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Research & Advocacy Digest

Linking Advocates & Researchers

Sexual Assault and The Body

Letter From The Editor

Janet Anderson, Advocacy Education Director, WCSAP

The effects of sexual victimization have been well documented. As advocates and therapists you are well aware that sexual violence impacts every aspect of a person's being. By its very nature, sexual violence impacts one's relationship and sense of connection to the self, it influences relationships with others and it certainly takes a toll on one's relationship with her own body. This edition of the Research and Advocacy Digest takes a fascinating look at how sexual assault and abuse impacts the body. In this edition we explore how sexual violence is linked to a negative self concept, body image, and impaired sexual functioning. It also examines the influence sexual assault has on child-bearing, dental health, decisions to undergo cervical screening and the development of symptoms consistent with chronic fatigue and chronic pain. Furthermore, one study links rape to body dysmorphia (an often debilitating preoccupation with the idea that one's body is not sufficiently lean or muscular), compulsive weight-lifting and anabolic drug use as a way for rape victims to become bigger, stronger, less desirable, attractive and ultimately, safer.

While most studies within this edition make the direct connection between a negative body image and sexual assault, one study of note expands on the research by examining the intersection between gender, race, childhood abuse and body image. The author calls our attention to the fact that our dominant/mainstream culture's perception of beauty and the "perfect body image" is deeply grounded in classism, racism and gender oppression and recognizes that these socio-cultural influences must be considered when drawing conclusions regarding body image and self-concept.

Although we are presenting but a bare snapshot of the complexities of sexual assault and its influence on the body, pointing out research gaps is also imperative. In her research, Kim Logio identifies that while much research has been conducted relating body image and sexual assault to white females, less has focused on this phenomenon as it relates to people of color and to males, regardless of race. Thus, these gaps illustrate that much more work needs to be done to paint as complete a picture as possible.

The research in this edition, as well as the gaps, has implications for advocates, therapists, health practitioners, doctors, dentists and school personnel and we hope that it increases your understanding as you work to assist every survivor in re-discovering a sense of self-worth, self-respect and sense of dignity.

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Janet Anderson, Editor, WCSAP
Penny Simkin, PT
Phyllis Klaus, CSW, MFT

Interview with Penny Simkin and Phyllis Klaus

Authors of "When Survivors Give Birth: Understanding and Healing The Effects of Early Sexual Abuse on ChildbearingWomen"

WCSAP: Can you tell us why you decided to write the book?

Penny: My background is in physical therapy and my entry into the subject of childhood sexual abuse was through my background in teaching childbirth preparation which I had been doing since 1968. During class reunions I found that many of the women reported being incredibly distressed about their birth experiences. In listening to them, I found that they were using assault language to describe their experiences as opposed to using birth language. Some of the women were describing their birth as if it was a rape. That started to shift things for me and I began to wonder if previous rape, if previous sexual assault, could have an impact on childbearing. I went to the literature and began hunting for any information about this and there was nothing there. I had even asked several psychologist friends of mine about possible connections between the two and they told me there weren't any. They weren't just saying, "We don't know," but were giving me a definitive "No" as an answer. But this did not fit with what I was experiencing, and then I happened to meet Phyllis who was also hearing the same thing from her clients.

Phyllis: My early background was in teaching, and then I moved into counseling and therapy. I first worked with at-risk youth who had all kinds of backgrounds and issues. Many of these youth were sexually assaulted, had been raped, and had pregnancy issues. Consequently, I began to look at the broader picture about the connections between these traumas; not just with childbirth but in other areas of their lives. One of the first adult clients who came to me to learn relaxation techniques for labor said, "I know that you do training for those who are anxious about childbirth." I didn't pick up on this. I didn't connect the word "anxious" to the possibility that something else might be going on. And of course I learned my lesson not to just stop there; I've learned that we need to explore what they were meaning by the word "anxious." In addition, another client who wanted to work on some personal concerns wrote me a letter saying, "There were six of us in the room and you only paid attention to one of us and we felt left out." She had an undiagnosed dissociative identity disorder. This introduced me to the whole field of trauma, dissociation and ego-state therapy and I started to study how trauma and traumatic memories are held in the body. I then started to apply this understanding to my child birth patients and began training residents and medical providers about how trauma was connected to medical symptoms and it all began to make so much sense; that sexual assault would be held in the body and that it would manifest itself through a variety of psychological, physical, and psychosocial symptoms. In the late 80's I participated in a childbirth conference and heard someone give a talk that was very raw about the horrors of birth. I was surprised to hear her speak that way. As a result of her presentation, I saw people running out of the room. I followed one participant and she told me that these horrors had happened to her. She explained how the childbirth triggered abuse memories for her. Penny Simkin was also giving a presentation at the same conference but she presented similar information in a kind and thoughtful way. After talking for awhile we both discovered that we wanted to write a book about this and therefore got together to do so. It actually took us about 12 years to complete this book.

WCSAP: I understand that you had a hard time finding a publisher for this book. Can you explain some of the reasons for this? Both of us are published authors but for this book publishers felt that the topic was too narrow and that the book would not be marketable. One publisher wanted us to write it in a very different way that felt insulting to us and to our potential readers. We kept trying to find a publisher, but eventually we decided to publish it ourselves.

WCSAP: I was impressed by your complete understanding of child sexual assault and in your book you do a beautiful job in laying out the

framework. If you had to describe this book to someone who doesn't know about it, how would you describe it?

Penny: It is for both healthcare providers and survivors. We were trying to bring these groups together. We wanted to help providers understand what is going on with a patient who may have experienced sexual abuse and lay out the connection between child birth and sexual abuse. Very often the health care provider will view the survivor as being difficult or uncooperative. It isn't because the provider is "evil," it's because they simply don't understand this issue or the connection between sexual assault and its impact on pregnancy and childbirth. Another purpose of writing this book is to give survivors tools. We found that many of these women assume that their providers are untrustworthy. Many have avoided getting care altogether because so much of medical care is reminiscent of their abuse experiences. But when they got pregnant, they realized they had to go and get care. So, our book is an attempt to help both sides –providers and survivor clients.

WCSAP: That's what really resonated with me. This book was written from such a loving, kind place and you could pick up both of your hearts throughout the book.

Phyllis: We also wanted women to realize that not only were they not alone in this experience, but that we could give them tools to help them with this issue. When we first started working on the book people believed that child sexual abuse was an isolated incident, that it wasn't really happening all that much. Luckily as time has gone on, this subject has come out of the closet, so to speak. Our culture is more aware of the prevalence, more and more people know that it is happening. But prior to recent history, it was a commonly held belief that this is fantasy and we know that that belief was very, very hurtful. And we now know that this just wasn't happening to females, but to many, many males as well. So this book was also an attempt to help survivors realize that they weren't alone, that they weren't crazy, that there was a connection between childbirth and the potential for abuse triggers to come to the surface and that there were things both the provider and the survivor could do to minimize the impact.

WCSAP: What we know is that sexual assault is the most under-reported crime there is. It is known that 1 in 3 girls and 1 in 5 boys will be sexually assaulted before age 18, but we are still living in a culture that minimizes this. I was just at a training where the trainer mentioned that she had quoted this statistic to someone and their response was, "Well, this just can't be, otherwise, how could we function as a society?"

Penny: Of course it can be. But I think this speaks to the amazing strength and resiliency we have as human beings, as women, as men. This speaks to one's ability to overcome obstacles and terrible hardship.

WCSAP: Could you outline some of the connections between sexual abuse and its impact on pregnancy and childbearing?

Phyllis: There is a connection at every level of care. For example, during pregnancy the woman starts to experience changes in her body; those changes reflect evidence of sexuality. For some women it could be a time when they feel very normal for the first time, "You see, my body is doing something right when they previously felt their body or themselves were damaged." But it is also a time when women are more exposed. It is a time when they are being subject to all the tests, being touched, and poked and prodded, and this can be very triggering and cause feelings of being invaded. And what we know is that it is hard not to have those memories be triggered. This is also a time when the woman feels a great sense of being out of control; the idea that they have to give themselves over to something. Our hope is that there are ways that they can be heard, that some of their needs during this time can be met, that caregivers, if they understood what was going on, could be more respectful of what their needs are. By providing women with choices, we know it could shift the sense of being helpless to feeling more empowered, to having a sense of self.

Penny: Another common manifestation of abuse, although not universal, is the inability to tolerate vaginal exams. This should be a red flag indicating a strong likelihood of early sexual abuse for any care provider. Other things that may trigger abuse memories include having IV's, being hooked up to machines, undergoing dental work; having hands in the mouth, etc. Many will seek the services of a female provider because the perpetrator may have been a man, but then they

may be faced with a female provider who is abrupt, or not understanding, and find they become very disappointed; they may feel that here is another female who is not protecting me ("like my own mother who did not protect me.") Another common issue is one of dissociation. Sometimes women will dissociate during labor and this troubles the nurses or other caregivers.

We also have to be careful about the language we use. For example, think about how saying, "Spread your legs and relax so this won't hurt" may trigger abuse memories. Some women that we have worked with fear parenting a child. They may be afraid that they will hurt their child or that they won't be able to keep their child safe. So, as you can see, a lot of complicated issues come up. The important thing in all of this is to help the survivor recognize what her triggers are, what her fears are. Then there can be some healing. Even if the provider doesn't know why a woman has fears, there are things that they can do to minimize the impact or reduce the amount of trauma that a woman might feel during this time. They can learn to communicate effectively, to contain their fears, to quiet down a panic attack, and more. There are simple ways to help them feel more empowered.

WCSAP: Could you give us some recommendations for care providers?

Penny: It is vitally important to tell people what is going to happen before hand and to check in with them every step of the way. If you screen for sexual abuse on your intake forms, do something with it, don't just ignore it, otherwise the survivor can feel hurt by disclosing and, once again, here is another person not saying anything or doing anything about it? In other words, don't ask if you aren't going to acknowledge it. When I speak to nurses who are required to ask this, I ask them, "Don't you hope they say no?" They just don't know what to do when they get a yes. All it would take to help would be to ask the survivor what she needs to help her feel more comfortable. I recognize that this is a tough dilemma. But it doesn't really have to be all that complicated. The nurse should acknowledge that no one deserves to be treated that way and ask the survivor what she needs and hopefully the provider can accommodate some of her requests.

Phyllis: One thing that comes to mind is our motto. If a care provider is finding a person "difficult," the first thing is to acknowledge that she has good reason for being and feeling this way, for saying these things. And because the provider may be taking this personally, the second part of the motto is, "you are not the reason." They can validate the person without getting stuck in some kind of conflict. It will help providers learn to treat survivors differently if they realize that there are good reasons for the behavior and that the provider is not the reason. When a provider can put a trauma lens on his or her behavior, everything begins to make more sense.

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Another thing providers can do is listen, listen, listen. Do not give premature advice or jump into a problem-solving mode. The caregiver must take the time to listen and not make assumptions or ascribe what they think this means to the survivor.

Many somatic complaints are a direct result of sexual abuse. Too many times, we just treat the symptom without asking the patients what's going on. Ask gentle open-ended type of questions and make clarifying statements and in a few minutes you can often learn what is important to the survivor. It's not important to get into a long history or litany of questions. What we try to tell providers is to assume everyone is a survivor of some kind of trauma and that it is important to recognize, particularly during this delicate stage of life, when giving birth. Every human being needs to be treated with kindness and tenderness. With birth, it can

be a very exciting time, but it also is a time when there are lots of unknowns, "a dangerous opportunity."

Penny: It is important to realize that the woman is always in a differential power position; she is the lowest person within this hierarchy. Do simple things like asking permission, explaining what is happening, making sure she understands, avoiding jargon, which is often a power play; create equal footing at every level. I had a woman who wrote in her birth plan: "Please knock before you come in, introduce yourself, and tell me what you are going to do, and keep me informed of my progress. Don't just leave without talking to me." Simple little things can make a difference. I would love for all providers to have to go through a "hospital gown day" so they understand what the patient is going through.

WCSAP: What recommendations would you give to survivors?

Penny: I would love for them to have a support system. If the survivor is challenged by the upcoming birth, I would love for her to connect with a childbirth educator or doula to help her develop a birth plan, which is an opportunity for her to outline her needs for the medical staff. She gets to write out her needs at a time when she can be more reflective and not in the throes of labor or in a state of trauma or chaos. Often these birth plans are placed in their charts. I would also recommend that survivors learn some self-help techniques like relaxation and grounding techniques. And finally, I would want survivors to know that they are not alone, that they can become empowered, that they can make choices to help make the birth experience less traumatic.

WCSAP: What are some recommendations that you would give to sexual assault advocates and therapists who are working with survivors?

Phyllis: I think it is vitally important to validate that she has the right to express her needs. Help them use "I" messages; help them learn ways to express their needs in ways that others can hear. For example, a survivor can ask a provider for a longer visit to discuss her needs. Try to help create as much of a sense of equality as possible.

As for therapists, I would love for them to begin to understand the connection between childbearing and sexual assault. I have found many who don't understand the significance of these two issues and I would love for them to become educated about it. It would be great if advocates and therapists help survivors connect with a good midwife or a doula, or someone else who can advocate on her behalf. Short-term therapy is also a good option to help survivors deal with these issues, as well as other ego-state therapeutic techniques.

Childbearing can be a time of wonder, of opportunity, of new changes, but it also can be a time of fear and bring up a lot of unknowns. Those who care for the survivor, be it a midwife, childbirth educator, doula, sexual assault advocate, or therapist, can help the survivor feel more empowered during this time by listening and understanding that there are ways to make the experience less traumatic.

WCSAP: I want to thank you both for not only writing this wonderful book, but for taking the time to talk with us about it. It is my hope that this information will be used to help survivors overcome their issues to help make their childbearing experience all that it can be.

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Gender, Race, Childhood Abuse, and Body Image Among Adolescents

Logio, Kim, A. Violence Against Women. Vol. 9(6), August, 2003, 931-954.

The author first lays out the groundwork for this study by discussing how socio-cultural factors such as our dominant/mainstream culture's perception of beauty and the "perfect body image" is steeply grounded in classism, racism and gender oppression. She argues that these ideal images emerge out of, and for, a white middle class, heterosexist majority and believes that this should be taken into consideration when examining factors that influence body image. She further identifies several research gaps stating that while much past research has been conducted relating body image to white females and childhood abuse, little has focused on body image considering the intersection of race, gender and childhood abuse, thus becoming the rationale for this research project.

Participants in this study were 1,427 9th and 11th grade students in public schools that took part in a larger evaluative study of the Delaware School Wellness Center. The sample breakdown was 57% (9th grade) and 43% (11th grade). More than half were female (53.9%) with 68% being White, 23% African American, 2% Latino, 2% Asian, and 1% Native Americans. The group was further divided into four comparison groups: black girls, white girls, black boys and white boys. The other races were not included due to their limited population size.

Measurements included questions regarding past physical and sexual abuse, variables measuring eating/dieting practices and examining body mass index and self-perceived body size to identify dissonant vs. accurate body images. This study demonstrated several findings:

- Black and white girls are more susceptible to overweight self-images than boys of either race.
- White girls have the smallest percentage of an accurate self-evaluation of normal weight.
- Boys were much less likely to have false self-images of being overweight.
- Black boys were most likely to have false self-images of underweight body size.
- Regardless of race, girls are more likely to engage in disordered eating and dieting practices than boys in either race category. Black girls were not significantly different from white boys with regard to engaging in unhealthy dieting behaviors. Gender differences in disordered eating and dieting are not consistent across race.
- Although white girls generally face greater risk for disordered eating and dieting than white boys, the influence of past abuse puts white boys in greater danger of developing unhealthy eating and dieting habits as well.
- Regardless of race, girls were more likely to experience abuse than boys.
- Experiences of abuse are more likely to correspond to an overweight body image than an underweight or accurate body image.
- Past physical and sexual abuse were predictors of unhealthy body images and eating and dieting practices among whites, but not for blacks, regardless of gender.

Understanding the relationship between gender, race, past abuse and its impact on body image can help educators, health professionals and schools in efforts to develop strategies to reduce health risks in adulthood.

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Past physical and sexual abuse were predictors of unhealthy body images and eating and dieting practices among whites, but not for blacks, regardless of gender."

Childhood Unwanted Sexual Attention and Young Women's Present Self-Concept

Whealin, Julia, M.; & Jackson, Joan, L. Journal of Interpersonal Violence, Vol. 17(8), (2002), 854-871.

The authors define unwanted sexual attention (UWSA) as including comments, looks and gestures directed toward one's sexuality and/or appearance and indicate that most girls begin to experience high levels of UWSA during preadolescence. This study examines the long-term impact of childhood UWSA on young women's body image and self-esteem.

They hypothesize:

1. High levels of UWSA would result in lower scores on academic performance, physical appearance, global self-concept, and body image.

2. Strong, negative internal reactions (anger, fear, guilt) to UWSA would impact long-term negative body concept and psychological adjustment.

Four hundred and forty-eight (448) college students were recruited and given a set of questionnaires that measured: 1) exposure to sexual attention and their reactions to it, 2) personal and academic self-concept, 3) body image and satisfaction and 4) anxiety related to one's body.

Of the 448, 434 (96.9%) reported being the recipient of UWSA, of which fellow students were the major perpetrators. Analysis of the data indicated that the first hypothesis was supported, in that women's current negative self-concept (academic performance, physical appearance, global self-concept and body image and body anxiety) was significantly predicted by childhood experiences of unwanted sexual attention. On the other hand, with the exception of physical appearance self-esteem, the results did not support the notion that one's internal reaction to UWSA played a significant role in developing a negative body concept; suggesting that the behavior of unwanted sexual attention may be more important than emotional reactions when considering the impact of this experience.

As a social phenomenon, repeated unwanted sexual attention places females at risk of developing an objective sense of self and negatively socializes them to defer to other's views at the expense of their own, which ultimately is extremely detrimental. In addition, many of the women indicated that this chronic attention impacted their desire to participate in school activities and affected their ability to pay attention in class, thus making the argument that schools need to take a more active role in seriously addressing this issue.

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Relating Body Image to Psychological and Sexual Functioning in Child Sexual Abuse Survivors

Wenninger, Kerstin & Heiman, Julia, A. Journal of Traumatic Stress, Vol. 11(3), (1999), 543-562.

Researchers studying child development and sexual violence have made the case that childhood sexual trauma has a profound and persistent impact on body image, and argue that a negative body image plays a critical role in long-term psychological functioning of survivors. This study was designed to identify what role both body image perception and consequential attitudinal feelings about their bodies played in the long-term psychological and sexual functioning of survivors.

Through newspaper ads, the researchers recruited 57 female Child Sexual Assault (CSA) survivors and 47 women with no history from the Seattle area. Using a battery of measurement tests, interviews consisted of questions regarding: 1) background of abuse, 2) body image, 3) body esteem, 4) psychological functioning variables including Post Traumatic Stress Disorder (PTSD), depression, substance abuse, dissociation, anxiety, sleep problems, and self-destructive behaviors) and 5) sexual functioning.

"Regarding the psychological variables measured, the Child Sexual Assault (CSA) group scored higher than the comparison group on all psychological related symptoms. In other words, there was significant evidence that survivors treated their bodies in ways that were destructive, punishing and neglectful."

In terms of group description, for the survivors group, the age of first sexual contact with the abuser was 9.6 with 47% reporting abuse by more than one perpetrator. A total of 121 abusers were reported, 12 being women. The majority of abusers were parents, step parents or other relatives with the remaining falling into the category of professional caretakers (baby sitters, doctors, teachers, acquaintances, and least reported, strangers. Repeated abuse up to 5 years was reported by 51%.

Measurement outcomes revealed that CSA survivors reported significantly more bodily symptoms of illness and vulnerability to illness and had overall lower body esteem and body image scores, including sexual attractiveness, compared to the control group. Regarding the psychological variables measured, the CSA group scored higher than the comparison group on all psychological related symptoms. In other words, there was significant evidence that survivors treated their bodies in ways that were destructive, punishing and neglectful. Consistent with other studies regarding sexual functioning, the survivors group reported feeling more aversion to sex, less arousal, and more pain during sexual activity. While no group differences were found between the two groups in relation to overall appearance, survivors differed significantly from the comparison group on satisfaction with sexual attractiveness.

Overall this study supports the association between childhood sexual abuse and body image and body esteem disturbances and predicts that these disturbances correlate with impairments in psychological and sexual functioning. Consequently, interventions that address these types of body image and esteem impairments are especially warranted as a way of minimizing their impact.

The Impact of a History of Child Sexual Assault on Women's Decisions and Experiences of Cervical Screening

Harsanyi, Anne; Mott, Sarah; Kendall, Susan; & Blight, Alison. Australian Family Physician Vol. 32(9), 2003, 761-762.

This study's aim was to determine what impact having a history of child sexual assault had on women's decisions to have, and her experience of, cervical screening. They postulate that women with this history may be at increased risk of developing cervical cancer due to avoidance because the screening can resemble childhood abuse.

A questionnaire, which sought information on demographics, cervical screening history, inappropriate touching before age 16, and the impact it had on their experience of cervical screening, was mailed to 100 known women with histories of child sexual abuse and to 200 women with no known history of abuse. Seventy-six (76) surveys were returned by survivors and 160 completed surveys were returned by the comparison group, of which 21 indicated a history of unwanted sexual contact before age 16.

Of the total 97 who identified as survivors, 12% said counseling and 17% said health concerns motivated them to undertake screening. Avoidance and fear of the screening was reported by 26%, 35% reported negative experiences and 24% sought out female doctors. Negative screening experiences caused by the doctor themselves were reported by 4% while 14% described positive behavior by the doctors, such as taking time, being gentle, explaining well and being sympathetic as motivating factors to undergo cervical screening.

Although this study demonstrated that a child sexual assault history was strongly associated with an avoidance of cervical screening, physician behaviors such as counseling, explaining and being sympathetic were also important factors in encouraging survivors to have the test taken. Therefore, they suggest that physicians tailor cervical screening to the needs of their patients and encourage opportunities for patients to disclose such histories.

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Compulsive Weight Lifting and Anabolic Drug Abuse Among Women Rape Victims

Gruber, Amanda, J; & Pope, Harrison, G. Comprehensive Psychiatry, Vol. 40(4) (2000) 273-277.

The authors of this study point out that literature supports the development of compulsive behaviors in some sexual assault victims as a response to their assault. In studying female athletes, they began to see a pattern of compulsive weight lifting and anabolic drug use and sought to determine if a relationship existed between this phenomenon and sexual assault.

They recruited women who previously competed in a bodybuilding contest or who worked out in a gym at least six times per week for two years or more. A total of 75 women responded. The evaluation consisted of demographic information, history about weightlifting, anabolic drug use dependence, medical history, family history of psychiatric disorders, and laboratory tests.

Resulted indicated that 10 women or 13% identified themselves as sexual assault survivors, nine of which reported that they greatly increased their bodybuilding activities after the rape in an effort to become bigger, stronger, less desirable and attractive, safer, and less vulnerable and helpless. In addition to other symptoms, results indicated that 80% developed PTSD following the rape, 50% reported some form of substance dependence, 50% reported developing eating disorders and 90% reported body dysmorphia after the assault, (an often debilitating preoccupation with the idea that one's body is not sufficiently lean and muscular). In addition, 70% began using anabolic steroids to gain muscle mass and strength. By contrast, only 34% of the comparison group reported anabolic drug use.

Citing some limitations of this study, the findings suggest a previously unrecognized relationship between sexual assault and compulsive weightlifting and anabolic drug use.

"Resulted indicated that 10 women or 13% identified themselves as sexual assault survivors, nine of which reported that they greatly increased their bodybuilding activities after the rape in an effort to become bigger, stronger, less desirable and attractive, safer, and less vulnerable and helpless."

"In addition, 70% began using anabolic steroids to gain muscle mass and strength. By contrast, only 34% of the comparison group reported anabolic drug use."

Chronic Fatigue, Abuse-Related Traumatization and Psychiatric Disorders in a Community-Based Sample

Taylor, Renee, R.; & Jason, Leonard, A. Social Science and Medicine, Vol. 55 (2002) 347-356.

The authors of this study hypothesized a significant relationship between chronic fatigue syndrome and sexual and physical abuse. A random sample of 18, 675 adults from ethnically and socioeconomically diverse backgrounds were sampled and split into two groups: individuals with chronic fatigue and those without. The two groups were evaluated using a multi-staged strategy.

Stage 1 (telephone interview) revealed that of the 18,675 respondents, 780 (4.2%) reported chronic fatigue with 408 being positively screened. The control group was comprised of 199 individuals who did not report chronic fatigue. Of the 408 positively screened, 227 (56%) completed the SCID (Structured Clinical Interview for the DSM-IV) and 225 (55%) completed the sexual-physical abuse history questionnaire. In the control group, 74 (33%) completed the SCID and 72 (36%) completed the sexual-physical abuse questionnaire.

The results indicated that:

Single abuse events - Of all the types of abuse variables studied, child sexual abuse emerged as the only significant predictor of chronic fatigue.

Cumulative abuse - Individuals who experienced a greater number of abuse events were significantly more likely to be members of the chronic fatigue group.

Psychiatric disorders - Childhood sexual abuse, childhood death threat, total number of childhood abuse events and total number of lifetime abuse events were identified as significant predictors of PTSD, while adolescence or adult sexual assault served as the only significant indicator of non-PTSD anxiety disorders.

The implications of this study demonstrate a need for primary and secondary child sexual abuse prevention programs as well as the need for medical providers to question patients about abuse history to develop an integrative approach to treatment.

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Cumulative abuse - Individuals who experienced a greater number of abuse events were significantly more likely to be members of the chronic fatigue group."

A Comparison of Chronic Pain Patients and Controls on Traumatic Events in Childhood

Goldberg, Richard, T; & Goldstein, Richard. Disability and Rehabilitation, Vol. 22(17), (2000), 756-763.

Recruited from Spalding Rehabilitation Clinic and Massachusetts General Hospital, 190 individuals, 92 patients, ages 20-62 with chronic pain and 98 hospital employees of the same age range without chronic were compared to determine the prevalence of sexual and physical abuse within these two populations.

The mean age of the pain group was 40.89 and consisted of 67 women and 25 men. The average length of time with chronic pain was four years. The mean age of the control group was 36.68 and was comprised of 88 females and 10 males.

Measures included two questionnaires: 1) childhood history of abuse (age of onset, relationship to abuser, frequency, and duration and 2) the Childhood Traumatic Event Scale with questions assessing death of a family member, separation or divorce, rape, molestation, major illness in childhood or other major upheaval that significantly impacted their life.

Using various statistical analysis methodologies, results indicated that child abuse was reported by 54.4% (all variables) within the chronic pain group as compared to 21.4% without chronic pain. Physical abuse was reported by 37% of pain patients compared to 11.2% of the control group. Twenty-seven percent of the pain group reported sexual abuse compared to 8.2% of the control group. Verbal abuse was reported by 43.5% of the pain group compared to 11.2% of the control group. In sum, the findings suggest a significant relationship between sexual, physical and verbal abuse and chronic fatigue.

Although a relationship between childhood trauma and chronic pain is demonstrated in this study, the authors stress that it is not a causal relationship and further study is needed.

"Using various statistical analysis methodologies, results indicated that child abuse was reported by 54.4% (all variables) within the chronic pain group as compared to 21.4% without chronic pain. Physical abuse was reported by 37% of pain patients compared to 11.2% of the control group. Twenty-seven percent of the pain group reported sexual abuse compared to 8.2% of the control group. Verbal abuse was reported by 43.5% of the pain group compared to 11.2% of the control group. In sum, the findings suggest a significant relationship between sexual, physical and verbal abuse and chronic fatigue."

Assessing Abuse and Neglect and Dental Fear in Women

Walker, Edward, A; Milgrom, Peter, M.; Weinstein, Philip, Getz, Tracy, & Richardson, Ralph. Journal of American Dentistry Association, Vol. 127 (1996), 485-490.

The purpose of this study was to determine whether a history of sexual, physical and emotional abuse increases the likelihood of survivor's developing dental fear and its ultimate impact on overall oral hygiene health.

Four hundred and sixty two females, who were members of Group Health Cooperative, responded to a questionnaire that was mailed to them seeking information regarding their sexual and physical assault history as well as their level of dental fear.

To assess dental fear the researchers included three 5-point Likert Scale questions and averaged them to obtain an overall global dental fear score. Low scores on these questions corresponded to lower degrees of fear. They assessed lifetime, sexual, physical and emotional abuse using a modified version of the Briere Child Maltreatment Interview. The authors counted the numbers of trauma episodes reported to create a global "unprotectedness" construct and hypothesized that this failure to be protected is likely to be associated with anxiety and a perceived loss of control, factors found in patients with dental fears.

The results indicated that of the 462 women who responded 164 (35.5%) reported no history of sexual or physical trauma, while 298 (64.5%) reported having at least one experience with these traumas. The amount of overall dental fear was significantly higher for those reporting a history of trauma. In comparing the two groups, (no history with history of trauma), women with high dental fears were significantly more likely to have been victims of trauma than women with low dental fear scores. They also found that women with high amounts of dental fear were nearly twice as likely to have experienced two or more classes of trauma predicting a relationship between the enormity of the trauma and the degree of dental fear.

This study has important implications for helping dental practitioners understand the particular needs of trauma survivors with respect to dental care. It points out the need for practitioners to increase their awareness of violence against women and for them to assess histories of trauma as part of their routine care of women. The authors also stress that ethical issues exist in treating such patients and encourage the need for practitioners to take care to avoid all forms of coercion and paternalism during treatment planning. Finally, they emphasize that treatment not sensitive to the patient's needs may result in additional trauma.

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Sexual Abuse and Perimenstrual Symptoms in Adolescent Girls

Al-Mateen, Cheryl, S.; Hall, Pamela, D.; Brookman, Richard, R.; Best, Al, M.; and Singh, Nirbhay, N. Journal of Interpersonal Violence, Vol. 14(11), (1999), 1211-1234.

The authors hypothesize that adolescent girls with a history of sexual abuse will have more perimenstrual symptoms with increased severity than girls without a history of sexual abuse. Perimenstrual symptoms are defined as those physical and behavioral symptoms occurring immediately before and during menstruation and include such symptoms as breast tenderness, water retention, depression, irritability, headaches and cramping.

A pilot project was conducted with 68 menarcheal females girls between the ages of 12 to 21 who were recruited from an adolescent health service outpatient clinic. Each participant was given a survey instrument that included questions regarding their demographic status, menstrual history, sexual abuse experiences, retrospective history of perimenstrual complaints and a calendar of premenstrual experiences (COPE) that includes 22 common symptoms which they completed over their next menstrual cycle.

Of the 68 who participated, 22 indicated a history of sexual assault who were then divided into four groups based on their perceptions of the impact of the sexual abuse on their lives. Group 1 described minimal impact and felt that it did not affect their current life. Group 2 indicated that the assaults caused guilt or shame in the past but not currently. Group 3 admitted to being affected by appeared to have minimized the effects and Group 4 was comprised of those who felt that the abuse substantially affected their lives.

Based on two sets of analyses, the researchers did not find any significant difference in past or current perimenstrual symptoms between those with a history and those without a history of sexual abuse. They postulate that this may have been due to the small sample size as well as having participants that were pretty homogenous in their makeup. In comparing their data with samples from other studies they found that those who reported sexual abuse in their study had significantly more perimenstrual symptoms than those in the general population. However, much more research is needed to develop correlations.

Additional Resources

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When Survivors Give Birth: Understanding and Healing the Effects of Early Sexual Abuse on Childbearing Women
By Penny Simkin, PT, and Phyllis Klaus, CSW, MFT
Classic Day Publishing, Seattle, WA
www.pennysimkin.com
This book provides survivors and their maternity caregivers with extensive information on the prevalence and short and long-term effects of childhood sexual abuse, emphasizing its possible impact on childbearing women. Challenges in the client-caregiver relationship are thoroughly portrayed, with much practical advice for improving trust and communication as well as self-help techniques to handle abuse-related distress. Chapters on birth counseling, psychotherapy, and clinical care of survivors make this book a useful resource for survivors and all who work with them.

The Survivor's Guide to Sex: How to Have an Empowered Sex Life After Childhood Sexual Abuse
By Staci Haines, Cleiss Press, 1999
www.generationfive.org

Healing Sex: The Complete Guide to Sexual Wholeness, DVD
By Staci Haines, Produced by S.I.R. Productions
Healing Sex is a revolutionary project mixing documentary style drama with education and mind/body exercises. The film follows a diverse cast of women and men healing from past sexual abuse. We witness their path to a more pleasurable and healthy sex life as they struggle to find peace, healing, and real intimacy.
www.healingsex.org.

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