

ORIGINAL RESEARCH—PAIN

History of Sexual and Physical Abuse in Women with Dyspareunia: Association with Pain, Psychosocial Adjustment, and Sexual Functioning

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DOI: 10.1111/j.1743-6109.2009.01581.x

ABSTRACT

Aim. Dyspareunia is a women's sexual health problem that still often goes undiagnosed despite its high prevalence and its detrimental impact on sexual, relationship, and psychological adjustment. Although sexual and physical abuse may constitute risk factors for the development of dyspareunia, the effects of past abuse on current pain and associated sexual and psychosocial impairments have never been examined. Thus, the aim of this study is to determine the relation between a history of sexual and physical abuse and a series of pain, psychological, dyadic, and sexual functioning variables in a sample of women with dyspareunia.

Methods. A hundred and fifty-one women took part in the study via health professional referrals and advertisements in local newspapers. Each participant underwent a standardized gynecological examination and a structured interview in order to confirm the diagnosis of dyspareunia. They also completed self-report questionnaires investigating past sexual and physical abuse, in addition to current pain, psychosocial adjustment, and sexual functioning. Dependent measures included: (i) The Brief Symptom Inventory; (ii) the Sexual History Form; and (iii) the Locke-Wallace Marital Adjustment Scale. Pain was assessed via the McGill Pain Questionnaire and a visual analogue scale.

Results. Results revealed that a history of sexual abuse involving penetration was associated with poorer psychological adjustment and sexual functioning. Additionally, findings showed that women who perceived a link between their dyspareunia and their past sexual abuse reported worse sexual functioning than those who did not. Finally, the experience of sexual abuse was not associated with pain intensity and physical abuse was not associated with any of the outcome measures.

Conclusions. Findings suggest that the presence of a sexual abuse history in women with dyspareunia is associated with increased psychological distress and sexual impairment, although there is no relation between a history of physical abuse and these outcomes. **Leclerc B, Bergeron S, Binik YM, and Khalifé S. History of sexual and physical abuse in women with dyspareunia: Association with pain, psychosocial adjustment and sexual functioning. J Sex Med 2010;7:971–980.**

Key Words. Sexual Abuse; Physical Abuse; Dyspareunia; Sexual Function; Psychological Distress; Vulvo-Vaginal Pain

Introduction

Dyspareunia, defined as painful sexual intercourse, is a women's sexual health problem that is still relatively unknown to the general popu-

lation and too often undiagnosed by health professionals, despite it being a highly prevalent condition [1]. In fact, painful sex is a frequent reason for consultation in gynecological settings, with community prevalence rates estimated at

21% in women under 30 years [2]. Moreover, dyspareunia is consistently associated with important negative sequelae, namely reduced levels of sexual desire and arousal, lower intercourse frequency, and psychological distress [3]. Several biomedical and psychological factors that could potentially play a role in the development or exacerbation of the pain have been identified in recent years, including central and peripheral mechanisms [3,4]. One of the psychosocial factors that has captured researchers' attention is the experience of sexual and physical abuse, both of which have been associated with increased reports of pain [5–7]. Although a systematic review has shown that sexual abuse may constitute a risk factor for the development of dyspareunia, the effects of past abuse on current pain and associated sexual and psychosocial impairments have never been examined [8].

To date, most research on the role of sexual abuse in the context of dyspareunia aimed at identifying whether such trauma is a potential risk factor for the development of painful sex. A review suggests that women presenting with dyspareunia are 2.67 times more likely to report having experienced sexual abuse compared with women without dyspareunia [8]. However, few studies have examined the role of physical abuse among chronic pain patients including dyspareunia, although these two types of trauma often co-occur [8–10]. Since previous studies have indicated that physical abuse might also be a potential predictor of chronic pain and its associated psychological correlates, it would therefore be important to control for the effect of physical abuse when studying that of sexual abuse [8–12]. In fact, Harlow et al. (2005) showed in a recent epidemiological study that in comparison to no-pain controls, women with complaints of vulvovaginal pain were 4.1 times more likely to report severe physical abuse, and 6.5 times more likely to report severe sexual abuse [12].

Despite the possibly important role played by sexual and physical abuse in the development of dyspareunia, little is known about how these traumatic events could impact current symptomatology and the psychological, dyadic, and sexual adaptation of women to this condition. Interestingly, studies generally show that sexual and physical abuse are associated with the same negative sequelae that are known to be associated with dyspareunia, namely sexual, interpersonal, and psychological impairments [13–18]. This leads us to believe that the high prevalence of sexual and physical abuse in women with dyspareunia might

explain part of the negative outcomes observed in this specific population. The experience of past abuse could render women with dyspareunia at greater risk of experiencing more severe pain and developing higher distress as well as more important functional impairments, such as sexual difficulties. Moreover, because dyspareunia symptoms may have occurred during the abuse per se and that painful sex may reproduce some aspects of the abusive experience, it is all the more relevant to examine the relationship between past abuse and current symptomatology in women with dyspareunia.

Emerging evidence suggests that sexual and physical abuse might be related to increased pain intensity, functional impairments, and psychological distress in different populations of pain patients; however, these issues have never been specifically examined in women with dyspareunia [9,19–26]. For example, Randolph and Reddy (2006) found that chronic pelvic pain patients who experienced more extensive sexual abuse reported greater pain intensity, interference of pain with life, in addition to significant sexual impairments [19]. However, these authors did not specifically inquire about pain during intercourse. Because dyspareunia is a specific type of chronic pelvic pain, it is likely that pain and psychosexual outcomes of women with dyspareunia might also be negatively influenced by sexual and physical abuse. Corroborating results of Randolph and Reddy (2006) on the association between pain intensity and abuse, some studies among patients suffering from other chronic conditions such as fibromyalgia and gastrointestinal disorders have also shown greater pain in sexually and physically abused patients compared with non-abused patients [6,20]. In addition, abused patients reported more functional disabilities, poorer ability to decrease or control pain, greater interference of pain with daily functioning, greater punishing responses to pain, as well as more overall psychological distress [6,20–26].

Aims

The aim of the present study was to determine the relation between sexual and physical abuse and a series of pain, psychological, dyadic, and sexual variables in a sample of women suffering from dyspareunia. Based on findings of previous studies among other chronic pain populations, we hypothesized that women with dyspareunia who reported past sexual and physical abuse would experience more severe pain as well as greater sexual, dyadic,

and psychological impairments, in comparison with women with dyspareunia without antecedents of abuse [6,9,19–26].

Methods

Participants

Our sample comprised women who presented with superficial and/or deep provoked dyspareunia and who responded to advertisements concerning pain during intercourse. Women were included in the study if they met the following inclusion criteria: (i) pain during intercourse lasting for at least 6 months; (ii) pain occurring in 75% of penetration attempts; (iii) pain triggered by sexual intercourse. Women were excluded if they met the following criteria: (i) unprovoked pain; (ii) severe psychiatric or medical disorder; (iii) active vaginal infection; (iv) vaginismus; (v) being currently under treatment for dyspareunia; (vi) being pregnant; (vii) being younger than 18 years and older than 45 years of age.

Procedure

Participants were initially recruited to take part in a treatment study via health professional referrals and advertisements in local newspapers [27]. Women who met the criteria were asked to give their written consent before undergoing a standardized gynecological examination. When the diagnosis of dyspareunia and the preceding criteria were confirmed by the gynecologist, women were considered eligible for the study and undertook a structured interview carried out by a trained, graduated-level research assistant. This initial interview aimed at collecting sociodemographic information such as age, marital status, education, income, and religious affiliation. They were then asked to complete a series of standardized questionnaires described in the next section. The present study obtained the approval of our institutional ethics review board.

Main Outcome Measures

History of Sexual and Physical Abuse

Participants were asked if they were ever exposed in their lifetime to a series of specific sexual and physical abuse incidents using the validated and reliable structured interview designed by Leserman and Drossman [28]. For each incident, participants were asked at what age they were exposed and how often it occurred. We adapted the ques-

tionnaire to our sample by asking participants whether they believed that these abuse incidents were linked to their pain during intercourse.

Psychological Adjustment

The Brief Symptom Inventory (BSI) is a 53-item, standardized questionnaire designed to evaluate clinical symptoms indicating emotional distress [29]. Participants indicate the frequency of each psychological symptom that occurred in the last month on a 5-point Likert scale (0 = *not at all*, 4 = *extremely*). The Global Severity Index (GSI) of the BSI reflects the depth of overall psychological distress, higher scores indicating higher distress. Validity and reliability are both well established [29,30]. GSI mean raw scores were transformed into *T*-scores with possible scores between 33 and 80.

Dyadic Adjustment

The Locke-Wallace Marital Adjustment Scale is a widely used measure assessing marital satisfaction. It can discriminate between successful and unsuccessful marriages [31]. It is a well-validated and highly reliable self-report questionnaire comprising 15 items with possible scores ranging from 2 to 158. Traditionally, researchers have classified couples who score under 100 in the distressed category, while couples who score above the 100 cutoff point are considered nondistressed couples [32]. We adapted the language to nonmarried, cohabiting couples.

Sexual Functioning

The female version of the Sexual History Form (SHF) was used to assess sexual functioning [33]. It is a self-report measure with 28 multiple choice items referring to various domains of sexual functioning: frequency of sexual activities, sexual desire, arousal, orgasm, pain, and sexual satisfaction. The Global Sexual Functioning Score is computed using 12 selected items and reflects overall level of sexual functioning. Possible scores ranges from 0.1675 to 1, lower scores indicating better functioning. The SHF can differentiate sexually functional and dysfunctional women based on their overall scores and demonstrates adequate reliability with an excellent temporal stability and acceptable internal consistency [34].

Pain

Pain was assessed via different means. First, pain was measured using the McGill Pain Questionnaire (MPQ) which is a well-validated, reliable,

and widely used pain measure consisting of 20 groups of words describing three dimensions of pain: sensory, affective, and evaluative [35]. The MPQ has been used for the evaluation of several types of pain including acute, chronic, and laboratory-induced pains [35]. Participants are asked to identify the word that best describes their pain in each group of words. The sum of all pain descriptors provides a total score reflecting an overall index of pain. Second, a visual analogue scale (VAS) ranging from 0 to 10 was used to assess pain intensity during intercourse and during the cotton swab test performed by the gynecologist. For both measures, higher scores indicate greater severity of pain. Validity and reliability of VAS for pain measurement have also been demonstrated [36].

Results

Sample Characteristics

Our original sample comprised 168 participants. Seventeen participants were excluded from the final sample because of missing data. Thus, our final sample consisted of 151 women with dyspareunia. The cause of dyspareunia identified by gynecological examinations was provoked vestibulodynia for the large majority of women (92.7%) and about one-third of these women also presented deep dyspareunia in addition to vestibulodynia. Participants' average age was 27 years. The majority reported being Canadian (88%), with 62.9% of francophones and 37.1% anglophones. They more frequently reported a catholic religious affiliation (54%), were engaged in a romantic relationship (78.8%), and had never experienced childbirth (90.7%). Average education was 16 years, which corresponds to an undergraduate degree. Finally, 59% of women fell within the annual income category ranging from \$0 to \$29,000.

Participants were divided into three groups of sexual abuse and three groups of physical abuse based on the presence or absence and severity of abuse. Sixty-one women (40.4%) fell into the "no sexual abuse" category, 60 (39.7%) into the "sexual abuse without penetration" category, while the remaining 30 (19.9%) fell within the "sexual abuse with penetration" category. The latter category included penile penetration as well as penetration with fingers or any other object. Regarding physical abuse groups, 57 (37.7%) women reported having never experienced physical abuse. Seventy-nine (52.3%) fell within the "physical abuse"

group that did not require medical attention, while only 15 (9.9%) reported having experienced more severe physical abuse that required medical attention. Results show that 39% of the sample reported having experienced both sexual and physical abuse, while 44% reported having experienced only one type of abuse (either physical or sexual). The remaining 26% reported no abuse. A chi-square analysis showed that sexual and physical abuse did not co-occur in this sample ($\chi^2 = 3.399$, $P = 0.183$) indicating that rates of physical abuse did not differ between groups of sexual abuse. The presence of either physical or sexual abuse was not associated with any of the sociodemographic variables.

Abuse Group Differences Analyses

In order to reduce the number of statistical analyses, we performed a multivariate analysis of variance (MANOVA) including all psychosexual outcomes, except for dyadic adjustment, which could not be included because not all participants were in committed romantic relationships. Since zero-order correlations showed that pain measures were correlated with each other, we treated them separately in a second MANOVA. When MANOVAs were significant, further univariate analyses were conducted. Because violations of the assumption of homogeneity of variance can have serious consequences on the robustness of the analysis of variance (ANOVA) when sample sizes are unequal, we verified that Levene's tests of homogeneity of variance were nonsignificant for all analyses. Finally, using correlations, we also assessed whether the ages at which the sexual and physical abuse occurred were associated with outcomes.

Physical Abuse Group Differences

Results from the first MANOVA were not significant with regard to psychosexual-dependent variables ($F(6, 292) = 0.431$, $P = 0.858$, partial $\eta^2 = 0.005$). With respect to pain intensity measures, results from the second MANOVA were also nonsignificant ($F(6, 292) = 0.607$, $P = 0.724$, partial $\eta^2 = 0.012$). Finally, the ANOVA performed on the dyadic adjustment variable was not significant ($F(2, 76) = 1.547$, $P = 0.220$, $r = 0.200$). Hence, physical abuse is not associated with any of the dependent variables. Correlations revealed that age at which the physical abuse took place was not associated with any of the outcomes.

Sexual Abuse Group Difference

Because rates of physical abuse did not differ between groups of sexual abuse and because the

Table 1 Means and standard deviations of dependent variables by group of sexual abuse

	No abuse		Nonpenetrative abuse		Penetrative abuse	
	Mean	SD	Mean	SD	Mean	SD
Sexual Functioning (SHF)*	0.4805	0.1286	0.4868	0.1076	0.5560	0.1525
Dyadic adjustment (LWMAS)	111.48	19.30	112.07	16.03	98.59	22.49
Psychological adjustment (BSI)*	55.69	9.65	57.08	8.30	60.93	8.03
Pain measures						
MPQ-PRI	27.74	14.50	30.13	14.37	29.46	16.44
Pain during gyne exam	5.73	1.97	5.71	1.75	5.33	2.18
Pain during intercourse	7.23	1.85	7.18	1.57	6.66	1.63

*Significant between-group differences, $P < 0.05$.

SHF = Sexual History Form; LWMAS = Locke-Wallace Marital Adjustment Scale; BSI = Brief Symptom Inventory; MPQ-PRI = Mc Gill Pain Questionnaire.

previous MANOVAS showed that physical abuse did not predict any of the outcomes, we did not statistically control for physical abuse in the following MANOVAS. Results from the first MANOVA showed significant group differences with regard to psychosexual-dependent variables ($F(4, 294) = 3.382, P < 0.05$, partial $\eta^2 = 0.044$) (Group means for each variable are listed in Table 1). Further univariate analyses revealed significant group differences for psychological distress ($F(2, 150) = 3.579, P < 0.05$, partial $\eta^2 = 0.046$) and for the SHF ($F(2, 150) = 3.402, P < 0.05$, partial $\eta^2 = 0.044$). Women reporting penetrative abuse presented significantly higher psychological distress scores than women in the “no-abuse” group ($t(148) = -2.666, P < 0.05, r = 0.21$) as well as higher scores on the SHF ($t(148) = -2.525, P < 0.05, r = 0.20$), indicating poorer psychological adjustment and sexual functioning. Women reporting nonpenetrative abuse were not different from women reporting no abuse with respect to psychological distress and sexual functioning.

As for dyadic adjustment, we performed a separate univariate ANOVA because not all women were cohabiting with their partner or married. Results showed that between-group differences did not reach statistical significance ($F(2, 76) = 2.802, P = 0.067, r = 0.265$). Concerning pain measures, results from the second MANOVA were also non-significant ($F(6, 292) = 1.102, P = 0.361$, partial $\eta^2 = 0.022$), indicating that sexual abuse is not associated with these variables. Correlation showed that age at which the sexual abuse took place was not associated with any of the outcomes.

Perceived Relation between Pain and Sexual Abuse

Twenty-two percent of sexually abused participants perceived that their pain was related to their sexual abuse history. *T*-test analyses with Bonferroni correction revealed significant differences between women who perceived a relation between

their pain and their sexual abuse experience and those who did not on the SHF. Women who reported such a link had higher sexual functioning scores ($t(123) = 2.900, P < 0.007, r = 0.25$), indicating poorer functioning. We observed no difference regarding other psychosexual variables. Chi-square analyses also showed that women in the “penetrative abuse” group were 4.33 times more likely to perceive a link between pain and abuse than women in the “nonpenetrative abuse” group: 12 out of the 30 (40%) women in the “penetrative abuse” group reported a link between pain and their abuse, while only eight out of the 60 (13%) women in the “nonpenetrative” group reported such a link ($\chi^2 = 8.229, P < 0.05$).

Discussion

Four main findings can be drawn from the present study: (i) a history of sexual abuse was not associated with pain intensity; (ii) sexual abuse involving penetration was associated with increased psychological distress and poorer sexual functioning; (iii) women who perceived a link between their pain and their past sexual abuse reported worse sexual functioning; and (iv) a history of physical abuse was not associated with any of the outcome variables.

The prevalence of sexual abuse in our sample was quite high, with 59.6% of women reporting at least one of the nine descriptions of sexual abuse experiences listed in our abuse questionnaire. This prevalence is near the superior end of the range of sexual abuse prevalence found in samples of women with dyspareunia, which ranges from 8% to 52% [12,37–43]. This high prevalence, as well as the wide range of prevalence rates found across studies, might be explained by different factors. First, our questionnaire includes items describing less invasive abuse experiences such as the ones that do not involve genital touching (e.g., has

anyone ever exposed the sex organs of their body to you when you did not want it?) which might lead to a higher prevalence estimate. When considering the prevalence of sexual abuse involving genital touching only, our estimated prevalence of 37.7% is comparable with what previous studies have found. Second, our study includes both childhood and adulthood sexual abuse experiences. Studies limiting the abuse to childhood may have lower prevalence rates than studies including childhood and adulthood abuse. Finally, the lack of use of a common assessment tool for sexual abuse makes it difficult to compare prevalence across studies and may lead to a wide range of prevalence estimates.

Contrary to our hypothesis, women who reported past sexual abuse seemed to experience levels of pain intensity similar to those who did not report such a history. These findings differ from those of Randolph and Reddy's (2006) study, which indicate that sexually abused women experience more severe pain than non-abused ones [19]. However, Randolph and Reddy's (2006) study used a composite index evaluating the extent of abuse instead of categorizing participants into abused vs. non-abused groups, which may be more sensitive than the categorical approach used in the present study [19]. Notwithstanding, studies linking sexual abuse with pain severity are still scarce and show mixed findings. Some find no association between pain intensity and the presence of abuse histories, while others demonstrate that sexual abuse predicts pain severity [9,19–21,23–26,44]. Experimentally induced pain studies also show contradictory findings. While Scarinci et al. (1994) reported lower pain thresholds among abused individuals, Fillingim and Edwards (2005) observed the opposite effect [45,46]. More studies including both measures of pain threshold and pain intensity are needed in order to gain a better understanding of the influence of a sexual abuse history on pain.

In contrast, past sexual abuse was related to psychological and sexual functioning variables. Indeed, women who reported penetrative sexual abuse exhibited significantly more psychological distress than non-abused women. These results are consistent with those derived from studies among chronic pain patients showing that sexually abused women presented higher levels of psychological distress compared with non-abused women [21,23–26,44,47,48]. Our study design did not allow us to evaluate how much of the distress is independently explained by the presence of pain,

sexual abuse history, or their combined effect. Women who were sexually abused could be more sensitive to the development of psychological problems when confronted with a pain disorder and especially with pain located in the genitals. If pain occurred during the past abuse experience, pain that is experienced during an actual desired intercourse event could trigger unpleasant memories of the trauma, leading to more psychological distress among women who combine a history of past sexual abuse with current dyspareunia.

Because sexual abuse is known to be associated with sexual impairments including dyspareunia, we hypothesized that a sexual abuse history in women with dyspareunia would be associated with greater sexual impairment [14,15,49–52]. Indeed, our results indicated that sexual functioning was worse in the presence of antecedents of sexual abuse. Specifically, women reporting penetrative sexual abuse exhibited poorer sexual functioning than women reporting no abuse or nonpenetrative abuse. The fact that only penetrative abuse experiences were related to poorer sexual functioning and greater psychological distress was unexpected. However, abuse involving penetration is a more severe type of abuse which might lead to more negative consequences. This explanation is supported by Lemieux and Byers (2008) whose results revealed that women who had experienced penetrative child sexual abuse reported more negative impact on their lives than women who were abused without penetration [53]. Rellini and Meston (2007) also identified vaginal penetration as a risk factor for the development of more severe sexual distress in women who experienced sexual abuse [54]. Moreover, our finding corroborates that of Randolph and Reddy (2006), who found that more extensive sexual abuse was associated with greater sexual impairments among a sample of women with chronic pelvic pain [19]. In a sample of women combining painful sexual intercourse and a history of sexual abuse, this finding also suggests that a portion of the sexual impairment may stem directly from the past sexual abuse experience, while another portion might be related to the interference of pain with sexual functioning. Clinically, this finding is highly relevant and points to the importance of being cautious when choosing a treatment for these women, especially those reporting past sexual abuse involving penetration. Treatments targeting solely the pain might not always be successful in terms of regaining optimal sexual functioning if some aspects of the sexual impairment are secondary to the abuse.

Although our results revealed significant differences with regard to sexual abuse groups, these results should be compared with normative data in order to evaluate whether these differences are clinically significant. BSI-GSI mean *T*-scores of our three groups of sexual abuse are at the near end of the normal range, almost reaching the clinical cutoff score of 63 suggesting that with or without sexual abuse, women with dyspareunia show elevated indices of psychological distress [29]. Despite the fact that between-groups differences did not reach significance for dyadic adjustment, women in the penetrative abuse groups scored below the 100 cutoff point, which leaves them in the category of distressed couples, while the other two groups fell under the nondistressed category [32]. Finally, with regard to results from the SHF, women in the penetrative abuse group showed a mean sexual functioning score that is similar to the ones found by Reissing et al. (2003) within samples of women with vaginismus and vestibulodynia, two conditions involving painful sexual intercourse [55]. No abuse and nonpenetrative abuse groups showed significantly lower scores, which nonetheless remained higher than the mean score measured by Reissing et al. (2003) within a control group of women presenting no pain during sexual intercourse [55].

To our knowledge, this is the first study to assess whether women perceived a relation between their sexual abuse experience and their pain. In our sample, 22% of sexually abused women perceived that their pain was in relation with their prior abuse history and those perceiving such a link had poorer sexual functioning than those who did not. Our results also showed that women reporting penetrative abuse perceived significantly more often their pain to be linked to their sexual abuse history. It may be that women who suffered more severe types of abuse such as those involving penetration are more likely to develop later sexual functioning disturbances and to attribute them to the sexual abuse. When faced with difficulties, people often naturally search for reasons to explain their problems and in the case of painful sex, sexual abuse may seem like a perfectly logical explanation. Because sexual abuse is a past event which one cannot change, believing it is the cause of the pain might lead to powerlessness and poor coping skills in response to the pain, which could in the end be detrimental and worsen the pain experience.

Contrary to our hypothesis, physical abuse was not associated with pain intensity, psychological

distress, sexual functioning, or dyadic adjustment. The absence of between-group differences for physical abuse could be explained by the fact that our sample comprised a very small proportion of more severe abuse such as that requiring medical attention. Of the two studies investigating the impact of physical abuse on pain descriptions among chronic pain patients, only Leserman (1996) found an association between physical abuse history and pain intensity, which only held when considering *severe* physical abuse involving a serious threat to the participant's life [9,26]. With regard to psychological distress, studies demonstrating an association with physical abuse have also included more severe types of abuse [11]. Corroborating these results, a recent population-based study among young women has shown that current adverse effects from abuse were similar for most severe forms of emotional, physical, and sexual abuse, while mild forms of abuse showed less intense adverse effects [56]. These findings support the assumption that the severity of physical abuse is an important factor to consider when predicting negative consequences associated with abuse experiences such as pain intensity and psychological distress, which may explain the lack of association between physical abuse and outcomes in the present study.

Some limitations of the study should be highlighted. First, our research is cross-sectional, which does not allow the establishment of causal relations between antecedents of abuse and current psychological and sexual functioning. A second limitation is the heterogeneity of our sample, which precludes the generalization of results to specific subtypes of dyspareunia (e.g., provoked vestibulodynia). The retrospective nature of the design and noncorroborative reports of abuse experiences are also limitations. Prospective research reveals that a large proportion of adult women do not recall abuse that has nonetheless been documented in their childhood, therefore suggesting that memories of abuse can be unreliable [57]. Finally, our measure of sexual and physical abuse could have included additional indicators of abuse severity in order to give a more complete picture of the abuse history. Because the differences we found only held for more severe types of abuse, future studies should assess more extensively the severity of abuse instead of categorizing individuals into abused vs. non-abused groups.

In terms of clinical implications, we should be careful not to attribute too quickly psychological

and sexual impairments solely to pain when studying women with dyspareunia. Other factors such as a history of sexual abuse need to be carefully examined and, when present, targeted in the treatment plan, in order to devise interventions that are more closely aligned with the patient's needs. Finally, future research should also explore treatment issues, specifically, whether interventions targeting the processing of sexual abuse experiences could be helpful at regaining optimal sexual functioning in women combining dyspareunia with such a history.

Conclusions

This is the first study to explore the influence of sexual and physical abuse on current symptomatology of women with dyspareunia. Results showed that sexual abuse involving penetration was associated with increased psychological distress and poorer sexual functioning. This suggests that severity of abuse is an important factor to consider when studying the impact of trauma on psychological and sexual function outcomes in women with sexual dysfunction. Finally, findings also suggest that for patients, believing dyspareunic pain is linked with sexual abuse may be detrimental at the level of sexual functioning.

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Conflict of Interest: None declared.

Statement of Authorship

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