Treatment For Rape Victims
In Catholic Health Facilities

Part Three: Present Possibilities and Directions for Research

The position has been made in the previous two articles of this series that Catholic health facilities can give valuable service to rape survivors, especially in light of their need for compassion, understanding and concern. While the liability threat to the hospital for not treating with abortifacients may have kept some Catholic facilities from treating such victims in the past, we have taken the position that in light of conscience clauses this no longer need be the case. We also have emphasized that in addition to the concern for the abortifacient effects that have kept Catholic facilities from prescribing it in the past, there are also teratogenic and carcinogenic implications of diethylstilbestrol, the commonly prescribed of such interceptive pregnancy prophylaxis for rape victims in the past.

Few Rape-Induced Pregnancies

All exaggerated claims of pro-abortionists to the contrary, one would expect relatively few rapes to result in pregnancy. The probability that any rape would occur during the woman’s fertile period is mathematically less than one out of five, so it follows that the highest probability of a rape-induced pregnancy would be about 20% even if all the women raped were of reproductive age and were otherwise free of infertility factors such as blocked tubes. But about 50% of rape cases involve oral or anal sex, so this would lower the probability to 10%. However, about 75% of rapists experience sexual dysfunction during rape (A. Nicholas Groth and Ann Wolbert Burgess, “Sexual Dysfunction During Rape,” New England Journal of Medicine, Vol. 297, No. 14, October 6, 1977, p. 765). Even 20% of married couples of reproductive age are infertile in spite of attempts to have a child. Also many rape survivors of reproductive age are infertile due to such factors as sterility from surgery (tubal ligations) and venereal disease, contraceptives, or are already pregnant. Such factors of infertility would be expected to lower the probability for pregnancy from rape even more. Actual studies confirm what was logically established in the discussion above. Many extensive studies of women not sexually active before a rape experience have found that no or few rape-induced pregnancies resulted. (Basile I. Uddo, “On Rape: Incest and the Right to Life”, Human Life Review, Summer, 1984, Volume X, No. 3, p. 58).

While it is obvious from this brief review that very few rapes end in pregnancy, still, even one such pregnancy is a tragedy. Also, the victim’s fear of pregnancy is real, and licit treatment that can alleviate such anxiety (and even slightly lessen the probability of pregnancy) should be considered. For these reasons and for the prevention of venereal disease, a spermicidal douche may be given, though the patient should be informed of the unlikeliness of any pregnancy-preventing action from the douche — as discussed in Part One of this series. In light of the fact, emphasized in this series, that non-abortifacient anti-fertility treatments of the rape survivor are viewed as morally acceptable, research for such agents should be encouraged and the possibility of using presently available agents in an exclusively anti-fertility (non-interceptive) way should be explored. In the hope of furthering such an effort, the following information and reflection are presented.

Methods That Delay Ovulation:
Present Value and Future Hope

Fertility experts place the risk of conception as approaching zero for intercourse between the second day after ovulation (day 16 in a “normal” cycle) and the second day following the onset of menstruation, or day 2 of the following cycle. While this more secure period includes approximately sixteen infertile days (“safe days”), a more realistic infertile period may extend in some instances to even twenty infertile days. Individual variations in ovulation times and in sperm viability, however, result in situations where anovulants to prevent fertilization following rape might well be medically prescribed. This is morally acceptable so long as there is no interference with nidation.

Fertility experts suggest (or recommend) that emergency room staff may obtain a quick estimate of the cycle day by combining information the rape survivor supplies (how long since her last menstruation) with the results of the dipstick test and/or the serum test for urinary LH. The results of the dipstick test may be available within two hours, while the blood serum test takes about six hours. If the woman is married or is otherwise sexually active and the possibility of pregnancy cannot be ruled out on the basis of age, sterility, contraceptives, IUD, etc., testing for pregnancy is a serious moral obligation.

The reasons for prescribing any anovulant early in the cycle (2nd-8th day) include the remote possibility that the rapist’s sperm may be viable for a longer period (over three days) and/or that ovulation might also be earlier than expected. The probability of this occurring is not known, but there is a slight possibility of pregnancy from rape this early in the cycle. For example, a woman raped on the sixth day of her cycle and ovulating on the twelfth day might become pregnant in a rare case where the sperm lived six days. Obviously, the longer the sperm are viable and the earlier in her cycle the individual ovulates the greater the possibility that rape on the sixth day of

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the cycle will result in pregnancy. Other combinations of early ovulations and long sperm life could occur that might be expected to result in a pregnancy from such early-cycle rape.

We need to keep in mind that there are three principal variables for any survivor: 1) the time in her cycle at which the rape occurs, 2) ovulation time, and 3) sperm viability. A second group of important variables that need to be observed or otherwise determined include the presence of sperm (absent in 50% of rapes), age, contraceptives or preventative such as the IUD. Pregnancy preventions would not be indicated for most rapes in consideration of these variables alone.

While estrogen in any dosage given from the second day of the cycle would be anovulant, a low dose combination oral contraceptive has been recommended for rape this early in the cycle. Such a regimen would be expected to prevent ovulation but not implantation. These medications will probably not inhibit ovulation if they are started after day 8 of the cycle, though some authors extend this period to day ten. Certainly the increasing probability of pregnancy from coitus from day 2 of the cycle up to the time of ovulation, together with the strong possibility that the typical low dose estrogens or combination pill are anovulant up to day 8 (or even day 10) makes their use in the treatment of rape victims during this period seem medically sound and morally acceptable. Their use would also be a reassurance to the rape survivor.

Progesterone, or a single dose of prolactin, are sometimes prescribed as anovulants in the treatment of rape victims when the attack is later in the cycle (after the 8th day). There is some inconclusive evidence that D-Norgestrel (dNG) can delay or inhibit ovulation when used in mid-cycle. The anovulants cited above and many others, such as the GnRh antagonists presently available (as a nasal spray in Europe), may be expected to give protection in at least some of the cases of rape from the eighth day of the cycle.

Medically, these are mere possibilities which have been raised in a rather extensive study of pregnancy prophylaxis by Dr. Charles Cavagnaro (Pregnancy Prophylaxis in the Treatment of Rape Victims — A Review for Catholic Health Care Professionals, unpublished). From the eighth day to ovulation is, medically, a controversial period for the prescribing of anovulants. Some authors hold that a high dosage of estrogens and progesterone (25-50 times that prescribed during the early phase) are effective anovulants during this time.

Other Directions for Research

The period between ovulation and the time when the egg is no longer open to fertilization, 24-48 hours later, would also be open to licit intervention. Another area of licit intervention is indicated by in vitro fertilization studies. These studies indicate a lapse of about ten hours between the contact of spermatozoa and ovum, and the fusion of their pronuclei. Also, methods to stop or prevent the steps of sperm capacitation, the acrosomal reaction, or spermatozoal penetration of the ovular investments leading to actual fertilization, would be morally permissible. The possibility of developing interventions up to and including these final steps of fertilization has been pointed out by Dr. Cavagnaro in the study cited above. Such research would offer hope for additional licit intervention and is certainly to be encouraged. Presently, however, there are no proven, reliable, safe methods to achieve these particular interventions.

Conclusion

Almost 80,000 rapes were reported in the United States in 1983. A recent study in St. Louis indicated that in 1984 only half of the rapes in that city were actually reported. Experts agree that most rapes go unreported with estimates indicating that the actual number of rapes may be anywhere between three and ten times the reported number. Catholic hospitals' commitment to Christ's own ministry to those who suffer calls them to provide caring support for these rape survivors. Policies, protocols and procedures developed for the treatment of rape victims should reflect this concern for the victim as well as any innocent new life that might result from this heinous crime.

Lloyd W. Hess, Ph.D.