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Responding to Prenatal Disclosure of Past Sexual Abuse

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Abstract

The American College of Obstetricians and Gynecologists recommends that physicians elicit a sexual abuse and rape trauma history for every patient. Yet in practice, physicians may still struggle to understand how best to obtain this history and what clinical obligations arise when a physician inquires and a woman discloses a remote history of childhood or adult sexual trauma during the course of her prenatal care. This commentary offers a practical strategy for responding to sexual trauma disclosure by developing a tailored obstetric care plan for avoiding re-traumatization in labor. In this way, obstetricians may avoid causing harm and begin to meet the unique obstetric and psychological needs of sexual trauma survivors during pregnancy and delivery.

Obstetrician–gynecologists are accustomed to the practice of screening for intimate partner violence. When a woman discloses current abuse, the clinician’s pressing concern is to assist her in securing a safe environment for herself and her family. However, a woman’s remote history of childhood sexual abuse or sexual trauma in adulthood may seem less urgent, and certainly less actionable, than cases of ongoing interpersonal violence. When a horrific event has occurred in the distant past, and the woman appears to be presently functioning well with no obvious signs or complaints of psychiatric sequelae, a clinician may be inclined to view this history as regrettable but not particularly relevant to her current obstetric care.

In light of the recent Committee Opinion on “Adult Manifestations of Childhood Sexual Abuse,” which recommends asking “every patient about childhood abuse and rape trauma,” I will consider how sexual trauma inquiry can be especially valuable for both patients and obstetric caregivers (1). Meeting the needs of pregnant women who are survivors of sexual abuse or assault requires obstetricians to develop a deeper awareness of the harms associated with forgoing sexual trauma screening or being unprepared to respond to a woman’s disclosure of such a history.

Guidelines encourage routine screening for a history of sexual abuse for compelling reasons (1). With 1 out of 5 women experiencing childhood sexual abuse, the prevalence of such trauma is alarming (1). The Committee Opinion recommends asking about past childhood abuse and rape trauma in a natural, routine manner (1). Appropriate responses to abuse disclosure should include supportive messages acknowledging the woman’s courage, attentive listening, questions about prior disclosure or any prior professional support after

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the traumatic incident, an offer of mental health referral, and special sensitivity to patient comfort during pelvic or breast examinations (1).

Clinicians may hesitate, however, to initiate discussions about sexual trauma. While some may worry about eliciting distressing memories that neither the patient nor the clinician are prepared to address, others may feel unease when a woman discloses past abuse yet declines the offer of mental health referral. Qualitative analysis of interviews with sexual trauma survivors has revealed that many pregnant women prefer to compartmentalize their memories of past abusive experiences rather than initiate psychotherapy to explore these memories during pregnancy (2). Without some reassurance that abuse screening can be helpful in cases when psychiatric therapy is not elected, sexual trauma inquiry may seem fruitless. Under these circumstances how should an obstetrician respond?

Shifting the Focus of Sexual Trauma Screening in Obstetrics

Obstetricians are in a unique position to respond to sexual abuse disclosure, even when a woman declines mental health referral. While the overarching goal of sexual trauma screening may be to facilitate full psychological recovery for women suffering longstanding effects of posttraumatic stress, there are other useful aims of such screening in obstetrics. As guidelines suggests, postponing or modifying the breast or pelvic examination may be important interventions for reducing stress triggers (1). Similarly, obstetricians can make preparations and modifications to help the patient cope with stressors that may arise during the course of prenatal care and, most importantly, at delivery. Sexual trauma screening can be valuable when the goal is to tailor obstetric care and thereby reduce the risk of childbirth becoming a re-traumatizing event.

A sexual abuse survivor who is receiving prenatal care may face stressors beyond those encountered during a gynecologic visit. While breast and pelvic examinations are common to both gynecologic and obstetric encounters, the perinatal period can be especially challenging for abuse survivors. During pregnancy, bodily sensations resembling disturbing elements of past abuse may lead patients to experience four categories of posttraumatic stress symptoms: recurrent and intrusive memories; avoidance of thoughts, activities, and other reminders of the traumatic event; heightened irritability and other manifestations of autonomic arousal; and negative changes in mood and cognition (3). These symptoms may recur or intensify in response to triggering reminders of the past event, new life stressors, or additional traumatic experiences (3). Unique triggers in pregnancy can include fetal movement, bodily changes, common procedures and examinations in prenatal care, and the stressors of labor and delivery (2). Indeed, Soet and colleagues demonstrated that sexual trauma survivors were 12 times more likely to perceive their childbirth experiences as psychologically traumatic compared to women without this history (4). A study by Lev-Wiesel and colleagues also showed that a woman's history of childhood sexual abuse conferred a higher risk of mental dissociation and birth-related posttraumatic stress reactions compared to women with other trauma exposures or to those with no trauma history (5). Data suggest that the prevalence of posttraumatic stress disorder (PTSD) is higher among pregnant women than in the population of nonpregnant women in the United States, at 6–8%

versus 4–5% respectively (6). Hence, the effect of a woman's sexual trauma history on her experience of pregnancy, labor, and delivery warrants special attention in obstetric practice.

The Obligation to Avoid Causing Harm

In the event that screening for a prior history of sexual trauma does not occur, and signs of posttraumatic stress are overlooked, an obstetrician risks doing further harm. While every pregnant woman might have difficulty feeling “in control” at various stages in the labor and delivery process, the sense of powerlessness that a sexual trauma victim once experienced may resurface in a way that compounds her sense of vulnerability. A childhood abuse survivor who loses control of her urine or bowel function during the pushing stage of labor may experience a flashback to a similar episode of losing control of bodily functions in the setting of prior abuse. Had the physician elicited an abuse history during prenatal care, the physician would have a greater chance of detecting panic and responding by keeping the patient as clean as possible and reassuring her that she is safe. Perhaps even more importantly, the physician can avoid making the situation worse by urging her to push even more forcefully, which may heighten her sense of powerlessness.

Labor is a particularly vulnerable time, not only because the woman may experience a sense of re-victimization, but also because subsequent difficulties bonding with her infant may have significant implications for the child's wellbeing. A recent study reported greater levels of mental dissociation during labor for childhood abuse survivors than for nonabused women, and higher dissociation scores were strongly correlated with more postpartum depression symptoms and with impaired bonding (7). Consequently, impaired maternal–infant interactions have been associated with disturbances in cognitive, behavioral, and emotional infant development that can have long-term effects on psychological and social functioning (8). Given the potential intergenerational impact of a psychologically traumatic birth experience on both mother and infant, obstetricians have a unique role in reducing the risk of psychological harm or revictimization of an abuse survivor with an underlying history of posttraumatic stress.

An Approach to Addressing Triggers

After offering mental health referral, an obstetrician has the opportunity to collaborate with the survivor during prenatal care to pursue a two-part strategy: minimizing posttraumatic stress triggers and preparing to cope with stressors that are likely unavoidable. Seng and colleagues found that some women who were aware of their own tendencies to develop acute stress reactions to painful or stressful stimuli appeared to overlook the relevance of this knowledge in preparing for the acutely painful and stressful elements of labor and delivery (2). It therefore becomes important for the obstetrician to help patients understand the value of discussing their known triggers and jointly preparing to prevent or respond to them.

In addition to speculum examinations, common triggers arising in the first prenatal care visit may include undressing, lying supine while the clinician is upright, inadequate draping, genital exposure, or intrusive touch (2,9,10). Each of these elements can be modified. Prior to performing a first-trimester transvaginal ultrasound, for instance, an obstetrician might

ask: “Is there anything I can do to make things easier if you begin to feel uncomfortable?” The obstetrician and patient can then agree together on an approach enabling the patient to stay partially clothed, raise her hand at any time to stop the procedure, notify the clinician if she experiences pain, or pursue other modification strategies.

Once triggers are identified in prenatal care, corresponding modifications can be applied in labor. Because sexual trauma involves the experience of powerlessness, one general approach for avoiding common triggers is to refrain from gestures that may be perceived as overpowering (9,10). To that end, sitting on the bed, or on a chair if the bed is too threateningly close, and speaking with the patient at eye level would be preferable to leaning over her during a discussion or an examination in labor. It also becomes important to avoid commands that accentuate powerlessness such as, “Relax (9).” Instead, I have found it more helpful to explain: “If you try to relax your muscles, you may feel less pressure when I check your cervix. Let me know when it’s okay to start.” Maximizing privacy by limiting the number of obstetric caregivers during labor, discouraging too many eager friends and family from being present if the patient prefers less company, discouraging these onlookers from photographing the perineum or other sensitive body parts, and minimizing genital exposure during vaginal examinations and at delivery are examples of trigger-avoidance strategies.

On the other hand, some triggers related to bodily sensations and elements of routine obstetric care may not be avoidable. The obstetrician’s focus must then shift from avoiding the stressor to helping the patient devise a strategy for stress-coping in anticipation of the stressor. The reality of discomfort during labor requires a candid discussion about realistic pain relief expectations and the loss of mobility with an epidural that may also trigger powerlessness. Multiple vaginal examinations, the limited mobility to expect with electronic fetal monitoring, and obstetric emergencies may all become unavoidable stressors at the time of delivery.

While childbirth education classes have not shown consistent results in stress coping beyond the first stage of labor, and many prenatal educational programs have not been tested in the trauma-exposed population, patient narratives and trauma experts have emphasized the value of both generating a tailored birth plan and arranging for a trained labor coach or doula to help facilitate stress coping (10,11). If a woman fears dissociating during labor, the encouragement of a partner or a doula can help her to remain oriented to time and place (10). The presence of a doula may also provide more consistent support than a frightened partner in an obstetric emergency, as the doula can facilitate communication between the woman and the obstetric care team when events are unfolding rapidly and the team’s attention is focused on expediting delivery. Since acute psychological trauma may occur despite a successful clinical outcome and a healthy infant, giving the woman an opportunity to ask questions and to describe her reaction to the unplanned obstetric events in her labor course may also be helpful for stress coping after delivery (10).

Overcoming Limitations and Barriers to Implementing This Strategy

This proposed strategy of focusing the sexual trauma inquiry on anticipated stressors of labor may present challenges to practicing obstetricians. First, this approach emphasizes intrapartum triggers due to the culmination of stressors that are present during labor. However, posttraumatic stress reactions may also be associated with triggers in the antepartum and postpartum periods (see the Appendix online at <http://links.lww.com/xxx>). Evidence-based tools to help obstetricians and patients identify potential triggers along the entire trajectory of pregnancy, labor, and the puerperium have not yet been developed. Future research aimed at developing such tools will be useful to guide clinicians as they attempt to address the needs of sexual trauma survivors across the perinatal period.

Another significant barrier may be a general lack of knowledge and training in addressing trauma-related issues. Reading published narrative experiences of sexual trauma survivors can be instructive, for these accounts illustrate patient perspectives, common triggers, and helpful responses of some obstetric providers (2,9,10). Although few published studies and continuing education modules are presently available to provide trauma-informed training for clinicians, ongoing and future development of such resources will be valuable.

Furthermore, a common barrier for many physicians is the limited time for in-office counseling that is allotted for a typical 15 minute prenatal care visit. Clinicians may struggle with the tension between a desire to provide reassurance and extra time for addressing trauma-related issues whenever they arise and pressure to keep the office running efficiently to avoid inconveniencing other patients. Any expression of frustration or even mild annoyance can heighten a woman's already acute sense of embarrassment and shame. While allocating extensive blocks of time for this counseling would be challenging, shorter conversations covering only one or two topics per visit in the second and third trimesters are more feasible in a time-pressured office setting. Individual providers can be reimbursed for extended counseling, and the Affordable Care Act designates intrapersonal violence screening and counseling as a preventive service that insurance companies must reimburse with no co-payment or cost-sharing for the patient. Ideally, obstetric practices will develop multidisciplinary teams of trauma-trained experts including nurse educators, certified nurse midwives, psychologists, and social workers to coordinate care with the primary obstetrician as early as possible after abuse disclosure. Such a team could assist a woman in identifying her triggers, generate an appropriate birth plan in collaboration with the obstetrician, and continue postpartum follow-up.

In summary, sexual trauma has affected a large segment of the female population. Healthcare providers who specialize in women's health must understand its unique consequences on the longstanding physical, psychological, and emotional well-being of women. Sexual trauma screening can be actionable and meaningful: it should involve a two-fold action plan that involves both mental health referral and an obstetric care plan that addresses the anticipated stress triggers a survivor is likely to encounter during delivery. Obstetric providers have the unique opportunity to prevent avoidable triggers in routine obstetric care and to collaborate with the survivor to generate plans for coping with unavoidable triggers that could lead to experiencing re-victimization in childbirth. This

focused approach to sexual trauma inquiry and response to abuse disclosure offers a framework that obstetric providers may wish to consider when caring for sexual trauma survivors. Adopting and continuing to refine these strategies has the potential to enhance the physical and mental health of this unique population of women.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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