The RINJ Foundation

Nurse Practitioner - Dealing With Rape Survivors
Pre-Intake Study

Symptoms and Signs -- Rape may result in the following:

- Extragenital injury
- Genital injury
- Psychologic symptoms
- Sexually transmitted diseases (STDs—eg, hepatitis, syphilis, gonorrhea, chlamydial infection, trichomoniasis, HIV infection [rarely])
- Pregnancy (uncommonly)

Most physical injuries are relatively minor, but some lacerations of the upper vagina are severe. Additional injuries may result from being struck, pushed, stabbed, or shot.

Psychologic symptoms of rape are potentially the most prominent. In the short term, most patients experience fear, nightmares, sleep problems, anger, embarrassment, shame, guilt, or a combination. Immediately after an assault, patient behavior can range from talkativeness, tenseness, crying, and trembling to shock and disbelief with dispassion, quiescence, and smiling. The latter responses rarely indicate lack of concern; rather, they reflect avoidance reactions, physical exhaustion, or coping mechanisms that require control of emotion. Anger may be displaced onto hospital staff members.

Friends, family members, and officials often react judgmentally, derisively, or in another negative way. Such reactions can impede recovery after an assault.

Eventually, most patients recover; however, long-range effects of rape may include posttraumatic stress disorder particularly among women. PTSD is an anxiety disorder; symptoms include re-experiencing (eg, flashbacks, intrusive upsetting thoughts or images), avoidance (eg, of trauma-related situations, thoughts, and feelings), and hyperarousal (eg, sleep difficulties, irritability, concentration problems). Symptoms last for > 1 mo and significantly impair social and occupational functioning.

Evaluation

Goals of rape evaluation are

- Medical assessment and treatment of injuries and assessment, treatment, and prevention of pregnancy and STDs
- Collection of forensic evidence
- Psychologic evaluation
- Psychologic support

If patients seek advice before medical evaluation, they are told not to throw out or change clothing, wash, shower, douche, brush their teeth, or use mouthwash; doing so may destroy evidence. Visit https://RINJ.org/rape/

Whenever possible, all people who are raped are referred to a local rape center, often a hospital emergency department; such centers are staffed by specially trained practitioners (eg, sexual assault nurse examiners [SANE]). Benefits of a rape evaluation are explained, but patients are free to consent to or decline the evaluation. The police are notified if patients consent. Most patients are greatly traumatized, and their care requires sensitivity, empathy, and compassion. Females may feel more comfortable with a female physician; a female staff member should accompany all males evaluating a female. Patients are provided privacy and quiet whenever possible.

A form (part of our rape kit) is used to record legal evidence and medical findings (for typical elements in the form; it should be adapted to local requirements. Because the medical record may be used in the ICC or a local court, results should be written legibly and in nontechnical language that can be understood by a jury.

PTSD

Posttraumatic stress disorder (PTSD) is recurring, intrusive recollections of an overwhelming traumatic event; recollections last > 1 mo and begin within 6 mo of the event. The pathophysiology of the disorder is incompletely understood. Symptoms also include avoidance of stimuli associated with the traumatic event, nightmares, and flashbacks. Diagnosis is based on history. Treatment consists of exposure therapy and drug therapy.

When terrible things happen, many people are lastingly affected; in some, the effects are so persistent and severe that they are debilitating and constitute a disorder. Generally, events likely to evoke PTSD are those that invoke feelings of fear, helplessness, or horror. These events may be experienced directly (eg, as a serious injury or the threat of death) or indirectly (eg, witnessing others being seriously injured, killed, or threatened with death; learning of events that occurred to close family members or friends). Combat, sexual assault, and natural or man-made disasters are common causes of PTSD.

Lifetime prevalence approaches 9%, with a 12-mo prevalence of about 4%.

PTSD Symptoms and Signs

Most commonly, patients have frequent, unwanted memories replaying the triggering event. Nightmares of the event are common. Much rarer are transient waking dissociative states in which events are relived as if happening (flashback), sometimes causing patients to react as if in the original situation (eg, loud noises such as fireworks might trigger a flashback of being in combat, which in turn might cause patients to seek shelter or prostrate themselves on the ground for protection).

Patients avoid stimuli associated with the trauma and often feel emotionally numb and disinterested in daily activities.

Sometimes symptoms represent a continuation of acute stress or they may occur separately, beginning up to 6 mo after the trauma. Sometimes full expression of symptoms is delayed, occurring many months or even years after the traumatic event.

Depression, other anxiety disorders, and substance abuse are common among patients with chronic PTSD.

In addition to trauma-specific anxiety, patients may experience guilt because of their actions during the event or because they survived when others did not.

Diagnosis

- Clinical criteria

Diagnosis is clinical based on criteria in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).

To meet the criteria for diagnosis, patients must have been exposed directly or indirectly to a traumatic event and have symptoms from each of the following categories for a period ≥ 1 mo.

Intrusion symptoms (≥ 1 of the following):

- Having recurrent, involuntary, intrusive, disturbing memories
- Having recurrent disturbing dreams (eg, nightmares) of the event
- Acting or feeling as if the event were happening again, ranging from having flashbacks to completely losing awareness of the present surroundings)
- Feeling intense psychologic or physiologic distress when reminded of the event (eg, by its anniversary, by sounds similar to those heard during the event)

Avoidance symptoms (≥ 1 of the following):

- Avoiding thoughts, feelings, or memories associated with the event
- Avoiding activities, places, conversations, or people that trigger memories of the event

Negative effects on cognition and mood (≥ 2 of the following):

- Memory loss for significant parts of the event (dissociative amnesia)
- Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world
- Persistent distorted thoughts about the cause or consequences of the trauma that lead to blaming self or others
- Persistent negative emotional state (eg, fear, horror, anger, guilt, shame)
- Markedly diminished interest or participation in significant activities
- A feeling of detachment or estrangement from others
- Persistent inability to experience positive emotions (eg, happiness, satisfaction, loving feelings)

Altered arousal and reactivity (≥ 2 of the following):

- Difficulty sleeping
- Irritability or angry outbursts
- Reckless or self-destructive behavior
- Problems with concentration
- Increased startle response
- Hypervigilance

In addition, manifestations must cause significant distress or significantly impair social or occupational functioning and not be attributable to the physiologic effects of a substance or another medical disorder.

PTSD Treatment

- Exposure therapy or other psychotherapy, including supportive psychotherapy
- SSRI or other drug therapy

If untreated, chronic PTSD often diminishes in severity without disappearing, but some people remain severely impaired.

The primary form of psychotherapy used, exposure therapy involves exposure to situations that the person avoids because they may trigger recollections of the trauma. Repeated exposure in fantasy to the traumatic experience itself usually lessens distress after some initial increase in discomfort.

Eye movement desensitization and reprocessing (EMDR) is a form of exposure therapy. For this therapy, patients are asked to follow the therapist's moving finger while they imagine being exposed to the trauma.

Stopping certain ritual behaviors, such as excessive washing to feel clean after a sexual assault, also helps.

Drug therapy, particularly with SSRIs, is effective. Prazosin

appears helpful in reducing nightmares. Mood stabilizers and atypical antipsychotics are sometimes prescribed, but support for their use is scant.

Because the anxiety is often intense, supportive psychotherapy plays an important role. Therapists must be openly empathic and sympathetic, recognizing and acknowledging patients' mental pain and the reality of the traumatic events. Therapists must also encourage patients to face the memories through desensitizing exposure and learning techniques to control anxiety. For survivor guilt, psychotherapy aimed at helping patients understand and modify their self-critical and punitive attitudes may be helpful.