physical or sexual abuse, pain experience, and depressive symptoms among women with chronic pelvic pain (CPP).

STUDY DESIGN: This was a cross-sectional study of women who presented to a tertiary referral center for evaluation of CPP (N = 273). All participants completed standardized questionnaires to assess a history of physical or sexual abuse, pain severity, pain disability, and depressive symptoms. Subjects were grouped by abuse category and compared to CPP participants without history of abuse. Multinomial logistic regression models were used to determine the association between adolescent or adult and childhood physical or sexual abuse with pain intensity, pain-related disability, and depressive symptoms.

RESULTS: Logistic regression analyses indicated that, after controlling for age and education, none of the abuse categories was associated with pain severity. However, adolescent or adult sexual abuse predicted greater pain-related disability (odds ratio, 2.39; 95% confidence interval, 1.05—5.40), while both adolescent or adult physical and sexual abuse were associated with higher levels of depression (both $P < .05$). Level of education was significantly associated with pain intensity, pain disability, and depression.

CONCLUSION: For our sample of women with CPP, a history of abuse during childhood or adulthood was not associated with differences in pain intensity, but adolescent or adult sexual abuse was associated with greater pain-related disability. A history of physical abuse or sexual abuse appears to hold a stronger relationship with current depressive symptoms than pain experience for women with CPP. Educational achievement holds a robust relationship with pain morbidity and depression for this population.

Key words: chronic pelvic pain, depression, educational achievement, physical abuse, sexual abuse

Cite this article as: As-Sanie S, Clevenger LA, Geisser ME, et al. History of abuse and its relationship to pain experience and depression in women with CPP. Am J Obstet Gynecol 2014;210:317.e1-8.

Many women with chronic pelvic pain (CPP) suffer from pain-related disability without a definitive medical diagnosis.[1,2] Early clinical reports asserted a causal role for childhood sexual abuse in explaining persistent pelvic pain in the absence of a definitive diagnostic workup.[3,4] Later comparative studies found a high rate of sexual abuse among women with CPP[4-7] and in comparison to women without pelvic pain.[8,9] Evidence from community-based surveys further strengthened the perceived association between a history of sexual or physical abuse and a higher prevalence of pain symptoms among women with CPP.[10] Recently, Fenton[11] proposed a model of limbic sensitization as a mechanism for explaining CPP without obvious medical etiology that invoked childhood sexual abuse as a primary trigger for the development of a reverberating cycle of pain and central nervous system sensitization.

More recently, a number of critical reviews have questioned the empirical evidence for a specific and direct association between abuse history and the development of CPP.[12-15] These authors note that the majority of relevant studies fail to adequately control for potential confounding factors, such as the presence of chronic pain, in considering the association of abuse history and CPP. For example, only 2 previous studies examining the relation of CPP and abuse have included a nonabused sample of CPP patients as a control, and both found no differences between the groups for pain severity.[16,17] Further, when women with CPP are compared with other chronic pain populations for a history of abuse, the results have been equivocal or negative for observing comparatively more severe pain experience for women with CPP who have been abused.[5,7,18]

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Received Aug. 4, 2013; revised Dec. 3, 2013; accepted Dec. 31, 2013.

This work was supported in part by grant number National Institutes of Health K12HD001438.

D.A.W. is a consultant for Eli Lilly Inc, Pfizer, and Health Focus Inc. The other authors report no potential conflict of interest.

Presented in part at the 32nd Annual Scientific Meeting of the Midwest Pain Society, Chicago, IL, Sept. 19-20, 2008.

Reprints not available from the authors.

0002-9378/$36.00 • © 2014 Mosby, Inc. All rights reserved. • http://dx.doi.org/10.1016/j.ajog.2013.12.048

A second methodological criticism of this literature concerns the lack of clarity for case definition across studies.[14,19] The issue of case definition is important as a history of abuse as a risk factor for pain can vary in terms of the type and timing of abuse (eg, sexual vs physical, childhood vs adult), and these dimensions of abuse are frequently collapsed in analyses, which questionably assumes heterogeneity across groups.[19] Moreover, childhood sexual or physical abuse rarely occurs in isolation from other forms of abuse or severe family disturbance during childhood,[20,21] and childhood abuse is known to significantly predict adulthood abuse.[22]

This study examined the association between a history of abuse and pain experience and depressive symptoms among women with CPP. The study compared a sample of women with CPP and a history of abuse to women with CPP with no history of abuse, thus controlling for the influence of chronic pain and pain diagnosis on the relation between a history of abuse and both pain and depressive symptoms. To further examine any differences due to timing and type of abuse, history of abuse was stratified across 4 categories—childhood vs adolescent or adulthood, and sexual vs physical—and each subcategory was compared to CPP patients without a history of abuse. In addition, a measure of depressive symptoms was included as a variable of interest due to previous evidence suggesting an association between CPP and depression[9,23-25] and to determine whether women with CPP who have experienced various types of abuse report more severe depressive symptoms.

Materials and Methods

Participants (N = 273) comprised a convenience sample of consecutive women with CPP seen for evaluation and treatment in a university hospital CPP referral clinic from March 2006 through September 2007. The mean age of the sample was 34.8 years (SD 11.3). Participants had a mean duration of pain of 67.6 months (SD 86.2). The sample included a heterogeneous group of women with a combination of various pain disorders including but not limited to endometriosis, adenomyosis, pelvic adhesions, ovarian remnants, vulvodynia, interstitial cystitis, irritable bowel syndrome, and abdominal and pelvic floor myofascial pain.

Prior to the first appointment, a packet of questionnaires was mailed to the participant and collected at the evaluation appointment. Participants received the questionnaires as part of routine medical care. The packet included both a general questionnaire soliciting relevant sociodemographic information (eg, age, marital status, educational achievement) and medical history, in addition to standardized inventories that assessed pain experience, depressive symptoms, and a history of abuse. The number of patients who reported CPP but did not receive or declined to complete the questionnaire as part of their routine medical care was not recorded in the medical record. The study was approved by the University of Michigan Medical School Institutional Review Board.

To assess pain experience, subjects completed the Brief Pain Inventory (BPI) short form (SF),[26] a self-administered questionnaire that assesses pain severity and functional interference from persistent pain. Subjects are asked to rate the severity of their pain and the degree to which pain interferes with a variety of life activities during the past week. The BPI-SF provides 2 summary measures of pain experience: (1) subjective rating of pain intensity (BPI Severity, range, 0−10); and (2) pain interference (BPI Interference, range, 0−10), which is defined as the degree to which a subject reports functional and activity-related disability attributed to pain. Higher scores indicate more severe pain intensity and pain interference. Several studies support the validity of the BPI-SF for a heterogeneous group of chronic pain patients.[27]

Participants also completed the Center for Epidemiological Studies Depression (CES-D) scale,[28] an inventory that examines self-reported mood and behavior during the previous week. Higher scores (range, 0−60) indicate greater depressive symptoms. Internal consistency of the CES-D is .85 for the community and .90 in a patient population.[28] The CES-D possesses good validity for predicting major depression in a chronic pain population.[29]

A history of sexual and/or physical abuse was obtained from the Sexual and Physical Abuse History Questionnaire, a standardized screening measure previously validated with a CPP population.[30,31] Physical abuse is defined as incidents separate from sexual abuse indicating a life-threatening physical attack with intent to kill or seriously harm, or less severe physical assaults such as being beaten, kicked, bit, or other attacks outside of normal parenting or interpersonal engagement. Sexual abuse is defined as the touching of private body parts by a perpetrator, making the subject similarly touch the perpetrator, or making the subject have vaginal or anal intercourse, with these actions occurring within a context of threat or harm. For individual items, separate prompts are used to assess abuse in childhood or adulthood. Separate measures are calculated for the physical abuse and sexual abuse scores, and both measures are stratified into childhood ($\leq$13 years) and adolescent or adult ($\geq$14 years) age brackets. Age brackets were defined according to the same age limits described by Leserman et al.[30,31] Test-retest reliability coefficients for both the physical abuse (0.81) and sexual abuse (0.77) scales are high, and the measures demonstrate adequate construct validity.[31] In the current study, abuse was categorized as having occurred or not occurred (eg, nonabused) if a subject endorsed any (or no) item in each category.

Statistical analyses

Group differences were examined separately for the BPI Pain Severity, BPI Pain Interference, and CES-D scores by the various groups with a history of abuse compared to subjects who reported no history of abuse. The abuse categories were arranged in a 2 × 2 design, with the dimensions of history of physical abuse and history of sexual abuse each divided into childhood and adolescent or adulthood groups. Independent samples *t* tests were used to examine whether mean differences between the group comparisons were statistically

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