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CASE REPORT

An Innovative Nursing Approach to Caring for an Obstetric Patient With Rape Trauma Syndrome

Cheryl Parker

Correspondence
Cheryl Parker, DNP, CRNA, RNC, Obstetric Anesthesia Consultants PSC, 601 S. Floyd Street, Suite 407, Louisville, KY 40202.
cpobrn@gmail.com

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ABSTRACT

Rape trauma syndrome (RTS) is a posttraumatic stress disorder that can be triggered by routine procedures experienced during childbirth. An explanation of the signs and symptoms of RTS is provided, including how to avoid retraumatization during intrapartum care. A case report is presented from a provider perspective to illustrate the seriousness of this disorder and the importance of delivering respectful care. A new approach to obstetric routines is warranted to avoid further traumatizing the woman with RTS.

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Cheryl Parker, DNP, CRNA, RNC, is a nurse anesthetist, Obstetric Anesthesia Consultants, Norton Women's and Kosair Children's Hospital, Louisville, KY.

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Women face many psychosocial challenges during the labor and delivery process, and those who have suffered from sexual abuse often find the experience even more daunting (Burian, 1995; Hobbins, 2004; Leeners et al., 2013). Although most women are able to cope with the challenges of pregnancy and childbirth, as many as 13% of parturients experience severe, disabling fear (Lukase et al., 2010). Sexual assault is frequently not reported and often directly related to negative birth experiences (Lukase et al., 2010). Research findings suggest that as many as one in five women has experienced sexual violence or forced sexual activity and, as a result, may describe their care during childbirth as reminiscent of their abuse (Halvorsen, Nerum, Oian, & Sorlie, 2013; Montgovmery, Pope, & Rogers, 2014; Nerum, Hlavorsen, Straume, Sorlie, & Oian, 2012). A posttraumatic stress disorder (PTSD) known as rape trauma syndrome (RTS) can develop and result in an extreme fear of childbirth, resistance to medical care, extremes in behavior, and increase the likelihood of cesarean (Halvorsen et al., 2013; Marriott, 2012; Nerum et al., 2012). Providers have a responsibility to ensure that the parturient's dignity remains intact through the birthing process, and that in efforts to achieve positive outcomes we do not perform tasks under the guise of hospital routines or standards of care that have the potential to trigger a post-traumatic stress episode. The challenge to providing quality care to these patients begins with the ability to identify them, since victims of sexual abuse do not typically divulge that information (Burian, 1995; Halvorsen et al., 2013; Hobbins, 2004; Nerum et al., 2012).

Given that women experiencing RTS are not easy to identify, the best approach is one of universal care. Respecting a woman's choices about her labor process, seeking permission prior to exams, and discussing the risks and benefits of alternative choices are essential to maintaining her psychological health. The parturient with a history of sexual assault may have difficulty coping with some routine procedures that occur during labor, such as cervical exams, placement of Foley catheters, and perineal massage (Burian, 1995; Klaus, 2010; Marriott, 2012). Altering our routine approach to these practices may be necessary to prevent retraumatization, and in most instances it can easily be done without compromising the patient's safety or that of her baby.

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The purpose of our case report is to illuminate the innovate approach to nursing care provided to a laboring woman suffering with RTS due to a history of sexual assault and a previous negative birth experience. An explanation of RTS, signs and symptoms, and how to avoid retraumatization will be addressed. The case report is presented from a provider prospective to illustrate the importance of respectful care.

Rape Trauma Syndrome

Burgess and Holmstrom first used the term *rape trauma syndrome* in 1974 to describe the anxiety disorder that often develops in victims of sexual abuse (Burgess & Holmstrom, 1974). A PTSD, it is distinguished by disruptions to normal physical, emotional, behavioral, and interpersonal characteristics. RTS symptoms can appear immediately following the rape and last for several years. RTS is one possible explanation for the increase rate of cesareans, instrument-assisted vaginal deliveries, and prolonged second stage of labor among women who experienced rape as adults (Nerum et al., 2012). Women suffering from RTS are also less likely to seek prenatal care, more likely to employ alternative approaches to care, and very likely to have control issues (Klaus, 2010).

Signs and Symptoms of RTS

Rape has a direct effect on a woman's ability to develop future relationships. As a result she may become untrusting of others and suffer with shame, guilt, and suicidal ideations (Halvorsen et al., 2013). If the assault was particularly violent, the woman may have suppressed memories that could resurface during the childbirth experience (Halvorsen et al., 2013). The display of signs and symptoms is very similar to those seen in women who have experienced childhood sexual abuse (CSA) and can include an extensive range of physical and psychological conditions (Burian, 1995; Hobbins, 2004; Klaus, 2010). Many survivors have a history of panic attacks, phobias, self-mutilation, personality disorders, depression, anxiety, substance abuse, asthma, irritable bowel syndrome, chronic pain, fibromyalgia, obesity, sleep disturbances, and migraines to name a few (Burian, 1995; Hobbins, 2004; Klaus, 2010).

Concerns Specific to Childbirth. Leeners et al. (2013) showed that women with histories of sexual abuse were more likely to have fewer than five prenatal visits due to their efforts to avoid reactivation of the rape trauma. Women may have a histories of abortion and multiple sexually transmitted diseases. They may have obsessions with cleanliness and insist on having only female providers. They will typically display an extreme sensitivity to body fluids, strongly object to nakedness or being exposed, and often recoil from any type of touch (Burian, 1995; Klaus, 2010). Control issues are very common, and these women can appear demanding, rigid, or mistrustful. To the the opposite extreme, they can display an overdependance on the provider.

Fighting and taking control are two distinct birthing styles that have been identified among parturients with histories of sexual abuse (Rhodes & Hutchinson, 1994). Women with RTS may often be labeled as difficult or demanding patients. To start with, their need for control may manifest in long and inflexible birth plans, and they may frequently test the care provider in an effort to determine if she or he is trustworthy (Klaus, 2010). Women with RTS may exhibit anger, cynicism, and behave in a manner that is intended to intimidate hospital staff. Demanding explanations for every action or intervention, insisting on her friends or family being present at all times to protect her, avoiding eye contact, using sarcasm, displaying hostility, struggling against contractions, crying out, and having an exaggerated response to exams are ways of fighting and taking control in an effort to maintain power and jurisdiction over a situation that is clearly beyond her control (Halvorsen et al., 2013; Hobbins, 2004; Klaus, 2010).

The woman with RTS often goes to extremes by either refusing all pain medications or asking for an epidural very early in the labor process. Because she appears so out of control, she may be encouraged by staff to have an epidural to relax. However survivors of RTS and CSA may equate the numb feeling of an epidural to how they felt during the rape: paralyzed and out of control (Halvorsen et al., 2013).

Nerum et al. (2012) compared the duration and outcome of labor between victims of RTS, CSA, and those who had not experienced abuse. They found that women with RTS had a significantly prolonged second stage, on average 120 minutes, which was more than double the duration for the