



Trauma-informed Adaptations to Routine Gynaecological Care (RGC) of Women who have Experienced Sexual Violence: A Narrative Synthesis

Lisshammar, J.E.L; Knight, M.T.D. *University of Oxford; Oxford Health NHS Foundation Trust, Oxford, United Kingdom*



Introduction and Objectives

Sexual violence history (SVH) is associated with post-traumatic sequelae; up to 50% of women experience PTSD symptoms (Perez Benitez et al., 2009; Walsh et al., 2012). Retraumatisation may occur when accessing routine gynaecological care (Watson, 2016). Women with a SVH may therefore avoid gynaecological care (Farley et al., 2002). This study aimed to summarise RGC retraumatisation-risks and identify potential Trauma-informed care modifications.

Methodology

- Inclusion Criteria
- Full-text, peer-reviewed
 - English Language
 - Women aged 18+
 - Hx of sexual violence (SVH)
 - Accessing Routine Gynaecological Care (RGC)
 - Published 1993-2022

17 articles were eligible for inclusion.

The overall quality indicator ranged from 33% (lowest quality) to 100% (highest) ($M=81.64\%$, $SD= 15.21\%$, skewness= -2.07, kurtosis = 6.28).

100% employed a survey methodology.

Eligible articles were analysed using a Narrative Synthesis.

Results

Retraumatisation Triggers

Triggering aspects of RGC are individual and dependent on women's prior traumatic experiences.

Psychosocial aspects are highly dependent on original trauma events and should be explored with each woman.

Trauma triggers can include specific phrases ("this will soon be over", "just relax"), clinician appearance, voice, smell, mannerisms, and gender, as well as people appearing angry or rushed. It can also include examination aspects, such as the lithotomy position, metal objects, and lubricants.

Practical Triggers (Odds ratios; all $p < 0.001$) Women with vs without SVH	
Vaginal examination	136.71
Nudity and Undressing	12.87
Abdominal ultrasound	22.01
Conversations about "intimate" procedure details	3.32

Care Modifications

Women requested increased clinician familiarity – seeing the same clinician each time, and the use of name badges. having a dedicated conversation about retraumatisation triggers and resulting care modifications would be most helpful. This care plan would be recorded in clinical notes for future reference. This requires clinicians to ask about SVH as routine, and be prepared to extend the appointment. The plan would be updated for each new procedure.

Prevalence of SVH and RGC impact in numbers: An overview

12.3-93.3% ($M=45.28$, 29.4)

Women reported a history of sexual violence

73.3%

Clinicians who estimated single-digit prevalence

2-68.9% (Med. = 7%)

Women who had ever disclosed to a clinician

0.001-19% (Median = 4%)

Women who had been asked about SVH.

48- 96.5% (Mean = 81.33, SD = 20.41%)

Women who wanted to be asked about SVH.

12 825 Women
38.11 years mean age
61.8 – 99% White
15- 22% Black
8 – 18% Latina
3.8 – 16.7% Other

Women with/without SVH who...

37.7% vs 3.5% ($p < .001$)

describe RGC as highly distressing

70.6% vs 87.6% ($p > .05$)

Continue to access RGC as needed

90% vs 49%

reported significant fear of pain accessing RGC

Women with SVH...

44% reported retraumatisation

55% of these experiencing dissociation

...when accessing RGC

Clinician characteristics

Clinicians communicating understanding of the impact of SVH, and expressing they are confident in caring for women who have experienced SVH, was reassuring to most women (70%). 60% of women also wanted clinicians to be trained in basic psychological de-escalation skills such as grounding and distraction techniques.

Most common negative experiences reported by Women with SVH in RGC	
Lack of control	52%
Powerlessness	43%
Feeling 'exposed'	38%
Feeling 'Like an object'	36%
Helplessness	19%

Conclusions

Articles reported an average SVH rate similar to the global average (40%) (Borumandnia et al., 2020). Disclosure was infrequent, and few women reported ever being asked about SVH by clinicians. Most wished to be asked.

Disclosure is an important foundation of trauma-informed RGC. Several women highlighted the power imbalance between clinician and patient, which reminded them of the experienced loss of power in the original sexual violence trauma.

Clinician awareness of their female patients' SVH facilitates trauma-informed care. There are several ways clinicians can make care more trauma-informed; particularly, through open dialogue with the patient, increasing knowledge and confidence on the topic, and by discouraging a complementary patient-practitioner relationship. Conversations about SVH should occur as routine.