Sexuality After Abuse

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11.1 Introduction

That violence is a "gender" problem par excellence is widely acknowledged and upheld by authoritative international organizations. Indeed, the term "gender violence" was coined by the World Health Organization (WHO) [1, 2]. With this term, it meant to group a complex panorama of anti-women behaviors that include domestic violence, sexual violence, and psychological violence, as well as mobbing or the use of the female body in an unseemly or disrespectful way. From the very first definition, made in 1993 [1], the WHO stressed the importance of the willfulness of the act regardless of its consequences, as well as the presence of a condition of asymmetry, whether due to physical strength or power, as the main feature.

Like many other worldwide problems, violence is not distributed uniformly between the sexes and/or age groups: it is "fragile" subjects like women, children, and old people, living in a condition of disparity of economic, relational, cultural, or social power, who are the main victims of these acts [3–5].

Even our supposedly civilized Europe is not immune from this problem, seeing that in 2006, the European Parliament felt the need to reaffirm in a plenary session the fact that the violence of men against women represents "a universal problem linked to an unequal distribution of power between genders that still characterizes our society."

In the last 10 years, it has been made increasingly clear that this phenomenon is not only a crime but also a serious problem for society, a violation of human rights, and a cause of "disease." It represents one of the most important global problems of public health, within the broader concept of the recognition of "gender inequality" as an epidemiological reality (along with social, economic, and cultural factors)

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which, through a wide range of structural and institutional conditions (laws, economic, and family systems), influences women's mortality, morbidity, and life quality [1].

There is no doubt that domestic violence negatively influences women's well-being, not only from a psychological and social point of view but also from the physical one: gender-based violence is at the root of many chronic pathologies and psychiatric case histories, and it is certainly present among many of the women who resort to medical services. Out of this awareness comes the WHO's alarmed concern about violence as a risk factor for a serious of important pathologies in the female population and its call for the urgent need to create awareness and competence regarding these issues among health operators [1, 6–8].

The sphere of reproductive health constitutes the most representative parameter of what an asymmetrical relationship can involve: gender violence is at the root of many chronic gynecological pathologies, of the absence of contraceptive protection, and of obstetrical complications, as well as of sexual disorders. Many studies show that it is in this arena that the close tie between domestic violence and sexual violence emerges most clearly. These are associated with and often contemporaneous aspects of violence used to maintain control over reproductive choices and to make sure that the relationship remains unbalanced and asymmetrical. In this context, in 2009 "Lancet" published the results of a multicentric study based on a sample of 24,097 women, which showed a considerable "overlap" between these two phenomena: from 30 to 56 % of the women interviewed reported having suffered both physical and sexual violence, showing that they are both situated in the same well-defined sociocultural sphere of gender relations [9, 10].

11.2 Violence and Abuse: Epidemiology of the Phenomenon

Estimating the incidence of the various forms of abuse is certainly not easy. There exist various studies on the phenomenon, not always comparable because they use different criteria and/or methodologies. What is more, the episodes, especially those that take place inside the home, are often not reported and so remain hidden. Nonetheless, all studies agree on the fact that violence against women is endemic in every country in the world and across all social strata [10]. At the global level, it is calculated that at least one woman out of three has been beaten or sexually abused and that one out of four has been a victim of a form a violence during pregnancy [11–15].

Violence committed within the home on the part of a partner or someone who is known represents the most frequent even. Some studies made in hospital emergency rooms show that about 30 % of traumatic injuries among women are caused by episodes of mistreatment on the part of the partner [16]. In fact, interpersonal violence is the second cause of injuries among women between 15 and 44 years of age, preceded only by road accidents, and is at times so serious as to cause the woman's death [17, 18].

In Italy the main source of information concerning this phenomenon is Istituto di Statistica Italiano (ISTAT). The first inquiry entirely dedicated to the question of

violence and mistreatment against women, inside and outside the family, was conducted in 2006, through telephone interviews of women ages 16 and 70. The findings showed that 31.9 % of the women interviewed had suffered physical or sexual violence at least once in their lifetimes. In the majority of cases, the violence was done by their partner or ex-partner (69.7 %), in 17.4 % by someone they knew, while a mere 6.2 % of the violence was the act of an unknown person [19, 20]. This inquiry was updated between May and December 2014 and presented to the Council of Italian Ministers in June 2015. Though the more recent data are not substantially different from the prior data, some important differences can be seen: while overall there are still 31.5 % of women who have suffered some form of violence, physical and sexual violence have declined from 13.3 to 11.3 %, with a particular reduction of cases of violence against teenagers, which falls from 17.1 to 11.9 %. Psychological violence has also been sharply reduced, from 42.3 % in 2006 to 26.4 % in 2014. Unfortunately, the data relative to violence suffered before the age of 16 shows that it has increased: in 2006, it concerned 6.6 % of the sample interviewed, while in the more recent inquiry, it had risen to 10.6 %.

Fortunately, awareness of the phenomenon seems to have increased: while in 2006 33.9 % of the women interviewed said they had not spoken to anyone of the violence they had suffered, in 2014 the percentage falls to 25.8 %; what is more, the number of women interviewed who hold this violence to be a crime has grown (from 14.3 % in 2006 to 29.6 % in 2014). Reports to police authorities have increased from 6.7 to 11.8 %, as has the percentage of women who seek held in specialized centers (4.9 % against 2.4 % in 2006).

Unfortunately, the percentage of rapes has not fallen (2.1 %), and serious acts of violence with consequent injuries have increased from 26.3 to 40.2 %, along with the percentage of women who were in fear for their lives (from 21.3 to 34.5 %). Finally, for the first time, the 2014 report contains data on "stalking," which involves 16.1 % of the interviewed sample [21].

Confidence in the police has grown (28.5 % declare they are highly satisfied with their performance); instead, the percentage of women who talk with health workers remains very low: only 1.6 %, which reaches 2.5 % if we include emergency room workers [21].

A highly disturbing aspect of the problem, which is also an indicator of the degree of violence against women present in Italy, is revealed by the data on voluntary homicides: the Ricerche Economiche e Sociali Europee (EURES) report, published in 2009 based on data from 2005 to 2006 and updated in 2015 based on data from 2013, confirms first of all that 70.5 % of feminicides are committed in the family, in 68.2 % (data 2013) of cases at the hand of a partner or former partner [22].

Moreover, the report shows that while there has been an overall reduction in cases of homicide, feminicides have remained stable in the last 20 years, with an average of one woman murdered every two days.

Other data concerning Italy refer to interviews conducted by the "Telefono Rosa" ["Pink Telephone"] observatory during the year 2010, involving roughly 2,000 women. Once again, it is confirmed that 4 acts of violence out of 5 occur within the confines of a sentimental relationship, and only 1 out of 100 takes place at the hand

of an unknown person. Violent behaviors are found within domestic walls in 61 % of cases, at least as far as Italian women are concerned. On the contrary, for foreign women in 30 % of cases, violent attitudes are found in public situations. What is more, among Italian women psychological prevails over physical violence (31 vs. 23 %), while among foreign women, the contrary is true, which obliges a far greater percentage to seek hospital treatment (14 vs. 7 %).

In conclusion, in Italy too, violence represents a significant, though often underestimated, reality. Despite noisy press campaigns that appear in the wake of sensational episodes, thereby contributing to create an impression of exceptionality, in everyday affairs the phenomenon of violence against women is virtually ignored, perhaps by reassuring ourselves that it is something rare and distant, something that does not touch us.

11.3 The Repercussions of Violence on Women's Reproductive Health

Many gynecological disorders, even in very young women, can be associated with this phenomenon: lack of family planning, recourse to abortion, sexually transmitted diseases (STD), sexual disorders, and pregnancy disorders are all situations that can mask a situation of violence.

The immediate consequences of sexual violence can naturally be an unwanted pregnancy (roughly 5 % according to the WHO) [8, 23, 24] and infections. As regards the latter, a review from 2000 reported in victims of sexual violence an increased incidence of *N. gonorrhoeae* (2–6.5 %) [24], *Chlamydia trachomatis* (6–17 %), and *Trichomonas* (2.3–14.7 %). Syphilis is another sexually transmitted disease for which screening is usually recommended for victims of sexual violence. However, its prevalence as reported in the majority of studies is extremely low (0–3 %), in countries outside of Italy as well. Certainly, among the risks of infection caused by sexual violence, we should also consider an increase in the transmission of the *Papillomavirus*, with all its consequences. However, since this infective agent has high frequency in the general sexually active population, it is very difficult, if not impossible, to estimate the risk of acquiring the infection following an act of sexual violence.

As regards HIV, we should remember that the average risk of contracting an HIV infection from a single act of unprotected vaginal intercourse with an infected partner is considered to be roughly 1–2 out of 1,000, a risk that increases in cases of unprotected anal penetration (5–30 out of 1,000) and if there are lacerations certainly more frequent in cases of violence. It is clear that this problem is most important in zones where HIV is endemic (e.g.,, in Uganda it is estimated that there is an eightfold increase in the chance of contracting HIV following an unwanted sexual relation). By contrast, in Italy the disadvantages of prophylaxis with antiretroviral drugs certainly outweigh the advantages, except in special cases.

The importance of the problem of STD increases in proportion to how young the victim is, since in the phase of its initial maturation the vaginal mucus is a less

effective barrier against infections. Consequently, young adolescents are more highly exposed to these risks, with possible serious consequences for their future reproductive capacity [25].

Type of violence	Effects on reproductive health
Childhood sexual abuse (once the victims become adults and adolescents)	Gynecological problems, STD, HIV/AIDS, precocious sexual experiences, precocious pregnancies, infertility, unprotected sex, unwanted pregnancies, miscarriages/abortions, re-victimization, risky behaviors, substance abuse, suicide
Rape	Undesired pregnancy, abortions, inflammatory pelvic disease, infertility, STD including HIV infection, suicide
Domestic violence	Scarce nutrition, worsening of chronic diseases, substance abuse, concussion, organ damage, temporary or permanent disability, chronic pain, unprotected sex, inflammatory pelvic disease, gynecological problems, underweight newborns, abortions, negative pregnancy outcomes, maternal death, suicide

From "A Practical Approach to Gender-based Violence: a Programme Guide for Health Care Providers & Managers" United Nations Population Fund, New York, 2001 (cit.)

The problem of STD is also present in situations of chronic violent relations because of the woman's lower capacity to protect herself and the frequent imposition of unprotected intercourse.

Particular attention should be given to the problem of chronic pelvic pain, a recently recognized pathology which involves many specializations and which, according to the American College of Obstetricians and Gynecologists (ACOG), in 40–50 % of cases has its origins in histories of physical and/or psychological abuse. There is no doubt that chronic pelvic pain is a vague, "functional" type of pathology that frequently correlates with a history of mistreatment. To the surprise of many gynecologists, in 1993 Milburn published a work in which chronic pelvic disease was related to a series of possible causes. Though he investigated that pathologies traditionally held to be closely connected to pelvic pain, such as endometriosis and the presence of laparoscopically revealed adhesions, only association with prior sexual violence and a history of depression reached statistical significance ($p < 0.01$).

The mechanisms involved in this type of association are certainly multiple and not easy to identify. It is likely that factors of a psychological and a neurological origin coexist. Some studies suggest that the trauma can provoke biophysical alterations that produce an altered sensitivity to pain. This could occur through actions on the hypothalamus-hypophysis-adrenal axis, with an increase in the production of cortisol and consequent damage to the areas of the hippocampus and circuits sensitive to cortocotropin-releasing hormone (CRH), which could lead to an altered perception of painful stimuli [26], or else through a "deregulation" of the autonomous nervous system with growing hypersensitivity due to "upregulation" of the visceral fibers. It is likely that different mechanisms build up and strengthen each other. Probably depression and sleep disorders, common outcomes of one or more episodes of violence, also constitute factors that make the victims more vulnerable to subsequent painful stimuli [27].

Prestigious scientific societies like the ACOG and the Royal College of Obstetricians and Gynaecologists (RCOG) recommend that medical operators should take into very careful consideration the possibility of a history of violence in the analysis of chronic pelvic pain and should ask explicit questions about this possibility. They identify as crucial in the approach to this pathology the time dedicated to listening and a multidisciplinary approach (evidence level I).

Given the possible risks it can involve, diagnostic laparoscopy, for a long time held to be indispensable in the analysis of chronic pelvic disease, should instead only be taken into consideration only if felt to be necessary after an overall examination (evidence level III) [27, 28].

Strictly reproductive problems include first of all unwanted pregnancy, with consequent recourse to abortion: an article in the British Medical Journal in 2005 showed a significant association between domestic violence and request for abortions, with a trend that grew in proportion to the number of abortions – it was present in 24 % of women at the first abortion, in 30 % at the second, and arriving at almost 40 % in women with histories of more than two abortions [29, 30].

We need to realize that these problems exist even among very young women: a study published by Miller in 2010 on "contraception" reports an incidence of the very young who perceive sex in their relationship as being "forced," amounting to 35% of the young women interviewed, with consequent boycotting of contraceptives (15%) and undesired pregnancies (1:5) [31].

Not even pregnancy represents a period free from the risk of violence and mistreatment: studies show an incidence of abuse in 5 to 20% of pregnant women. Indeed, pregnancy makes a woman more vulnerable, among other things by reducing her emotional and financial independence. The changes related to this period can be experienced by the partner as an opportunity to establish power and control over the woman. It is not by chance that in 30% of cases, abuse starts precisely during pregnancy, especially in the second and third trimester, that 69% of previously abused women continue to suffer abuse during pregnancy, and that in 13% of cases, the episodes become even more frequent and serious. These are rarely isolated episodes: the acts of aggression are repeated at least twice during the course of pregnancy (60%) or even more often (15%).

The women most at risk are those who are already in a violent relationship (OR 67.6), very young women (for the age group between 16 and 19 years, the risk increases by roughly threefold), and women belonging to immigrant ethnic groups. Violence is an important risk factor in pregnancy, with consequences for both the mother and the fetus that can even lead to death: we need only recall that it represents the second cause of maternal death worldwide. Hyperemesis, detachment of the placenta, breaking of the uterus, repeated miscarriages, and blood loss in the first trimester, along with fetal death, premature birth, chorioamnionitis, and low birth weight, are some of the possible complications associated with violence in pregnancy [32–33].

In a study published in 2006 in the *American Journal of Obstetrics and Gynecologists* on a sample of over 118,000 women, Silverman showed that violence in pregnancy constitutes a significant risk factor for hypertension (OR = 1.40), blood loss (OR = 1.66), hyperemesis (OR = 1.63), urinary tract infections (OR = 1.55), premature birth (OR = 1.37), and intrauterine growth restriction (IUGR) (OR = 1.17) [34].

A study carried out by a group in Trieste coordinated by Patrizia Romito and published in 2009 in *Health Care Women* showed that violence on the part of the partner also plays an extremely important role in postpartum depression. Indeed, women who suffer violence are 13 times more likely than others to develop the so-called blue syndrome. Often alcohol, psychotropic medicine, and drug abuse are associated with maltreatment, as a way to control anxiety. It is clear that all this has potentially negative effects on the course of the pregnancy. Another characteristic is an insufficiently self-protective attitude, resulting in delayed recourse to medical assistance and missed appointments, behaviors that contribute to making pregnancy occurring in a violent relationship "at risk" [35].

11.4 Female Sexual Dysfunctions

Female sexual dysfunctions (FSD) are highly prevalent in the general population of women between 18 and 59 years of age. 33.4% of women complain of scarce sexual desire, 24.1% have difficulties in arriving at orgasm, 18.8% have problems with arousal, 14.4% suffer from pain during intercourse, and 21.2% do not find sex pleasurable. These problems increase after menopause, when the most frequent disturbance is the loss of sexual desire. Observational studies show that the decline of desire in women increases with age [36]. However, the distress caused by this disturbance is inversely correlated with age and so is greatest among younger women.

We speak of "hypoactive sexual desire disturbance," which is clinically significant, when the loss of desire is felt as stressful. Vaginal dryness, with or without dispareunia, is the second most frequent disturbance after menopause. Orgasmic disturbance is often present in comorbidity. Given the multisystemic nature of sexual functioning, often found in comorbidity are moodiness (depression is the affective disturbance most frequently associated with decline in desire), urological problems (recurrent and postcoital cystitis, stress, and urge incontinence), gynecological problems (prolapsed uterus, cystocele, rectocele), and proctologic symptoms (obstructive stipsis or, more rarely, the opposite condition of flatulence). The impact of hormone replacement therapy (HRT) on FSD is still being debated.

For FSD, the benchmark nosography today is the interdisciplinary consensus conference, "The Consensus Panel on Definition and Classification of Female Sexual Dysfunction," held in 2003 [37], which updated the definitions made during the first consensus in Boston in October 1998[38].

11.5 Present-Day Classification

11.5.1 Desire Disorders

11.5.1.1 Disorders of Desire and Sexual Interest in Women

The woman has weak or absent feelings of sexual interest or desire; she has no sexual thoughts or fantasies and is also lacking in responsive desire (i.e., response to the partner's advances). She has scarce or no motivation (reasons or incentives)

to attempt arousal. The lack of sexual interest is considered beyond the reduction considered physiological for her phase of the life cycle (at the time of the consultation) and the duration of the relationship.

11.5.1.2 Sexual Aversion Disorders

Extreme anxiety and/or disgust at the mere thought of and/or at the attempt at any sort of sexual activity.

11.5.2 Arousal Disorders

11.5.2.1 Subjective Sexual Arousal Disorder

The mental sensations of sexual arousal (sexual excitement and pleasure) deriving from any type of sexual stimulation are markedly diminished or absent. Nonetheless, vaginal lubrification or other signs of arousal may be present.

11.5.2.2 Genital Sexual Arousal Disorders

Absent or weak genital sexual arousal. The woman may report a minimum response of vulval swelling and/or vaginal lubrication from any type of sexual stimulation and reduced sexual feelings with genital fondling. Subjective mental sexual arousal can, however, be present from non-genital sexual stimuli.

11.5.2.3 Combined Genital and Subjective Arousal Disorder

The absence or marked reduction of feelings of sexual arousal (sexual arousal and pleasure) associated with absent or impaired genital sexual arousal (vulval swelling, vaginal lubrication) in response to any type of sexual stimulation.

11.5.2.4 Persistent Sexual Arousal Disorder

Spontaneous, intrusive, and unwanted genital arousal (congestion, pulsating, lubrication) in the absence of desire or sexual interest. Awareness of sexual arousal is typically – but not invariably – unpleasant. The arousal is not relieved by one or more orgasms. The sensation of physical arousal can last for hours or days or longer.

11.5.3 Orgasmic Disorder

Lack of orgasm, markedly diminished intensity of organic sensations or marked delay of orgasm from any type of stimulation, despite the self-report of a high level of sexual arousal/excitement.

11.5.4 Sexual Disorders Characterized by Pain

11.5.4.1 Dyspareunia

Persistent or recurrent genital pain during attempts at penetration or during complete vaginal penetration in intercourse.

11.5.4.2 Vaginismus

Persistent or recurring difficulties of the woman to allow vaginal entry of a penis, a finger or any object, despite her expressed wish to do so. There is often a phobic avoidance and anticipation of pain. Anatomic or other physical abnormalities must be ruled out or treated.

11.6 Abuse and Sexuality

Considering the close connection between sexuality and the psyche, it is predictable that histories of abuse involve the self-image and the sphere of desire and in the end lead to various types of sexual disorders. However, there are some differences to be taken into consideration between a history of chronic abuse, maybe in childhood, and "acute" sexual violence, like a single incident outside of the context of a violent relationship.

Disorders of the sexual sphere are found more frequently in the context of a violent relation, as the direct consequence of an unbalanced relationship, and also through the mechanism of activation of the ANS and consequent alternations of the hypothalamus-hypothesis-suprarenal axis described above. In a review of 2007, Cocker evidences the strong association between disorders of the sexual sphere and domestic violence, present in 17 of the 18 studies considered. These were mainly vulvodynia, dispareunia, and interstitial cystitis. Moreover, being or having been the victim of violence often leads to at-risk sexual behaviors – promiscuous relations and prostitution are not rare. Vice versa, reduced sexual desire and problems in reaching orgasm are also common [39].

Sex represents a form of control and domination within a violent relationship. Not infrequently, unwanted and humiliating sexual practices are imposed. Through them a form of power is achieved that makes the victim feel impotent, insecure, and unable to resist. The devaluation of a woman's body through violent and forced sexual relations makes her feel she is at the mercy of the abusive partner. Frequently she turns to antidepressants, alcohol, or drugs as an attempt to survive in a virtually unbearable situation. What is more, the implementation of a sort of "contraceptive sabotage" leads to a greater incidence of unwanted pregnancies and recourse to repeated abortions, as many studies report [31].

When violence is perpetrated by an unknown person, which as we know is actually less frequent than is commonly believed (6.2% in Italy, according to ISTAT data), the most important consequences for the woman are fear, insecurity, and lack of trust in the opposite sex. Following episodes of this type, we often see post-trauma stress syndrome, which can be accompanied by attacks of panic, flashback, or the activation of repression mechanisms. At times the pathology shows up immediately after the violent episode, but it is not infrequent to find sequela afterward, with lasting difficulties in sexual relations [40].

Many studies show that young age and penetration in the course of sexual violence are more important risk factors for future sexual problems than the use of physical violence. Immediate reactions such as anger or a sense of guilt or shame can correlate with future sexual problems, while living in a stable, loving relationship can be an important and essential element in helping to overcome the trauma [41, 42].

Certainly, one of the most difficult conditions to deal with is that of childhood abuse. These are cases in which the child places her/his trust in an adult, often a figure that ought to be protective (the father, the mother's partner, an uncle, or family friend). She trusts him also because she thinks that the adult can only want what is good for her and so the things he asks for cannot be "bad": thus the child finds himself/herself in a dramatic conflict in which he/she no longer knows what is right and what is wrong and does not even completely understand what his/her perceptions really are. Pleasure turns into pain and shame, and trust is slowly transformed into fear and suspicion.

Childhood abuse does not always come to light, because there exists a sort of blackmail or pact of mutual complicity that often keeps these episodes hidden until adulthood. Mothers who do not wish to see what is happening, perhaps because even they cannot believe it to be possible, become parts of a mechanism whose specific function is to keep these "inconfessable" episodes hidden. Seemingly small clues like lower achievement at school, behavioral changes, less willingness to play with friends, or moments of depression should arouse suspicion in these cases.

Numerous studies show that childhood abuse constitutes an extremely serious trauma that can trigger a series of physical changes that lead to alterations in behavior and sensitivity. These alterations remain over time and can show up as chronic pathologies like chronic pelvic pain, fibromyalgia, and various other disorders. In many studies the altered sensitivity to painful stimulus represents a sort of "marker" that should signal a history of abuse and cause us to ask pertinent questions (evidence level III).

Thus, though the mechanisms involved in repercussions on sexuality can be many and various, according to the type of abuse, there exist some recognizable shared features, of which the most frequent are:

Avoidance or fear of sexuality
Considering sex as an obligation
Negative feelings about contact, such as anger, disgust, or guilt
Difficulties in enjoying preliminaries or pleasurable sensations
Emotional distance during sex
Disturbing thoughts or images about sex
Unsuitable or compulsive sexual behaviors (such as sexual consumption or selling one's body)
Problems in reaching orgasm
Pelvic pain, vaginismus, and pain at penetration
Problems in holding a stable relationship

It is clear that the conditions frequently associated with histories of abuse can emerge as diverse forms of sexual dysfunction. The most common of these are those that aim at holding back intrusion by refusing sexuality as pleasure (vaginismus, disturbances of desire, anorgasmia) and those that become pain (dispareunia, chronic pelvic pain).

Conclusions

Episodes of violence and abuse have important effects on women's health (WHO). Among these we must include repercussions on sexuality, which is an essential part of the sense of well-being.

At times the history of abuse or violence can emerge by chance in the course of a gynecological, urological, or sexological examination. At other times it is the woman herself who looks for help and wants to tell her story. It is important for all medical operators to know the incidence and importance of these phenomena, as the first approach taken is crucial for working through after a trauma and also because their awareness can help uncover hidden wounds and lead the victim toward a self-awareness that is in itself therapeutic.

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