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CLINICAL ARTICLE

Q1 Sexual dysfunction risk and quality of life among women with a history of sexual abuse

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ABSTRACT

Objectives: To assess scores for sexual dysfunction risk and quality of life in a cohort of women in Brazil who had a history of sexual abuse. **Methods:** The present study was a secondary analysis of a cross-sectional study conducted between February 1, 2011 and May 31, 2012. Women aged 18–49 years attending a family planning clinic at the University of Campinas, Brazil, who were in a heterosexual relationship and reported engaging in sexual intercourse in the 4 weeks prior to the study were enrolled. Participants were asked to complete the World Health Organization Quality of Life Questionnaire, Abbreviated Version, and the Female Sexual Function Index (FSFI) questionnaire. Data were grouped based on a history of sexual abuse. An FSFI score of no higher than 26.55 was considered the cut off for sexual dysfunction. **Results:** The prevalence of FSFI-defined sexual dysfunction was higher in participants with a history of sexual abuse ($P < 0.001$) and participants with a history of sexual abuse had significantly lower scores across all quality of life domains. **Conclusion:** Increased risk of sexual dysfunction among women with a history of sexual abuse suggests potential problems in the sex lives of individuals in this population. Healthcare professionals should be alert to this diagnosis.

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1. Introduction

Sexual violence is a worldwide public-health problem, and the majority of individuals who experience it are women [1]. Women who experience sexual abuse are prone to experiencing psychiatric symptoms (e.g. post-traumatic stress disorder and depression), somatic symptom disorder, suicidal tendencies, to use illicit drugs, to contract and be exposed to sexual transmitted infections (STIs), and to experience unplanned pregnancies [2–4]. Other complaints including chronic pelvic pain, dysmenorrhea, and heavy menstrual bleeding have been reported to be late sequela of sexual abuse that might not be linked to sexual abuse by healthcare professionals until many years after the event [5].

Women with a history of sexual abuse in childhood or adolescence have been reported to experience high rates of sexual dysfunction. A previous study investigated the sexual behavior of 774 adult women and described negative perceptions of sexuality and the enactment of high-risk sexual behaviors among individuals with a history of childhood sexual abuse [4]. Although some women can maintain adequate, satisfactory sexuality after experiencing sexual abuse, some studies have reported that many develop psychological and sexual problems including dyspareunia, difficulty achieving arousal and orgasm, and a lack of interest in sexuality [2,3,5,6].

Potential explanations for sexual disturbances include memory recall of sexual abuse during consensual sexual intercourse [4,6]; additionally, studies have described individuals experiencing feelings of guilt regarding abuse, and that this can develop into self-recrimination following feelings of arousal or sexual excitation [3,6]. Physical and psychological problems, including difficulty in social and working activities, can jeopardize quality of life for a long period of time after sexual abuse events [2,3,6].

During gynecologic consultations, women are not typically asked about having any history of sexual abuse, and most individuals are reluctant to spontaneously report sexual complaints or a history of sexual abuse during medical consultations. Consequently, the objectives of the present study were to assess and compare sexual-function and quality-of-life scores using self-reported instruments. Questionnaire responses were compared between individuals who reported a history of sexual abuse and those who reported no history of sexual abuse.

2. Materials and methods

The present study was a secondary analysis of a cross-sectional study conducted at the family planning clinic at the Department of Obstetrics and Gynecology of the School of Medicine at the University of Campinas, Brazil between February 1, 2011 and May 31, 2012 with the aim of comparing the awareness of contraceptive methods and fertility between individuals who were using long-acting reversible contraception and those who were not (unpublished data). Individuals attending the family

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planning clinic were eligible for inclusion in both the cross-section study and present secondary analysis if they were aged 18–49 years, had been in a heterosexual relationship for at least 6 months at enrollment, and reported having engaged in sexual intercourse in the 4 weeks prior to enrolling in the cross-sectional study. The ethics committee of the study institution approved the study protocol and all participants provided written informed consent at enrollment for study participation and for data inclusion in the present secondary analysis.

The necessary sample size for the present analysis was estimated based on the previously reported standard deviation (22.5) in Childhood Trauma Questionnaire Sexual Abuse scores for sexual dysfunction among a group of women with a history of childhood and adolescent sexual abuse [6]. Assuming a difference of 10 points in the median sexual-dysfunction scores between participant groups that did or did not have a history of childhood or adolescent sexual abuse, with α error of 0.05 and β error of 0.20, a sample size of 80 participants in each group was calculated.

The previous cross-sectional study compiled a database that included data from 2112 individuals using a range of contraceptive methods. For the purposes of the present analysis, all women in the dataset who reported a history of sexual abuse were included. Data for a comparison group were included from individuals with similar baseline characteristics who did not report a history of sexual abuse. The participant data included in the comparison group were selected at random, using a computerized program, from the remaining 2028 participants in the main research cohort without a history of sexual abuse.

The data retrieved from the database include participants' responses to three self-report questionnaires. All the instruments were self-administered; however, a healthcare professional was available to help participants to complete questionnaires if needed.

Data were collected from a questionnaire developed to collect demographic information including sociodemographic data, education, and socioeconomic class, which was determined using participants' mean gross monthly household income, grouped as A (US\$5148–\$3720), B (US\$2132–\$1191), C (US\$655–\$432), D (US\$305–\$187), or E (US\$ <186), according to the Brazilian Market Research Association's social-class definitions [7]. In addition, information was recorded on sexuality (dyspareunia, personal history of sexual abuse, and partners' sexual dysfunction, such as erectile dysfunction or premature ejaculation) and medical history (presence of co-morbidities, such as chronic diseases, psychiatric illness, daily alcohol and tobacco consumption, daily use of any medication, and history of STIs).

The second self-reported questionnaire included in the present analysis was the Female Sexual Function Index (FSFI); the FSFI has been proposed as a tool for evaluating sexuality among women diagnosed with female sexual arousal disorder [8] and has been validated for evaluating sexual function in orgasmic disorder and female hypoactive sexual desire disorder [9]. This instrument has also been validated for use in Brazilian populations [10].

The FSFI includes 19 questions divided into six domains measuring (a) desire (two questions; 2–10 points); (b) arousal (four questions; 0–20 points); (c) lubrication (four questions; 0–20 points); (d) orgasm (three questions; 0–15 points); (e) satisfaction (three questions; 2–15 points); and (f) pain (three questions; 0–15 points). The FSFI requests that participants answer based on experiences during the preceding 4 weeks. Scores for individual items are added before being multiplied by a domain factor (each domain has one specific factor), producing scores for each individual domain. A composite full-scale score is obtained by adding the scores from the six domains, which all have the same power when calculating the full-scale score; higher total scores equate to a higher sexuality index. A FSFI full-scale score of no higher than 26.55 has been described as the cut-off level for screening for sexual-dysfunction risk; women reporting a full-scale score of 26.55 or below are considered to be at increased risk of sexual dysfunction [11]. For the present analysis, FSFI full-scale scores were used to compare the groups of participants (domain scores were not compared individually).

The final questionnaire included in the present study was the World Health Organization Quality of Life Questionnaire, Abbreviated Version (WHOQOL-BREF). The WHOQOL-BREF, based on the generalized World Health Organization Quality of Life Questionnaire, was developed by the World Health Organization's WHOQOL group to provide a brief, convenient, accurate means of collecting data for quality of life research studies. The WHOQOL-BREF consists of 26 questions across four domains (physical health, psychological, social relationships, and environment) and includes an overall score. High correlations between domain scores and the overall score using the generalized questionnaire have been reported [12]. The questionnaire used has been validated for use in the Brazilian population [13].

Data from the two groups of individuals were compared using the Student *t* test, χ^2 test, the Fisher exact test, and the χ^2 test including a continuity correction, when appropriate. The frequency of individuals having at-risk scores for sexual dysfunction (FSFI total ≤ 26.55) was compared between both groups using the χ^2 test with continuity correction. Mean WHOQOL-BREF domain scores were compared using the Mann–Whitney test for independent samples. A multiple regression analysis was performed to investigate associations between participant variables and at-risk FSFI scores for sexual dysfunction; the variables included in the model were history of sexual abuse, age, ethnicity, marital status, duration of schooling, economic class, employment, BMI, smoking, daily consumption of alcohol, any chronic diseases, any current psychiatric illnesses, any history of STIs, ongoing medication use, whether a participant's partner experienced premature ejaculation, and the duration of participant's current relationship. $P < 0.05$ was considered statistically significant.

3. Results

The present study included data from 84 women reporting a history of sexual abuse and 90 women without a history of sexual abuse. The mean $\pm$ SD age was 33.2 ± 6.4 and 30.8 ± 8.0 among the participants with and without a history of sexual abuse, respectively. Increases in the frequency of participants being not white and of being involved in a relationship not longer than 1 year in duration were observed among participants with a history of sexual abuse. No differences were observed between the groups for the other sociodemographic variables recorded (Table 1). A significantly higher frequency of having a history of psychiatric disease, experiencing STIs, medication use, and experiencing dyspareunia were reported by participants with a history of sexual abuse (Table 2).

Data of at-risk FSFI scores (≤ 26.55) for sexual dysfunction were available for 78 participants with a history of sexual dysfunction and 77 without a history of sexual dysfunction; at-risk scores were recorded for 45 (58%) individuals with a history of sexual abuse and 18 (23%) participants without a history of sexual abuse ($P < 0.001$). The mean scores for all WHOQOL-BREF domains were significantly lower among the participants with a history of sexual abuse (Table 3). The results of the multiple logistic regression analysis demonstrated significant associations between risk of experiencing sexual dysfunction (FSFI score ≤ 26.55) and individuals having history of sexual abuse, having a partner who experienced premature ejaculation, having completed no longer than 8 years of schooling, and having a body mass index (calculated as weight in kilograms divided by the square of height in meters) of 25 or higher (Table 4).

4. Discussion

The results of the present study demonstrated an increased prevalence of FSFI scores indicating sexual dysfunction risk and lower WHOQOL-BREF scores among women with a history of sexual abuse. Although there were missing data in both groups, it is unlikely that this affected the results. These findings are in agreement with studies that have described a high frequency of sexual difficulties among

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