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Re-Traumatization of Sexual Trauma in Women's Reproductive Health Care

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Abstract

In the U.S., 15 to 25% of women will be sexually abused in their lifetime. Health care providers can inadvertently trigger re-traumatization of previous sexual abuse through commonplace women's health care practices (e.g. pelvic and breast examinations) that resemble a patient's previous trauma. In the event of re-traumatization, women can develop post-traumatic stress symptoms, post-traumatic stress disorder, and exacerbations of the numerous sequelae associated with sexual trauma. This study summarizes research on physical and situational triggers for re-traumatization in clinical practice, signs and symptoms of re-traumatization, and best practices for women's health providers in gynecological, prenatal, labor and delivery, and postnatal care. Studies were selected based on the presence of research questions addressing presentation of posttraumatic stress symptoms in women's reproductive health care. The bibliographies of selected sources were reviewed to identify additional relevant publications. Studies were coded into gynecological care, prenatal care, labor and delivery, and/or postpartum care and were analyzed for discussion of triggers of re-traumatization, signs and symptoms of re-traumatization, and provider recommendations. Triggers reminiscent of sexual trauma via loss of control, bodily manipulation, and lack of consent were found to incite arousal, intrusive re-experiencing and avoidance post-traumatic stress symptoms in women with histories of sexual trauma. Recommended best practices included gaining consent before initiating touch or procedures and working with women to ensure they maintain a locus of control in their reproductive health care.

Background

In the U.S., 15% to 25% of women are likely to experience sexual abuse in their lifetime.¹ As such, most, if not all, women's health care providers will interact with a patient who has a history of sexual trauma. Within the context of this study, sexual trauma is defined as penetrative and non-penetrative vaginal, oral, or anal sexual assault, non-consensual touching, and sexual coercion with or without threat of harm.²⁻⁴ Like any traumatic event, women who experience sexual trauma are at risk of developing posttraumatic stress symptoms and, in extreme situations, posttraumatic stress disorder.^{2,5-12} Repeated exposure to environmental factors that could act as triggers for re-experiencing trauma or re-traumatization, is considered an additional risk factor for developing posttraumatic stress disorder.¹³

The likelihood of providers being aware of their patients' traumatic histories is low due to the low rates of prompted and unprompted patient disclosure to health care providers.^{1,14} Disclosing past sexual trauma can be very intimidating due to the shame and stigma surrounding sexual assault. Health care providers can face many barriers to screening patients for sexual trauma history, including lack of training, frustration that they may not be able to adequately help the patient, and difficulty discussing this sensitive topic.^{1,15}

The life-long effects of trauma and re-traumatization are numerous and negatively impact the health and wellness of this population of women. A better understanding of the relationship between sexual trauma and women's health care can help providers to fulfill their Hippocratic oath to "do no harm" when working with women with histories of sexual

trauma. This study examines the environmental factors present in women's reproductive health care that can re-traumatize women with histories of sexual trauma.

Women and Sexual Trauma

Rates of sexual assault vary by racial and ethnic groups.^{1,16} African American women experience a slightly higher rate of sexual assault than Caucasian women (17.7% vs. 18.8%), while American Indian and Alaskan women experience a significantly higher rate of sexual assault than other North Americans (34.1%).¹⁶ Approximately 80% of all sexual assaults were perpetrated by a non-stranger, with 25% of perpetrators being intimate partners and 5% being family members.¹⁷ Of sexual assault victims, 44% were under the age of 18 during their first assault, with the majority of childhood sexual abuse being recurrent.^{18,19} Nearly all childhood sexual assault victims knew their assailant (93%).²⁰

It is important to note that two terms can be used to describe women with a history of sexual trauma: survivors and victims. A woman may self-identify as a survivor if she has been sexually traumatized in her lifetime and has begun to heal and move past her trauma. A victim is a woman who may or may not recognize her sexual trauma, who may or may not accept her trauma as sexual assault, and who has not begun the healing process. This distinction is necessary as women in different stages of trauma recovery react differently to related challenges.²¹

Responses to Sexual Trauma

Much like a war veteran might experience a flashback to an armed conflict after hearing a car backfire, victims and survivors can re-experience or relive their trauma through physical and situational triggers that resemble their abuse, such as fetal movements, labor pains, lying supine, or sitting with one's back to the door.^{8,12,14,22-26}

Women's reproductive healthcare can be particularly triggering for victims and survivors of sexual trauma as this field focuses on the health of body systems closely associated with sexual assault. Reminders of past abuse can occur at the hands of women's health care providers through the touch and treatment of survivors and victims. Being aware of an individual's status of recovery from sexual trauma could be useful knowledge for providers in terms of coping styles and education on the sequelae of sexual trauma. However, even if a woman has reached survivorship or is multigravidas, she could still re-experience her trauma through maternity care due to the unique physical changes and physical interventions characteristic of pregnancy, labor and delivery, and the early stages of motherhood.¹⁵ Women with a history of sexual trauma are 12 times more likely to experience labor and delivery as traumatic than women without such history; this indicates that a history of sexual trauma is a significant predictor of traumatic childbirth via re-traumatization.²⁷ Women who have experienced their sexual trauma in childhood exhibit higher rates of postpartum posttraumatic stress disorder than both women with no history of trauma and women with a history of non-sexual trauma.²

Post-traumatic stress symptoms presenting in women who have been re-traumatized can be grouped into the three categories of post-traumatic stress symptomatology: (1) intrusion or intrusive re-experiencing, (2) avoidance, and (3) arousal.²⁸ Intrusion or intrusive re-experiencing can be described as symptoms that involve reliving memories, such as flashbacks and nightmares, accompanied by psychological and/or physiological distress or feelings of numbness.²⁸ Avoidance is characterized by the victim or survivor avoiding reminders of their trauma, being unable to experience joy, and not actively engaging in interpersonal relationships due to emotional

numbing.²⁸ Arousal symptoms include exaggerated startle responses, irritability, problems with memory and concentration, and becoming easily distressed by unexpected stimuli.²⁸

The long-term effects of sexual trauma outside of posttraumatic stress disorder are diverse, with sequelae ranging from various psychological disorders such as anxiety disorders and depression to somatization in the form of various gynecological and gastrointestinal disorders.^{1,7,29} These sequelae are quite prevalent in this population of women, as sexually traumatized women exhibit more physical symptoms, especially gynecological symptoms, and higher overall rates of medical utilization than women without a history of sexual trauma.^{1,3,6,9,13,29,30} These sequelae are also most severe in women who experienced completed, penetrative rape, longer duration of abuse, and childhood sexual abuse.^{1,13}

Health Care and Sexual Trauma

Left untreated, posttraumatic stress can have deleterious long-term effects on the health and livelihoods of sexually traumatized women. For example, due to the negative perceptions of routine gynecological care amongst survivors and victims, these women are less likely to receive routine pap smears and therefore at higher risk of developing preventable diseases, such as cervical cancer.^{14,31} Women with a history of sexual trauma have more recorded diagnoses, greater presentation of physical symptoms, more emergency department visits, and more major surgeries in their lifetime than women without a history of sexual trauma.¹ One study revealed that women with a high incidence of PTSD symptoms exhibited double the median total health care costs compared to women with low incidences of PTSD symptoms. It is important to note that only a small

portion of the increased health care costs of women with PTSD symptoms could be attributed to mental health care costs.³⁰

When working with victims and survivors, providers cannot only consider signs and symptoms that are within the standard definition of posttraumatic stress disorder. A gynecologist or family nurse practitioner are more likely to see a patient with generalized pelvic pain than a woman seeking help for posttraumatic stress symptoms secondary to sexual assault. Therefore, providers need to pay attention to the tools at hand. They must recognize the underlying trauma when somatic disorders have no medical explanation to be found.²⁸ By recognizing the signs of previous trauma, re-traumatization, and common sequelae of sexual trauma, health care providers can appropriately treat, refer, and manage patients who are victims and survivors to prevent further mental and physical suffering.

Utilization of women's health care is diverse and women's health providers need to be prepared to meet these diverse needs. Women's reproductive health care can be divided into four categories: gynecological care, prenatal care, labor and delivery, and postpartum care. The reproductive life cycles of women are as unique and dynamic as the women themselves. This life cycle can be defined as the complex order that each category is utilized. For example, a woman who remains nulligravidous throughout her life span will only utilize gynecological care, whereas a woman with three children will have utilized all four categories in a varying sequence. Some women may have a different likelihood of experiencing all categories of reproductive health care than others. For example, a study addressing the associations between gynecological symptoms, sexual assault history, and hysterectomy risk in female military veterans found that veterans who had experienced completed sexual assault with vaginal penetration were twice as likely to have a

hysterectomy in their lifetime than veterans without a history of sexual assault.³ While removal of reproductive organs may seem like an attractive treatment for the various gynecological disorders that are typical of women with a history of sexual trauma, hysterectomies render women who are still of reproductive age infertile and removes them from the possibility of entering the three women's health categories associated with maternal health. Some woman may receive both gynecological and prenatal care in the same visit with her health care provider.

The physical and situational triggers characteristic of each type of gynecological care may be unique or shared among two or more types of care. For example, fetal movements will only be experienced during the prenatal care category while pelvic exams are likely to occur in a woman's experience with all four categories. Similarly, exposure to one or all types of care may vary by health care provider. An obstetrician/gynecologist will work with women in all four categories, a nurse midwife could work with women in prenatal care, labor and delivery, and postpartum care, and a family medicine practitioner in a rural community may provide gynecological and prenatal care.

The interactions between victims and survivors of sexual trauma and their health care providers are approached categorically so that the experience of every woman in this patient population is recognized and validated. Providers treating in one or more of these areas should be equipped with the knowledge of how a history of sexual trauma could alter the patient experience of women's reproductive health care.

Previous reviews on sexual trauma and women's health care focused on maternity care without distinctions between the categories of the perinatal experience. This review further examines the unique and common experiences of women in different women's

healthcare settings. By approaching sexual re-traumatization by categories of care, this review applies a broader, more inclusive lens than previous studies. This inclusive approach was used to address three questions. What are the physical and situational triggers in women's reproductive health care that lead to re-experiencing previous sexual trauma? What are the signs and symptoms of re-traumatization presenting in women with a history of sexual trauma? And how can health care workers tailor women's reproductive health care experiences to prevent re-traumatization?

Methods

Database searches were conducted on *PubMed*, *PsycINFO*, *ERIC*, *CINAHL Complete*, and *Cochrane Library* using the following key words: posttraumatic stress, sexual trauma, and childbirth, prenatal care, or pelvic exam. Relevant qualitative, quantitative, and review studies were selected based on thematic material addressing presentation of posttraumatic stress symptoms in one or more of the four designated categories of female reproductive health care: gynecological care, prenatal care, labor and delivery, and postpartum care. Publication dates reflected in the literature chosen for this review ranged from 1992 to 2015. Within the context of this review, studies were coded by care categories based on the following listed criteria. Gynecological care reflected women's health care outside of obstetrics, e.g. endometriosis, dysmenorrhea, menorrhagia, PID, pelvic pain. Prenatal care included medical visits pertaining to gestation, or from conception to labor. Labor and delivery health care during labor and delivery. Postpartum care included provider care after delivery until 6 weeks post delivery, which includes recovery from delivery and initial adjustment to motherhood.

The references associated with the initial twelve studies chosen from the database searches were reviewed to further identify relevant publications (n=6). For the final analysis the data reflected four manuscripts in gynecological care, seven manuscripts for prenatal care, eight manuscripts for labor and delivery, and seven manuscripts for postpartum care. Several publications were not mutually exclusive when categorized, as they addressed two or more stages of reproductive health care (n=7). Manuscripts were coded into one or more of the four categories of reproductive health care based on discussion of women's reproductive health care experiences of victims and survivors of sexual trauma. Studies were then further analyzed for discussion of physical triggers, situational triggers, signs and symptoms of re-traumatization, and provider recommendations or best practices for each category.

Results

Gynecological Care

Sexually traumatized women often experience gynecological care differently than non-traumatized women due to the unpleasant memories associated with their sex organs. Women with a history of sexual trauma are more likely to experience their encounters with gynecologists as significantly more painful and plagued with negative emotions, such as shame and vulnerability, than non-traumatized women.¹⁴ Avoidance of gynecological care due to these negative perceptions could lead to a lifetime of preventative care avoidance, increased physical somatization or presentation of gynecological symptoms secondary to psychological distress, and greater medical utilization later in life.^{31,32} Intervening early in a victim or survivors reproductive healthcare experience could not only prevent re-traumatization, but also the development of sexual trauma comorbidities.

Physical Triggers

A common physical trigger for re-traumatization in gynecological care is the pelvic examination. Commonly used in preventative and annual women's health exams, the pelvic exam is useful for screening women for cervical cancer and sexually transmitted infections. Insertion of the vaginal speculum and/or fingers during vaginal or rectal examinations is often cited as a physical trigger that reminded women of their trauma and/or encouraged flashbacks to their traumatic event.^{14,31} Robohm and Bittenheim¹⁴ observed that the pelvic examination can contain many shared features with a patient's sexual trauma and can thus be a classically conditioned stimulus for a traumatic stress response. Survivors and victims of sexual trauma are more likely to be uncomfortable with breast and pelvic examinations than women without a history of sexual trauma. These women are also more likely to attribute this discomfort to the "examination of sexual organs"^{14(p66)} and to endorse past sexual abuse as their reason for discomfort. Intrusive thoughts, flashbacks, dissociation, body memories, and feelings of intense vulnerability were experienced during pelvic examinations.¹⁴

Situational Triggers

The American College of Obstetricians and Gynecologists addressed the issue of self-agency, or self-protection of survivors and victims of sexual assault in a Committee Opinion report in 2011.³² The lack of self-agency in these women as a result of vulnerability after sexual exploitation has contributed to repeated victimization.³² This process is often facilitated by authority figures, especially when a woman is a victim or survivor of childhood sexual abuse and was abused by a patriarchal family member.^{22,25} Physicians can fill this patriarchal role via the doctor-patient relationship. Specifically patients can fall into

the victim role while their gynecological care providers assume the role of abuser. Such re-traumatization may be why many women are unlikely to report their discomfort during examinations.¹⁴

Signs and Symptoms

Victims and survivors reported being overwhelmed with posttraumatic stress arousal symptoms such as panic, terror, helplessness, shame, disgust, humiliation, grief, rage, or fear during or shortly after a gynecological care visit.¹⁴ Women also reported having intrusion symptoms, such as involuntary thoughts and flashbacks relating to their trauma, during or soon after a gynecological care visit.⁸ Dissociation, an avoidance symptom that involves mental detachment from the body during triggering situations, was also reported by victims and survivors in association with gynecological care.⁸ Avoidance of routine pelvic examinations and cervical cancer screenings was identified as a sign of a history of sexual trauma.³¹

Prenatal Care

Some of the concerns related to prenatal care reflected those previously reviewed under gynecological care. For example, fear of pelvic examinations in prenatal care due to previous re-traumatization can lead to late term care initiated past the first trimester or avoidance of prenatal care altogether.^{12,22} Unlike gynecological care, health care providers are not always the facilitators of the physical triggers that lead to re-traumatization during prenatal care. Identifying and appropriately treating women who are at risk of re-traumatization and developing posttraumatic stress symptoms before or during early pregnancy could greatly benefit both maternal and fetal health.

Physical Triggers

Similar to gynecological care, prenatal care is associated with a high frequency of invasive procedures, such as pelvic examinations. The sensations associated with pelvic exams are frequently cited as re-traumatization triggers for victims and survivors of sexual assault, inducing flashbacks and other re-experiencing symptoms.^{11,12,25,33} Fetal movement was reported as a trigger that is unique to the prenatal experience.¹² These sensations have been reported to cause flashbacks due to their invasive nature.¹²

Situational Triggers

Pregnancy can be very difficult for victims and survivors of sexual trauma, even when children are planned and desired. Sexual assault oftentimes strips a woman of her self-agency, or perceived control over herself. During pregnancy, women share their bodies with another being and have reported feeling loss of control through fetal movements and the demands of carrying a fetus.²⁵ Montgomery, Pope, and Rogers²⁵ conducted qualitative interviews with survivors of childhood sexual assault and found that several subjects reported “ I felt that immense feeling of being controlled by someone else,” “this baby was taking over,” or “I felt very much trapped.”^(p4) Sharing their bodies with another being violated personal boundaries similar to the way their abusers violated their boundaries in childhood.

The loss of control associated with pregnancy has been very triggering for victims and survivors during the prenatal period.²⁵ Similar to gynecological care, women have reported issues with their health care providers assuming the role of their abuser during prenatal care.¹¹ This can occur by not informing women of impending invasive procedures or not obtaining consent for these procedures.²¹ Women also described the power providers hold over their patients as being reminiscent to the power experienced through

abusive behavior.¹¹ The prenatal care setting has also been reported as a trigger if reminiscent of the earlier abuse, such as being unclothed in an examination room while providers are coming in and out of the room.²¹

Signs and Symptoms

Women with a history of sexual trauma have reported using negative behaviors to cope with, or “take charge”^(p491) of the anxiety induced by physical and situational triggers associated with pregnancy and prenatal care, such as the use of tobacco, alcohol, or illicit drugs.¹² Women have also presented with pre-term labor as a result of this anxiety¹³ and have exhibited post-traumatic stress symptoms as an indication of re-traumatization. In a quantitative study of mid-pregnant women in Israel, women with a history of childhood sexual trauma experienced more post-traumatic stress symptoms, excluding arousal symptoms, than women with a history of other trauma or no trauma.²

In general, research discussed avoidance symptoms in relation to prenatal care of victims and survivors of sexual trauma. These symptoms included paralysis and inability to speak after loss of control during a pelvic examination, becoming submissive towards providers as they reenact the role of the woman’s abuser, and dissociation to cope with the stresses of pregnancy and invasive procedures.^{11,25,33,34} Some women reported dissociation so severe that they could not recall information from prenatal care visits.³⁴ Women who were submissive or not able to exert control during their prenatal care experiences resumed the coping strategy employed during their abuse. One woman stated that she became “completely passive” and “didn’t advocate for myself at all” as a result of her loss of control.^{21(p367)} Intrusion symptoms also presented in victims and survivors receiving prenatal care in the form of nightmares and flashbacks.³⁴ Women presenting with

hypervigilance, an arousal symptom, reported being fearful of medical interventions during pregnancy and exhibited exaggerated startle responses due to a strong sense of threat.³⁴

Labor and Delivery

After conducting a series of qualitative interviews, Halvorsen et al.²³ identified one main theme of childbirth for women with a history of sexual trauma: “being back in the rape.”^(p184) Labor and delivery are often particularly trying for women, but more so for survivors and victims of sexual assault as the experience of birth and sexual trauma share many physical and situational similarities.²⁵ Many multiparous women continued to re-experience their trauma during subsequent deliveries.^{25,26}

Physical Triggers

Survivors and victims have reported persistent memories of re-experiencing previous sexual trauma during childbirth, in instances of both vaginal delivery and cesarean section.²³ Women attributed these flashbacks to both the pain of childbirth that reminded them of the violent penetration of vaginal sexual assault and the repetitive entering of their body by birth attendants’ hands and birthing tools, often without warning or explanation of the repetitive procedures.^{23,25,34} Thus, survivors and victims found themselves in an “intense internal struggle”^(p185) regarding their personal conflict with their trauma during childbirth and the standard routines of delivery in a labor ward.²³ In addition, for some women the birthing position itself served a trigger when their bodies were oriented similarly to when they experienced their trauma, such as lying supine, having their legs forced apart and placed in stirrups, or being restrained during cesarean sections.²³ Feelings of restraint from the use of monitors and intravenous fluids have also

been reported as a trigger during labor and delivery, as well as gestures that are meant to be comforting, such as holding women by their shoulders.^{8,25,27}

Situational Triggers

Labor is largely characterized by loss of control: loss of control of one's body and, possibly, loss of control of health care decisions as practitioners work without consultation of the patient.^{22,25} The intimate nature of labor and delivery, both between mother and baby and mother and birth attendants, has been reported as a trigger. For example, some women reported flashbacks so vivid that they found it hard to distinguish between their abuser and their birth attendants during the labor.^{12,23,25} Delivery is often experienced while completely undressed, and this physical exposure in front of numerous medical staff has also been experienced as triggering for victims and survivors.²³ Working with a consistent group of birth attendants has been found to make women feel like they are maintaining a locus of control during delivery, while receiving invasive examinations from multiple birth attendants was reported as triggering.¹¹ Epidural anesthesia, even when desired, was also triggering for women, as the paralysis associated with anesthesia was reminiscent of the physical and mental paralysis experienced during sexual assault.^{23,25} Position in the delivery room was also a concern for some victims and survivors. For example, women have reported being uncomfortable when their back is to the door due to uncertainty of who is entering and exiting the room.²⁵

Medical interventions employed after failure to deliver naturally triggered immense feelings of shame in some women; they viewed their bodies as having failed to deliver their children just as their bodies failed to protect them during their assault.²³ When birth attendants treated victims and survivors as vessels for delivery, these women experienced

objectification that was extremely reminiscent of what they endured during and after sexual trauma.^{11,23} When survivors and victims were objectified during their childbirth experience, they internalized feelings of shame and failure after re-traumatization much like the internalization of blame endured after their sexual trauma.²³

Signs and Symptoms

Some women have reported the sensation of extreme, unwanted weight on top of them during the delivery, a sign that could be indicative of a history of sexual trauma.⁸ When describing their labor experiences, some women spoke of their bodies as separate entities from themselves; this rhetoric is similar to survivors and victims who believe that their body's betrayed them during their trauma and did so again during childbirth.⁸ The urge to self-harm as a means of coping with re-traumatization during labor has also presented. One respondent in Seng et al.'s 2004 study described repetitively hitting her head on a wall through the progression of her labor.³⁴

Rhodes and Hutchinson outlined four labor styles that victims and survivors of sexual trauma tend to employ during labor and delivery: fighting, taking control, surrendering, and retreating.⁸ Loss of control lead some laboring women to "fight" delivery to maintain feelings of control and safety, resulting in excessive labor times and increased risk of medical or surgical delivery interventions.^{8,35} These women adopted self-defensive postures, such as shielding their faces, tensing their buttocks and vaginal muscles, moving their bodies away from providers, and reaching out to ward off the birth attendants' hands.⁸ They also presented with a variety of post-traumatic stress arousal symptoms, such as appearing fearful, mistrusting, and protective of body privacy.⁸

Some women attempted to take back their control during labor by using the taking control labor style. Some of these women presented to labor and delivery with a highly detailed birth plan, and often adamantly refused any treatment or procedure that varied from that plan.⁸ Women reported negotiating with their providers to keep men out of the delivery room, to discuss where and how birth attendants could touch them, and to any prevent procedures that were not preceded by obtaining consent.²¹ Hypervigilance, an arousal symptom of post-traumatic stress disorder, was evident in this labor style.

If women perceived that they had lost control, they were found to surrender by adopting the same coping mechanisms used during their assault.²³ Some victims and survivors appeared very eager to please, or as a “star patient,”^{25(p5)} and very complacent.⁸ While this was interpreted as positive behavior by some birth attendants, women could have been behaving this way because they were conditioned to believe that complying with persons of authority would ease their pain and suffering.^{12,25} Some victims and survivors surrendered by dissociating during labor and delivery to cope with the invasion of their bodies.^{8,33,34} Many women described this as an out-of-body experience during which they watched their captive bodies being controlled during childbirth.^{8,23} The participants in Halvorsen et al.’s²³ study stated that they felt like “passive object[s] instead of a participant”^(p186) during their deliveries and credit their dissociation to believing that they were simply obstacles in the way of the baby’s birth. These symptoms of dissociation and emotional numbing are considered avoidance symptoms of post-traumatic stress disorder.^{8,34} Birth attendants often interpreted surrender as giving-up or an inability to deliver naturally, and began to employ medical interventions.

Retreating labor can also include dissociation. Women who employed this labor style appeared stoic, with flat facial expressions and affect.⁸ These women may also “retreat” by becoming disoriented to place and time and confusing labor and delivery with their trauma.⁸ Victims and survivors may assume childlike voices and protective body postures, such as the fetal position and protecting themselves with bed sheets, as they experience intrusion symptoms of PTSD.^{8,34}

Postpartum Care

Triggers that affect new mothers’ abilities to cope with their history of trauma and the challenges of motherhood can also afflict the postpartum period. Having a newborn baby at home can also equate to the loss of control experienced by women during their assault.²² Helping women to heal from their trauma and/or subsequent re-traumatization before or during the postpartum period can lead to healthier maternal outcomes in the care of newborns.

Physical Triggers

Physical touch of breasts through provider manipulation and breastfeeding was frequently reported as triggering by survivors and victims.^{33,34} In Seng et al.’s study, women considered their re-traumatization through breastfeeding to be detrimental to early motherhood. One woman stated, “I was really looking forward to the cuddling time with the baby and breast feeding ... I didn’t expect this whole other ugliness.”^{21(p367)}

The daunting task of learning how to breastfeed in the period after labor served as a mode for women to relive their trauma.^{11,22,25} Similar to physical triggers discussed under the previous three sections, health care providers assumed consent when instructing new

mothers on breastfeeding techniques and subsequently triggered them to have a post-traumatic stress reaction.¹¹

Situational Triggers

Loss of control concerning women's bodies after childbirth and the bodies of their newborns was a common theme throughout the postpartum re-traumatization literature. Loss of control associated with breastfeeding served as a trigger for some women.²⁵ A respondent in Montgomery et al.'s qualitative study stated in relation to the needs of her nursing newborn, "I felt that immense feeling of being controlled by someone else."^{25(p4)} Some victims and survivors were triggered by the care of their newborns by medical staff without their consent.²⁵ For example, several respondents in Montgomery et al.'s study referred to the staff feeding their babies formula milk without their knowledge and consent and discussed how this paralleled with the loss of control during their sexual trauma.²⁵ Examination of newborns without consent or explanations of procedures, examining newborns away from the mothers, and performing genital exams of newborns were all reported as triggering for victims and survivors due to loss of control over the protection of their child.¹¹

Signs and Symptoms

A common complaint of victims and survivors of sexual trauma during the early postpartum period was of feeling "dirtied."²³ After being re-traumatized by the high volume of invasive procedures and physical touch associated with childbirth, these women felt as if their bodies had been re-invaded and reported feelings of violation similar to that experienced after their sexual trauma.²³ New mothers reported an immediate need to wash themselves after delivery.²³ One woman in Halvorsen et al.'s qualitative study commented

that “everything had to be washed away ... all the hands that had been there, had to go.”^{23(p186)} These women also complained of these “dirtied” feelings persisting into the late stages of the postpartum period and served as an obstacle to adjusting to new motherhood.²³ If re-traumatized, some women experienced impairments in many interpersonal relationships, which negatively affected motherhood the family structure as a whole.^{34,36}

Some women reported feeling immense panic, helplessness, shame, humiliation, and grief during or shortly after breastfeeding consultations with medical staff.¹¹ Some women, especially those who were sexually traumatized as children, even reported being concerned that pediatricians were going to sexually assault their newborns.¹¹ If providers conducted routine postnatal checks without first consulting the mother, women reacted with feelings of powerlessness and the inability to protect their children as they were unable to protect themselves during their trauma.¹¹

Victims and survivors were at risk of developing posttraumatic stress symptoms through postpartum care. In fact, women with a history of sexual trauma in childhood exhibited higher levels of arousal symptoms and higher levels of dissociation symptoms than women with no history of trauma and women with a history of non-sexual trauma. A respondent in Seng et al.’s³⁴ study described her intrusion symptoms while breastfeeding as “the *physical manifestations* of the incident”^(p608) in reference to her previous sexual trauma. Victims and survivors of sexual trauma were also at risk of developing postpartum depression as a comorbidity to their PTSD.³⁴

Best Practices

The literature reviewed for this study provided a diverse range of provider recommendations for the prevention and intervention of re-traumatization of sexual trauma in women's reproductive healthcare, with one overarching theme standing out: patient-provider relationships.^{1,25,31,34} Improving the patient-provider relationship into a relationship that is based on open, honest communication and mutual trust could greatly help to improve the healthcare of women with histories of sexual trauma.

Julia Seng and Jane Hassinger¹⁵ co-authored a publication discussing the improvement of maternity care with survivors of childhood sexual abuse. When summarizing their suggestions for health care providers, they organized their suggestions for interpersonal practice into three categories: egalitarian work, exploring meaning, and framing and boundaries. This categorization will be applied here to organize the best provider recommended best practices. "Egalitarian work" will recommendations concerning respect of patients' self-protection and loci of control. The "exploring meaning" subgroup will include consideration of post-traumatic stress disorder secondary to sexual trauma as the underlying cause of signs and symptoms presenting during women's reproductive healthcare and opportunities for healing. Lastly, "framing and boundaries" will contain recommendations that focus on mutual respect for the victims' or survivors' founded fears and anxiety about reproductive health care and providers' preferred health care practices.

Egalitarian Work

The following recommendations are provided to prevent victims and survivors from feeling like they have lost control of their reproductive healthcare reminiscent to the loss of control experienced through their sexual traumas. Providers can collaborate with victims

and survivors during procedures by showing the patient the equipment they are using, describing procedures, and explaining the necessity of the procedure to the patient.^{11,14,27}

Providers should ask the victim or survivor how they can tailor procedures and examinations to the patient's comfort level, ensuring the patient maintains a locus of control by engaging in exams (e.g., using mirrors during procedures).^{11,25,32}

Providers should maintain eye contact when speaking with or touching the patient.²³ Providers should never assume consent for procedures or touch of patients or newborns.^{11,23} Birth attendants can describe standard hospital procedures for labor and delivery and should discuss possible medical interventions used during labor before the victim or survivor reports for labor and delivery.²⁷ Preparing expecting mothers with histories of sexual trauma for the likelihood of a difficult labor and delivery could aid in the prevention of posttraumatic symptoms and the success of natural birth ^{22,37}. Birth attendants can also encourage patients to make birth plans prior to reporting for labor and delivery.⁸

Providers should never discourage their patients from maintaining control, and should support victims and survivors to "take charge" as suggested by Roller's study.¹² This could include switching to a different women's health care provider if the victim or survivor feels triggered by their current provider.

Exploring Meaning

Universal screening of all patients is integral to the normalization of discussing sexual trauma in healthcare settings.¹⁴ From a preventative standpoint, being aware of a woman's history of trauma would greatly help providers avoid re-traumatizing their patients. Robohm and Bittenheim¹⁴ found that an overwhelming majority of the victims

and survivors in their study sample wanted to be asked about their sexual trauma history, contradicting the belief of some providers that patients resent physicians who bring up sexual assault. Survivors sought out reproductive healthcare providers who used interdisciplinary approaches to focus on posttraumatic growth along with reproductive health.²¹

If a victim or survivor discloses to her reproductive healthcare provider, providers should ensure that patients are aware of beneficial community services and support.¹¹ Providers should make every effort to build their patients' confidence in the provider's ability to work with victims and survivors of sexual trauma, through continuous screening and visual cues in the healthcare setting notifying patients of the opportunity to discuss sexually traumatic histories with their provider. Robohm and Buttenheim¹⁴ suggest that the treatment of posttraumatic stress disorder within the context of sexual trauma should be included in women's healthcare training curricula. However, the victim or survivor should be referred to a trauma-therapy professional, with her consent, if she needs treatment outside of the scope of reproductive healthcare.³²

Providers should encourage patients to stay focused on the task at hand when they appear to be experiencing intrusive thoughts, flashbacks, or dissociation during a procedure.^{8,23} One method for keeping patients grounded in the moment is to describe the sensations they are experiencing, such as describing a pelvic examination while conducting it or contractions during labor.⁸ Shortly after labor and delivery, some victims and survivors have reported the benefits of postpartum debriefing to discuss possible posttraumatic stress reactions during labor and any medical interventions employed during delivery. The purpose of this debriefing is to avoid arousal symptoms of PTSD

manifesting in the sense of shame during the early postpartum period by educating the new mothers on the physiological or psychological origins of their responses to labor and delivery.²³

Framing and Boundaries

Just as the trauma experiences of victims and survivors can be very diverse, triggers for these women can also vary. For example, one woman stated in an interview during Coles and Jones qualitative study¹¹ that men were triggers during her prenatal care experience as well as “lying flat on my back with my underwear off.”^(p233) A respondent in Montgomery et al.’s study²⁵ stated that penlights triggered her to experience flashbacks because her abuser would observe her genitals with a flashlight before assaulting her. With a trigger as unique as a concentrated bright light, a provider could easily replicate a victim or survivor’s trauma. While these examples may not be triggering for every survivor and victim a health care provider encounters, these women’s experiences with reproductive healthcare show that dialogue about triggers between providers’ and patients’ needs to be open and continuous.

Due to the previous violation of victim and survivor’s bodily boundaries, providers should minimize bodily manipulation as much as possible.^{8,23} Examinations should be stopped or slowed at the request of the patient, or should be done in response to patient distress.¹¹ If a patient does appear distressed during any procedure or examination, or during childbirth, the provider should validate that distress to prevent the victim or survivor from internalizing arousal symptoms through feelings of shame.²⁵

Providers should inform patients of the potentially triggering effects of anesthesia before administration. Birth attendants should respect the wishes of patients who want to

wash after birth in a timely manner.²³ Birth attendants should avoid placing patients in the supine position if possible, and all women's healthcare providers should respect patient wishes to stay clothed.^{8,23} Discussing expectations of labor and delivery during prenatal care can help dispel some fears while preparing victims and survivors for potential triggers associated with childbirth.²⁷

Conclusion

Victims and survivors of sexual trauma experience physical and situational triggers through their reproductive health care that often relate to loss of control, bodily manipulation, and the absence of consent. Women experiencing these triggers can exhibit post-traumatic stress symptoms reminiscent of those experiencing during or after their trauma due to re-traumatization. Providers can prevent and intervene in re-traumatization by building a trusting patient-provider relationship, ensuring that women's boundaries are respected through their health care interactions, and appropriately referring women to trauma-therapy professionals.

The potential for women to heal through their maternity care is worthy of mention. It is well documented in the literature that some victims of sexual assault made the transition into survivorhood through posttraumatic growth during the perinatal period.^{12,25,33} These women worked with their healthcare providers to ensure that their prenatal, labor and delivery, and postpartum care were a positive healing opportunity from their posttraumatic stress.² Some women reported increased confidence in their bodies and self-worth after delivering their children vaginally and spontaneously.²³ While this may not be the best choice for every victim and survivor, some may find this experience to be an empowering avenue for growth and healing from posttraumatic stress.

As demonstrated by this review, there are numerous manifestations of posttraumatic stress secondary to sexual trauma in women in reproductive health care and equally numerous avenues for health care providers to exacerbate those manifestations. Ultimately, a provider's best resource in the prevention and treatment of re-traumatization is their patient. Educating patients about the permeating and long-lasting effects of sexual trauma, compounded with a trusting relationship with health care providers, can help normalize the discussion of sexual trauma.³² If victims and survivors better understand the physiological origins of their distress and posttraumatic stress reactions regarding reproductive healthcare, they may be more likely to disclose their sexual trauma history.

As Leserman¹ discussed in her review of sexual abuse, remembering sexual trauma may be just as significant as the experience of trauma. Women may repress their memories of sexual trauma as a defense mechanism against posttraumatic stress, only to be remembered as "body memories".^{8,33} These memories can be triggered through reproductive healthcare, especially during prenatal care and labor and delivery, and are examples of the exceptions to consistent and education-based screening.⁸ Providers should make every effort to become well versed in the signs, symptoms, and needs of posttraumatic stress or they need to be prepared to refer women to the appropriate women's health care providers when they disclose sexual trauma or a history of sexual trauma is strongly suspected.

If the patient ultimately decides that she does not feel safe enough to disclose her traumatic history, even after building a trusting patient-provider relationship and being educated about the sequelae of sexual trauma, providers should still be alert to the signs and symptoms of posttraumatic stress and potential re-traumatization. Just as it was not

the victim's responsibility to defend herself from sexual assault, it is not the patient's responsibility to anticipate posttraumatic stress reactions to her reproductive healthcare.

Limitations and Future Directions

Women who do not participate in reproductive health care, such as postmenopausal women and girls from early childhood through adolescence, were not included in the context of this review. A more inclusive approach to reviewing the women's health care experiences of all women affected by sexual trauma would have increased the generalizability of this review. This review also largely focused on health care providers most likely to interact with a victim or survivor seeking reproductive health care, such as gynecologists and birth attendants. The role of providers in re-traumatization of sexual trauma in other settings of primary care should also be considered in future research.

While the provider recommendations found through this review are extensive, longitudinal studies are needed to better understand the feasibility of implementing these recommendations in clinical practice and how effective these practices are in patient recovery. Future exploration of the experiences of women with histories of sexual trauma in gynecological care is needed as evident by the small number of studies found for this review. Women's health care is often dominated by an obsession with the perinatal experience, which, while important to women's reproductive health, ignores the experiences of women with infertility, women who choose to remain nulliparous, and women's bodies independent of their fetuses or infants.

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Figures

	Qualitative	Quantitative	Review	Content Analysis	Total
Gynecological care	1 ²⁰	2 ^{12,26}	1 ¹⁶	0	4
Prenatal Care	4 ^{8,10,14,20}	1 ⁹	1 ¹¹	1 ²⁸	7
Labor and Delivery	6 ^{5,8,10,14,18,20}	1 ²²	0	1 ²⁸	8
Postpartum Care	4 ^{8,14,18,20}	2 ^{9,31}	0	1 ²⁸	7

Table 1. Number of studies coded to each category of women's reproductive health care.