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"It was the Best of Times, It was the Worst of times:" The Lived Experience of Childbearing from Survivors of Sexual Abuse

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ABSTRACT

The adverse pregnancy outcomes associated with a history of sexual abuse, combined with the alarmingly high prevalence of sexual abuse, illustrate the need for research to understand survivors' childbearing experiences. One in every five women will experience sexual violence in her lifetime. Research has demonstrated that survivors are at higher risk for more difficult pregnancies, substance abuse during pregnancy, greater stress and fear, and preterm deliveries. A history of sexual abuse can impact all aspects of a woman's pregnancy and childbirth, thereby affecting her long-term physical and emotional wellbeing.

The purpose of this study was to understand the lived experience of childbearing, including both pregnancy and labor and delivery events, from survivors of sexual abuse. A qualitative, descriptive phenomenological research design was utilized. The purposeful sample included eight participants who were all female, self-identifying survivors of sexual abuse with at least one childbearing experience. Six participants engaged in semi-structured interviews. One participant shared her experiences via email, and one participant via a telephone interview. Colaizzi's (1978) method was followed and resulted in 302 significant statements, which formed seven overarching themes.

The final result was the essence of the childbearing experience for survivors' of sexual abuse. Survivors were not screened for a history of sexual abuse. Enjoyment and excitement were juxtaposed with guilt and fear at various moments of pregnancy, and labor and delivery. Survivors had no voice and lacked support. They overwhelmingly desired control. They experienced an innate need to protect their children from harm, from infancy into adulthood. For survivors of sexual abuse, the childbearing experience is a complex, emotional roller coaster, permeated by the past. Women's healthcare providers can utilize the results of this study to provide safe, therapeutic care to survivors to prevent re-victimization during childbearing. The results make clear the importance of screening women for a history of sexual abuse and discussing the connections such a history could have on the childbearing experience.

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Pregnancy is a time of monumental change for women – a time when the past, present and future all come together, a time of openness, a time of vulnerability. Being pregnant causes memories of one's own childhood to surface. Past events are stirred up. The present evokes the paradox of excitement over the baby on the one hand, and fears and anxiety on the other. (Simkin & Klaus, 2004, p. 33)

Chapter One: Introduction

In chapter one, the research study, '"It was the Best of Times, It was the Worst of times:' The Lived Experience of Childbearing from Survivors of Sexual Abuse" is introduced. Childbearing includes the events of both pregnancy, and labor and delivery. The background section contains substantial statistical information regarding the prevalence of sexual abuse. This section also highlights both the historical and the current social context of sexual abuse. The significance section explores the long-term sequela of sexual abuse, specifically the adverse consequences this history can have on the childbearing experience. The chapter concludes with my call to this area of research and the purpose of the study.

Background

The prevalence and consequences of sexual abuse are staggering. One in every five women will experience sexual violence in her lifetime (Black et al., 2011). The Centers for Diseases Control and Prevention (CDC) (2011) present a clear stance that "sexual violence against girls is a global human rights injustice of vast proportions with severe health and social consequences" (webpage). Sexual violence is defined as

> any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus

with a penis, other body part or object. (World Health Organization, 2014, Fact Sheet #239)

The knowledge that numerous women are affected by such heinous crimes demands the attention of society and researchers alike. Survivors have unique needs that must be addressed by healthcare providers so they may continue to lead healthy, productive lives in the context of their pasts.

In the United States, women experience sexual violence at a disturbing rate. The CDC's ongoing national intimate partner and sexual violence survey reports that 18.3% of women, nearly one in five women, have been raped at some point in their lives (Black et al., 2011). A meta-analysis of the worldwide prevalence of sexual abuse revealed that in the United States, 201 per 1000 girls experience childhood sexual abuse (Stoltenborgh, van IJzendoorn, Euser, & Bakermans-Kranenburg, 2011). The global prevalence of childhood sexual abuse is 11.8%, making the U.S. prevalence nearly double this globe rate (Stoltenborgh et al., 2011).

In the U.S., someone is sexually assaulted every two minutes and as many as 90% of the victims are female (Rape, Abuse, Incest, & Neglect Network, 2009). One-third of women will be affected by sexual violence, which includes intimate partner violence, trafficking, prostitution, assault, and/or exploitation and the long-term sequelae of this violence can be staggering (Luce, Schrager, & Gilchrist, 2010). The alarmingly high prevalence of sexual violence against women illustrates the importance of understanding survivors' healthcare experiences. For the purposes of this research, survivors' childbearing experiences will be explored.

To begin, it is essential to address the lack of societal progression toward raising awareness about survivors of sexual abuse and their unique needs. The following section will present the historical context of sexual abuse and then move to the more current societal views

surrounding sexual abuse. In the significance section, the specific consequences of sexual abuse on the childbearing experience will be explored.

Historical Context: Freud on Hysteria

In the late nineteenth and early twentieth centuries, Freud's work, especially treating women diagnosed with hysteria was evolving. Freud's thinking and psychoanalytic work addressed the notion of sexual abuse. He explained that women had dissociative states

> because the actual *content* of those memories and feelings was disturbing, unacceptable and in conflict with the rest of the person's ideas and feelings. It was not that they just happened to be recorded in a different way, to have fallen into a different part of the patient's mind – they were incompatible with the rest of consciousness and were therefore actively kept out of awareness. (Mitchell & Black, 1995, p. 4-5)

Freud believed that hysteria and memories of childhood sexuality must be linked back to an actual history of a sexual encounter (Mitchell & Black, 1995). This belief lead to his hypothesis on infantile seduction: "If the memories of childhood sexuality were systemically peeled back to their troublesome core, they were invariably connected to an actual sexual encounter of one sort or another" (Mitchell & Black, 1995, p. 11).

Freud was at the forefront of psychoanalytic thought and the first to publish and discuss the topic of early childhood sexual encounters. Freud made great progress uncovering that the roots of hysteria in women were early, and presumably unwanted, sexual encounters (Herman, 1997). Freud however negated these findings when he refuted his own theory (Herman, 1997). Freud's writings on this matter indicate that he was "troubled by the radical social implications of his hypothesis. Hysteria was so common in women that if his patients' stories were true, and if his theory were correct, he would be forced to conclude that what he called 'perverted acts

against children' were endemic" (Herman, 1997, p.14). Consider for a moment that if Freud had continued his work and brought to light these private atrocities which were occurring in the homes of the privileged and the impoverished alike, society would not just be acknowledging the prevalence of these hidden crimes today in the 21st century. Progress toward raising public awareness would be a century ahead in its efforts. However this progression has not occurred. Freud perceived that society was not ready for the social implications of the prevalence and repercussions of childhood sexual abuse. Herman (1997) further posits,

> The real conditions of women's lives were hidden in the sphere of the personal, in private life. The cherished value of privacy created a powerful barrier to consciousness and rendered women's reality practically invisible. To speak about experiences in sexual or domestic life was to invite public humiliation, ridicule, and disbelief. Women were silenced by fear and shame, and the silence of women gave, license to every form of sexual and domestic exploitation. (p. 28)

Freud's publications on the "discovery of childhood sexual exploitation as the roots of hysteria crossed the outer limits of social credibility" and further ostracized him (Herman, 1997, p. 18). Instead of moving forward with his discovery, Freud began explaining women's behaviors as sexual drives, not as the repercussions of sexual abuse he had first theorized.

Dora, one of Freud's (1963) prominent case studies, marks the shift in his thinking from sexual abuse as the cause for hysteria to his more well known theory that hysteria arose from women's sexual desires and drives. The case centers on the plight of an adolescent client Dora, brought to therapy by her father, who was using her as a pawn in his own extramarital affair. The case alludes to the fact that Dora's father was offering Dora to the husband of the mistress he had taken. In the case study, Freud blatantly ignores Dora's classic presentation of having

suffered from sexual abuse. Freud turns each of Dora's somatic and psychological complaints into issues arising from her own sexual desires. "Freud refused to validate Dora's feelings of outrage and humiliation. Instead he insisted upon exploring her feelings of erotic excitement, as if the exploitative situation were a fulfillment of her desire" (Herman, 1997, p. 14). Dora eventually leaves treatment on her own, presumably because she was not being validated with her actual experience.

Freud would have stood out at the helm of the discussion of childhood sexual abuse and the manifestation of such abuses later in a woman's life, if he had not turned away from his original theory on hysteria being caused by unwanted, early sexual encounters.

Current Social Context

After Freud turned his attention away from sexual abuse as the root of hysteria, it would take until the 1970s, when the feminist movement gained momentum, for women's experiences to be heard (Herman, 1997). The prevalence of sexual abuse is still alarmingly high today, despite the increased awareness by the feminist movement that crimes against women and children were taking place in the homes. Over the past 44 years, the long-term sequelae of childhood sexual abuse has been prominently published and brought into the public's awareness. However, the reaction has been abysmal, begging the question: Is society still not ready to "know" the truth?

Survivors require and deserve support from their communities in order to heal from their pasts. In the United States in the year 2014, far too often women are still perceived as "having asked for it" when they report a rape or sexual assault. The public's treatment and response to survivors when they report the abuses they suffered prevent more women from coming forward; therefore survivors are being silenced and justice is being obstructed. For example, when a 16-

year-old girl from Steubenville, Ohio was raped by two male peers in August 2012, a national conversation was stirred regarding rape. The case garnered public attention in the Spring of 2013 when the two male perpetrators went on trial. The news media CNN (Cable News Network) has faced sharp criticism for its handling of the case. A news report centered on the disappointment over the ruined athletic careers of the perpetrators and never once mentioned the potential life long suffering that the survivor faced given the crimes committed against her (Shapiro, 2013). Further reports centered on the fact that she was only penetrated digitally. It is imperative to recall that the World Health Organization (2014) defines sexual violence as any unwanted sexual act by any body part or object. The crime in Steubenville was an act of sexual violence; it was rape.

Furthermore, as a society, until we can recognize that our children's lives and early beginnings set the precedent for future generations, and that if we do not stop the cycle of violence now, we will be forever encircled in it, we cannot move forward. As Siegel (2003) poignantly summarizes,

> Our role in treating individuals with unresolved trauma clearly has important implications for the next generation. Attachment research has pointed the way to the idea that if an individual has unresolved trauma or grief, conditions we know are treatable, then we need to lend ourselves to facilitating the individual's innate healing process so that we can try to help not only this generation, but also the well-being of future generations. (p. 53)

Herman (1997) additionally points out that society must come together and raise awareness of the crimes suffered by women and children in their own homes, and no longer turn a blind eye.

As a society, we must support survivors in their disclosures and care for them throughout their recovery process. Awareness of the issue alone does not promote justice for women.

Significance

Pregnancy and childbirth represent a distinctive part of a woman's lifecycle that are intrinsically linked to her overall physical and emotional health (Schwerdtfeger & Wampler, 2009). Childbearing has been identified as one of women's strongest learning experiences (Belenky, Clinchy, Goldberger, & Tarule, 1997). The experience can potentially be negatively affected by a fear-mediated response due to past trauma, such as childhood or adult sexual abuse (Heimstad, Dahloe, Laache, Skogvoll, & Schei, 2006; Schwerdtfeger & Wampler, 2009). For example, a survivor shared,

> From my studies, I knew that rape could interfere with the birth process, but I thought I was so far past the intense pain of it and so far through the healing and so "aware and centered" that rape feelings would not hinder me. WRONG. When my water broke and the contractions began, the pain in my womb felt to me like the pain of forced penetration. It felt like rape. (Sperlich & Seng, 2008, p. 75)

The childbearing experience has the potential to be negatively affected by a past history of sexual abuse.

Overall, pregnancy and childbirth are vulnerable times in a woman's life. During these childbearing experiences, women undergo both physical and psychological changes. From a physical stand point; a woman's body undergoes significant alterations in order to nourish the fetus. Not only does her uterus grow as the pregnancy progresses, but also her blood volume nearly doubles, her gastrointestinal system slows, and her breast tissue increases in size. From a

psychological standpoint, she faces the task of adapting to these physiologic changes and to the lack of control she has over these changes. Women with a past history of sexual abuse can have a heightened vulnerability to these physical and emotional transformations. Specifically, survivors of sexual abuse stand to have adverse childbearing experiences due to their past histories.

A history of sexual violence puts women at risk for grave health consequences, such as anxiety and depression, sexually transmitted diseases, and gynecologic and pregnancy complications (Black et al., 2011; Kendall-Tackett, 2007). Specifically, women with a history of sexual abuse often manifest systems of chronic pelvic and/or abdominal pain (World Health Organization, 2014).

In the context of pregnancy complications, past research has demonstrated that survivors of sexual abuse have more difficult pregnancies and childbirth experiences than their counterparts due to an increased level of stress (Benedict, Paine, Paine, Brandt, & Stallings, 1999; Jacobs, 1992). "Negative life experiences, including childhood sexual abuse, may be associated with increased stress during pregnancy and/or may exacerbate pre-existing maternal symptomology" (Benedict et al., 1999, p. 659). Compared to women without a history of sexual abuse, "survivors reported longer labors, longer pregnancies, higher birth weights, more pregnancy terminations, earlier age at first pregnancy, more medical problems, greater stresses and more use of ultrasound during first pregnancies" (Jacobs, 1992, p. 103).

Furthermore, survivors of childhood sexual abuse are more likely to have a preterm delivery, which is a severe complication of pregnancy with long-term implications for the child (Leeners, Rath, Block, Görres, & Tschudin, 2014). Women with a history of sexual abuse are more likely to use tobacco and drugs during pregnancy, which can have severe consequences,

such as growth restriction and cognitive delays in their children (Leeners et al., 2014; Seng, Sperlich, & Low, 2008). These women are also more likely to have partners who abuse drugs and/or partners who emotionally, physically, or sexually abuse them currently (Leeners et al., 2014). In addition to depression, suicidal ideation is also significantly more common in survivors when compared to non-survivors (Leeners et al., 2014).

Women with a history of childhood sexual abuse also have impaired prenatal care experiences and therefore report feeling unprepared for labor (Leeners et al., 2013). Survivors of sexual violence are particularly vulnerable to fear throughout pregnancy, during labor and delivery, and postpartum (Coles & Jones, 2009; Eberhard-Gran, Slinning, & Eskild, 2008; Heimstad et al., 2006; Parratt, 1994; Schroll, Tabor, & Kjaergaard, 2011). The distress of survivors places them at higher risk for poor pregnancy outcomes (Yampolsky, Lev-Wiesel, & Ben-Zion, 2010). Potentially, a history of sexual abuse can affect all aspects of a woman's pregnancy and childbirth, thereby affecting her long-term physical and emotional wellbeing (Burian, 1995; Coles & Jones, 2009; Palmer, 2004; Parratt, 1994; Rhodes & Hutchinson 1994; Richmond, 2005; Seng, Sparbel, Low, & Killion, 2002; Schwerdtfeger & Wampler, 2009; Waymire, 1995). These adverse pregnancy outcomes associated with a history of sexual abuse combined with the alarmingly high prevalence of sexual abuse illustrate the need for research to understand the childbearing experiences of survivors.

Call to Research

As a practicing Certified Nurse Midwife (CNM), I have spent countless hours caring for women during their pregnancies and deliveries. Early on in my career, I cared for a patient who would come to define why I enrolled in doctoral studies and carried out this research study. Her

experience brought me first to tears, and then instilled in me a drive to improve the healthcare experience for survivors of sexual abuse.

I first met Lydia[1] when she presented to labor and delivery at a community hospital with a full term pregnancy. She was in her early twenties and this was her first pregnancy. Her mother and her sister arrived at the hospital with her, but the father of the baby was absent and uninvolved.

When I walked in to meet Lydia, her contractions were frequent at every five minutes apart, but were mild to palpation. I introduced myself and then kindly asked her family members to step out of the room in order to afford her privacy as I obtained her past medical history. After obtaining her history, I asked, as I always do, if she had ever experienced sexual violence in the past. She disclosed a history of a rape a few years prior and then stated that she did not want to discuss the topic any further. At this point, I acknowledged how difficult this must have been for her and that if at any time she felt that she needed to discuss how she was feeling, I was available. She again stated that she did not want to discuss the topic.

As I wrote up her admission history and physical note, I reviewed her prenatal chart and I was able to see that she had been screened and reported her history of rape. However, in her prenatal record, I was unable to find documentation of referral to therapy or discussion of the connection this history may have to her pregnancy and/or labor and delivery experience. I asked her if she had this discussion with a healthcare provider, and she said, no. I did my best, summarized what I routinely discuss over the course of several office visits with survivors of sexual abuse, and explained that labor and delivery had the potential to bring up repressed

[1] pseudonym

feelings of the abuse. She acknowledged what I was saying and then stated that she was fine, and again, did not want to discuss the topic.

As her labor progressed, it was clear that she was not "fine." Part of the assessment of a laboring woman involves exams to check for cervical dilation. I explained the procedure in depth, including the reason for needing to do the exam. She verbalized understanding, and I informed her we could stop the exam at any point. Despite my efforts to prepare her, she held her legs staunchly closed and retreated to the head of the bed. It took nearly twenty minutes before the exam was performed. Several times I would start the exam with her consent, but then she would need me to stop.

Even when medicated with an epidural, the pressure of the fetus descending into the birth canal was too much for Lydia. I distinctly recall her dissociative state. She was unable to tolerate even the fetal monitors, which were on her stomach. From my clinical perspective, she was struggling to regain control. Even though I explained the purpose of each intervention and engaged her as best I could in the labor and delivery process, it was too late. The process had not begun during her pregnancy. The conversation about the connections of her past history of sexual abuse to her childbearing experience had not been had. She was now in the moment, and there was limited opportunity to make up for lost time.

As the fetus was crowning, she refused to push for a full minute. As she had done during the vaginal examinations, she closed her legs, retreated to the head of the bed and refused to push. The safety of the fetus was a concern at this stage and fortunately, after a minute, she was able to reconnect to my voice and to relax her body enough to safely deliver her baby.

Throughout my 5 years of clinical practice as a full scope CNM attending births, I often reflected on this experience. Although Lydia did deliver a healthy baby vaginally, I could not

get past the fact that she had been re-victimized during this experience. Furthermore, it was a disservice to her that she was not referred to a counselor or given information about being a survivor. And then it dawned on me; there was limited information available on this topic. Moreover, I thought back to my own education and that of my colleagues. There is little, if any, training on the healthcare needs of survivors of sexual abuse.

The lack of universal screening for a history of sexual abuse, despite current recommendations to screen, combined with the limited information on caring for survivors perpetuates a state of re-victimization for women such as Lydia in the healthcare care setting. Women's healthcare providers specifically can help survivors during the childbearing experience. One purposed method is to understand these women's pasts and to create individualized and thoughtful plans of care for them (Lev-Wiesel & Daphna-Tekoa, 2007; Parratt, 1994; Rhodes & Hutchinson, 1994; Schwerdtfeger & Wampler, 2009). From my experience in the clinical setting and from the limited body of research on this topic, these plans of care are rarely being made for survivors. Caring for Lydia ignited the spark for this research.

Purpose

The purpose of this study was to understand the childbearing experience of survivors. The childbearing experience included both pregnancy, and labor and delivery events. The high prevalence of sexual abuse, as well as the long-term healthcare consequences of this violence, highlighted the need for this research study to qualitatively examine the childbearing experiences of survivors of sexual abuse.

Colaizzi's (1978) method of descriptive phenomenology was utilized for this study on the childbearing experiences of survivors of sexual abuse. Descriptive phenomenology aligns with

the purpose of the study in that I set out to understand the childbearing experiences of survivors. The method allows for participants to openly describe the essence of their experience. This method also allowed me to examine the phenomena as participants experienced it, and to let the research findings speak for themselves, without interpretation.

The study aimed to attain an understanding of the childbearing experience of survivors in order to improve care. The improvements made to caring for survivors will ultimately stand to provide more sensitive, individualized care. Healthcare providers are called to change the culture surrounding sexual abuse. For decades, the topic of sexual abuse has been "off limits" and the culture surrounding sexual abuse has been one of blame on the victim. Healthcare providers are called to challenge this culture of stigma and to break the silence on this issue. This study aims to open the dialogue by understanding the childbearing experiences of survivors. With an understanding of survivors experiences, concrete changes can be made to the way in which healthcare is delivered in order to provide safe, therapeutic care to survivors, preventing potential re-victimization in the healthcare setting.

Conclusion

In Chapter one, the research study, '"It was the Best of Times, It was the Worst of times:' The Lived Experience of Childbearing from Survivors of Sexual Abuse" was introduced. Statistical information regarding the prevalence of sexual abuse was discussed in the background section. Both the historical and the current social context of sexual abuse were also highlighted. The significance section explored the long-term sequela of sexual abuse on the childbearing experience. Lastly, the purpose of the study and a call to research was discussed.

Chapter two contains a systematic review of the literature on the childbearing experiences of survivors of sexual abuse. In chapter three, the method of inquiry, descriptive phenomenology and specifically the utilization of Colaizzi's method are described. The results of this research are presented in chapter four. Chapter five contains the clinical practice, research, and educational implications of the study, and discusses the research findings in relation to the review of literature.

> The memory of the violations during my childhood was locked in my birthing muscles for all these years, only recently coming to the surface of my conscious awareness. Such armoring can hinder the ability to open one's body, to trust that body really can work okay and be safe. It's hard to believe that intense sensations in that region of the body do not have to mean bad things are going to happen. (Rose, 1992, p. 216)

Chapter Two: Review of Literature

Introduction

Chapter two highlights the literature over the past 22 years related to the childbearing experiences of survivors of sexual abuse. The literature largely explores these experiences specifically from the perspective of survivors of childhood sexual abuse (CSA). The literature review is presented in the following categories: published qualitative research, doctoral dissertations and master's thesis, meta-synthesis, personal stories, and theoretical publications. The published qualitative studies, doctoral dissertations and masters' thesis on this topic are presented and summarized in Table 1. The remainder of chapter two contains the relevant literature on breastfeeding, fear of childbirth, recommendations for care, and trauma-informed care as each relates to survivors of sexual abuse. Lastly, a current perspective from psychology on the effects sexual abuse is offered.

Procedure

The literature review for studies on the childbearing experiences of survivors of sexual abuse was challenging because few studies have been published in this area. Several online databases, as well as multiple search terms, were necessary to complete the following comprehensive search.

An exhaustive search of the literature took place utilizing the following online databases: Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed, PsychINFO, Scopus, and Proquest Dissertations and Theses. The search was not limited by publication dates. The following keywords were used for this search: sexual abuse, sexual assault, sexual abuse survivor*, or sexual assault survivor* AND childbirth, childbearing, postpartum or pregnan*. Also, within PubMed and CINAHL, the specific keyword combinations of sexual abuse AND pregnan*; sexual abuse AND childbirth; sexual abuse AND postpartum; and primary care AND sexual abuse survivor* were used. Additional keywords used were: secondary traumatic stress and trauma informed care. During the literature review, the reference lists of identified articles were utilized to locate primary sources. These original articles were obtained using the journal locater of the University of Connecticut Homer Library website and ILLiad, the interlibrary loan service. For example, Waymire's (1995) unpublished master's thesis was not found via a formal literature search but instead in the reference list of her 1997 publication of a patient case. Additionally, two doctoral dissertations were found from the reference list of Montgomery's (2012) meta-synthesis (Garratt, 2008; Lasiuk, 2007).

Results

The exhaustive search as described above revealed 14 qualitative research studies, one meta-synthesis, nine personal accounts, and two theoretical publications focused on the childbearing experiences of survivors of sexual abuse. Each of these 26 qualitative research studies, meta-synthesis, personal accounts, and theoretical publications will be discussed in this chapter. No quantitative studies on the childbearing experiences of survivors of sexual abuse were identified during this search. Personal stories were included in this review of literature,

because although they do not report any findings, they have profound insight on personal experience (Sandelowski & Barroso, 2007). Given the scientific rigor of the research studies in comparison to the personal accounts, each group will be discussed separately. Additionally, the meta-synthesis, which aims to uncover the connections between participants and findings in order to create one comprehensive synthesis, will be discussed separately (Noblit & Hare, 1988; Sandelowski & Barroso, 2007).

Fourteen qualitative research studies focused on the pregnancy and/or childbearing experiences of survivors of sexual abuse were located. Seven of these studies were published in peer-reviewed journals. Of the remaining studies, four were unpublished nursing dissertations, two were unpublished psychology dissertations, and one was an unpublished nursing master's thesis. No subsequent journal publications were found for any of the dissertations or the thesis. One dissertation was published as part of a book (Garratt, 2008; Garratt 2011). The bulk of the studies (n=10) focused specifically on survivors of childhood sexual abuse (CSA) (Coles & Jones, 2009; Garratt, 2008; Lasiuk, 2007; Lee, 2001; Palmer, 2004; Parratt, 1994; Rhodes & Hutchinson, 1994; Richmond, 2005; Roller, 2011; Waymire, 1995). Three studies focused on survivors of sexual trauma (Burian, 1995; Chambers, 2010; Schwerdtfeger & Wampler, 2009). Only one study focused on women with both a history of CSA and abuse related posttraumatic stress (Seng et al., 2002). Three of the studies also included healthcare providers or professionals, including midwives, nurse-midwives, nurses, labor and delivery/obstetric nurses, and childbirth educators, some of whom were survivors themselves (Burian, 1995; Garratt, 2008; Rhodes & Hutchinson, 1994). One study also included social workers, child abuse counselors, psychologists, transition workers, victim service workers, psychiatrists, and six perinatal nurses, four of whom reported a history of CSA (Palmer, 2004). The bulk of the studies (n=9) focused

on both the pregnancy and childbirth (labor and birth) experience of survivors (Coles & Jones, 2009; Chambers, 2010; Garratt, 2008; Lasiuk, 2007; Lee, 2001; Palmer, 2004; Richmond, 2005; Roller, 2001; Seng et al., 2002). Four studies focused exclusively on the childbirth (labor and birth) experience of survivors (Burian, 1995; Parratt, 1994; Rhodes & Hutchinson, 1994; Waymire, 1995). Only one study focused solely on the pregnancy experience of survivors (Schwerdtfeger & Wampler, 2009). Two studies conducted interviews with survivors while they were pregnant, and the remaining studies were conducted retrospectively (Palmer, 2004; Schwerdtfeger & Wampler, 2009). The range of time between survivors having given birth to participating in the study ranged from one week to 40 years (Lasiuk, 2007; Parratt, 1994; Schwerdtfeger & Wampler, 2009; Seng et. al., 2002; Waymire, 1995).

The 14 qualitative research studies ranged from 1994 to 2011 (Burian, 1995; Chambers, 2010; Coles & Jones, 2009; Garratt, 2008; Lasiuk, 2007; Lee, 2001; Palmer, 2004; Parratt, 1994; Rhodes & Hutchinson, 1994; Richmond, 2005; Roller, 2011; Schwerdtfeger & Wampler, 2009; Seng et. al., 2002; Waymire, 1995). The majority of the studies were from after 2001, with only four from the mid 1990s. Unfortunately, there have been no major changes to healthcare practice when working with survivors of sexual assault that would have changed survivors' experiences over this 17-year span in publications. However, it is important to note that in 2011, the Institute of Medicine (2011) identified universal screening of all women of childbearing age for intimate partner violence as a key element of preventative health services for women, although guidelines for screening, which are vastly underutilized, have existed in hospital settings since the early 1990s.

The qualitative studies came from a variety of countries and disciplines. Nine of the studies included were conducted in the United States, one in the United Kingdom, and two each

in Australia and Canada. Ten of the studies came from the discipline of nursing, two from psychology and one each from medicine and human development/family science. Grounded theory, descriptive design, and phenomenology were the most common qualitative research designs utilized. More information regarding specific characteristics of these 14 studies can be found in table 1.

In addition to the above qualitative studies, a meta-synthesis on the maternity care needs of women who were sexually abused in childhood was found (Montgomery, 2013). This meta-synthesis from the discipline of nursing integrated the findings of eight of the qualitative studies that were also found during this literature search (Burian, 1995; Coles & Jones, 2009; Garratt, 2008; Lasiuk, 2007; Palmer, 2004; Parratt, 1994; Rhodes & Hutchinson, 1994; Seng et al., 2002). This meta-synthesis will be discussed in depth later in this chapter.

Also, nine published personal accounts from survivors of sexual abuse, midwives or nurses caring for survivors, and midwives who themselves were survivors were found (Hanan, 2006; Lewars, 2006; Rose, 1992; Rouf, 1999; Skinner, 2010; Smith, 1998a; Smith, 1998b; Tilley, 2000; Waymire, 1997). Personal stories offer robust insight into a survivor's individual experience; however, they reveal no generalizable findings. These nine published personal accounts will also be discussed later in this chapter. Two theoretical publications discussing conceptual frameworks for research and healthcare practices on sexual trauma and childbearing were examined and will also be discussed (Rodgers, Lang, Twamley, & Stein, 2003; Seng, 2002).

The literature review described above will be presented in the following sections: published qualitative research, doctoral dissertations and master's thesis, meta-synthesis, personal stories, and theoretical publications.

Published Qualitative Research

One of the first published research studies on this topic took place in Australia by a midwife. Parratt's (1994) interest in this area of research arose from her clinical practice as a midwife. Parratt (1994) conducted a phenomenological study to examine the childbirth experiences of survivors of incest. Analysis of the six participant's semi-structured interviews found that memories, or flashbacks, of the past abuse were triggered by the childbearing experience. Parratt (1994) noted that responses to these flashbacks were individualized for each survivor. Privacy, touch, and control were identified as important issues for survivors during childbirth. Survivors described the lack of control they experienced during childbirth. Being touched, especially in areas of the body related to the incest, caused some women to recall the past abuse. During the immediate postpartum period, touching their babies (i.e. wanting or not wanting to touch them) was an important issue. Parratt (1994) concluded that women must have individualized care during childbirth.

Also in 1994, but in the United States, Rhodes and Hutchinson used the ethnographic method over 6 years in order to explore the labor and delivery experiences of childhood sexual abuse survivors (CSA). Participant observation and interview data from seven survivors and eight healthcare providers, in addition to anecdotal material from the literature, was utilized during data analysis. Rhodes and Hutchinson (1994) found that women can both forget and remember the abuse. Furthermore, they reported that the birth experience was reminiscent of survivors' past abuse, and that survivors can be forced to remember the past abuse due to the similarity of bodily sensations felt when delivering a baby (Rhodes &Hutchinson, 1994). Rhodes and Hutchinson (1994) also identified that having control during labor was important to survivors. These findings align with Parratt's (1994) work. In addition to survivors, five nurse-

midwives and three labor and delivery nurses took part in this study revealing the labor styles of survivors of CSA to include fighting, taking control, surrendering, and retreating. Surrendering and retreating both involved survivors dissociating during labor. Taking control involved survivors wanting to direct their labor experience and make decisions for themselves during labor. In this vein, it was reported that many survivors wrote birth plans or sought out midwifery care. In order to improve the healthcare experience for survivors, Rhodes and Hutchinson (1994) concluded that providers must understand the connection between a history of sexual abuse and labor and birth, as well as the repercussions this history can have.

Burian (1995) conducted a descriptive, qualitative study in the United States with five survivors of sexual abuse, two nurses who were also survivors, one obstetric nurse, and one childbirth educator. Like Parratt (1994), Burian's (1995) drive for this research was her work with survivors as a practicing midwife. Interviews were conducted with the nine participants and subsequently themes were identified. Burian (1995) reported that the strongest themes were disclosure and validation, avoidance of healthcare, frequent somatic complaints, issues of control, and dissociation during medical procedures. Under the theme of avoidance of healthcare, survivors reported looking for holistic providers when they did seek care, specifically midwives, nurse practitioners, acupuncturists, and chiropractors (Burian, 1995). Burian (1995) identified that survivors benefit from having control and a trusting relationship in the context of the healthcare setting. Based on her findings, Burian (1995) shared strategies for sensitive care for healthcare providers to utilize when working with survivors. Suggested strategies involved giving the woman complete control during vaginal exams and assuring her she was safe repeatedly during labor and birth.

Coles and Jones (2009) completed a descriptive, qualitative study with survivors of

childhood sexual abuse in Australia. Semistructured, in-depth interviews were conducted with eighteen women to explore their perinatal healthcare experiences and early postpartum experiences of mothering. Two key themes were identified: safety issues for survivors and their babies during the healthcare encounter, and ways to make the healthcare encounter safer. For the first key theme, clinical exams, especially vaginal exams, caused memories of the past abuse and some survivors also experienced flashbacks when their babies were examined. The second key theme, making the healthcare encounter safe, included the following themes: the relationship with the healthcare provider, access to healthcare, and the provider's awareness of the longstanding effects of trauma. "Universal precautions," which include recommendations for healthcare providers to give survivors control, to explain procedures, to ask for consent before touching them or their babies, and to stop the exam upon request or signs of distress, were formed as a result of the research (Coles & Jones, 2009, p. 235).

Seng et al. (2002) conducted the only qualitative study on woman with a history of CSA and abuse related posttraumatic stress in order to understand what these women view as ideal maternity healthcare practices. Interviews from 15 women were conducted and analyzed, following the qualitative research design of narrative analysis. Three groups emerged from this analysis: "(1) women far along in recovery, (2) women who were not safe, and (3) women who were not ready to 'know'" (Seng et al., 2002, p. 360). In the first group, the women were in safe relationships and had appropriate social support. Their ideal healthcare provider was a "collaborative ally" (Seng et al., 2002, p. 363). Overall, these women had the best childbirth experiences. In the second group, the women were not safe and did not have adequate social support. They sought safety and their ideal healthcare provider was a "compassionate authority figure" (Seng et al., 2002, p. 363). The third group of women were not ready to address or

discuss their past histories of sexual trauma. Their level of safety was uncertain and their ideal health care provider was a "therapeutic mentor" (Seng et al., 2002, p. 363). Based on the results, Seng et al. (2002) summarized the "desired practices" survivors hope for from their healthcare providers (Seng et al., 2002, p. 364). The "desired practices" include asking about a history of abuse, acknowledging the longstanding effects of the trauma, assessing for issues related to the abuse, arranging for the specific needs of each patient, avoiding triggers, and advocating for social support (Seng et al., 2002, p. 364). These "desired practices" are comparable to the "universal precautions" that resulted from Coles and Jones (2009) research.

Schwerdtfeger and Wampler (2009) were the only researchers to qualitatively examine the impact of past sexual trauma on women's current pregnancy experiences, all other research has been retrospective. Following a descriptive phenomenological approach, the aim of the study was to understand the lived experience of pregnant woman who have a history of sexual trauma (Schwerdtfeger & Wampler, 2009). One-on-one, semi-structured interviews (23 questions) were conducted with 10 pregnant women from west Texas. Participants were between 18 and 34 weeks gestation, and the majority (n=9) were Caucasian. Four dominant categories arose from data analysis: "(1) negative consequences of sexual trauma, (2) becoming a survivor, (3) pregnancy: a new beginning beyond sexual trauma, & (4) the integration of sexual trauma and motherhood" (Schwerdtfeger & Wampler, 2009, p. 100). The first category, negative consequences of sexual trauma, had five sub-themes: "ongoing reminders, changed social relationships, altered sex and sexuality, loss of self regard, and overwhelming emotions (Schwerdtfeger & Wampler, 2009, p. 107). The second category, becoming a survivor, resulted in the following subthemes: "finding a inner strength, gaining a new perspective, using a support system, and letting it out" (i.e. discussing the past) (Schwerdtfeger & Wampler, 2009, p. 110).

The third category, pregnancy: a new beginning beyond sexual trauma, had four subthemes: "distinctly different experiences, a new beginning, a new relationship, and a new found hope" (Schwerdtfeger & Wampler, 2009, p. 111). The fourth category, the integration of sexual trauma and motherhood, focused on three subthemes largely centered around the care of their children: (1) being more protective, (2) how the gender of their child impacted their mothering, and (3) future hopes for their child (Schwerdtfeger & Wampler, 2009). In this category, participants described intense worry and concern about their daughters being sexually abused and how they sought to protect them. From the categories and subthemes as a whole, Schwerdtfeger and Wampler (2009) concluded that pregnancy "may function as a catalyst for posttraumatic growth and healing" in some pregnant women who have experienced a past sexual trauma (p. 116).

The most recent published study by Roller (2011) followed a grounded theory approach "to construct a theoretical framework describing how CSA survivors manage intrusive reexperienceing of their CSA trauma during the perinatal period" (p. 488). The study was conducted in the United States and recruitment occurred in an urban, low socioeconomic, Midwest setting. Twelve survivors of CSA were interviewed individually and data analysis followed the constant comparative method. The majority of participants (n=8) were African American. The psychosocial problem was the challenges survivors faced when they were triggered to relive their CSA by having flashbacks during the perinatal period. Triggers included pregnancy itself, as well as medical procedures. The core category that emerged was "moving beyond the pain" (Roller, 2011, p. 489). The framework developed describes how survivors moved beyond the pain of their past in three phases: reliving it, taking charge of it, and getting over it. Reliving it resulted from triggers such as the physical changes of pregnancy, like the baby kicking, as well as vaginal exams. Taking charge of it involved CSA survivors choosing a

specific healthcare provider, usually female, or being their own advocates. Getting over it represented how woman coped with their past to move forward.

Overall, in the qualitative literature, dissociation and flashbacks were common themes among survivors when describing their birth experiences. Further, the qualitative literature highlights the need for survivors to have control in the healthcare setting. In summary of the above literature review, this control should be provided within the context of a therapeutic provider relationship in order to mitigate the dissociation and flashbacks to former abuses that can be caused by the lack of control and the sensations of childbearing.

Doctoral Dissertations and Masters Thesis

The discipline of nursing provided four doctoral dissertations and one master's thesis, which will be discussed first.

Waymire, a registered nurse (1995) conducted a qualitative study for her masters thesis. This was the only unpublished master's thesis found during the literature review. Waymire's (1995) well-conducted study followed the interpretative method of hermeneutic phenomenology to understand how survivors of incest experience childbirth. Unstructured interviews were conducted with six survivors. Data analysis revealed the following three themes that describe survivors' childbirth experiences: (1) the knowing body, (2) seeking connection, and (3) striving for safety (Waymire, 1995). These themes were connected by an underlying constitutive pattern, "Haunted Birthing," which was present in each participant's story (Waymire, 1995). The first theme, the knowing body, represented feeling uncomfortable with the body and feeling as though the body doesn't work properly. The second theme, seeking connection, was comprised of survivors describing the importance of feeling connected during birth, as well as the contrary experience of disconnecting through dissociation during birth. The third theme, striving for

safety, represents a survivor's need to feel safe and have control during the birthing process; however in the experiences shared women often felt vulnerable and unsafe. Survivors often sought control during childbirth. The issue of control was prevalent in the published literature as well (Burian, 1995; Coles & Jones, 2009; Parratt, 1994; Rhodes & Hutchinson, 1994)

Palmer (2004), a certified nurse-midwife, conducted a qualitative study for her doctoral dissertation following a grounded theory approach to provide a theoretical explanation of CSA survivors' childbearing experience. The study included 68 participants, 46 of whom were survivors of CSA and 22 of whom were healthcare professionals such as social workers, child abuse counselors, psychologists, transition workers, victim service workers, psychiatrists, and six perinatal nurses, four of whom reported a history of CSA. Data were collected through semi-structured, in-depth interviews, focus groups, and participant observation. "Protecting the inner child" was the core social psychological process generated from this study (Palmer, 2004, p. 74). This theory explains that survivors manage childbirth through a process in which they seek to protect themselves. This process consists of both "(over) protecting self and (2) (over) protecting child" (Palmer, 2004, p. 134). The two core concepts supporting this process are vulnerability and resiliency (Palmer, 2004). Palmer (2004) identified that various triggers such as the sights, sounds, and touch of childbirth, the lack of control during pregnancy, and having a female baby, can cause survivors to overprotect themselves or their child. Overall, survivors sought to find "a sense of inner peace and balance" through the process of "protecting the inner child" (Palmer, 2004, p. 129, 74).

Richmond (2005), a registered nurse, conducted a qualitative study utilizing a grounded theory research design for her doctoral dissertation. In-depth interviews were conducted with 11 survivors of CSA to understand how survivors perceived their prenatal care in the context of

their past histories. The constant comparative method was utilized during data analysis and revealed "aligning personhoods" as the basic social process survivors use to have a positive childbirth (Richmond, 2005, p. 35). The substantive theory of "being whole: aligning personhoods through discerning safety and managing vulnerabilities" resulted from Richmond's (2005) research (p. 36). The subcategories of "discerning safety" were provider gender preference, assumptions, disregarded/regarded, and attitudes/actions (Richmond, 2005, p. 35). Survivors sought to feel safe in the context of childbirth. The subcategories of "managing vulnerabilities" were rectifying pregnancy, controlling actions, avoiding/delaying, prescencing, enduring, and changing (Richmond, 2005, p. 35). The subcategories of managing vulnerabilities largely centered on survivors seeking control.

Lasiuk (2007), a registered nurse, conducted a qualitative interpretative inquiry study (following van Manen's approach) for her doctoral dissertation to understand the lived experience of childbearing for survivors of CSA. Open-ended interviews were conducted with seven survivors of CSA in Canada. Data analysis resulted in the following three themes: "living in the wake of CSA, response-ability to motherhood, and regeneration" (Lasiuk, 2007, p. 107). For the first theme, survivors spoke of flashbacks to the past and difficulty with coping skills in the wake of CSA. Response- ability to motherhood spoke of the weight of motherhood and adapting to the job of mothering. For the final theme, regeneration, survivors shared that childbirth was a rebirth of for them personally and they were beginning anew.

Garratt (2008), a community midwife, conducted a grounded theory, qualitative study from a feminist standpoint for her doctoral dissertation aimed at understanding the challenges faced during childbirth by survivors of CSA. In-depth interviews took place with 20 survivors of CSA, 12 of whom were also hospital, community, or student midwives in the United Kingdom.

Data analysis utilized a voice-centered rational method. Findings were discussed using Finkelhor and Browne's traumagenic model as a framework. Survivors experienced re-traumatization by healthcare provider's impersonalized care and lack of communication. Powerlessness, betrayal, and humiliation were the three major themes that emerged from the negative childbearing experiences shared. Powerless was most often related to medical procedures such as vaginal exams. Betrayal occurred from having expectation of the childbirth experience that were not met by their healthcare providers. Survivors felt humiliation, described further as shame and self-blame for their past history, due to the lack of respect they received during childbirth. Survivors also experienced humiliation from not having their privacy respected or encountering rough attitudes from healthcare providers. Survivors who had positive childbirth experiences stated good relationships with their healthcare providers contributed to this experience. Although not stated as a theme, Garratt (2008) devoted an entire chapter discussing dissociation as a coping mechanism utilized by participants in her study. Participants' interviews revealed they often dissociated during childbirth. Furthermore, the midwife survivors from this study experienced "professional" detachment or dissociation and "emotional numbing" (Garratt, 2008, p. 259). Garratt (2008) further reported that almost half of the survivors in this study choose to have a homebirth, so that they were in an environment in which they have control. Garratt (2008) concludes that survivors need individualized care during pregnancy and childbirth.

Additionally, two doctoral dissertations found during the literature review came from the discipline of psychology (Chambers, 2009; Lee, 2001). Lee (2001) conducted a qualitative study utilizing a descriptive research design to examine the connection and interaction between healing from sexual abuse and childbearing (pregnancy, labor and birth, and postpartum). Open-ended

interviews were conducted with seven women with a history of CSA and subsequently analyzed to find themes. Themes identified from the data included "confrontations, reconciliations, and moving beyond sexual abuse in childbearing; intrusions and remembering; shut down, being open, and dissociation; body perception; coping; care providers and hospitals" (Lee, 2011, p. 104). Participants shared that a healthy relationship with their healthcare providers led to a positive experience. The process of recovery was individualized for each survivor, making connections between a women's stage of recovery and childbearing experience challenging. The results showed that for survivors of CSA, childbearing "can be influenced by affect tolerance, meaning making, and a tendency to either approach or avoid affect" (Lee, 2001, p. ix).

Chambers (2010) conducted a qualitative study utilizing a descriptive research design to explore the factors that contribute to a positive childbirth experience for survivors of sexual trauma. In-depth, semi-structured interviews were conducted with five survivors and subsequently analyzed for themes. Twelve themes arose from the data which were put into four domains: (1) prior to becoming pregnant: themes included identity development, role of therapy, and positive reframing of trauma; (2) during pregnancy: themes include fears regarding delivery (either seeing the trauma and birth as separate or seeing them as connected) and decision to homebirth, (3) during labor and delivery: themes include letting go of agendas, external factors supporting internal factors, and traumatic births and the prevention of re-traumatization , and (4) after birth: themes included the transformative nature of birth, need for more open dialogue, and context and privilege (Chambers, 2010). Of note, Chambers (2010) stated 12 themes emerged; however in both the results section and table of themes only the 11 themes above are discussed or listed. Chambers (2010) further explained that survivors' "positive birth outcomes are associated with women being given (1) space to process their trauma prior to giving birth, (2)

time to reflect on their fears during pregnancy and labor, (3) a supportive physical and emotional birthing environment, and (4) assurance that their desires will be respected" (p. ii).

Meta-synthesis

A meta-synthesis is aimed at uncovering the connections between qualitative study participants and findings in order to create one comprehensive synthesis (Noblit & Hare, 1988; Sandelowski & Barroso, 2007). Montgomery (2013) conducted the only meta-synthesis on the maternity care needs of women who were sexually abused in childhood. This meta-synthesis integrated the findings of eight qualitative studies on CSA survivor's needs during childbearing (Burian, 1995; Coles & Jones, 2009; Garratt, 2008; Lasiuk, 2007; Palmer, 2004; Parratt, 1994; Rhodes & Hutchinson, 1994; Seng et al.; 2002). "The key themes identified were control, remembering, vulnerability, dissociation, disclosure and healing" (Montgomery, 2013, p. 88). Control was the strongest theme identified. Control in the healthcare setting and a positive relationship with healthcare providers resulted in survivors feeling safe and possibly even having a healing experience (Montgomery, 2013). In contrast, lack of control and lack of a trusting relationship with healthcare providers can cause survivors to feel re-traumatized. Montgomery (2013) concluded that healthcare professionals are charged to help survivors feel safe.

Personal Accounts

Nine personal accounts written by either survivors of sexual abuse, midwives or nurses caring for survivors, or midwives who themselves were survivors were found during the literature search. Although these stories provide first hand insight about survivors' childbearing experience, they do not report any specific findings (Sandelowski & Barroso, 2007). For the insight they do provide on this topic, it is noteworthy to discuss each account.

In 1992, Anna Rose's story was published under this pseudo name in *BIRTH*. This seminal article was the first to articulate the hopes and the fears of giving birth from the vantage point of a woman who has survived CSA. Rose (1992) shared the following thoughts (also found at the outset of this chapter):

> The memory of the violations during my childhood was locked in my birthing muscles for all these years, only recently coming to the surface of my conscious awareness. Such armoring can hinder the ability to open one's body, to trust that body really can work okay and be safe. It's hard to believe that intense sensations in that region of the body do not have to mean bad things are going to happen. (p. 216)

Rose (1992) recounted the horrors of her first delivery and "feeling powerless and helpless" just as she had in childhood (p. 217). Rose's (1992) personal story, although it is not a research study, is the foundational publication which brought the connection of a past history of sexual abuse and a woman's childbearing experience to the attention of healthcare providers and survivors alike. It was not until this courageous woman spoke out about her experience of violent CSA from multiple family members and its connection to childbirth that researchers turned their attention to these women. Two years after Rose's (1992) story was published, the first qualitative studies on this topic were published (Parratt, 1994; Rhodes and Hutchinson, 1994).

Furthermore, after Anna Rose's (1992) story was published, four more personal accounts were published in the late 1990s, one in 2000, and three in the late 2000s, by survivors after they themselves had given birth or by midwives or nurses who attended the births of survivors (Hanan, 2006; Lewars, 2006; Rouf, 1999; Skinner, 2010; Smith, 1998a; Smith, 1998b; Tilley, 2000; Waymire, 1997). These women were courageous enough to share their stories, which

have added to the limited body of literature on the topic of survivors of sexual abuse and their pregnancy and childbirth experiences. Each account is discussed.

Khadj Rouf (1999) was sexually abused by her father throughout her childhood and she published how her pregnancy and birth were connected to the past abuse. The physical changes of pregnancy, touching of her abdomen, and multiple vaginal exams during labor by different providers were difficult for Rouf (1999). However, a "strong, consistent relationship" with her midwife and writing a birth plan allowed her to feel supported during pregnancy and labor (Rouf, 1999, p. 30).

Hanan (2006), a childbirth educator, reflected on how CSA affected her pregnancy and birth. She utilized Kubler-Ross's theory of the stages of grief to recount her experience. Hanan (2006) shared this sentiment of her pregnancy, "there was one thing I didn't like, - why was my body now public property? Why did people think it was alright to touch my belly without asking? Or comment on the size and shape of my body?" (p. 38). Hanan (2006) offers both suggestions for survivors and midwives in order to improve the childbearing experience.

Corbin Lewars (2006) explains the constant feeling of betrayal of her body she experienced after she was date-raped as a teenager. Having a miscarriage later in life made this betrayal more pronounced. During her subsequent pregnancy, she had a lack of faith in her body and questioned whether she could birth a child (Lewars, 2006). She received prenatal care from a midwife and offered that it was through this care that she began to trust her body again. She chose to have a homebirth. Birth was a healing experience for Lewars (2006) and she expressed, "not only do I trust by body, I am in awe of all it can do. I don't know if I will ever be able to accomplish anything as marvelous as birthing and nursing two babies. …I have created and nurtured life; nothing tops that" (p. 25).

In a personal reflection, Asheley Skinner (2010), a survivor of CSA, shared her vulnerabilities during pregnancy. Skinner (2010) expressed that as a survivor she had a lack of control over her past abuse, and during pregnancy she experienced this same loss. Skinner (2010) shared, "pregnancy itself was a huge loss of control, another life for which I had both full responsibility and little ability to protect" (p. 181). Suggestions for healthcare providers to ask patients about a history of abuse and to give them freedom and control were offered by Skinner (2010).

In addition to the masters thesis discussed in the previous section, Vickie Waymire (1995, 1997), a perinatal clinical nurse, published a story of the labor experience of Barbara, a survivor of CSA. Barbara experienced memories of her rape during her first birth due to feeling tied down to the monitors and intravenous lines attached to her after she received her epidural. During the birth of her second child, she had an extensive birth plan to remain in control. Waymire (1997) implores fellow nurses to screen women on the labor ward for a history of sexual abuse so that survivors have the opportunity to talk about concerns or fears they may have. Additionally, Waymire (1997) offers that women should be given control, permission to stop, and affirmation that her body is capable of birthing a baby.

Maggie Smith (1998a), a practicing midwife, shared a case from when she was a student midwife caring for a woman whom she believed had a history of sexual abuse. Of note, Smith served as an adviser to Garratt (2008), whose doctoral dissertation was discussed previously in this chapter. Smith (1998a) offered that a woman she was caring for in labor had not disclosed a history of abuse, yet lost control each time a vaginal examination was about to be performed and ultimately attempts to examine her were stopped. Smith (1998b) also published a second case of Mary, a woman with a 10-year history of CSA by her father. Mary needed an epidural in labor

because she was terrified of feeling the pain of labor. Even with an epidural, Mary shared that her labor and delivery felt like rape. Smith (1998b) shared this quote from Mary, "the feeling of powerlessness was there because in labour, you can't get out of bed in the same way I could never escape as a child" (p. 43). Mary also stated that she would not have been able to cope with having a daughter due to the fears she would have of her being sexually abused Smith, 1998b).

Additionally, a student midwife, Jo Tilley (2000) published her experience of being sexually assaulted at the age of 24. Her sexual assault took on new meaning in the context of her midwifery career. She first recounted the violent assault and then shared "I now see so clearly between what happened to me and what often happens to the vulnerable and trusting pregnant women in our care" (Tilley, 2000, p. 18). She began to question the frequency of vaginal exams performed during labor, as well as the issue of who has control during labor. Tilley (2000) hopes midwives will allow women to have control and help them to feel safe during childbirth.

In conclusion, the personal insights shared from these accounts share similar characteristics with the findings from several of the qualitative studies on this topic. Largely, the issue of control in the context of pregnancy and birth, which was prevalent in the qualitative studies, was also an issue women discussed in these personal accounts.

Theoretical Publications

Two theoretical publications discussing conceptual frameworks for research and healthcare practices on sexual trauma and childbearing were uncovered (Rodgers et al., 2003; Seng, 2002).

Seng, PhD, CNM is a women's health provider whose research has centered on survivors of trauma. Seng (2002) expanded on the CDC's framework for research on violence occurring at the time of first pregnancy. She sought to highlight posttraumatic stress disorder (PTSD) as "the

main psychosocial and biobehavioral factor that mediates between violence trauma and poor [pregnancy] outcomes" (p. 341). Seng (2002) added PTSD to the conceptual model to emphasize that given the severity of PTSD, it may be the driving factor leading to poor pregnancy outcomes for survivors of violence trauma.

Seng has formed theoretical concepts around her work with survivors. Her conceptual framework illustrates how trauma and PTSD negatively affect pregnancy and childbirth. Seng (2002) states that her framework can be utilized to "guide research with women who are not experiencing current violence but whose current behaviors and physiologic health and childbearing may be affected by negative sequelae from childhood or past adult trauma exposures, including PTSD" (p. 340).

Seng's (2002) conceptual framework focuses on the emotional toll of sexual violence in the context of childbearing. Seng has devoted her trajectory of research to PTSD and the associated negative maternal and fetal outcomes that stem from PTSD. Seng's (1999) doctoral research, which has helped to shape her conceptual framework, explored the association of pregnancy complications with a diagnosis of PTSD. She performed a secondary data analysis on Medicaid records, yielding a group of 455 women diagnosed with PTSD and a control group of 638 women. Seng (1999) found that the women with PTSD had more pregnancy complications such as low birth weight babies and a pregnancy diagnosis of hyperemesis. Her research has led to the development of a conceptual framework for research with survivors. The concepts involved in the framework take on a holistic approach to research, addressing the physical and emotional tolls that trauma and violence have on survivors. This holistic approach sets Seng's work apart.

Additionally, Rodgers et al. (2003) presented a conceptual framework showing the relationship between a history of sexual trauma and pregnancy outcomes. The hypothesis is that sexual violence negatively impacts pregnancy outcomes. The mediating factors are the woman's psychopathology, health, and health behaviors (e.g. PTSD, obesity, substance abuse) (Rodgers et al., 2003). Rodgers et al. (2003) propose that poor physical and mental health, as well as negative health behaviors, will increase "the risk of poor pregnancy outcomes (e.g. pregnancy complications, pain and complications during delivery, and premature births) and negative effects on offspring" (p. 966).

Additional Supporting Literature

Although not uncovered directly during the literature search, it is important to discuss the relevant literature on breastfeeding, fear of childbirth, recommendations for care, and trauma-informed care as it relates to survivors of sexual abuse.

Breastfeeding

Literature on the breastfeeding experience of women with a history of sexual abuse is limited. The limited publications reviewed below offer that the breastfeeding experience can be reminiscent of past abuse or a healing experience for survivors.

Prentice, Lu, Lange, and Halfon (2002) reported that women with a history of CSA were more than twice as likely to initiate breastfeeding when compared to women without a history. However at one month postpartum, women without a history of sexual abuse were more likely to still be breastfeeding than those with a history of CSA. This finding at one month postpartum did not however reach significance.

Klingelhafer (2007), a heath professional in the Women, Infants and Child (WIC) program, provided a qualitative description of three of her patient's experiences with breastfeeding. In these cases, survivors of sexual abuse linked feelings of disgust and dirtiness to their breastfeeding experiences. One woman expressed that because her baby could not consent to breastfeeding and she felt as though she was abusing her baby. This woman shared, "It's the consenting, being allowed to make a conscious choice, and a baby can't make a choice and I just feel like I'm doing a dirty thing to my baby" (Klingelhafer, 2007, p. 195). On the other hand, Klingelhafer (2007) shared survivors she meet with in a group offered that for them breastfeeding was a way to reclaim both their bodies and identities.

Beck (2009) published a qualitative single-case study on the breastfeeding experience of a survivor of CSA. Rigorous data analysis revealed the profound impact a history of CSA has on a survivor's trials of breastfeeding.

> When I placed my baby to the breast, I experienced panic attacks, spaced out, and dissociated. It triggered flashbacks of the abuse and a sick feeling in my stomach. I hated the physical feeling of breastfeeding. I hated having to offer my body to a my child who felt like a stranger. (Beck, 2009, p.95)

Beck (2009) offers this case for healthcare providers to consider when working with breastfeeding women. Breastfeeding is the recommended method of infant feeding, however survivors of sexual abuse may struggle with the connection of breastfeeding to their past abuse. As a result, healthcare providers need to be sensitive and when indicated give women permission to stop breastfeeding to prevent further suffering (Beck, 2009).

Wood and Van Esterik (2010) conducted a descriptive qualitative study with 6 mothers who had a history of CSA. "Shame, touch, breasts, dissociation, medical care, and healing

emerged as analytic themes" (Wood & Van Esterik, 2010, p. e136). Wood and Van Esterik (2010) informed healthcare providers that breastfeeding is a vulnerable time for survivors and care should be sensitive to these women's needs.

Overall, the literature supports that healthcare professionals should be aware that the breastfeeding experience can either be reminiscent of past abuse or a healing experience for survivors. As a result, care of the breastfeeding woman should be sensitive and individualized to meet the woman's needs. Although breastfeeding is the recommended method of infant feeding, woman with a history of sexual abuse may benefit from a healthcare professional telling them it is okay not to breastfeed for their mental health (Beck, 2009)

Fear of Childbirth

No qualitative studies specifically exploring the childbearing experiences of survivors of sexual abuse were found. However, quantitative studies examining fear of childbirth were identified (Alehagen, Wijma, & Wijma, 2006; Eberhard-Gran et al., 2008; Heimstad et al., 2006; Lukasse et al., 2010; Schroll et al., 2011). These studies explored the construct of fear in survivors of sexual abuse; however, have conflicting results.

Schroll et al. (2011) conducted the most recent research on this topic examining the prevalence of sexual violence and if women with this history have a higher risk of fear of childbirth before, during, or after delivery. The study was conducted in Denmark with 2,638 low-risk primiparous women using the Wijma Delivery Expectancy/Experience Questionnaire (W-DEQ). Nearly 10% of the sample (9.2%) had experienced sexual violence. The results demonstrated "no association between exposure to violence and fear of childbirth before or during labor" (Schroll et al., 2011, p. 22). However, women with a history of sexual violence experienced an increased risk for severe fear of childbirth (defined as W-DEQ score >84) after

delivery when compared to women who never experienced sexual violence, odds ratio 1.5 (95% CI: 1.02-2.27) (Schroll et al., 2011). Theoretically, survivors may repress their history of violence during pregnancy, however then experience flashbacks to the abuse during delivery, thus causing increased fear postpartum.

In contrast, Eberhard-Gran et al. (2008) examined if fear during labor was associated with sexual abuse in adult life. The study was conducted with women 6-weeks postpartum (n=414) in Norway; however, it did not use the W-DEQ. Instead, a 3-point scale of "no fear, some fear, or extreme fear" measured participants' fear. One third of the women experiencing extreme fear during labor had a history of sexual violence, odds ratio 3.7 (95% CI: 1.0-3.7). The contrasting findings of Eberhard-Gran et al. (2008) to Schroll et al. (2011) are most likely due to the difference in data collection instruments.

In Norway, Heimstad et al. (2006) administered the W-DEQ to 1,452 women at 18 weeks gestation in order to assess the prevalence of fear of childbirth and to examine an association of fear to sociodemographic characteristics. The overall prevalence of serious fear of childbirth (defined as a W-DEQ score >100) was 5.5%. Women with a history of childhood sexual abuse had a higher score (71) on the W-DEQ than non-abused women (61, p <0.01). Contrasting Schroll et al.'s (2011) findings, Heimstad et al. (2006) found exposure to sexual and/or physical abuse as a child, but not as an adult, was associated with fear of childbirth. Heimstad et al. (2006) also found that a history of childhood sexual abuse, not fear of childbirth, negatively influenced the mode of delivery. "Among those who reported exposure to physical and sexual abuse in childhood, only 57% and 54% respectively, had uncomplicated vaginal deliveries at term, compared to 75% among those who did not report abuse (p <0.001)" (Heimstad et al., 2006, p. 438).

Lukasse et al. (2010) examined if there was an association between a history of childhood abuse and fear of childbirth in a cross-sectional study of 2,365 women in Norway. The W-DEQ was administered after 18 weeks gestation and severe fear of childbirth was defined as a score of 85 or more. "Women with a history of childhood abuse reported severe fear of childbirth significantly more often than those without a history of childhood abuse, 18% versus 10% (p = 0.001)" (Lukasse et al., 2010, p. 267). Lukasse et al.'s (2010) findings resonate with Heimstad et al. (2006).

Research by Alehagen et al., (2006) in Sweden explored the association between fear of childbirth during pregnancy and postpartum and fear and pain during early labor. Women who received epidural anesthesia in labor were compared to those who did not. The W-DEQ was administered to 47 nulliparous women at 37-39 weeks gestation, the Delivery Fear Scale was administered during early labor, and the W-DEQ was again administered 2 hours, 2 days, and 5 weeks postpartum. The findings "show a relationship between fear of childbirth experienced during late pregnancy, early active labor, and the postpartum period" but are not specific to women with a history of sexual abuse (Alehagen et al., 2006, p. 56). Additionally, no difference was found in fear of childbirth during pregnancy between the women who received epidural anesthesia versus those who did not; however, the women who received epidural anesthesia reported more fear postpartum. An epidural can slow down labor, which Alehagen et al. (2006) hypothesize is the reason these women experienced more fear postpartum.

To summarize, recent research on this topic showed association between exposure to violence and fear of childbirth in the postpartum period, but no association before or during labor (Shroll et al., 2011). Conversely, research in which the same instrument, the W-DEQ, was given during pregnancy demonstrated a correlation between a childhood history of physical, emotional,

or sexual abuse and fear of childbirth (Heimstad et al., 2006; Lukasse et al., 2010). The timing of the questionnaire administration and the varying cut off scores utilized for data analysis may both account for the variance in these study results. Overall, the findings again point to the individual needs of survivors before, during, and after childbirth.

Recommendations for Care

Importantly, survivors themselves have made suggestions for improved healthcare services for other women with this history. Having a relationship with care providers as well as the providers understanding of the long-term effects of trauma were imperative for survivors (Chambers, 2010; Coles & Jones, 2008; Rhodes & Hutchinson, 1994). Prior to examining a woman in an obstetric or gynecological setting, it was viewed as essential to ask her about a history of sexual abuse (Heritage, 1998). Women who disclose a history of sexual abuse or assault to their provider, reported an overall better experience receiving healthcare services (Having, 2008). However, this conclusion assumes the woman's experience is validated by the healthcare provider and acknowledged in a thoughtful manner (Having, 2008).

McGregor, Glover, Gautam, and Julich (2010a) surveyed survivors and asked them what recommendations they can offer healthcare providers when working with other women who have a history of sexual abuse. These recommendations were qualitatively examined and six themes emerged. The themes revolved around providers gaining knowledge about sexual abuse victims, creating a therapeutic provider-patient relationship, asking about any past history of sexual abuse, and creating an environment for a comfortable examination. The study participants also identified routine screening and provider follow up with the patient post examination as important parts of care. Additionally, the providers "should explain and discuss what is involved in the whole procedure [examination] beforehand, and how long it is going to take. During the

actual procedure, … explain what is going to happen, and why, and then what is happening, step by step" (McGregor et al., 2010a, p. 750). Following an examination, it is helpful to these patients to have the visit conclude with an overall statement such as: Everything appears normal and healthy (Holz, 1994, McGregor et al., 2010a). Survivors expressed a desire for healthcare providers to understand the implications of sexual abuse and to inquire about a history. McGregor et al. (2010a) concluded that because the healthcare provider and patient "interface is a two-way process, it is worth investigation [of healthcare providers'] perceptions on their interactions with childhood sexual assault survivors, and so should be the topic for future research" (p. 753).

McGregor, Julich, Glover, and Gautam (2010b) surveyed female sexual abuse survivors in order to investigate these women's experiences with disclosing their history to a health care professional. This quantitative study revealed, "despite the high disclosure rate [68.9%] by participants, the rate of childhood sexual abuse inquiry by health professionals was low at 22.8%" (McGregor et al., 2010b, p. 248). The research findings also concluded that women are more likely to disclose a past history of abuse to a female healthcare provider.

Additionally, Roberts, Reardon, and Rosenfeld (1999) performed a qualitative pilot study to survey women's experiences with healthcare in a primary care setting. The women in this study were all survivors of CSA. Roberts et al. (1999) found that "survivors suggested that providers explain what they are about to do, move slowly, and give feedback through the examination" (p. 44). It has been overwhelming repeated in the research, that survivors are looking for understanding from their healthcare provider and control throughout the examination.

However, healthcare providers do not routinely inquire with their patients about a past or current history of sexual abuse. For example, research by Robohm and Buttenheim (1996)

examined the gynecological care experiences of 44 women who had suffered childhood sexual abuse. The quantitative research design also had a control group of 30 non-abused women and gave a self-administered survey about experiences receiving gynecological care to both groups. Survivors spoke of emotions such as shame and vulnerability during exams, while the control group more often described physical, rather than emotional discomforts. Overall, survivors reported a higher level of discomfort throughout the exam compared to the control group. The study also looked at the prevalence with which the participants were asked about a history of sexual abuse. The results demonstrated that 82% of the survivors and 87% of the controls were not asked; however, over 93% of the women in both groups thought that they should have been asked (Robohm & Buttenheim, 1996). One of the study conclusions was "that provider silence on or insensitivity to the issue of sexual abuse and its sequelae has undoubtedly had profound implications for gynecological care experience of these women" (Robohm & Buttenheim, 1996, p. 70). The study limitations are an unequal number of women in the affected versus control group and the vague term gynecologic care provider used instead of specifying if the providers were doctors, midwives, or other healthcare professionals. However, the findings resonate with previous research that concluded the majority of patients would like healthcare providers to screen them for a past history of sexual assault (Friedman, Samet, Roberts, Hudlin & Hans, 1992).

Survivors report the clinical exam to elicit the most fear and anxiety during a healthcare encounter (Coles & Jones, 2009; McGregor et al., 2010a). They often report feelings of violation, vulnerability and disassociation during exams (Burian, 1995; Coles & Jones, 2009; Heritage, 1998; Parratt, 1994; Roussillon, 1998; Simkin, 1992). Research suggests that women's healthcare providers can provide a more comfortable exam by asking women how they are doing

throughout the physical exam and by stopping the exam at any point if asked to do so (Burian, 1995; Coles & Jones, 2009; McGregor et al., 2010a). Longer office visits to decrease the feelings of being rushed have also been suggested to help survivors feel more comfortable in healthcare settings (Heritage, 1998).

Overall, survivors have "complained about the societal invisibility of the aftermath of abuse in adult life and lack of opportunity to speak freely about the meaning of the former abuse to their current life" (Dijkstra, 1995, p. 291). Discussing sexual abuse histories with healthcare providers acknowledges the experience for the patient, sometimes for the first time, allowing her to recognize the event as real and to have someone listen to her story (Coles & Jones, 2009). Survivor's verbalization of their past abuse has lead to therapeutic healing (Coles & Jones, 2009; Dijkstra, 1995). Furthermore, helping survivors learn about their own bodies can help them to heal (Heritage, 1998). Healthcare providers caring for survivors need to become proficient in community resources and referral agencies (Heritage, 1998; Holz, 1994). Each of these suggestions discussed by survivors have the potential to positively impact the childbearing experience for survivors of sexual abuse.

Trauma-Informed Care

A model of care called trauma-informed care has been developed for use with men and women who have experienced violence of any type and are now seeking help to recover (The National Association of State Mental Health Program Directors, 2014).

> Trauma-informed care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma informed care also emphasizes physical, psychological and emotional safety for

> both consumers and providers, and helps survivors rebuild a sense of control and empowerment. (The Trauma Informed Care Project, 2014)

The National Association of State Mental Health Program Directors (NASMHPD) (2014) has created The National Center for Trauma-Informed Care (NCTIC) for use largely with patients in the public health setting. Specifically, through this program, training has taken place across the United States for the implementation of trauma-informed care in homeless programs, residential treatment centers for substance abuse, and criminal justice programs.

This model of care is spilling over into healthcare settings as well. Linden and Bell (2012) discussed their utilization of trauma-informed care when working with survivors of sexual abuse or of any other past trauma during pregnancy and childbirth (Linden & Bell, 2012). The model involves supporting the patient throughout disclosure, giving the patient control of the healthcare encounter, and allowing for informed decision-making (Linden & Bell, 2012). An example of giving the patient control is letting her direct the order procedures are performed in, and how fast the exam takes place. Another example is allowing her to remain in her own clothing instead of a hospital gown or paper gown and to conduct much of the visit while she is fully clothed.

Unfortunately, healthcare providers have not universally adopted this model of trauma-informed care. As a result, survivors of sexual abuse "often do not obtain the adapted pre- and postnatal care, which could have favorable effects not only on their pregnancy and birth experience, but which could also open up chances for better parenthood" (Leeners, Richter-Appelt, Imthurn, & Rath, 2006). Trauma-informed care aims to enhance the healthcare experience for survivors of sexual abuse and other traumas.

Current Perspective from Psychology on the Effects Sexual Abuse

Sexual abuse, whether it occurs as a singular experience or over a protracted period of time, is life altering. An individual is forever changed after being so personally traumatized. "Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning" (Herman, 1997, p. 33). A traumatic event suffered early in life has lasting effects deep in the structure of the child's brain, causing negative changes to his or her ability to regulate emotions and to cope during stressful periods (Siegel, 1999). As a result, a female survivor of childhood sexual abuse can have a difficult childbearing experience. The following section aims to illuminate the main tenets of Siegel's theoretical field of interpersonal neurobiology, which includes a mindsight approach to trauma and recovery. An exploration of Siegel's interpersonal neurobiology specific to trauma is prudent given the prevalence of sexual assault and the grave consequences of unresolved trauma. The traumatic event of a sexual assault pervades a female survivor's relationships and interactions with others throughout her lifespan. The actual structure of the brain becomes modified after a traumatic event, such as sexual abuse (Siegel, 1999; Siegel, 2001).

Overview of Siegel's Interpersonal Neurobiology: A Mindsight Approach

Daniel Siegel, MD specializes in pediatric and psychiatric medicine, and continues today to be active in the field of trauma research. Interpersonal neurobiology is a field of study that seeks to understand how one's relationships with others, particularly early relationships, have a dominant influence on brain structure, affect regulation, organization of memory, and personal narratives (Siegel, 1999; Siegel, 2001). This field is deeply rooted in attachment theory. At the core of Siegel's theory is that one develops largely through his or her interface with other humans, specifically close family members (Mind your Brain, Inc., 2010; Siegel, 1999).

Through these relationships with others, a person develops mindsight. According to Siegel, mindsight is "a powerful lens through which we can understand our inner lives with more clarity, integrate the brain, and enhance our relationships with others" (Mind your Brain, Inc., 2010, About Dan webpage).

Additionally, mindsight can be viewed as thoughtfulness, allowing a person to process the internal workings of the mind and to successfully regulate emotional states. Mindsight provides an individual with affect regulation, a skill that begins at birth through the dyadic relationship between an infant and his or her primary caregiver, usually the mother. When this dyadic relationship is insufficient or neglectful, the infant does not successfully develop affect regulation. A poor dyadic relationship also negatively influences an individual's state of mind, which is the ability of the brain to function cohesively at any one moment (Siegel, 1999). States of mind heavily influence one's internal working model and one's narrative self; therefore early relationships are crucial for one's development.

Central to his theory, Siegel (2003) posits that relationships with others mold the neural connections in our brains, thereby affecting our minds and our ability to have self-regulation, which is essential to mental health. According to Siegel (2003), "The simple idea is this: Human relationships can shape the neural connections of the brain from which the mind emerges" (p. 14). A traumatic event greatly alters the structure of the brain (Siegel, 2003). Neural integration, which is influenced by synaptic connections in the brain, is the process by which the brain makes connections between an actual event and the memory of that event (Siegel, 2003). This integration is critical for self-regulation (Siegel, 2003).

Two distinct types of memories, implicit and explicit can be formed. Implicit memory, such as driving a car, can be behavioral and lack the subjective internal experience of recollection (Siegel, 2003). Implicit memory can also have an emotional component, if for

example a young child is bit by dog and then has intense fear every time he or she sees a dog (Siegel, 2003). Importantly, in this example, the child feels the fear but does not mentally process or say why they are fearful (Siegel, 2003). Traumatic events, such as sexual abuse, are usually implicit memories full of emotions and elicit fear when the survivor is in a similar situation, such as having a vaginal examination. In contrast, explicit memory involves a sense of self and of time, and is a healthier memory (Siegel, 2003).

The Impact of Trauma on the Brain and on Integration. Fundamentally, the process of integration is gravely disrupted by a traumatic event(s). Over the first few years of life, the right hemisphere of the brain is actively shaped and is responsible for intense emotional states (Siegel, 2003). In contrast the left-brain is responsible for logic and sequencing (Siegel, 2003). Overall, "the human mind is a complex system," which is flexible and multidimensional (Siegel, 2003, p. 3). Siegel (2003) supports that complexity theory is salient to mental health in that "complexity is achieved through the *balancing of two fundamental processes of differentiation and integration*" and a system becomes stressed if it is not moving toward complexity (Siegel, 2003, p. 4). A person with an unresolved traumatic experience has a system that becomes stressed because it is no longer integrating. Through therapy, the therapeutic relationship should lead a survivor to have experiences that promote complexity in order to re-balance the mind (Siegel, 2003). In this process, "healing is achieved as overwhelming events and suboptimal developmental experiences, encoded in various forms of memory, become freed from their restrictive or chaotic patterns" (Siegel, 2003, p. 7). As a result, new representational processes are formed and the mind is once again driven toward complexity (Siegel, 2003).

Other researchers support Siegel's theory as well. Teicher (2002) studied the impact of trauma on one's brain structure and has used electroencephalography (EEG) to look at the left

and right hemispheres of the brain of psychiatric patients with a history of physical or sexual abuse compared to healthy people. The findings revealed that the right hemispheres were markedly more developed than the left in the abused patients, meaning that the negative emotions caused by the abuse were taking over, blocking the logical left side of the brain and preventing the integration of the two sides (Teicher, 2002). Teicher (2002) additionally reports that the hippocampus, responsible for forming and recalling memories, and the amygdala, responsible for processing emotions, are smaller in victims of early trauma, such as abuse and incest.

In other words, in order for a person to recall a memory coherently, the left-brain must pull on the emotions from the right brain. The two sides of the brain are connected by the corpus callosum in order to transfer information (Siegel, 2003; Teicher, 2002). Trauma, specifically sexual abuse, has been associated with a reduction in size of the corpus callosum, disrupting integration (Siegel, 2003; Teicher, 2002). Integration is necessary to prevent blocks in one's recall of events. When a blockage occurs, as does in posttraumatic stress disorder from sexual assault, one has a disjointed narrative (Siegel, 2003). Furthermore, when the body is stressed from a traumatic past, excessive levels of the stress hormone cortisol are released and can cause neuronal cell death, further disrupting integration (Siegel, 1999; Siegel, 2003).

Siegel's Therapeutic Process. In order to heal from a traumatic event, a healthcare provider must help the client to integrate both the left and right brains once again. When an individual suffers a traumatic event, especially as a young child, the ability to have mindsight through integration is gravely affected, notably because the structure of the brain is changed as a result of the trauma (Siegel, 2003). "Early adverse experiences might impair the ability of the prefrontal cortex to respond to new overwhelming events via balanced self-regulation" (Solomon

& Siegel, 2003, p. xv). Our minds develop over the lifespan, with early life events having the greatest consequence because of the rapid brain growth occurring at this time (Siegel, 2003). Therefore, a traumatic experience can be especially life altering to a young child (Siegel, 1999). Siegel (2003) describes "states of mind" such as fear and shame that can result from early trauma and become lifelong personality traits in the survivor. Social interactions can and do "shape how the brain gives rise to the mind" (Siegel, 2003, p. 18). Without successful integration of the two sides of the brain, many clients will suffer from protracted periods of mental illness and will be affected in their relationships throughout their lives.

Healing from trauma through the integration of the two hemispheres of the brain is achieved largely by the development of a therapeutic relationship between the clinician and the trauma survivor. Siegel (2003) suggests

> The brain becomes literally constructed by interactions with others. As we participate in the "co-construction" of each other's minds, intimately sculpting the unfolding of our mutually created life stories, we find that our most intimate personal processes such as self are actually created by our neural machinery that is, by evolution, designed to be altered by relationship experiences. (p. 18)

The dyadic relationship formed in the therapeutic healthcare setting can provide the corrective emotional experience the survivor needs to recover. Although not yet empirically tested, Siegel's theory rests on the hypothesis that in order to aid a trauma survivor in healing, the provider must be focused "on how the therapeutic interpersonal experience enables integrative fibers to actually grow and thus enable new abilities to be attained" (Siegel, 2003, p. 3). Neural integration, the goal of therapy, can create neural connections between regions of the brain that

had not been interacting allowing the individual to regain self-regulation (Siegel, 2003). The success of neural integration is seen in the form of the trauma survivor's narrative sense of self.

As evidenced by this process of integration, therapists and healthcare providers have a large task ahead of them when working with trauma survivors. Solomon & Siegel (2003) remark "healing professionals are challenged to bear witness to this pain and join together in the mission to help people heal unresolved trauma and achieve lives that are not only free from symptoms but filled with new sense of vitality and hope" (p. xxi). In the process of achieving integration and mindsight, the survivor must reflect on the past, understand the present, and only then will be able to positively shape their future (Siegel, 1999).

Reflective Function. Additionally, the use of reflective function is an effective tool when working with trauma survivors. Reflective function, when utilized correctly, involves working with a client to reflect on what it felt like to have a particular experience (Siegel, 1999). Many survivors of trauma block their feelings as was described in the above section on the right and left-brain split. Reflecting on these blocked feelings and bringing them to the surface are crucial to healing from trauma. As Siegel (1999) points out, in disordered attachment situations, such as childhood sexual abuse, the brain structure is altered and the individual develops maladaptive states of mind. The use of reflective function can serve as a way for the survivor to learn more adaptive states of mind and to develop healthy internal working models. This therapy teaches mindsight, which allows for the understanding and processing of emotions.

Childbearing Clinical Application. Siegel (2003) specifies that attachment trauma is especially disastrous for an individual's development and hinders one's ability to form meaningful relationships with others. Sexual abuse by a person known to the victim is one such example of attachment trauma, which can lead to posttraumatic stress disorder. In the nursing

literature, it wasn't until 1992 that the first seminal article was published making a connection to a history of childhood emotional, physical, and sexual abuse, and the experience of childbearing (Rose, 1992). Anna Rose (1992) suffered abuse at the hands of her mother, father, stepmother, and several boys and men, with her earliest recall of being raped just before the age of three. Applying Siegel's theory to Rose's case, it is clear that her brain structure was altered as a result of numerous sexual assaults. Since Rose had not received therapy nor had she been properly prepared for the sensations of childbirth and their connection to her past abuse, these sensations caused her to relive the abuse. Siegel and Bryson (2011) aptly explain, that in posttraumatic stress disorder, "an implicit memory of a disturbing experience becomes encoded in a person's brain, and a sound or image triggers that memory without the person even realizing it's a memory" (p. 72). In applying Siegel's theory, one can see the physical experience of childbirth triggered Rose's brain to recall the abuse she had suffered. Had the memory of her abuse previously been made explicit, the childbearing experience may have been different for Rose.

Support of Siegel. Other prominent trauma researchers and psychiatrists support Siegel's concepts of trauma and its impact on the brain from their own work in the field and with survivors. One such person is Judith Herman (1997), a prominent psychiatrist and researcher specializing in trauma and the impact of trauma on individuals and groups. Herman (1997) also makes clear that "traumatic events produce profound and lasting changes in physiological arousal, emotion, cognition, and memory. Moreover, traumatic events may sever these normally integrated functions from one another." (p. 34). From her research, Herman (1997) posits that the survivor is inundated with powerful emotions but no clear memory of the trauma, because of the disconnect between the way the memory is stored and retrieved in the brain. Herman (1997) does not go into the detail about neuron integration that Siegel does; however, her research

makes clear that she views trauma as altering the brain structure as well. Furthermore, Herman (1997) has written extensively about the benefits of a survivor reconstructing the trauma story in order to move towards recovery, a point in line with Siegel's work.

Herman (1997) describes two stages of the recovery process for trauma survivors. The first stage involves forming a relationship with a caregiver in which the survivor is empowered. In the second stage, the survivor speaks aloud the story of the trauma and over time works to reconstruct the traumatic memory. "This work or reconstruction actually transforms the traumatic memory, so that it can be integrated into the survivors' life story" (Herman, 1997, p. 175). Women seek to speak about their past and its meaning to their current life (Dijkstra, 1995). Both Siegel and Herman address the notion that speaking about the past is a crucial step in the recovery process. "By making sense of our lives, we become free to join with others in creating emerging layers of meaning and connection" (Siegel, 2003, p. 8).

Conclusion

Chapter two contained a thorough review of the literature related to the childbearing experiences of survivors of sexual abuse. This review included published qualitative research, doctoral dissertations and master's thesis, a meta-synthesis, personal stories, and theoretical publications. The chapter also highlighted the relevant literature on breastfeeding, fear of childbirth, recommendations for care, and trauma-informed care as each relates to survivors of sexual abuse. Lastly a current perspective from psychology on the effects of sexual abuse was discussed. Chapter three will explore the research method, descriptive phenomenology, which was utilized for this research.

Chapter Three: Method

Introduction

Chapter three contains a detailed description of the research method utilized in this study. The research question, research purpose, general and applied description of the research design (descriptive phenomenology), sample, procedure, data analysis, general steps, methods ensuring rigor, protocols to protect research participants, and the researchers resources and skills are all addressed.

Research Question

The research question for this study was, "What is the essence of survivors' of sexual abuse childbearing experiences, including both pregnancy and labor and delivery events?"

Research Purpose

The purpose of this study was to understand the lived experience of childbearing, including both pregnancy and labor and delivery events, from survivors of sexual abuse. The dissemination of this understanding may lead to improvements for all survivors during their pregnancy and childbirth experiences. More specifically, this understanding may assist healthcare providers in their delivery of care to survivors throughout the childbearing process.

Research Design

Descriptive Phenomenology: Philosophy

The methodology of descriptive phenomenology was followed for this study. Descriptive phenomenology describes the essence of an experience and therefore, aligned with the aims of

this study. The method allows participants to openly describe the essence of an experience. This method also allows the researcher to examine the phenomena as the subjects experience it. The importance of having participants openly discuss their experiences is that "each individual has his experienced things, that is, if we understand by this what in particular is valid for him, what is seen by him" we come to understand the essence of an experience (Husserl, 1970, p. 164). Furthermore, the method allows the research findings to speak for themselves, without interpretation by the researcher. The method of descriptive phenomenology is inductive. As a result, the method begins with participants sharing specific experiences, and through analysis of these experiences, it leads to generalizable themes. These generalizable themes describe the essence of the experience.

To review the origins of descriptive phenomenology, it is essential to discuss Edmund Husserl who began the philosophical discussion of phenomenology. Specifically, descriptive phenomenology follows Husserl's philosophy. Husserl was a German, mid twentieth-century philosopher, and his philosophy is epistemologic. Husserl is often referred to as the father of phenomenology. His philosophy aimed to answer the question: What do we know as persons? Merleau-Ponty (1956) further offers

> Phenomenology is the study of essence and accordingly its treatment of every problem is an attempt to define an essence, the essence of perception, or the essence of consciousness, for example. But phenomenology is also a philosophy which replaces essences in existence, and does not believe that man and the world can be understood save on the basis of their state of fact. It is a transcendental philosophy which suspends our spontaneous natural affirmations in order to understand them, but it is also a philosophy for which the world is always "already there" as an inalienable presence

> which precedes reflection. The whole effort of phenomenology is to recover this naïve contact with the world and to give it, at last, a philosophical status. It is a philosophy intent upon being an "exact science," but it is also an account of space, time and the world "as lived." It is an attempt to describe our experience as it is and to describe it directly, without considering its philosophical genesis or the causal explanations which the scientist, historian or sociologist may give. (p. 59)

In order to return to things themselves, descriptive phenomenology has several main tenets. These main tenets are eidetic reductionism, intentionality, bracketing, transcendental subjectivity, intersubjectivity, and intuiting, all of which will be described in-depth in the following paragraphs. Bracketing, or the epoché, involves suspending ones' beliefs and previous experiences with the topic. This concept is unique to descriptive phenomenology and will be discussed at length given its importance to the methodology.

Reductionism and Bracketing

One of Husserl's (1970) main philosophical principles was a call to return to things themselves. In doing so, Husserl explained, a person is free to see things as they are, without any assumptions or preconceived notions. This principle is referred to as eidetic reductionism, and according to Husserl, it is central to descriptive phenomenology. "It seeks to describe *what* shows itself in experience or consciousness and *how* something shows itself" (van Manen, 2014, p. 229). Further, eidetic reductionism is the process by which the researcher brackets any preconceived notions on the experience being studied. The process of bracketing (the epoché) allows the researcher to look at the phenomena with a new lens. Bracketing can be best understood by visualizing mathematical brackets being placed around the researcher's prior experiences and preconceived notions on the research topic. Everything bracketed is then

suspended as much as is humanly possible during the research process. Van Manen (2014) further describes that the researcher puts "into brackets the various assumptions that might stand in the way from opening up access to the originary or the living meaning of a phenomenon" (p. 215).

Husserl (1964) stated, "the carrying out of epistemological reduction: bracketing everything transcendent" (p. 247). This principle further allows the researcher to see things as the participants describe them, free from his or her own presuppositions. The area of research is explored anew, free from any potential bias from the researcher. Husserl (1970) explains, "what is required, then, is a *total* transformation of attitude, a *completely unique, universal epoch*ē" (p. 148). Husserl made clear with this explanation that the researcher must deny any preconceived notions, and get rid of any attitudes about the phenomenon being investigated. Through abstention with preconceived notions, the researcher becomes "fully free: above all, free of the strongest and most universal and at the same time most hidden, internal bond, namely of the pregiveness of the world" (Husserl, 1970, p. 151). Phenomenology, therefore allows the research findings to speak for themselves because the researcher follows eidetic reductionism and brackets as much as is humanly possible. Van Manen (2014) aptly summarizes this notion when he states,

> I need to open myself (the epoché) and try to bracket all my presumptions, common understanding, and scientific explanations; at the same time, I need to regard the phenomenon that was given in my experience (the reduction) and observe how the remembrance emerged. (p. 217)

It is therefore through the suspension of scientific knowledge (bracketing) and an attentive turning to the world (reduction), that the researcher is led to the essence of an experience (van

Manen, 2014). Van Manen (2014) summarizes that "the underlying idea and purpose of the reduction [is] to gain access, via the epoché and the vocative, to the world of prereflective experience-as-lived in order to mine its meanings" (p. 221).

Intentionality

Another aspect of phenomenology central to Husserl is the concept of intentionality. Intentionality, or intentional consciousness, is the meaning we ascribe when we perceive something. Intentionality follows that the researcher will construct meaning from the participants' thoughts, feelings, and perceptions of an experience. It is crucial that the researcher constructs this meaning as authentically to the actual experience as possible. Merleau-Ponty (1956), further offers the following thoughts about intentionality:

> Whether it is a case of something perceived, or a historical event or doctrine, "to understand" means to seize again *the total intention*. To understand, one must grasp not only what these are when represented: the "properties" of the thing perceived, the dust of "historical fact," the "ideas" introduced by the doctrine. Seizing the total intention means grasping the unique manner of existing which is expressed in the properties of the pebble, the glass, or the piece or wax, in all the facts of a revolution, in all the thoughts of a philosopher. (p. 67-68)

Intentionality means, for example, that I understand a statement made by another individual about the trimesters of pregnancy because I myself have had experience personally and professionally with pregnancy. Since I have had my own experiences and feelings about the trimesters of pregnancy, I bring my own meaning to my interactions with others on this topic. It is imperative to descriptive phenomenology to acknowledge that in normal day-to-day interactions we ascribe our own meaning to other people's experiences and words.

In descriptive phenomenological research, the danger of ascribing our own meaning to participants' narratives is that we do not then know the actual meaning of the experience for the participants. Merleau-Ponty (1956) posits "certainly a doctrine cannot be refuted simply by connecting it to this or that accident in the life of its author – its meaning extends beyond that" (p. 68). Intentionality therefore leads directly into the concept of bracketing. Bracketing is essential in order for the researcher to suspend his or her presuppositions about the topic. Through bracketing, the researcher can glean the meaning of the experience for the participants.

Transcendental Subjectivity and Intersubjectivity

Other important tenets of phenomenology are transcendental subjectivity and intersubjectivity. In his numerous writings on the methodology, Husserl explained the important notion of transcendental subjectivity. Husserl (1970) wrote that,

> Each individual, as a subject of possible experiences has his experiences, his aspects, his perceptual interconnections, his alteration of validity, his corrections, etc.; … Here again, properly speaking, each individual has his experienced things, that is, if we understand by this what in particular is valid for him, what is seen by him, and through the seeing, is experienced as straight-forward existing … (p. 164)

Husserl (1970) described a person's ability to self reflect, to share their thoughts and feelings, as transcendental subjectivity. The knowledge that other people also have this ability to share their innermost emotions and perceptions is known as intersubjectivity. Husserl's above quote draws attention to this concept of intersubjectivity. Additionally, Munhall (2012) describes that "intersubjectivity is the verbal and nonverbal interplay between the organized subjective worlds of two people in which one person's subjectivity intersects with another's subjectivity" (p.139). A person's subjective world is made up of all of their thoughts feelings and perceptions

(Munhall, 2012). Therefore, it is impossible to know about another person's subjective world unless they tell us about it, and even still we cannot be certain (Munhall, 2012).

Intuiting

As a methodology, descriptive phenomenology allows the findings, the facts, to speak for themselves. The participants' descriptions of the experience are the findings. These findings speak for themselves because they are free from interpretation by the researcher. Intuiting is the term Husserl (1970) applied to describe the findings as being free from interpretation. More specifically, intuiting is the process of examining things just the way they are. Munhall (2012) describes this process as

> 'unknowing' in which you listen with 'the third ear' free, to the extent possible, of any prejudice or bias …and other noise that might prevent you from hearing clearly, uninterrupted when you are listening to others by 'noise' about the meaning of the experiences. This is also an important step in seeing the experience in whatever forms it shows itself. Often, we see something and automatically overlay that sight with our own interpretation. (p. 137)

This concept of intuiting is at the core of descriptive phenomenology and accomplished by the researcher bracketing.

In reading Husserl's philosophy, it is apparent that phenomenology is rooted in examining the life experiences of the subjects. Husserl (1970) wrote

> Is it not in the end our human being, and the life of consciousness belonging to it, with its most profound world-problematics, which is the place where all problems of living inner being and external exhibition are to be decided? (p. 114)

Phenomenology seeks to uncover all the thoughts, feelings, and perceptions participants may have related to an experience. As a phenomenological researcher, the researcher looks beyond simply what something is like, but seeks the meaning of the participant's experience (Munhall, 2012). The examination of the meaning of life experiences, the childbearing process of survivors of sexual abuse, is exactly what this study set out to accomplish. Therefore, descriptive phenomenology, aligned seamlessly with the aims of this research.

Descriptive Phenomenology: Method

Colaizzi's (1978) method of descriptive phenomenology was utilized for this research. The "method remains with human experience as it is experienced, one which tries to sustain contact with experience as it is given" (p. 53). The experiences shared are the results when applying this method.

I followed the general steps outlined by Colaizzi (1978) to analyze the data.

(1) First, I read the transcribed interviews multiple times in order to become familiar and comfortable with the material.

(2) Next, I identified significant statements from the interviews by highlighting and numbering each individual statement.

(3) I derived formulated meanings from the significant statements. Formulated meanings uncover the significance and specific meaning of each statement.

(4) I arranged the formulated meanings into clusters of themes using the long table approach.

(5) After validating the themes, I wrote an exhaustive description of survivors' childbearing experiences. At this point in the study, the exhaustive description was emailed to two participants who had agreed to review it when they had been interviewed. Colaizzi (1978) focuses on the participant as an essential part of the process of descriptive phenomenology,

referring to the participant as a "co-researcher." Both participants responded to the email agreeing completely with the exhaustive description. Neither suggested any changes. These two participants, my "co-researchers," validated that the exhaustive description captured the experience of childbearing.

(6) In this final step, the validated exhaustive description of survivors' childbearing experience was finalized. I ensured that the exhaustive description of survivors' childbearing experience was "as unequivocal a statement of identification of its fundamental structure as possible" (Colaizzi, 1978, p. 61). The exhaustive description was as true to the participants own experiences and words as it could be.

Sample

Recruitment for this research took place through a support, counseling, and advocacy organization for survivors of domestic abuse and sexual abuse in Connecticut. I was granted permission to recruit for this research study from a support group leader at this organization (Appendix A). In order to ensure adequate recruitment I utilized several methods: (1) Flyers were placed at the physical office buildings (Appendix B). (2) Flyers and call for participants were available and discussed at sexual abuse support groups (Appendix B and C). (3) I directly recruited participants before and after sexual abuse support group meetings. (Appendix C). (4) Flyers and/or a call for participants were emailed to members of sexual abuse support groups by the group leader (Appendix B and C). (5) Referrals from other participants. (6) Snowball sampling. The support, counseling, and advocacy organization for survivors of domestic abuse and sexual abuse in Connecticut was an ideal location to recruit given the women had access to support groups should the interview or written narrative have caused them upset feelings as they recalled their childbearing experiences.

A purposeful sample was utilized for this study in which study participants were chosen because they met the study criteria and would be the best informants on this topic area (Polit & Beck, 2012). Participants self identified as having a history of sexual abuse. The inclusion criteria for the sample was as follows: self-identifying, female survivors of sexual abuse who have had at least one childbearing experience, English speaking, and at least 18 years of age. The age at which the abuse occurred, type of sexual abuse, and/or length of time over which the abuse occurred was not used as inclusion or exclusion criteria, but rather collected for demographic information. Additionally, no limits were placed on how many childbearing experiences participants had, the types of childbearing experience (i.e. vaginal birth, cesarean birth, miscarriage, elective termination), or how many years have past since the childbearing experience. Women of all races, ethnicities, and education levels were eligible to participate.

Recruitment ended after the eighth interview because data saturation was reached, meaning no new information was revealed from the interview. This process aligns with the tenets of descriptive phenomenology. Depending on the topic, a typical descriptive phenomenology study has a sample size of 7-10 (Polit & Beck, 2012). This study's sample of eight participants falls well within the normal range for phenomenological research. The eight participants were all female survivors of sexual abuse who have had at least one childbearing experience.

Further, the sample of eight survivors of sexual abuse ranged in age from 38-58 years. The average age was 45 years. Seven participants self identified their race as Caucasian and one as Hispanic. Seven participants experienced childhood sexual abuse in which the abuser was a family member. Four suffered abused by their fathers, two by an uncle, and one by a family "friend." Two participants, one of whom was also abused by her father, were raped by a

stranger. The age at which the abuse first began ranged from age five to age 14. The length of time over which the abuse occurred ranged from one year to 15 years (with the exception of one participant who was raped by a stranger in an isolated incident). For the protection of the woman in this study, no further information regarding the specific ages of the abuse, or the exact relation to the abuser are reported.

The participant breakdown of highest level of education completed was as follows: three high school/diploma, three associate degrees, and two bachelors degrees. Two participants shared during their interviews that they were Registered Nurses (RNs). The participant breakdown of marital status was as follows: three participants were currently married, two in a committed relationship, and one each divorced, single, and widowed.

Each participant shared between one and six childbearing experiences, for a total of 22 childbearing experiences. Sixteen of these experiences resulted in a live birth, four were spontaneous miscarriages, and two were elective terminations of pregnancy. Two participants gave a child up for adoption at the time of delivery. Six participants reported having between one and four vaginal deliveries each, two of which involved the use of forceps. Two participants reported having two and three cesarean sections respectively. Participant's age at their first delivery ranged from 16 to 30 years. The average age at first birth was 23.6 years. Five participants had an obstetrician provide care to them during pregnancy and delivery, one participant had both an obstetrician and midwife, and one participant received no prenatal care, but had an obstetrician deliver her child. Only one participant was specifically or directly asked about a history of sexual abuse during her childbearing experiences.

Participant's ranged from having their first childbirth experience resulting in a live birth between 13 and 36 years prior to the interview. On average, participants' first childbirth

experience was 21.5 years before this interview. Arguably, this length of time appears extreme and raises questions about the validity of the participant's experience. Simkin (1991) found that a women's memory of childbirth is still very much "vivid" and that women have "recalled exact details" of their experience twenty years after the delivery (p. 209). The participants in this study also shared minute details from their childbearing experiences and had no difficulty recalling these events, aligning with Simkin's (1991) work.

Participants' age when they first disclosed their history of sexual abuse ranged from 9 to 42 years. The average age of disclosure was 27.9 years. One participant did not remember her past history of sexual abuse until 29 years after it occurred and well after she had given birth to her children. Another participant knew she had been sexually abused by her uncle, but during her childbearing experience recalled that there was another family member who also sexually abused her. Six participants have received counseling specific to their history of sexual abuse. Only four of these six still remain in counseling currently.

Setting

Each interview took place in a setting the participant felt the most comfortable in. On average, the time to complete the interview or the written narrative was estimated to be between 30 and 60 minutes. The interviews began on January 23, 2014 and were completed by February 27, 2014. On average, the interviews lasted between 15 and 33 minutes. A total of 25 to 60 minutes was spent with all participants. The non-interview time after the research interview consisted of a debriefing with the participant. During the debriefing, I first assessed how each participant was feeling emotionally after participating, provided them with information about experiences they discussed in their interview, and offered to share the findings of this research

with them. This non-interview time after data collection was not included in the research findings.

Six participants were recruited in person, when I directly recruited prior to the start of the support group meetings. These six participants each took part in a face-to-face, in-depth, semi-structured interview. Each of these interviews took place on an afternoon or evening just prior to the sexual abuse support group meeting time. The intention of this scheduling was purposeful so that if a participant became emotionally upset as a result of participation, she could meet with the group leader/counselor immediately. Fortunately, no participant became emotionally upset or needed this resource. Five of the participant interviews were conducted in a private office space at the same location that the support group meets. One participant chose to have the interview conducted at her home, where she felt most comfortable.

The additional two participants were recruited as follows: one saw a recruitment poster and contacted me, and the other was recruited through snowball sampling. These two participants partook in the study, but elected not to have face-to-face interviews. One of these participants shared her experiences through a written narrative she emailed to me. The other participant shared her experiences via a one on one telephone conversation. These two participants choose these methods as they worked best for their schedules. They also had access to a counselor, should they have needed one.

Additionally, one potential participant who saw the recruitment poster contacted me. I emailed her information about the study, but she never responded to the email. I did not send her a reminder email, as to not burden or pressure her. I assume from the lack of a response that she decided not to participate.

Procedure / General Steps

Upon receiving the University of Connecticut's Institutional Review Board (IRB) approval for this study in January 2014, I attended the beginning portion of a support group for survivors of sexual abuse run by the established recruitment organization. At this time, I introduced myself and the research study to potential participants (see Appendix B & C).

Participants were given the choice to engage in a one on one interview discussing their experience(s), to write a narrative of their experience(s), or to speak over the phone about their experience(s). Six participants engaged in a face-to-face, one on one interview. One participant shared her experiences via email, and one participant shared her experiences in a one on one interview over the phone. As the researcher, I interviewed all participants and subsequently transcribed the interviews myself. Throughout this research process, I bracketed my past experiences of caring for survivors in the healthcare setting as a Certified Nurse Midwife. At the end of this chapter, under the section "Researchers Skills and Resources" I provide a detailed description of my past experiences and knowledge that was bracketed throughout this research study. As much as humanly possible, bracketing allowed me to analyze the data without any presuppositions. Furthermore, I bracketed all of my thoughts, feelings, or beliefs surrounding the research topic throughout the interviews and data analysis.

The specific steps of the research process were as follows. First, I recruited participants who meet sample criteria. I then scheduled a time to conduct the interview with seven of the participants. I also provided the information about the study via email to one participant. The first part of each interview began with obtaining informed consent (Appendix E). During the six face-to-face interviews, two copies of the informed consent were signed, one was kept on file by the researcher and the other was given to the participant to keep for her records. Any questions the participants had were answered at this time. Prior to the telephone interview, informed

consent was obtained via email correspondence during which the participant signed the informed consent and then I signed it and emailed it back to her for her records. This same process occurred for the participant who shared her experience via a written narrative, which she emailed to me.

The general steps for this research are as follows. (1) For the six participants who had a face-to face, one on one interview, the recording device was turned on at the start of the interview. For the one participant who was interviewed over the phone, the conversation was also recorded. The participants were asked to complete a participant profile form (Appendix D). The opening statement to begin the interview was, "As a survivor of sexual abuse, please describe for me your experience of childbearing, including both pregnancy and labor and delivery. Share all your thoughts, feelings, and perceptions until you have no more to say about the experience. Specific examples are helpful." As the researcher, I was bracketing as the participant described her experiences. I did not ask any specific questions; however, at each of the interviews I needed to obtain more experiences from the participant. I used general probing questions, such as "Thank you for the experiences you have shared. They are very helpful to the research project. Can you please describe from beginning to end, one specific memory of your childbearing experience, either from pregnancy or labor and delivery." The interviews each concluded when the participant had no further experiences to share. At the end of each interviews, I thanked the participant for what she shared and expressed that her experiences were very important to the research project. I also utilized process content, by asking the participant if there was anything she would like deleted from the recorded interview prior to transcription. None of the participants choose to delete any portion of their interview. After this formal part of each interview, I debriefed with each participant. We had a conversation about the topic of

childbearing in the context of being a survivor of sexual abuse and I offered to share the research findings with the participant. We also discussed any emotions they had as a result of participating. Each participant was grateful for the opportunity to discuss her experiences. No participant became emotionally upset as a result of this interview. This portion of the conversation, the debriefing, was not recorded and was not used in the data analysis. At the end of each interview, I gave each participant a $20 gift card to Target as a thank you for her time and participation in this research study. I subsequently mailed the participant who was interviewed over the phone a $20 gift card to Target.

(2) For the one participant who choose to write her response, I emailed her both the demographics form and the research statement "As a survivor of sexual abuse, please describe for me your experience of childbearing, including both pregnancy and labor and delivery. Share all your thoughts, feelings, and perceptions until you have no more to say about the experience. Specific examples are helpful." She responded with a completed demographics form and a two-page word document in response to the research statement. She included in her email that she hoped the information she provided would be helpful to the research study. I replied to her email and thanked her for her time, experiences shared, and participation in the study. I subsequently mailed her a $20 gift card to Target.

Rigor of General Steps

After each interview, I wrote down the non-verbal cues of the participant and took field notes. These field notes were of parts of the interviews that seemed to be particularly important as well as my working thoughts of similarities amongst experiences shared by participants as the interviews went on. These cues and notes were kept in the research diary. I transcribed the eight interviews myself, which aided in the process of becoming comfortable with the data. From the

eight transcriptions, 302 significant statements were extracted in the spring of 2014. These significant statements were each cut out of a printed copy of the transcriptions and then pasted onto 302 individual index cards. Simultaneous to this step, formulated meanings were written for each significant statement. This process allowed me to sort the formulated meanings into piles as theme clusters were identified.

On June 1, 2014, I identified 21 clusters of themes. On June 5, 2014, 10 themes were collapsed, leaving 11 themes. At this stage, the four themes, "vaginal exams as triggers," "delivery as a trigger," "epidural as a trigger," and "flashbacks," were collapsed together to form the theme "and all of a sudden I was that little girl again: triggers during labor and delivery." The two themes, "freak show" and "no privacy," were collapsed together to form the theme "freak show." The two themes "no support/no where to turn" and "feeling judged," were collapsed together to form the theme "all too familiar: no support, no where to turn." The three themes "grief for what could have been a better experience," "guilt," and "positive/happy emotions," were collapsed together to form the theme "an emotional roller coaster: from excitement, to grief for what could have been a better experience." The two themes, "not being listened to" and "nothing was explained to me," were collapsed to form the theme "Am I even here?: Nothing was explained and I had no voice." The two themes "no one asked me about my history" and "just ask me!," were collapsed together to form the theme "No one asked me. Just ask me!"

On August 10, 2014, themes were further collapsed, leaving seven themes. At this stage the two themes "no connection/memory to the abuse" and "compartmentalizing" were collapsed together to form the theme "no connection/memory to the abuse." The three themes, "and all of a sudden I was that little girl again: triggers during labor and delivery," "freak show," and "no

connection/memory to the abuse" were collapsed together to form the theme "all of a sudden I was that little girl again and/or I compartmentalized it: the all or nothing experience." The two themes, "infant feeding choice" and "provider choice" were collapsed to form the theme "Holding on to the choices I can make: who my doctor is and how I feed my child."

Over the next 10 days, I could not further collapse any themes. The end result was seven themes, which will be discussed in detail in the findings section. During this data analysis process, I documented each step in the research diary. This documentation of the interview and data analysis process both added to the auditability of the pilot study. After writing up each of the seven themes, an exhaustive description of the childbearing experience of survivors of sexual abuse was written based on these themes.

Further following Colaizzi's (1978) method of descriptive phenomenology, the participants, the co-researchers, were asked at the time of their interviews if they were willing to review the results. Two participants agreed to review the results and each decided that email would work best for this process. I emailed the exhaustive description that resulted from this research individually to these two participants in early September. I asked them to read it over and to please let me know if it was an accurate reflection of what they had shared during the interview. Both participants replied to my email and stated that the description was accurate and no changes were necessary. These two co-researchers validated the findings, which adds to the credibility of this research.

The fittingness of the study was enhanced by inclusion of participants who had both experience with the phenomena of study and were able to articulately voice their experiences with the phenomena. The trustworthiness of the study findings was accomplished through bracketing.

Protocols to Protect Research Participants

IRB

The University of Connecticut's Institutional Review Board (IRB) approved this study in January 2014. The study was selected for a random audit by the IRB in July of 2014. This audit was successfully completed on September 10, 2014 with no concerns reported in the implementation of the study protocol.

Human Subject / Ethical Considerations

A copy of the informed consent can be found in Appendix E. The participants signed informed consent form was kept separate from the audio recordings, interview transcripts and the written narratives. Furthermore, these items were kept in separate locked drawers.

Participants were informed of how confidentially of their interview narratives would be protected. The issue of secrets that can be disclosed during an interview was addressed using process content, which was described in the previous section. None of the participants asked for any portion of the interview to be deleted.

As a result of the sensitive nature of this study, I made several decisions as the researcher to further protect the participants in this study. First, the sample for this study was recruited from an established support group for women who have experienced sexual abuse, so that participants would have a built in support network if they needed one. Furthermore, the six face-to-face interview took place on an afternoon/evening just prior to the sexual abuse support group meeting time. The intention of this scheduling was purposeful so that if a participant became emotionally upset as a result of participation, she could meet with the group leader/counselor immediately. Additionally a plan was in place that if any participant became emotionally upset

as a result of the study, she would have had immediate access to a professional counselor through the recruitment agency, which offers counseling services to survivors of domestic abuse and sexual abuse. Thankfully, no participant needed these safeguards, because no one became emotionally upset during the interview.

The only "costs" to the participants was the time they devoted to participating in this study. Each participant was given a $20 Target gift card to compensate them for their time and efforts for partaking in this study. The amount was decided based on the fact that $20 is not an amount that would coerce participants. This amount simply acknowledged their time for participating in the study. Participants were given the gift card upon completion of either the interview or the written response.

Although there are no direct benefits to participants from participation in the study, past research has shown that discussing childbearing experiences has been helpful to survivors. Women have found it therapeutic to share their childbearing stories as they relate to a history of sexual abuse (Coles & Jones, 2009; Dijkstra, 1995). "Although the risk of lasting harm stemming from participation in trauma research is a legitimate concern, the benefits of confiding a traumatic experience to a trustworthy other seem to outweigh the immediate distress that accompanies discussion of painful experiences" (Draucker, 1999, p. 161). Furthermore, from her work on birth trauma and the breastfeeding experience, Beck (2009) offers the following quote from a participant,

> I am eternally grateful that you have made it possible for me to tell my story. Part of why I shared my story with you was in the hope that it might help inform the way child sexual abuse is considered, understood and addressed by healthcare providers. It would do my heart good if you felt my experience was helpful in achieving that goal. (p. 97)

Each participant in this current study was also grateful to have participated and thanked me for researching this important, under researched topic. They were all interested in how the research findings would reach healthcare providers so that changes could be implemented. I told them each my intention to publish the study findings in a healthcare journal read by practicing women's healthcare providers. Furthermore, I shared with each participant that the understanding gained from this study will inform women's healthcare providers on ways to improve the care of survivors, potentially leading to better outcomes and experiences for survivors.

Lastly, the two participants that validated the findings both shared gratitude again for this research. After reviewing the exhaustive description, one participant thanked me for allowing her to be part of this research study. The other participant thanked me for bringing attention to a topic no one really wants to talk about.

Researcher's Resources and Skills

The following section describes my background of working with survivors of sexual abuse, as well as the skills and the resources I utilized to complete this research. Importantly, my background and past experiences working with survivors of sexual abuse is necessary to explain, so that the reader may understand that to the best of my ability, I have attempted to bracket all of these experiences leading to this research interest.

The impetus to focus my time and efforts researching the experiences of survivors' childbearing experiences began when I was in college. I am fortunate to have never personally experienced sexual abuse and to have grown up in an environment free of violence. My knowledge regarding this topic stems exclusively from my clinical work as a Certified Nurse

Midwife and my scholarly research. As an undergraduate nursing major at Fairfield University in Fairfield Connecticut, I became aware of the prevalence of sexual assault on college campuses across the United States. I was appalled when I learned that 44% of all rape victims are under the age of 18 and that girls aged 16-19 are four times more likely than other age groups to be victims of rape (The Rape, Abuse, Incest, and Neglect Network, 2009). I came face to face with these statistics as a Resident Assistant caring for freshman females. When faced with the reality and prevalence of sexual assault, I personally felt that I needed to act to help raise awareness. I developed an interactive rape awareness program geared toward first year female college students that ran for about 3 years at Fairfield University.

Additionally, in 2005, I was a research assistant in a study assessing women's past exposure to personal violence. The data collection occurred in an emergency room setting and followed a set script with which to obtain informed consent and then to conduct the interview. I assisted the Primary Investigator by consenting participants to the study and then administering the study questionnaire. From this experience, I am aware of the necessity to avoid interjecting any of my own thoughts, opinions, or advice. As a result I am very comfortable with bracketing. My past research experience has added to my comfort in discussing the topic of sexual abuse and violence with women. Following my undergraduate career, I attended Yale University to complete a masters in nursing with a specialty in midwifery where I continued to have a keen interest in research and education surrounding sexual assault.

However, it was not until I began practicing as a full scope Certified Nurse Midwife (CNM), in 2008, in an inner city in Connecticut that I witnessed the realities of the pervasive repercussions of a history of sexual abuse. The impetus for my trajectory of research to focus on survivors of sexual abuse arose from my clinical practice, as I shared in chapter one with my

experience of caring for Lydia. I have observed differences in the abilities of women to cope during labor or with pelvic examinations during my clinical practice. Often, women with a history of sexual abuse have a more difficult experience coping with the vaginal pressure and the contractions associated with childbirth than their counterparts without this history. In my experience, the difference in experiences is due to the connection of these sensations (i.e. lack of control, exposure of body) to a past history of sexual abuse.

Throughout my practice as a Certified Nurse Midwife, I have had experience providing gynecologic and obstetric care to victims of sexual abuse. I begin all patient visits and encounters by discussing a health history, and I specifically ask about any past or current experiences with sexual abuse, violence, or assault. If a woman reports a history, I then ask if she is comfortable discussing the experience. If she is comfortable, I devote the time to validating her experiences. Often, survivors have had limited exposure to someone who is willing to listen to what happened to them and to acknowledge it as a traumatic event in their lives. Screening women for such abuse is often neglected in the healthcare setting due to time constraints of office visits and/or providers being unprepared to address the woman's needs if she reports a history of sexual violence (Finnbogadóttir & Dykes, 2012; Herzig et al. 2006; Jackson & Fraser, 2009). Personally, my experience has been that screening women for sexual abuse has lead to strong therapeutic relationships, continuity of care, and an overall more positive healthcare experience for the patient.

A strength I bring to this research is my knowledge of Colaizzi's (1978) method of descriptive phenomenology gleaned through completion of the qualitative methodology in nursing inquiry class taught by Dr. Cheryl Beck at the University of Connecticut. Primary sources of Colaizzi's (1978) methodology were read. Furthermore, Dr. Beck, an expert in

qualitative methodology, served a mentor throughout this research and as the chair of my dissertation committee.

In conclusion, this section is important for the reader to understand my background, and to know that I bracketed all of these past experiences throughout this research study.

Timetable

The topical idea and outline for this dissertation began at the outset of my doctoral studies in the Fall of 2011 and was enhanced throughout my studies. In July of 2013, I first contacted the recruitment agency and made a connection with a counselor there to discuss the feasibility of recruiting through sexual abuse support groups. The relationship between this counselor and myself developed over several months, and the organization agreed to be the recruitment site for my dissertation pending IRB approval. The research proposal was submitted in October 2013 and following acceptance of the proposal by my major advisor and associate advisors, the IRB-1 protocol application for the involvement of Human Participants in Research was submitted in November 2013. The IRB at the University of Connecticut approved this protocol on January 7, 2014. One week later, I attended a sexual abuse support group meeting and introduced myself and the project to the women who were present at the meeting. Over the course of the end of January through the end of February, interviews were conducted with eight survivors. In March, all of the interviews were transcribed. From April through May the transcribed interviews were read several times and significant statements were identified. Formulated meanings were also written for each significant statement at this time. In early June, themes were identified. On June 27, I gave birth to my second daughter and did not work on this study for the subsequent six weeks. When work resumed on this study in early August, the

themes were collapsed for a final time. The results were subsequently written in Chapter 4 of this dissertation. The end result was an exhaustive description of the childbearing experiences of survivors of sexual abuse. Two participants reviewed and validated this exhaustive description as representative of the childbearing experience. The completed dissertation was submitted in the Fall of 2014.

Summary

Descriptive phenomenology was the method used for this research study. The sample consisted of eight self-identifying survivors of sexual abuse who had at least one childbearing experience. Seven interviews and one written narrative were collected and transcribed. Colaizzi's (1978) descriptive phenomenological data analysis was followed. Ethical considerations regarding human subjects were discussed. The next chapter presents the findings of the inquiry.

Chapter Four: Results

Introduction

In chapter four, the seven overarching themes derived from this research are discussed in depth. An exhaustive description of the childbearing experiences of survivors of sexual abuse is then presented. The exhaustive description was reviewed and validated by two participants and

is “as unequivocal a statement of identification of its fundamental structure [the childbearing experiences of survivors of sexual abuse] as possible” (Colaizzi, 1978, p. 61).

Findings of the Inquiry: General

From the eight transcriptions, 302 significant statements regarding the childbearing experience of survivors of sexual abuse were identified. Table 2 contains 10 selected examples of significant statements with the corresponding formulated meanings. Each formulated meaning was then arranged into clusters of themes. A total of seven clusters of themes were formed. Examples of two of these theme clusters can be found in Table 3. Under each theme in Table 3, examples of the formulated meanings that comprise that theme are illustrated. Table 3 allows the reader to follow the researchers thought process during the formation of the seven overarching theme clusters.

Findings of Inquiry: 7 Overarching Themes

The following seven overarching themes were identified. They describe the essence of childbearing for survivors’ of sexual abuse.

1. No one asked me. Just ask me!
2. An emotional roller coaster: From excitement, to grief for what could have been a better experience
3. All of a sudden I was that little girl again and/or I compartmentalized it: The all or nothing experience
4. Am I even here?: Nothing was explained and I had no voice
5. All too familiar: No support, nowhere to turn

Subtheme: 1. Feeling judged

6. Holding on to the choices I can make: Who my doctor is and how I feed my baby

7. Overprotection: Keeping my child safe.

Subthemes 1. Family Dynamics

2. How can I leave them?

These seven themes identified describe the essence of the childbearing experience of survivors of sexual abuse. Before individual discussion of each of the seven theme clusters, a portion of one participant's interview will be shared. The following quote from the transcribed interview of a survivor, aptly summarizes the themes identified in this research study:

> The hospital I gave birth in was a teaching hospital. [The doctor] never asked me but in the delivery room like I said I wound up being/feeling like a Freak Show because she invited seven medical students to come in. So I had three nurses, the doctor, seven medical students, and it was like she had no sense of my privacy. When she checked me to see if I was dilating she just pulled the sheet off and did her thing. And I'm sort of like you know! By the time I realized what she was doing, she was done. When it came time, fully dilated and started pushing, I can still see the medical students are all along the wall behind the doctor. The doctor is there, the nurses are there, she kept the sheet off me the whole time. And I was just like, why don't you just put a video camera here and broadcast it on the national news, that's what I'm thinking. There's no privacy, nothing. And then as soon as my daughter was born she told the nurse to take my johnny off and she put the baby right on my chest and then she sort of threw the johnny over me, and I'm sort of like, What? And she's like alright you should nurse the baby now. And I'm like, I'm not keeping it and she's like you need to bond with the baby. But I'm like I don't want to.

Throughout the following discussion of the seven clusters of themes identified in this research study, the reader can refer to this exemplar quote to fully appreciate the connections between each theme as it pertains to childbearing experiences of survivors of sexual abuse. An exhaustive description of the essence of the childbearing experience for survivors of sexual abuse is provided after the discussion of the seven themes.

Theme 1: No one asked me. Just ask me!

Six participants spoke passionately about the fact that no one asked them about a history of sexual abuse. Neither the doctors they saw for prenatal care, nor the nurses on labor and delivery inquired about a history of abuse. Even in the presence of red flags suggesting that there may be a history of abuse, healthcare providers did not ask. Overall, survivors said that they would like to have been asked.

Survivors made it clear they were never screened for a history of sexual abuse by sharing the following thoughts: "I never had anyone ask me about my past abuse. I was never asked by any physician" "None of those doctors knew that I was sexually abused." "Never, never did anyone ask."

Furthermore, survivors often had red flags that they had experienced sexual abuse. Healthcare providers, both doctors and nurses, did not screen survivors for a current or past history of sexual abuse even when red flags were present. The missed opportunity to be screened was noted by survivors during their childbearing experiences. A survivor whose college roommate attended her delivery as her support person recalled, "Nobody asked why's your partner female? Where's your boyfriend? I'm like well I don't have a boyfriend, but I was never asked. It could have been done differently." Later in her life, a survivor of incest joined a

convent, and it was during this time in religious life when two men raped her. The rape resulted in a pregnancy and subsequent miscarriage. When this survivor presented to the emergency room due to complications of this miscarriage, she recalled, "They never asked me …How did this happen? You know, you're a nun, and you're pregnant, what happened? It was just, oh there's a pregnant nun in that cubicle." This same survivor shared that during another pregnancy that resulted from incest by her father, her obstetrician failed to pick up on the abuse. Her experience captures this theme.

> My doctor was a female OB [obstetrician] and she knew I was going to give up the baby for adoption but she never, she never asked any questions. I mean I don't know whether she thought it was like none of her business or whatever, but she never asked who the father was, never asked if I was a sexual abuse survivor, none of that.

Despite the presence of red flags indicating a potential history of sexual abuse, healthcare providers did not screen survivors.

Furthermore, survivors felt strongly that it would have been helpful to be asked about a history of sexual abuse and to discuss this history in the context of their childbearing experience. A survivor illustrates this theme with the following thoughts,

> There was a nurse there, but she never asked me if anything had happened. I definitely think it would have helped, because you're thinking your emotions are one thing for one reason, and they're not. And they're not getting dealt with and it needs to be dealt with.

Even beyond the childbearing experience, survivors felt every gynecologist should ask about a history of sexual abuse. A survivor of CSA offered,

> I believe that even at every female doctor [obstetrician/gynecologist] you go to, that [asking] should be a part of it [the visit] so that you can deal with it. Because even just

the exam itself when you're not pregnant, it's uncomfortable, and it could bring back memories that you don't want.

Survivors further had suggestions for how healthcare providers could screen for a history of sexual abuse. Questionnaires at the start of healthcare visits were suggested as a method for screening. "That [screening] should be in a questionnaire when you first go to a place," a survivor suggested. Overall, survivors felt that healthcare providers should just ask them about a history of sexual abuse.

In conclusion, survivors were not asked about a history of sexual abuse and said that they just want to be asked. The following thoughts from a survivor of CSA capture the importance of this theme, "I think that if I had help way back then, I think I would have had a totally different experience."

Theme 2: An emotional roller coaster:

From excitement, to grief for what could have been a better experience

All eight of the participants in this study expressed a variety of emotions related to their childbearing experience. Participants shared both positive and negative sentiments. Six participants shared positive emotions, such as love, enjoyment, and excitement, related to their childbearing experience. Of these six participants, five also shared negative emotions. Two additional participants discussed only negative emotions, such as guilt and anxiety related to their childbearing experience. The juxtaposition of having both positive and negative feelings within the same childbirth experience is discussed in this theme. This theme is representative of the emotional roller coaster experienced by survivors of sexual abuse. The theme "an emotional roller coaster: from excitement, to grief for what could have been a better experience", will be

discussed in the following two categories: “I actually enjoyed it” and “grief for what could have been a better experience.”

“I actually enjoyed it”

Notably, the positive emotions shared by six participants were not as plentiful as the negative ones. Of these six participants, the five who also had contrasting negative emotions shared more negative than positive emotions during their interviews. Discussion of the positive emotions is, however, important given the juxtaposition of survivors experiencing both positive and negative emotions during pregnancy and labor and delivery. Enjoyment, excitement, and love were the positive emotions experienced by survivors during childbearing.

Two participants welcomed the physical changes of pregnancy. “It’s a just a miracle, just the fact that something’s growing and living inside of me,” a survivor poignantly shared. They shared their enjoyment of the changes their bodies were going through during that time. As the first statement made during her interview, a survivor of incest stated, “As a survivor of sexual abuse, I actually loved my pregnancy. I loved being pregnant.” She continued, “Physically I loved it [pregnancy].” Another survivor of incest said, “But as far as having the pregnancy itself, I actually enjoyed it. I like the different stages, the different trimesters.”

In addition to love, survivors experienced excitement and enjoyment for being pregnant. The excitement survivors felt during pregnancy captures their anticipation for starting over with their own children. They were excited as they as they prepared to become mothers and enjoyed their pregnancies. A survivor of CSA shared, “my first pregnancy was with my son and I was very excited (nervous and excited).” In discussing her fourth pregnancy, a survivor of sexual abuse shared, “I did get to enjoy that pregnancy. I wasn’t working, I was already clean and sober,

I was more settled in." She repeated how much she enjoyed this fourth pregnancy twice during her interview. Another survivor recounted she had a "healthy pregnancy, no problems."

Survivors also discussed the excitement they had during labor and delivery. A survivor of incest recalled that during her daughter's birth, "I honestly had nothing but excitement." A survivor recalled this memory of her childbearing experience: "It was a really great time. With my first son, EVERYONE was so excited. The first grandchild on either side. First nephew, etc." In discussing her delivery, a survivor of incest shared, "I was actually happy to have my baby, I didn't have any negative feelings about it. The physical part was fine. I didn't have any contraptions, nothing helping me deliver the baby. I had no problems delivering the baby." Also during a planned cesarean delivery, a survivor of incest recounted, "Everything went perfect. [My] mood going in was great. [The] doctors were great. I was happy, kidding around going in." During pregnancy, and labor and delivery survivors experienced positive emotions such as enjoyment and excitement.

Survivors additionally spoke of their pregnancy and/or labor and delivery experience going smoothly and being uneventful. A survivor of incest recounted, "I had a wonderful delivery. Long, 14 hours of labor, the best 14 hours ever. …I was lucky with my delivery." She further expressed, "As far as being pregnant and my delivery go, I had no problems. Everything was fine." A survivor of CSA shared "the pregnancy was pretty unremarkable."

Survivors experienced positive emotions such as love, excitement, and enjoyment during their childbearing experiences. They felt comfortable with the physical changes their body underwent during pregnancy and spoke of labor and delivery being fine. These positive emotions were often juxtaposed with negative sentiments as well. Survivors often felt both

nervous and exited simultaneously. Further contrasting negative emotions, are discussed in the following section "grief for what could have been a better experience."

Grief for what could have been a better experience

Seven participants shared negative emotions surrounding their childbearing experiences. Participants experienced negative emotions such as guilt, grief, nervousness, stress, anxiety, fear, and unpleasantness in the context of their childbearing experiences, which sharply contrast the enjoyment, love, and excitement discussed previously. The childbearing experience is an emotional roller coaster for survivors of sexual abuse, full of highs and lows.

Survivors felt guilty when they were pregnant, as if yet again they were the ones who had done something wrong. They felt that they had done something to cause the sexual abuse and this guilt resurfaced when they became pregnant. A survivor of CSA revealed, "And I think in the back of my mind I felt that I did something wrong then, when I was abused, and then now when I got pregnant." Guilt pervaded even if the pregnancy was planned later in life, as well as when the pregnancy occurred as a direct result of the abuse. They felt guilty for not reporting the fact that they had been sexually abused, as well as for hiding their pregnancy from family and friends. A survivor of incest who was raped by her father time and time again, expressed guilt over hiding the three pregnancies that resulted from the abuse. She obtained abortions for the first two pregnancies. When speaking about the third pregnancy, which she carried to term, she revealed, "I always feel guilty about things, Always. My whole pregnancy I felt guilty that I should be telling people but I never, never told anyone." Another survivor of CSA who did not tell her family that she had been sexually abused, also chose to hide her pregnancy several years later. She recalled "feeling guilty because I'm not telling my family." Overall, survivors experienced guilt in the context of either not telling family members about their pregnancy, or

about the sexual abuse. Survivors who became pregnant by their abusers also felt responsible and guilty for both the abuse and the pregnancy occurring.

Grief for what could have been a better childbearing experience was a shared sentiment by survivors. Survivors understood that birth could be a beautiful moment in women's lives, but unfortunately this was not their experience. "I've seen some beautiful birth experiences and in a way that's been hard too. …Mine could have been so different" a survivor recalled. Survivors often experienced grief for what could have been a better experience. A survivor of incest captured this theme as she shared the following reflection of her childbirth experience,

> I'm also a registered nurse, so I've gone through nursing school. I've been in the delivery room and I've seen it is a very beautiful thing, but I'm like this [mine] was not. There are births that I attended when I was a nursing student, the mother was listened to, the lights were turned down low if she wanted. The nurse would listen: You only want the father in the room? Okay. Do you want students in the room? Is that okay with you? Yes? No? Fine? She [the patient] was covered. What happened [for my birth]?

Survivors often knew that birth could be a positive, healing time, however, this was not their experience.

Feelings of nervousness, stress, anxiety, and fear pervaded survivors' childbearing experiences. Survivors were nervous, scared, and anxious during pregnancy, just as they had been when the abuse occurred. A survivor of CSA recalled,

> When I first found out I was pregnant, I wasn't overly thrilled. I was very nervous. I was very scared, and I thought: How can I commit to something like this? What did I do? Maybe I made a mistake.

A survivor of incest similarly shared,

> When I found out I was pregnant, I was very torn. I planned this. I had a hard time getting pregnant and when I found out I was pregnant, I was like oh my god, what am I going to do? Can I take care of a child?

A survivor expressed, "I was scared because you're having a child, you want to make sure everything's going okay." Survivors can become emotionally upset, cry, and mistrust their bodies when they first discover they are pregnant. A survivor of incest shared, "trust for the body is horrible."

In the context of the childbearing experience, fear also centered around becoming pregnant as a result of the abuse that was occurring. A survivor of incest recalled her fears of getting pregnant when she began menstruating and was still being raped by her father, "And you just have those fears, and luckily I wasn't one that was pregnant from my father."

Survivors also expressed anxiety regarding labor and delivery. The knowledge of what was going to happen to their bodies was almost too much to handle. "I never went to Lamaze. I didn't want to know the information. When it [labor] comes I'll deal with it. I didn't want anyone to educate me, prepare me, because it brought up anxiety," recalled a survivor of incest. In addition to anxiety, survivors were fearful of the unknown during their childbearing experience. A survivor who has had four vaginal deliveries said, "For the first pregnancy, you don't know what to expect, so it's sort of like the unknown." A survivor shared, "It's just the fear of the unknown." Survivors further feared that the birth experience could bring back feelings of their past abuse. The thought of pushing the baby out provoked anxiety. A survivor of incest who has had three cesarean deliveries shared, "I remember afterwards I'm like, I'd rather have a cesarean section than doing vaginal. I was just like thank God, that's so much

easier, you don't have to push." Overall, anxiety and fear pervaded the childbearing experience of survivors.

Unpleasantness was another emotion survivors experienced. In discussing her delivery, a survivor shared, "that was just really not a blessed event so to speak." Survivors often felt their pregnancies were unpleasant. Two survivors discussed unpleasant pregnancies and turning to drugs and/or alcohol as a means to cope with their past histories of abuse. "So again it wasn't a pleasant pregnancy at all, it was full of violence, dysfunction, chaos. Again I didn't experience a good, healthy, pregnancy where I got to enjoy my pregnancy," a survivor recounted. She continued later, "so the pregnancy itself wasn't a loving, nurturing, safe one." Survivors shared how substance abuse often had negative implications during childbearing and led to feelings of anger. A survivor of incest offered, "This is why maybe Mom drank too much, or maybe why mom was angry. Anger was a big issue for me, when there weren't any consequences on their [the abuser's] end. I was the one suffering." Substance abuse further played a role in survivor's ability to raise their children.

> For my son, I couldn't take him out of the hospital because we didn't have a safe place to bring him home to. So he stood behind in the hospital until we got things situated and then he got to come home with us.

Survivors experienced unpleasant pregnancies due to their past history and some tried to escape what happened to them by turning to drugs and/alcohol. A survivor shared, "I think, with me, it's more emotional, shutting down emotionally …coping with drugs and the alcohol …I know it's connected to the sexual assault." Substance abuse was a distinguishing factor between survivors who experienced healthy pregnancies that they enjoyed compared to those who had unpleasant pregnancies.

In conclusion, survivors experience a multitude of emotions surrounding their childbearing experience. Enjoyment, excitement, and love are juxtaposed with guilt, unpleasantness, nervousness, stress, anxiety, and fear at various moments of pregnancy and labor and delivery. For survivors of sexual abuse, childbearing is an emotional roller coaster, full of highs and lows throughout the experience.

Theme 3: All of a sudden I was that little girl again and/or I compartmentalized it: The all or nothing experience

The most complex theme is this third one. Survivors had an all or nothing experience throughout the childbearing process. Five survivors in this study had flashbacks to the past abuse when common procedures such as vaginal exams and/or epidurals were performed. On the other hand, three survivors had no connection or memory to the past abuse during their pregnancy or labor and delivery experience. They consciously compartmentalized their abuse from their childbearing experiences. Although these three participants did not experience flashbacks in the context of pregnancy and labor and delivery, it is important to note that they did experience triggers to their past abuse in the postpartum period as they raised their children and sought to protect them from harm. This protection is discussed in depth in the last theme, "Overprotection: Keeping my child safe." Furthermore, survivors who had experienced flashbacks at certain times either dissociated or compartmentalized at other times, representing both aspects of this current theme. For example, one participant first stated she had no triggers but later recounted her epidural experience, which triggered a flashback. The concept of compartmentalizing will be discussed in depth.

All of a sudden I was that little girl again

Survivors reported that vaginal exams, a routine and frequent procedure during pregnancy, and especially during labor and delivery, triggered flashbacks to their past abuse. A survivor of incest recalled when she was examined, "and it just brings you back to when you were touched there before." "I just stiffened up and was just tense, just tense," another survivor recalled. "That first exam was very hard, because outside of your husband, or your boyfriend, or whoever you choose to have sexual relationships with, it's just different because doctors are probing and touching and that type of deal."

Even when survivors felt they were mentally prepared for the vaginal exam, they still experienced flashbacks. Survivors collectively shared the following sentiments that are representative of how even in the context of feeling prepared for an exam, flashbacks still occurred. "You think you can handle it until it [the vagina] is actually being touched. And then it's hard to decipher how you feel about it." "The first time actually going to the doctor and having the exam, because you know in your mind what's going to be happening, and you think you can deal with it until you start being touched." Despite mental preparation, survivors were faced with their body remembering. "And your body, even though you're thinking you're okay, your body reacts automatically and it even surprised me because I didn't really think I was going to have any trouble at all," revealed a survivor.

In addition to the physical act of having a vaginal exam, the fact that other healthcare providers, such as nurses or medical students, were present to witness the exam was appalling to survivors. Survivors felt uncomfortable with having the exam, as well as with having other people in the room witnessing the exam and documenting the entire process. The verbalization of how many centimeters dilated their cervix had become, was also painful for survivors to hear.

When survivors were told how far open their cervix was, they were flooded with feelings reminiscent to the past abuse. A survivor of incest captured this experience when she explained,

> And then of course it gets more invasive as your further along in your pregnancy because they check to see how much you've dilated …two fingers, three fingers, four fingers and that kind of bothered me, that actually did, the verbal, because the nurse was always there and of course she was writing down everything he [the doctor] was saying and for some reason mentioning how many fingers, that triggered, that was like a trigger.

Survivors often felt like they were part of a "freak show" that anyone could come and watch. A survivor recalled, "I wound up being/feeling like a Freak Show because [the doctor] invited seven medical students to come in." Survivors felt that there was no respect for their privacy, which further invoked flashbacks. Not only the act of having a vaginal exam performed, but also the fact that other people, albeit they were healthcare professionals, present during the exam caused flashbacks. Furthermore, they perceived the opening of their body in a negative manner, while healthcare professionals around them were cheering and excited about it happening.

The lack of privacy survivors had during vaginal exams and throughout the labor and delivery was extremely challenging for them. In the context of their past abuse, they were exposed and afforded no privacy, and now in the healthcare setting they were yet again exposed for all to see. A survivor recalled,

> I had no privacy, no options. Just stick her on a gurney and strip everything off of her and invite anybody in. You know why don't you get the janitor while you're at it? I mean that was my feeling.

Often, having their body exposed for all to see was a trigger for survivors. The fact that their hospital gowns were lifted from their body and subsequently kept off of them was appalling.

Furthermore, in a similar vein to the abuser, healthcare providers performed a task such a vaginal exam and then left the room. This task oriented approach by healthcare providers, also set into motion flashbacks of survivor's past abuse. The profound lack of privacy survivors experienced in the healthcare setting was reminiscent of their past history of sexual abuse.

In addition to vaginal examinations, medical procedures such as having an epidural placed were reminiscent of the past abuses survivors suffered. During an epidural procedure, women must remain still and not move their body at all. For survivors, having to face the opposite direction from what was happening to their body, being told to hold still and to not move, having their body exposed, and feeling trapped during the epidural procedure were all too familiar feelings. These emotions were the same as those they experienced during the sexual abuse. Furthermore, during the epidural procedure a catheter is placed in a woman's back, causing survivors to relive genitalia and/or fingers penetrating them during the abuse. A survivor of CSA illustrated this point as she shared,

> The one part, when they were giving you the epidural and you're sitting there and they're telling you not to move. Like they're telling you what to do and I just felt, so uncomfortable. I just felt like, you can't tell me what to do. And then I'm thinking they're telling me not to move because I could injure myself, but I felt like a child again. Like you can't move, you can't do this, you can't do that, you have to sit here. Like basically, what I was told to do when I was little. And that was tough. And I was crying, but they didn't know why I was crying. Being told what to do when you were getting the epidural, and they're sticking this object in my body that I just wasn't sure of. What was going on? So like I said, I felt like that little girl, that couldn't do what she wanted to do.

Later in her interview she again revisited the epidural experience and the flashbacks experienced.

> The part basically telling me what I had to do and that I couldn't move. I felt trapped is what it was. Just like the trapped little girl that I was. You're supposed to be this adult that's giving birth and you feel like this little child that shouldn't be giving birth. It was really tough.

A survivor of incest shared these sentiments about the epidural being one of the most invasive parts of her childbearing experience. "Just not knowing…the epidural completely, obviously was the worst part about it, the pain, the position, the contractions were happening at the same time" and "you're exposed."

Another trigger to the past abuse survivors experienced was their baby being placed skin to skin on their chest after delivery. Immediately after birth, the infant is often covered in vernix, amniotic fluid, and blood. The infant is slimy in this natural state. For survivors, having a wet foreign object placed on them can be a trigger to having a penis ejaculate onto them. A survivor recalls that immediately following the delivery of her child, "I'm hysterical, cause this squirmy, slimy thing, I mean I'm sure it was beautiful and everything, but I'm like this squirmy, slimy thing is crawling all over me." Two common obstetric procedures, an epidural and skin-to-skin contact with the baby, cause flashbacks for survivors.

Survivors often dissociated to get through the painful flashbacks that occurred during the childbearing experience. A survivor shared,

> I know when they do the physical examination to see how low the baby is that's very hard. It's a stranger, a person you don't know, really putting their hands in and checking you. I know that's part of the job and everything, but that's where you go somewhere else, like you just don't want to be present at that moment. That would be the most invasive part of it.

Survivors would distance themselves from what was occurring in order to cope with the flashbacks. Survivors shared the following sentiments illustrating how dissociation was utilized to cope with the painful memories.

> But I really wasn't aware of it, that I was like that until I started getting help. You know, how we disconnect from people, pain, all of that. We just go to another place and that's associated with the sexual assault.

When recalling her childbearing experience, a survivor explained, "I realize that I block [it] out …I dissociate …that's my way to just get through." A survivor who battled with drug and alcohol abuse during the time of her pregnancy recalled, "I was so troubled with the drugs and alcohol that I was already disconnected, I never really reconnected." Blocking out the connection between the present situation and the past abuse by dissociating was a coping mechanism survivors utilized during childbearing.

Additionally, survivors described that the physical act of giving birth brought back new and distinct memories of their abuse. These memories were not yet on a level of conscious awareness in a survivor's memory. A survivor of CSA recalled,

> I mean, I always knew I was abused. It [childbirth] just brought out different memories. It just brought back a memory that I didn't remember, and it wasn't the same uncle, it was a different uncle. Before that I always thought it was the same uncle that did stuff to me. And then, when it was that night during delivery, it was just a flashback that I had, that it was not the same person, it was someone else too, but around the same time. And that was tough, that was tough to deal with.

Minute details of the abuse often resurfaced during the childbirth. As a survivor of incest revealed,

> Delivery was kind of difficult, because when you're sexually abused like that and you get older and you get away from the person, you want to make the decisions of what's happening to your body. And so when the delivery was happening, my thoughts kept going back to my father and my sexual abuse, it went on up when I was almost 13, I had gotten my period, it's like all these thoughts all of a sudden hit me.

At the time when they are bringing new life into the world, survivors were flooded with new and old memories of the sexual abuse they suffered. A survivor of CSA shared,

> It brought back more memories and it brought me to be like I need to tell someone. For some reason I needed to tell people and I needed them to know at that time. I don't know, I guess they say a lot of times when someone has a child that, that brings it out.

Survivors experienced flashbacks as well as the occurrence of new memories regaining consciousness while they were giving birth. The connections of birthing a child and the past history of abuse were unfortunately strongly associated, resulting in flashbacks. The flashbacks to past abuse were commonplace for survivors during their childbearing experience.

I compartmentalized it

It is important to note that survivors compartmentalized their abuse and their labor and delivery experience. Compartmentalizing is a process in which a person consciously separates in their mind two experiences or events. The result for survivors who did compartmentalize, was that they either did not experience any flashbacks at all or experienced significantly less flashbacks than those who were not able to compartmentalize the two events. Three participants fully compartmentalized the past abuse and the childbearing experience. They reported no triggers during pregnancy and labor and delivery, however, raising their children was a trigger

for these three women. Three participants only compartmentalized certain aspects and at other times, they did in fact have some pervading flashbacks.

The three participants who fully compartmentalized the past abuse and the childbearing experience shared the following reflections. "I definitely cope with things by compartmentalizing: You know that happened to me in the past, this is here [and now]." "I actually, not that I know of, never even thought of my rape in conjunction with my pregnancy. In nine months (twice), I don't think it ever entered my mind." "I think I was very compartmentalized and I don't remember it [childbearing] being traumatizing. It definitely was very compartmentalized." By separating the two events, survivors were able to avoid triggers. Survivors shared, "I can see how pregnancy/delivery would be a trigger, but I had never contemplated such" and "I don't remember anything specific related to the abuse to my deliveries." Furthermore, one survivor, who was also a registered nurse, shared that because she was consenting to vaginal exams, she was able to separate them from her past history of sexual abuse. She recalled,

> I knew obviously as a nurse, I knew it [vaginal exams] had to be done and I knew what was appropriate, and what was not appropriate. So I felt comfortable with it, obviously it was consensual. [I was] consenting to exams."

Three participants only compartmentalized certain aspects and at other times, they did experience pervading flashbacks. A survivor of incest recalled flashbacks during many of the vaginal exams she had, but eventually states she was able "to separate the two, because it wasn't my father [performing the exam], it was my doctor." Another survivor of CSA who had suppressed the memory of her past abuse at the time of her childbearing experiences had difficulty with vaginal exams but also shared she compartmentalized "when the pain started, it's

like I don't want to do this today, can we do this tomorrow, not today?" A survivor who experienced a flashback during the epidural procedure also reported, "But during the labor [my past abuse wasn't even my priority." In conclusion, survivors may not have any triggers during their childbearing experience, because they can separate the two experiences as distinct entities. Some survivors, however, can compartmentalize certain aspects of the childbearing experience and at other times still face triggers that cause flashbacks.

In conclusion of the theme, "All of a sudden I was that little girl again and/or I compartmentalized it: The All or Nothing Experience," survivors notably have an all or nothing experience during childbearing in the context of their past abuse. Survivors either felt "trapped …just like the trapped little girl that I was" or they "coped with things by compartmentalizing" during the various aspects (i.e. vaginal exams and medical procedures) of pregnancy and labor and delivery.

Overall, for survivors of sexual abuse, the childbirth experience felt like "a Freak Show" burdened with flashbacks to their past abuse and a lack of respect for their privacy. For some survivors, compartmentalizing the past abuse from the childbearing experience provided them with a more positive experience of childbearing. However, even when trying to compartmentalize, the flashbacks were still pervasive for some survivors.

Theme 4: Am I even here?: Nothing was explained and I had no voice

Five participants reported that they had no voice and nothing was explained to them throughout the childbearing process. Healthcare providers rushed through procedures without explaining to survivors what was happening. Survivors especially lacked information from their

healthcare providers when they were actively in labor and when they were delivering their babies. Regardless of the type of delivery, vaginal birth or cesarean birth, healthcare providers did not explain events. Survivors felt that they had no voice in their own childbearing experience.

Healthcare providers did not take the time to explain procedures to survivors. "Again the doctor never really explained much to me; never really explained to me what my options were." This survivor further recounted, "And she never really explained anything she was doing for the prenatal visits. Never [said] we're going to do this. She just came in: How you doing? Okay? Fine. And she just did things." Having things done to their body without explanation was reminiscent of the past abuse, when the abuser(s) also "just did things" to them. A survivor shared, "I remember being very traumatized by the experience, because nothing was ever really explained to me about the procedure. Sort of very cold and very clinical is really all I remember."

Continually, healthcare providers did not communicate with survivors about procedures they were performing on them or on their babies. A survivor shared,

> There was one point in the delivery process where they [doctor and nurses] came in, grabbed me by my ankles, lifted me up, had me on my head and started moving me, and wouldn't tell me why. And there was another point where things weren't going right [with the baby]. I knew something was wrong, but they got her back.

Survivors further lacked information about things that were being done to their baby once he or she was born. A survivor discussed, "the baby came out, they [healthcare providers] scared me a bit, the umbilical cord was around her neck. Probably normal for them. But they just kind of moved quickly."

Survivors reported in labor and delivery, healthcare providers neglected to tell them how close to delivery they were or what was occurring if they were not progressing in a normal manner. A survivor of rape recollected,

> I remember falling asleep. I fell asleep. And then they came into the room, and it was sort of a rush. Okay, let's get this baby going. Let's get this baby out. Sort of scary, because the nurses walking in, the doctors walking in, and everyone just sort of walking in, like okay it's time to go. It's like oh, where are we going?

Another survivor recalled, "She [the doctor] never really explained, okay you're going into transition, okay you're almost there. I mean she didn't explain anything really."

The experience was unfortunately no different for survivors having a cesarean birth. Healthcare providers still failed to inform survivors about what was happening before major surgery. The following experiences captured the lack of explanation survivors experienced prior to delivery by cesarean section. A survivor of CSA shared,

> So when I was in labor, I remember them coming in and taking the measurements. I was like 7 centimeters. Then they checked me a little while later and I was only 6 centimeters. I was freaking out. What do you mean I am going backwards? Apparently, I [my cervix] was swelling, so all of a sudden they just whisked me, I had a fever, and they whisked me in for emergency C-section.

Even prior to having this major surgery, the procedure and rationale for having a cesarean birth were not explained. Another survivor illustrates this theme when she recalled that no one explained to her what was occurring when she needed to have an emergency cesarean birth. This survivor of incest recalled,

> My blood pressure in the first pregnancy I remember now was an issue, they had me flipping side to side. Why am I doing this? What's going on? …There was something like not enough oxygen going across the placenta. So maybe that's what triggered the cesarean section at 5 centimeters. It was never really [explained] …they had control of it. I was like okay, you're doing this …What's a C-section?

Overall during the childbearing process, regardless of having a vaginal or a cesarean birth, survivors reported that healthcare providers failed to communicate with them. They did not know what was happening and nothing was explained. "Nothing was really communicated to me" a survivor expressed.

In addition to being uninformed about what was happening to their own bodies, survivors felt that they had no voice during the childbearing process. In the context of prenatal visits, as well as during labor and delivery, survivors were not heard. A survivor recalls, "I didn't feel like I was heard. I didn't feel like I was respected. I wasn't informed." Additionally, survivors who made plans and expressed their desires for delivery, did not have their choices respected. A survivor who had made arrangements for her baby to be adopted stated that despite having a plan to not have the baby in her room, her specific wishes were not respected. She recalled,

> I did ask to have the baby put in the nursery and the nurse did put the baby in the nursery. But then the doctor came by at one point and brought the baby back into my room and I thought I really don't want the baby here. And she's like, well, you need to bond with the baby. I'm not keeping the baby! She's like well the baby needs to bond with somebody. And I'm like yeah, but not ME!

Survivors felt like no one was listening even when they attempted to speak up. "I didn't feel like I had much of a voice. I'm trying, but she [the doctor] kept cutting me off."

In conclusion, survivors were not listened to and they were kept in the dark about what was happening to their own bodies. During prenatal care, labor and delivery, vaginal births, and cesarean sections alike, healthcare providers failed to communicate what was happening, why it was occurring, and the alternative options available. Commonly, survivors felt as though they had no voice in their own childbearing experience.

Theme 5: All too familiar: No support, nowhere to turn

Five participants shared that they had limited support during their childbearing experience. They lacked support largely from family. In addition to lacking support, survivors felt they were being harmfully judged during their childbearing experience. Healthcare providers, mostly nurses, were the ones to place negative judgment on survivors. The theme of "no support, no where to turn" has one subtheme, "feeling judged."

Survivors experienced a lack of support during their childbearing experience. Their family members did not support them, especially when the abuser had been a family member or when the pregnancy (for one participant) occurred as a result of the abuse. Healthcare providers then detrimentally judged survivors during the childbearing experience. Survivors found themselves with no one to turn to further negatively affecting their childbearing experience.

Survivors were often not supported when they attempted to tell their families about the sexual abuse that was occurring, especially when the abuser was a family member. A survivor offered, "I feel my mom kind of protected my Dad even though I told her that it [the sexual assault] happened in second grade; told her it happened [again] in fifth grade after the third sexual assault, and she was never there [for me]." The lack of support and lack of protection survivors experienced from family members when they were being abused led to survivors

keeping their pregnancies and/or history of sexual assault to themselves later in life. Therefore, survivors had nowhere to turn during their pregnancies. A survivor of incest recalled, "The perpetrator for three of my four pregnancies was my father …my family dynamic was such that I couldn't tell anyone in my family ...didn't tell my Mom, I certainly couldn't tell my Dad." Survivors weren't protected or cared for when they being sexually abused, and so didn't think they would be supported by their families when they were pregnant. To this end, a survivor of CSA shared,

> When I found out I was pregnant no one knew [about the abuse or the pregnancy]. No one knew until after I had my child. I don't know why. I think I know why now I didn't share it with anyone. Because, when I was younger and abused, my cousin and sister came out to our family and said that they were abused and nobody did anything about it. So I didn't say anything about my abuse until I had my child at the age of 21.

The lack of support was challenging for survivors. "It was tough. It was really tough going through it by yourself. Nobody being there." Survivors found themselves with no one to turn to which negatively affected their childbearing experience.

Feeling judged

As a subtheme, feeling judged represents how survivors felt healthcare providers, especially nurses, perceived them. Survivors experienced harmful judgment from doctors, as well as nurses. They were judged negatively throughout their childbearing experience. A survivor recalled this sentiment from her prenatal care appointments which illustrates this subtheme,

> [The doctor] would say, are you feeling the baby move? Isn't that wonderful? And I'm like NO. I'm getting the whole messages that I'm a bad person. My self-esteem was

> already around my ankles and I was given the impression that I was a bad person that I'm not bonding with this thing in me.

Another survivor, whose father sexually abused her over the course of many years, ultimately became pregnant as a result of the abuse. She did not tell anyone in her family about the abuse or the pregnancy, and recalled how the labor and delivery nurse obtaining information for the birth certificate judged her. Her experience offered below aptly summarizes this subtheme,

> I do remember there was one nurse that was, I guess she was doing the birth certificate or something, she did ask me who the father was. And I can still remember clear as a bell, I said I didn't know, even though I knew perfectly well. I just couldn't deal with it, so I said I don't know who it is. I distinctly remember hearing her muddle under her breath, oh, irresponsible kid. I was just [thinking]…. Oh my god, I am irresponsible. Who does this?

The harmful judgment survivors experienced in the context of the healthcare setting negatively affected their childbearing experience.

In conclusion, survivors lacked support and had nowhere to turn during their childbearing experience. "It's hard to go through a pregnancy without the support," a survivor shared. Survivors further felt judged in a negative light during the childbearing experience.

Theme 6: Holding on to the choices I can make:
Who my doctor is and how I feed my child

Control was an important aspect of the childbearing experience for survivors of sexual abuse. Six participants discussed their desire for control during the healthcare experience. These

woman sought control over choosing who their healthcare providers were during pregnancy. Furthermore, they controlled the decision regarding how to feed their babies. These women consciously chose to either breast or bottle-feed. The common thread amongst survivors' childbearing experiences was the quest for having control whenever possible.

Control over healthcare providers

For survivors, control during pregnancy took the form of choosing their healthcare provider. Survivors chose a female healthcare provider to avoid the pain of their past sexual abuse. All the survivors in this study were sexually abused by men and having a male healthcare provider often elicited flashbacks to the abuse.

> I turned around and choose a woman doctor and it must be because having the man obstetrician bothered me …I think I choose a female doctor and then a midwife around the fourth month because it felt more comfortable to me.

Survivors sought female healthcare providers whenever possible given the increased level of comfort they experienced. Another survivor shared, "My second child was 2 years later, and I had changed doctors. I had chosen a woman. I felt a little bit more comfortable. I didn't feel as stressed and tense." The choice to have a female healthcare provider was an aspect of the childbearing experience that survivors could control. "I choose to see a different doctor in the practice and she was much more my style," a survivor of CSA offered." "I've always had female doctors. …a female always did the deliveries" another survivor shared. Having control over this choice was important to survivors. Survivors strove to care for themselves by choosing a female healthcare provider.

Control over how I feed my baby

Interestingly, the actual choices survivors made around breastfeeding were staunchly on one end of the spectrum or the other, either they wanted to breastfeed or breastfeeding was viewed as "dirty." What was constant for all survivors was that they controlled the decision of how to feed their baby. Survivors were either adamantly against breastfeeding because it was reminiscent of their past abuse, or they wanted to breastfeed to feel a sense of physical closeness to their baby. Control over infant feeding, whether it was bottle-feeding or breastfeeding is captured in this theme. A survivor of CSA shared,

> And then with breastfeeding, there was no way. I couldn't do breastfeeding. I felt that it was dirty. My cousins, some of them and my friends, they breastfed and I don't know how they do it, because to me that's not what it [the breast] is for …I know it's what it's for in my head, I know it is but, I just feel like it's a dirty thing. That was another thing that bothered me because I know that it's like the best thing for the baby, but I was like I can't do it. It just felt dirty. The nurses mentioned something, but I said nah give him a bottle, because it's not what I'm doing. I just felt really uncomfortable, I knew before I even had a kid I would never breastfeed because it didn't feel natural to me, it felt dirty.

A survivor of incest offered, "I did not breastfeed. …I didn't want to be committed to it." Also exerting a strong sense of control, a survivor of CSA shared how she was resolute in her decision to breastfeed her child. She recalled,

> I was bound and determined to breastfeed. And it was tricky at first, it was definitely, it didn't happen quickly, and I remember my husband getting like 'maybe we should just give him a bottle' and I was like if you can't be supportive then you just need to leave the room. And then once it happened, I nursed for a year. I nursed both my kids for a year.

The sense of control pervaded survivors' childbearing experiences. They sought control wherever they could, because during the sexual abuse control was taken way from them. In their childbearing experiences they looked for control in the decisions they could make for themselves. These decisions largely centered on controlling who would care for them during their pregnancies and how they would feed their babies. Survivors sought control over having a female healthcare provider and deciding for themselves how they would feed their infants.

Theme 7: Overprotection: Keeping my child safe.

The strongest theme identified from this research study was the overprotection nearly every participant described having of their child/children. The only participant who is not represented in this theme planned to and subsequently did give her child up for adoption immediately following delivery.

It is of interest to recognize, the women in this study were not directly asked about their postpartum experiences of mothering. The participants were asked to describe their experience of childbearing including both pregnancy and labor and delivery. However, each of the seven participants who shared these feelings of overprotection for their children felt this information was an imperative part of their childbearing experience. This theme has two subthemes: (1) Family Dynamics and (2) How can I leave them?

Survivors recalled the struggles they faced raising their children, and their constant quest to keep them safe from harm from infancy through adulthood. Specifically, survivors sought to protect their children from being sexually abused. Collectively, survivors shared obstacles experienced with having both sons and daughters. Fear of a daughter being sexually abused was

expressed. However, survivors who had given birth to boys also expressed they struggled with the dread of something happening to them.

Having a girl often triggered survivors to fear for their daughter's safety and to strive to protect her from being harmed in any way. A survivor recalled the moment she gave birth to her daughter, that her thoughts were "I was so excited, tears running down my face, you know its miraculous, so miraculous, and yet immediately I had a shield around her from the day she was born." A survivor shared that the emotional toll of having a daughter prevented her from having any more children. "I knew when I came home with her probably within a week that I knew I was not going to having any more children because I wasn't emotionally capable of taking care of them." The emotions of raising and protecting a daughter were life changing for survivors.

Throughout pregnancy, a survivor who did not know the sex of their child just assumed it would be a boy due to the immense fear she had regarding giving birth to a girl. This survivor who has one daughter shared,

> The entire time I was pregnant I didn't know what I was going to have because I wanted to be surprised, but I had it in my head that I was going to have a boy, because I was so afraid of what would happen if I had a little girl.

This participant who had survived many years of incest by her father, further discussed,

> So I proceeded to buy everything blue. Everybody around me was looking at me like why are you doing this? You don't know you're having a boy. And I said, no, I KNOW I'm having a little boy, because in my mind I was thinking I can't have a girl. If I have a little boy it'll be safe, and if I have a little girl she won't be safe. So that was my mental state throughout my pregnancy.

It was at the delivery that she first learned she had given birth to a daughter. She shared,

> My husband was so funny because when she came out he said, it's a boy, but he saw the umbilical cord hanging down between her legs. And the doctor's like no it's a girl. So I went from 'oh it's a boy [relieved], to it's a girl, oh no [scared].

She continues, "So she was my trigger. When she was born, it was shear joy and happiness and also 'huhhh [big breath in] oh no!'" This survivor's experience captures the fear of having to keep a daughter safe and overprotecting her to do so.

Beyond pregnancy, survivors spoke of overprotecting their daughters as well. A survivor of incest shared that her adult daughter told her one-day, "You're always hovering, you're always hovering. Yeah! And I don't know if I would have been so smothering and hovering if she would have been a boy." This same participant, who had spoken recently with her daughter about the fact that she was participating in this study, shared this exchange between her and her daughter: "mom, you know bad things happen to little boys too. I said no, I know. I know a lot more now than I did then. I'm more educated than I was."

Additionally, survivors who had given birth to boys discussed the inherent parenting challenges they faced due to having a history of sexual abuse. A survivor of CSA shared, "when my son was little I was so afraid that something was going to happen to him." A survivor with a history of rape recalled, "raising my kids, that having them, was somewhat a trigger for me." She shared, "I never had an ounce of PTSD until I had my boys and began to worry that they too would be kidnapped."

In the context of having a son, another survivor of CSA spoke of her challenge the first time she had to let him use a public men's restroom alone. He had come to the age where he could no longer use the female restroom with her. She shared, "I mean I remember the first time

that I had to send my son into a bathroom without me. I was hysterical. I was so traumatized. I was beside myself, but you know you have to at some point."

One participant, a survivor of CSA, discussed that she even went so far as to feel the need to protect her son from herself. Due to her past history, she felt uncomfortable with the idea of placing her infant son skin to skin on her chest. She recounted,

> Even when my son was a baby baby I would always be fully clothed. I see some mothers with just a tank top or bra, holding their kid and I'm like no. I always had to be fully clothed, and so did he.

Survivors overprotected both their sons and their daughter.

Survivors offered that throughout their children's life they had been striving to keep them safe. Survivors spoke of overprotecting their children from the time they were infants, all the way through adulthood. Immediately postpartum, survivors wanted to keep their children close in proximity in an effort to protect them and to keep them safe. A survivor, who had given birth to both boys and a girl, shared "I wouldn't let him leave the room. I wanted him always in the room." For her daughter's childbirth experience she recalled, "I didn't let her go out of the room at all."

During childhood, survivors further discussed overprotecting their children. One survivor of incest labeled herself as "a helicopter mom." She offered, "I was very strict with her, but I was very open too with her. But, I was always hovering." Another survivor of CSA recalled, "I just remember being very protective." A survivor of rape offered that she "was/am a little more vigilant than most parents when it comes to watching their kids and teaching them about awareness and self-defense." She also wanted her sons to be able to protect themselves, and recalled "when they were old enough, I enrolled my kids in martial arts/boxing."

However, the overprotection of their children did not cease once their children reached adulthood. Many participants still felt they needed to protect their sons and daughters. A survivor shared the childbearing experience of her now adult daughter and offered, "I was very strict with her …when we first got the computer it had to be someplace where I could see it, someplace where I could hear her talk. You know it's scary nowadays." Another survivor who now has an adult son shared, "I stress about him now. I think I'm more overbearing now. He's 20 years old and I still call him [asking]: Are you alright? Did you get to school okay?" Regardless of their children's gender or age, survivors sought to protect them.

Family Dynamics

Family dynamics is the first subtheme of the overarching theme "Overprotection: Keeping my child safe." Survivors faced the struggles of having the family member who sexually abused them still present in their lives. This presence wrecked havoc for survivors once they had their own children to also protect. Specifically, three participants spoke of their difficulties with family dynamics in the context of their childbearing experiences. Two of these participants had experienced incest by their fathers, and one had a history of CSA by her uncle.

One survivor discussed the challenges with the relative who abused her still attending family functions and being present around her own son. She shared an experience when she arrived at a family member's home and he was there. She feared him doing something to her son now and expressed, "it was tough, especially and then having a child and knowing that he's around still. Is he gonna hurt my child too?"

Survivors of incest by their fathers also spoke of the fact that their child would never know his or her grandparents in the way a child normally does. A survivor shared, "He's not a grandfather, my parents don't know how to be grandparents, that's the one thing that I can say

could be missing, that emotionally had done its damage." Another survivor of incest by her father recalled, "my only thoughts were after giving birth, because I had a daughter, the sad part was that she would never really know her grandparents, not the normal way a child would."

How can I leave them?

"How can I leave them?" is the second subtheme of the overarching theme "Overprotection: Keeping my child safe.'" This subtheme was identified from participants' discussions of not using daycare, rearranging their own schedules to stay home with their children, or not trusting anyone else to watch their children. Specifically, three participants spoke of the challenges they experience with leaving their children in someone else's care. Two of these participants had experienced incest by their fathers, and one had a history of CSA by her uncle.

A survivor of CSA expressed, "I knew that even before I had my children that I was going to be with them." This same participant shared, "I felt very protective of them. Not that I didn't think anybody else could take care of them but I needed to know what was going on. I think that's just definitely part of the abuse, I mean definitely."

Survivors discussed the struggles faced when they needed to leave their children in someone else's care. A survivor of childhood incest by her father shared, "Everything was fine up until she was two, or so I thought and that whole trigger came with the babysitting, cause I didn't want anybody taking care of her but me." She went on to discuss what occurred when her daughter was two: "My husband had suggested that we let my father babysit her and that was it, I went off the wall. And that was the beginning of my spiral. My husband did not know before."

For survivors, having to leave their children in someone else's care led to feelings of anxiety and fear. While sharing her childbearing experience as a survivor of sexual abuse, a

participant expressed, **"**Certainly daycare was not an option for me. I needed …to schedule so that either myself or my husband were with the kids so I guess maybe that [my past history of sexual abuse] has affected it." Another survivor explained, "But I was very, very discriminatory about who I left my kids with. And it's something that's still with me actually even though that they're older." She continued,

> I mean I wasn't crazy about it. I mean I wasn't crazy like no, I can't leave them with anybody. I definitely left them with people. And I have left them with babysitters before, but I definitely follow my gut on it.

One survivor even struggled with leaving her children at school, a presumably safe environment. She shared the following about her daughter starting school, "She did go to preschool and that was very difficult for me. I would make unannounced visits, just pop in. I'm very protective."

In conclusion of the theme "Overprotection: Keeping my child safe." survivors experienced fear for their children's safety. This fear was pervasive at times, causing many to struggle with family dynamics and negotiating whom to leave their children with. As one survivor expressed, "there was the protectiveness that you feel of your children afterwards which is unique [to survivors of sexual abuse]." Overall, survivors expressed an innate, overpowering need to protect their sons and daughters from any harm, from infancy all the way into adulthood. The thought of their own children being sexually abused was more than they could handle, and they therefore protected them as much as humanly possible.

Exhaustive Description

The final result was the essence of the childbearing experience for survivors' of sexual abuse. No one asked survivors if they had a history of sexual abuse. Neither the doctors they saw for prenatal care, nor the nurses on labor and delivery inquired about a history of abuse. Even in the presence of red flags, healthcare providers did not ask. Survivors unmistakably want to be screened for a history of sexual violence. Survivors experienced an emotional roller coaster, full of highs and lows, during childbearing. Enjoyment, excitement, and love were juxtaposed with guilt, unpleasantness, nervousness, stress, anxiety, and fear at various moments of pregnancy, and labor and delivery. Survivors had an all or nothing experience throughout the childbearing process. Survivors either (1) had flashbacks to the past abuse when common procedures such as vaginal exams and/or epidurals were performed, (2) they compartmentalized the experiences, and had no connection or memory to the past abuse during their childbearing experience, or (3) they experienced flashbacks at certain times and compartmentalized at other times. Largely, the childbirth experience felt like "a Freak Show" burdened with flashbacks to the past abuse. Survivors perceived they were not even present, because no one listened to them and they were not told what was happing to their own bodies. Healthcare providers rushed through procedures without explaining what was happening, leaving survivors in the dark. During prenatal care, labor and delivery, vaginal births, and cesarean births alike, healthcare providers failed to communicate what was happening, why it was occurring, and the alternative options available. Survivors had no voice in their own childbearing experience. Survivors further had limited support. They lacked support from their own families and had nowhere to turn. Healthcare providers, typically nurses, placed negative judgment on survivors. Additionally, a powerful desire for control pervaded survivors' childbearing experiences. They

sought control of having a female healthcare provider and deciding for themselves how they would feed their babies. Survivors experienced an innate need to protect both their sons and daughters from harm, beginning in infancy and continuing into adulthood. The thought of their own children being sexually abused was more than they could handle. They therefore overprotected them, making every attempt to keep them safe. Survivors feared for their children's safety, causing many to struggle with both family dynamics and the decisions surrounding whom, if anyone, to leave their children with. For survivors of sexual abuse, the childbearing experience is a complex, emotional roller coaster, permeated by the past.

Summary

This chapter has provided a detailed description of each of the seven overarching themes and any subthemes resulting from this research. Lastly, an exhaustive description of the childbearing experiences of survivors of sexual abuse was offered.

Chapter five presents a discussion of the above research findings. In this discussion, the findings will be compared to the review of the literature from Chapter two. Lastly, the implications for clinical practice and for future research will be considered.

Chapter Five: Discussion

Introduction

Chapter five contains a discussion of the research findings in light of the literature on the childbearing experiences of survivors of sexual abuse. In this chapter, both the clinical practice and the educational implications of the study will be explored. The limitations of this study and suggestions for future research are offered. Finally, a conclusion is provided.

It was the Best of Times, It was the Worst of Times

Charles Dickens' (1948) quote, "it was the best of times, it was the worst of times," aptly describes the essence of childbearing for survivors of sexual abuse from this study. The experience of joy in regards to bringing life into the world can be overshadowed by a history of sexual abuse, as the findings have highlighted. Theme two, "An emotional roller coaster: from excitement, to grief for what could have been a better experience" and theme three, "All of a sudden I was that little girl again and/or I compartmentalized it: the all or nothing experience", specifically speak to the application of Dickens' (1948) quote for the title of this research study. For survivors of sexual abuse the childbearing experience can be exciting, however, the past juxtaposes this excitement, making the experience both the best of times and the worst of times. Furthermore, the finding of these contrasting emotions is heavily supported in the existing literature on the childbearing experiences of sexual abuse (Lasiuk, 2007; Lee, 2001; Roller, 2011; Schwerdtfeger & Wampler, 2009). Each of these studies also discusses the ups and downs of the childbearing experience for survivors.

Support of Existing Literature

The current research findings further validate the existing literature on the childbearing experiences of sexual abuse. This section will discuss the relationships between this study and the existing literature regarding control, flashbacks to past abuse, compartmentalizing, communication with healthcare provider, having no voice, and lack of support during the childbearing experience. The findings will also be discussed in the context of Siegel's theory of interpersonal neurobiology.

This current study found survivors seek control, reported in the theme "Holding on to the choices I can make: Who my doctor is and how I feed my baby." Control is the most commonly reported theme in the literature on the childbearing experience of survivors (Burian, 1995; Garratt, 2008; Montgomery, 2013; Palmer, 2004; Parratt, 1994; Rhodes & Hutchinson, 1994; Richmond, 2005; Roller, 2011; Waymire, 1995). Survivors seek control given that this control was stripped from them during their abuses. Healthcare providers can wrongfully label these women as difficult patients who want to control minute details of their care if they do not have the knowledge of the woman's past history of sexual abuse.

Survivors may write a birth plan, seek midwifery care, and/or seek a female healthcare providers in order to have more control of their childbearing experience (Burian, 1995; Chambers, 2010; Garratt, 2008; Palmer, 2004; Parratt, 1994; Rhodes & Hutchinson, 1994; Richmond, 2005; Seng et al., 2002). In this current study, survivors controlled their choice of healthcare providers, as well as their choice to breastfeed or to bottle-feed their children. It was important to survivors in this study to hold on to the choices they could make, and to have control of these decisions. Control of the childbearing experience is important to survivors given they did not have control during the time of their abuse.

This current study also found that survivors could experience flashbacks to the past, compartmentalize the past from the current experience, or go through both flashbacks and compartmentalizing at different times during the childbearing experience. This was reported in the theme "All of a sudden I was that little girl again and/or I compartmentalized it: The all or nothing experience." Survivors in this study who did experience flashbacks to the past frequently reported that the vaginal exam was the most reminiscent of past abuse. This finding that the sensations of a vaginal exam can trigger flashbacks is strongly supported in the existing literature (Coles & Jones, 2009; Parratt, 1994; Rhodes & Hutchinson, 1994; Roller, 2011; Waymire, 1995). Survivors in this study also reported that medical procedures, such as having an epidural placed, could provoke flashbacks to the past. Survivors may have flashbacks during an epidural given the position of one's body, vulnerability, and fear of the unknown experienced during the procedure. The literature also supports that medical procedures associated with childbirth are difficult for survivors and cause flashbacks (Burian, 1995; Lee, 2001; Roller, 2011).

The survivors who compartmentalized their experiences of childbirth and past history of sexual abuse acknowledged that these were two distinct experiences. The literature supports that survivors who are far along in their own recovery are able to compartmentalize (Seng et al., 2002). Schwerdtfeger and Wampler (2009) also discussed that survivors often compartmentalize sexual trauma from their current pregnancy to protect their pregnancy experience. Overall, survivors in the existing literature, and in this study, report flashbacks to the past abuse more frequently than they do compartmentalizing.

During the childbearing experience, especially during labor and delivery, survivors in this study reported that healthcare providers did not communicate with them. They were not

informed of what was happening to them or to their baby during labor. The lack of communication and explanation survivors experienced is traumatic since it can be reminiscent of their abuse when things where done to their body with no explanation. This current research highlights that healthcare providers, must explain what is happening, especially in the context of labor and delivery to prevent survivors from feeling re-victimized. The existing literature further supports that survivors desired to be informed about what is happening during their care, especially during procedures (Chambers, 2010; Coles & Jones, 2009; Seng et al., 2002).

Survivors in this current study also reported that they had no voice throughout the childbearing process and were not listened to. Often, not being heard as a child can transcend to adulthood. When healthcare providers fail to listen to survivors it stands to further re-victimize them in the healthcare setting. The vast majority of survivors lived in silence about the abuses that were occurring. They had no voice at the time of the sexual abuse. Therefore, when survivors are not being heard during their pregnancies, and labor and delivery, when uncontrollable things are also happening to their bodies, they stand to be re-victimized in the healthcare setting. In some instances, survivors may have tried to tell someone the abuse was happening when they were younger and if they were not listened to then, not being listened to later in life by a healthcare provider can be traumatic and re-victimizing. The existing literature supports again this finding, the theme of "Am I even here? Nothing was explained and I had no voice" (Chambers, 2010; Coles & Jones, 2009; Seng et al., 2002). Being treated this way in the healthcare setting would be problematic for all women, but especially so for survivors.

Survivors in this study experienced a lack of support from their families during their childbearing experience. The theme of "All to familiar: No support, nowhere to turn" adds to the literature. Given this finding it is therefore crucial for healthcare providers to fill this void by

supporting survivors throughout their childbearing process. The existing literature does highlight that survivors desire their healthcare providers to offer this support to them (Burian, 1995; Coles & Jones, 2009; Chambers. 2010; Lee, 2001; Montgomery, 2013; Seng et al., 2002). Additionally, although the finding of desired support is common in the literature, survivors in this current study felt judged by their healthcare professionals. Garratt (2008) also reported survivors felt shame and humiliation during the childbearing experience, similar to feeling judged.

Past sexual abuses, even when repressed, often resurface during pregnancy and/or childbirth. In this current study, survivors reported that the physical act of giving birth brought back new and distinct memories of their abuse. These memories were not yet on a level of conscious awareness in a survivor's memory. Siegel's (2003) theory of interpersonal neurobiology can be linked to this finding as it was reported in the theme "All of a sudden I was that little girl again and/or I compartmentalized it: The all or nothing experience."

Interpersonal neurobiology seeks to understand how one's relationships with others, particularly early relationships, have a dominant influence on brain structure, organization of memory, as well as personal narratives (Siegel, 1999; Siegel, 2001). With interpersonal neurobiology, the goal is to integrate the past and present to create harmony within an individual, and to link body sensation to logic (Siegel, 2010). An example is to relate the fear and discomfort of a bodily sensation, such as a vaginal exam to the underlying memory of sexual abuse causing the fear and discomfort. The memories stored in the brain and the mind can be triggered by a childbirth experience that resembles past sexual abuse in many ways (i.e. placing one's feet in stirrups, someone looking at and touching one's vagina, lack of control of one's body). The memories of the sexual abuse can resurface, even if they were previously repressed.

During childbirth, a survivor who has no previous memory of the abuse, can suddenly have flashbacks given the similarities of childbirth to the past abuse(s). The existing literature also reported that the body could be forced to remember the abuse during childbirth (Rhodes & Hutchinson, 1994; Roller, 2011; Waymire, 1995). At a seemingly joyous time, this can be horrific for survivors who relive their past abuse(s) during childbirth. No one should have to suffer sexual abuse, let alone have the repressed memory resurface when they are bringing a baby into the world; an experience that has the potential to be one of the greatest joys of womanhood. Healthcare providers are called to utilize current guidelines to screen women for a history of sexual abuse and to discuss the connections of the past abuse to the current childbearing experience. Through this dialogue, survivors stand to have more positive childbearing experiences.

Adding to the Literature

This research study has added to the limited body of research on the childbearing experience of survivors of sexual abuse. Although Parratt (1994) also conducted a descriptive phenomenological study on the childbearing experiences of survivors, only labor and delivery experiences were explored. This current research examined both the events of pregnancy, and labor and delivery, from the perspective of survivors.

Additionally, the theme, "An emotional roller coaster: From excitement, to grief for what could have been a better experience" was not previously reported in the existing literature. In this current study, enjoyment, excitement, and love are juxtaposed with guilt, unpleasantness, nervousness, stress, anxiety, and fear at various moments of pregnancy and labor and delivery. Previous study findings have touched on survivors' emotions, but not to the extent of the current

study. Garratt (2008) reported similar negative emotions of powerlessness, betrayal, and humiliation related to the childbearing experience. Schwerdtfeger and Wampler (2009) reported overwhelming emotions such as sadness, guilt, anger, loneliness and stress as a subtheme. Chambers (2010), Eberhard-Gran et al. (2008), and Schroll et al. (2011), all reported survivors experience fear of childbirth. This current study however found that although survivors had negative emotions, they also had positive emotions during their childbearing experience, consequently the theme title "An emotional roller coaster." In this study, survivors reported enjoyment and excitement in the context of their childbearing experience. Survivors even loved what their body was capable of when they were pregnant. Schwerdtfeger and Wampler (2009) similarly reported "Pregnancy: A new beginning beyond sexual trauma," as a theme and discussed that women can enjoy pregnancy as a new hope.

Unintended Finding

The direct benefit of using descriptive phenomenology for the research method of this study was that participants were able to openly share the thoughts, feelings, and perceptions they had of their childbearing experience. The more structured interview approach of other research methodologies may have missed this opportunity for participants to openly discuss their experiences. Survivors in this study were asked to discuss their experiences with pregnancy and labor and delivery events; however, seven of the eight participants heavily focused on how their histories affected their parenting. This emphasis from survivors led to "Overprotection: Keeping my child safe" as the strongest theme identified.

This study highlighted that survivors, given their past, seek to protect their children from harm. This protection may begin during pregnancy or infancy, and continue into adulthood. Survivors appear anxious about the realistic concern of sexual abuse. It is important to note that

two previous research studies also reported the finding of survivors' protection of their children (Palmer, 2004; Schwerdtfeger & Wampler, 2009). Palmer (2004) reported that survivors worried about their female children being sexually abused and sought to overprotect them. Schwerdtfeger and Wampler (2009) found that survivors overprotect their children, specifically female children. In this current study, survivors overprotected both male and female children, adding to the literature on survivors' childbearing experiences.

Furthermore, although other studies have found that survivors overprotect their children, this current study is the first to report overprotection as the strongest theme. This overprotection is rooted in real world anxieties about how to raise children in the wake of a history of sexual abuse. Survivors in this study expressed how having their children was often a trigger to their past. Survivors fiercely sought to shield their children from harm starting in infancy and continuing throughout the child's life. For some, having to leave their children with a babysitter was incomprehensible and they became overcome with worry about leaving them.

This research study has therefore made a significant contribution to the literature given the finding of "Overprotection: Keeping my child safe" as the parenting style of survivors of sexual abuse. The implications of this finding go far beyond the aim of the study, which was to understand the lived experience of childbearing for survivors of sexual abuse. Healthcare providers can utilize this finding when working with survivors as a means to understand why they are overprotecting their child. By discussing the fact that survivors often feel overprotective of their children, other survivors may in turn be more open to discussing their emotions surrounding parenting in the wake of their past. An open dialogue stands to help survivors in their childbearing experiences as well as their parenting experiences.

Clinical Practice Implications

The findings of this current study are important for women's healthcare providers to consider and utilize to adjust their practices in order to enhance the childbearing experience for survivors. In this section, the following clinical practice implication topics will be highlighted: "just ask me," how to speak about cervical dilation, therapeutic relationship, skin-to-skin, breastfeeding, and trauma-informed care.

"Just ask me"

Overwhelmingly in this research and in the existing literature, survivors report wanting to be asked about their past history (Friedman et al., 1992; Robohm & Buttenheim, 1996). The survivors in this study repeatedly shared they were not asked about their history, and perhaps the experience could have been different if they were asked. Even in the presence of red flags, survivors in this study were not asked.

The American College of Obstetricians and Gynecologists (2012) recommends screening all women "at the first prenatal visit, at least once per trimester, and at the postpartum checkup" as well as continually offering support and referral options (p. 1). The Institute of Medicine (2011) also promotes universally screening women for violence. Even with these recommendations, many women are not being screened at any time during their childbearing experience. In a meta-synthesis on prenatal screening for intimate partner violence (IPV), LoGiudice (2014) reported that providers report barriers to universally screening women such as their partners being present, variations of how and when to ask, and feeling lost about what to do when a patient does disclose. Moreover, it is imperative for women's healthcare providers to not only screen women, but to create an atmosphere where disclosure is comfortable for the woman.

As the literature supports, survivors seek out healthcare providers who are perceived as open (Burian, 1995; Coles & Jones, 2009; Lee 2001).

Verbalization of how far dilated and having others in the room

In the context of the healthcare setting, advancing cervical dilation is viewed as an exciting time, as the birth of the baby gets closer. It is imperative for healthcare providers to remember that although in labor it is a positive finding to be increasing in cervical dilation, this experience is very different for survivors of sexual abuse. When survivors hear how open their cervix has become in the excited voice of healthcare providers, it can be evocative to when their abuser was touching and talking to them, triggering a flashback. Survivors therefore can negatively perceive the excitement of the body opening. Healthcare providers can help survivors by remaining neutral and not showing overly excited emotions when they discuss cervical dilation. Furthermore, asking the woman if she even wants to know the actual number of centimeters dilated versus just knowing she is making progress could be helpful for survivors. This leads to the notion of trauma-informed care.

Additionally, having multiple people present during a vaginal exam is traumatizing for survivors. Often, registered nurses and medical or nursing students are all present during a vaginal exam because cervical dilation is a marker that labor is progressing in a healthy manner. The vaginal exam is a routine assessment approximately every two hours during a woman's labor. For survivors, having witnesses (albeit healthcare professionals) present during an exam that triggers flashbacks to past abuse is incredibly invasive and traumatizing.

Therapeutic Relationship

Central to the childbearing experience is a therapeutic relationship between the woman and her healthcare provider(s). In this study, many survivors sought out female healthcare

providers, reporting they felt more comfortable with a female caring for them. Previous research reported that survivors are more likely to seek midwifery care (largely a female dominated profession) than non-survivors (Burian, 1995). In the qualitative literature, survivors of sexual abuse have identified midwifery care as a means to feel more in control of their childbearing experiences (Burian, 1995; Palmer, 2004; Parratt, 1994; Rhodes & Hutchinson, 1994; Richmond, 2005; Seng et al., 2002). Although this was not a finding of the current research, it is important especially for midwives, to understand that many of their patients are survivors and seeking therapeutic relationships. The current study and existing literature further suggest and support that care must be more holistic; focused on the woman's overall experience, inclusive of her emotional experience, and not simply based on her physical symptoms. This point speaks to the need for greater awareness of mind-body connections throughout health care, not just with trauma survivors, linking this research again to Siegel's (2003) model and theory.

Skin-to-skin

Skin-to-skin is recommended immediately following the delivery of a baby and providers often place the baby directly onto the woman's chest. At this time the baby is covered in blood, vernix, and amniotic fluid. Survivors have reported that having a wet foreign object placed on them, even though it is their baby, can be a trigger to the past. The baby covered in body fluids can be reminiscent to having had a penis ejaculate onto them.

A survivor in this study recalled that having her son skin-to-skin was not an option for her given the connections this had to her history of CSA. This finding is important for healthcare providers, especially labor and delivery, postpartum, and neonatal intensive care providers who encourage skin-to-skin contact to promote thermoregulation of newborns.

Breastfeeding

Survivors in this research spoke about wanting control over their decision to breastfeed or to bottle-feed. As was explored in the literature review, the breastfeeding experience can be reminiscent of past abuses for women and it is imperative that healthcare providers give permission to women that it is okay to not breastfeed if they emotionally and/or physically struggling to breastfeed (Beck, 2009). The mantra "breast is best" is often all women hear, and for survivors, this message and the experience of breastfeeding can be incredibly traumatizing.

Trauma-informed care

All of the clinical implications discussed thus far can be aptly summarized in the tenets of trauma-informed care (The Trauma Informed Care Project, 2014). The tenets of giving the patient control, providing informed care, and discussing past histories, are at the core of trauma-informed care. Through this current study and the existing literature, it is clear that survivors stand to benefit from this sensitive, individualized care (Coles & Jones, 2009; Seng et al., 2002). The tenets of trauma-informed care, although not explicitly stated as such, have been reported in the existing literature. Seng et al., (2002) discussed "desired practices" that include asking about a history of abuse, acknowledging the longstanding effects of the trauma, assessing for issues related to the abuse, arranging for the specific needs of each patient, avoiding triggers, and advocating for social support (p. 364). Similarly Coles and Jones (2009) discussed "universal precautions" that resulted from their research (p. 235). "Universal precautions" include recommendations for healthcare providers to give survivors control, to explain procedures, to ask for consent before touching survivors or their babies, and to stop the exam upon request or signs of distress (Coles & Jones, 2009, p. 235). From this current research and the existent literature, it is clear that trauma-informed care should be utilized when working with survivors of sexual

abuse or of any other past trauma. In summary, this model involves supporting the patient throughout disclosure, giving the patient control of the healthcare encounter, and allowing for informed decision-making (Linden & Bell, 2012).

Educational Implications

The need for educational programs to implement content about survivors of sexual abuse is clear. Healthcare education programs are called to teach students about the prevalence and long-term sequela of sexual abuse, as well as best practices for screening and caring for survivors. All educational programs in nursing and medicine alike would benefit from the addition of these topics to their curriculum. Specific attention should be given to highlighting the importance of applying trauma-informed care to all healthcare practices. Learning to utilize these practices at the outset of one's career in healthcare will increase the potential that the standard of care necessary for survivors is met.

Limitations

The limitations of this current study are addressed in this section. Notably, the three major limitations are that all birth experiences shared were hospital births, no teenagers were involved in this study, and recruitment took place exclusively through a support and advocacy group.

First, home birth experiences were not represented in this study. The homogeneity in experiences all being hospital births may limit the transferability of the findings for survivors who choose homebirths. In the existing literature, Garratt (2011) found that when survivors deliver in their own home they have more control because they are in their own space. A study

specifically on survivors choosing home births would be necessary to better understand the specific childbearing experiences of these women.

Second, teenagers were not included in this research due to the vulnerability of young adults under the age of 18 and protection of minors in research. Pregnant teenagers represent a vulnerable population given their age and the immense responsibility of having a child at this age, however they were not included in this current research. The childbearing experience of teenage survivors of sexual abuse is a notable gap in the literature that needs to be addressed. Teenage survivors of childhood sexual abuse are likely to be more sexually promiscuous, likely because they are trying to regain control of themselves in the context of a sexual relationship (Saewyc, Magee, & Pettingell, 2004). Research with teenage mothers who are also survivors of sexual abuse would have to be undertaken with great care to protect the participants and is needed to better understand the experiences of this vulnerable population.

Another limitation is that six of the eight participants in this research study were active participants in a weekly support group for survivors of sexual abuse. It is possible that these women had a more organized view of how their past histories affected their childbearing experiences from the counseling they received and their weekly discussions with other survivors. Despite this potential limitation, I decided to utilize a support group for this sample, because these women were connected to resources should they become emotionally upset as a result of participation in this research. Of note, no participant did become emotionally upset or need immediate counseling following participation in this study. Future work in this area may benefit to recruit survivors more broadly.

Suggestions for Future Research

Continued research on the childbearing experience of survivors is necessary. Proposed ideas will be discussed and include qualitative research designs, survivor's experience of conception, elective cesarean births, and home births. Lastly, a proposal for an intervention study to implement the suggestions to improve care that survivors have given and explore how these ideas affect survivors' childbearing experience is discussed.

Previous qualitative studies have largely employed descriptive and grounded theory research designs; however only one, published 20 years ago, has followed an ethnographic research design (Rhodes & Hutchinson, 1994). A current ethnographic study following survivors of sexual abuse throughout their pregnancy, labor and delivery and postpartum periods would be informative regarding the real-time experience of childbearing. This study would also closely follow both the women's healthcare providers providing prenatal care and those in the labor and delivery setting, adding to the existing literature.

Additionally, survivors' experience of conception (becoming pregnant) is an area that has not been examined and is an important topic for future research. To begin, research with women who conceive more traditionally from heterosexual intercourse is first needed. Additionally, research with all women (i.e. single, heterosexual, and lesbian woman) who conceive from reproductive assistance such as in vitro fertilization (IVF) would be beneficial. For initial research, these groups of women should be studied individually to identify, any differences in their experiences. Furthermore, the medical procedures necessary for reproductive assisted conception are invasive and may potentially be triggers for survivors. Given the increased use of reproductive assisted conception, in the United States especially, this research would be timely.

Another proposed idea, is a mixed methods study aimed at examining the birthing experience of survivors having an elective cesarean birth compared to those having a vaginal

delivery. For the quantitative portion of the study, both the elective cesarean birth group and the vaginal birth group would first complete a survey. For the qualitative portion, interviews would be undertaken with a select portion of women in both groups regarding their experiences. To date there have not been any studies on this topic. This research is both necessary and timely given the national health goal to reduce the cesarean birth rate in hospitals.

Additionally, one mentioned limitation of this research was that all participants had hospital deliveries. Future research further examining at the demographics of women who choose homebirth is necessary to elicit what percentage of survivors seek homebirth as an option. Additionally, research would be beneficial to explore why survivors choose to have a homebirths.

This current study is the fifteenth study undertaken in the past 20 years on survivors' childbearing experiences. The findings among these studies have provided an understanding of the experiences survivors have during pregnancy, labor and delivery, and the postpartum period. With this foundation, future research must now turn toward developing interventions to implement the recommendations survivors have provided in these studies. An intervention study utilizing the changes in healthcare practices offered by survivors themselves stands to benefit future survivors. Additional benefits from this type of research include determining the best methods to teach these recommendations to healthcare providers, as well as how to prevent judgmental attitudes in providers. Methods and techniques of delivering and improving healthcare to survivors stand to be more universally implemented from this type of future research.

Conclusion

In Western culture specifically, pregnant women often face the societal expectation that they are experiencing the most joyous occasion of their lives. However, as this study, and past research have demonstrated, survivors' pasts can haunt them throughout pregnancy and childbirth (Heimstad et al., 2006; Waymire, 1995). As a result, the physical and psychological adaptions of pregnancy can be especially difficult for survivors (Schwerdtfeger, & Wampler, 2009; Palmer, 2004; Roller, 2011; Simkin, 2009). This research and the existing literature have highlighted the need for specialized, individualized, trauma-informed care for survivors.

The first step towards implementation of this care for survivors is simply asking women if they are survivors of sexual abuse, recalling that one in five women asked are in fact survivors (Black et al., 2011). The literature is clear that women desire to be asked about their histories (Burian, 1995; Roberts et al., 1999; Robohm & Buttenheim, 1996). Moreover, with the appropriate support and interventions, the childbearing experience can potentially provide a survivor with a reconnection and rebirth of herself (Rhodes & Hutchinson, 1994). The first step in the process of improving the childbearing experience for survivors of sexual abuse is to simply ask women if they have a history and to listen to their experience. Survivors seek to make meaning of their past in the context of their present lives in order to move beyond the pain (Coles & Jones, 2009; Dijkstra, 1995; Roller, 2011). Siegel's work with interpersonal neurobiology has further explained the process of making the memory of sexual abuse an implicit memory in order to work through the past.

The following passage from Waymire (1997), a women's health nurse, is fundamental for all women's healthcare providers. Waymire (1997) implored

> Many women in our society have been sexually abused. Because it is so common, and because labor and birth may bring up issues or memories related to abuse. I ask every woman if she has any recall of being abused, or if she as anything she wants to ask related to abuse. Do you? (p.48)

One in every five women cared for will directly benefit from this opportunity to share their experience with another and to make meaning of what occurred to them, perhaps for the first time in their lives (Dijkstra, 1995). Research has supported that there is no more likely time for the abuse to resurface than during the childbearing experience, which is largely a time when control is out of the woman's hands (Simkin & Klaus, 2004). Survivors especially struggle with the lack of physical and emotional control associated with pregnancy and labor and delivery. Healthcare providers efforts towards utilizing the experiences of survivors from this research will shape more positive childbearing experiences for survivors moving forward. The experiences of 20% of women cannot be ignored. Improving the healthcare experience of survivors of sexual abuse begins with this proposed statement and question: "I have cared for many survivors of sexual abuse, and ask all of my patients if they have a history of sexual abuse. Are you a survivor of sexual abuse?"

Childbearing is a joyous, yet vulnerable experience for women, particularly for the one in five women who are survivors of sexual abuse. This research has further highlighted the need for application of trauma-informed care in the childbearing setting. Additionally, survivors stand to benefit from having support, being screened, and remaining in control of their childbearing experience. Childbearing for survivors in this study was aptly the best and worst of times. Through the knowledge gained from this study and the existing literature on the childbearing

experience of survivors of sexual abuse, healthcare providers can work towards helping survivors experience the best of times.

"Positive birthing outcomes have the potential to serve as powerfully corrective experiences, in that survivors reported a sense of renewed faith in their physical and emotional selves." (Chambers, 2009, p. ii)

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Table 1

Qualitative Studies of the Childbearing Experiences of Survivors of Sexual abuse

Author(s)/ Year	*Country*	*Discipline*	*Sample*	*Focus*	*Qualitative Research Design and Data Analysis*	*Results*
Burian, 1995	United States	Nursing	N = 9; 5 survivors, 2 nurses & survivors, 1 nurse, 1 childbirth educator	Childbirth (labor & birth) experience of sexual abuse survivors	Descriptive, Thematic Analysis	Strongest themes: disclosure and validation, avoidance of healthcare, frequent somatic complaints, issues of control, and dissociation during medical procedures.
Chambers, 2010*	United States	Psychology	N = 7	Pregnancy, delivery, and motherhood experience of survivors of sexual trauma	Descriptive, Thematic Analysis	Twelve themes put into four domains: (1) prior to becoming pregnant: themes included identity development, role of therapy, and positive reframing of trauma; (2) during pregnancy: themes include fears regarding delivery, and decision to homebirth, (3) during labor and delivery: themes include letting go of agendas, external factors supporting internal factors, and traumatic births and the prevention of re-traumatization, & (4) after birth: themes included the transformative nature of birth, need for more open dialogue, and context and privilege

Coles & Jones, 2009	Australia	Medicine	N = 18	CSA survivors' experiences of perinatal professional touch and examination of themselves and their babies (labor & birth, & the postpartum period)	Descriptive, Thematic Analysis	Two key themes: safety issues for survivors & their babies during the healthcare encounter, and ways to make the healthcare encounter safer.
Garratt, 2008*	United Kingdom	Nursing	N = 20; 8 survivors, 12 midwives & survivors	Childbearing experiences of CSA survivors	Feminist Standpoint, Grounded Theory, (Glaser & Strauss, 1967), voice-centered rational analysis	Three themes: Powerlessness, betrayal, and humiliation. Findings of re-traumatization were discussed using Finkelhor and Browne's traumagenic model.
Lasiuk, 2007*	Canada	Nursing	N = 7	Pregnancy and birthing experiences of CSA survivors	Interpretative Inquiry, (van Manen, 2002)	Themes: living in the wake of CSA, respons-ability to motherhood, & regeneration
Lee, 2001*	United States	Psychology	N = 7	Childbearing (pregnancy, labor, birth, & the postpartum period) experiences of CSA incest survivors	Descriptive, Thematic Analysis	Themes: confrontations, reconciliations, and moving beyond sexual abuse in childbearing; intrusions and remembering; shut down, being open, and dissociation; body perception; coping; care providers and hospitals

Palmer, 2004*	British Columbia	Nursing	N = 68; 46 survivors & 22 healthcare professionals	Childbearing experiences (pregnancy, labor, & birth) of CSA survivors	Grounded Theory, (Glaser, 1992); Strauss & Corbin, 1998)	Core category: "Protecting the inner child." Processes of (over) protecting self and (over) protecting child contribute to core category.
Parratt, 1994	Australia	Nursing	N = 6	Childbirth (labor & birth) experience of CSA incest survivors	Phenomenology, (Patton, 1990)	Memories of past abuse were triggered during childbirth. Privacy, touch, and control are important aspects of survivors' experiences.
Rhodes & Hutchinson, 1994	United States	Nursing	N = 15; 7 survivors, 5 nurse-midwives, & 3 labor & delivery nurses	Childbirth (labor & birth) experience of CSA survivors	Ethonography, (Spradley, 1979)	Forgetting and remembering. Birth can cause forced remembering: body memories. Control is important for survivors. Survivors' laboring styles include fighting, taking control, surrendering, and retreating.
Richmond, 2005*	United States	Nursing	N = 11	Childbearing (pregnancy, labor, & birth) experience of CSA survivors	Feminist Research, Grounded Theory, Constant comparative method, (Glaser & Strauss, 1967)	Substantive theory: Being whole: Aligning personhoods through discerning safety and managing vulnerabilities

Roller, 2011	United States	Nursing	N = 12	Perinatal period (pregnancy, labor, & birth) of CSA survivors	Grounded Theory, Constant comparative analysis (Glaser & Strauss, 1967; Strauss & Corbin, 1998)	Core category: Moving beyond the pain. CSA survivors manage the reexcperirencing of their past abuse triggered in the perinatal period by 3 processes: reliving it, taking charge of it, & getting over it.
Schwerdtfeger & Wampler, 2009	United States	Human Development and Family Science	N = 10	Current pregnancy experience of survivors of sexual trauma	Descriptive Phenomenology, (Colaizzi, 1978)	4 dominant categories: (1) negative consequences of sexual trauma, (2) becoming a survivor, (3) pregnancy: a new beginning beyond sexual trauma, & (4) the integration of sexual trauma and motherhood.
Seng, Sparbel, Low, Killion, 2002	United States	Nursing	N = 15	Childbearing (pregnancy & birth) perspectives of CSA and abuse-related posttraumatic stress survivors	Narrative Analysis, (Riessman, 1993)	3 groups emerged: (1) women far along in recovery, (2) women who were not safe, & (3) women who were not ready to 'know.'
Waymire, 1995**	United States	Nursing	N = 6	Childbirth (labor & birth) experience of CSA incest survivors	Hermeneutic Phenomenology, (Diekelmann, Allen, & Tanner, 1989)	3 themes: (1) The knowing body, (2) Seeking connection, & (3) Striving for safety. Themes were connected by an underlying constitutive pattern, Haunted Birthing.

Notes: CSA = childhood sexual abuse
*unpublished dissertation
**unpublished master's thesis

Table 2. Selected Examples of Significant Statements of the Childbearing Experiences of Survivors of Sexual Abuse and Corresponding Formulated Meanings

SIGNIFICANT STATEMENTS	FORMULATD MEANINGS
1. When I found out I was pregnant no one knew. No one knew until after I had my child. I don't know why. I think I know why now I didn't share it with anyone. Because, when I was younger and abused, my cousin and sister came out to our family and said that they were abused and nobody did anything about it. So I didn't say anything about my abuse until I had my child at the age of 21. (1)	1. For this survivor, no one knew she had a history of sexual abuse until after her delivery. At the time, she was unsure why she kept her history and the pregnancy a secret. Now, she recognizes that it was because at the same time that she was being abused, her sister and cousin told family members that they were being sexually abused. No one in the family did anything about the abuse therefore, she did not tell her family she was also abused until she was 21.
2. That [screening] should be in a questionnaire when you first go to a place. (26)	2. A survivor suggested that screening for a past history of abuse should on a questionnaire at the start of every new healthcare visit.
3. My doctor was a female OB [obstetrician] and she knew I was going to give up the baby for adoption but she never, she never asked any questions. I mean I don't know whether she thought it was like none of her business or whatever, but she never asked who the father was, never asked if I was a sexual abuse survivor, none of that. (54)	3. A survivor shared that even though her obstetrician knew she was giving the baby up for adoption, potentially a sign that she had history of trauma, she was not asked if she had a history of sexual abuse or who the father of the baby was. She thought perhaps the obstetrician thought it was none of her business.
4. So again I didn't feel like I had much of a voice and like I'm trying but she kept cutting me off and everything (74)	4. The survivor didn't feel like she had a voice. Her doctor kept cutting her off when she tried to speak.

SIGNIFICANT STATEMENTS	FORMULATD MEANINGS
5. The baby came out, they scared me a bit, the umbilical cord was around her neck. Probably normal for them. But they just kind of moved quickly. (143)	5. When the baby was born, the healthcare providers moved quickly because the umbilical cord was around the baby's neck. This scared the survivor although it was likely routine for the providers.
6. I felt very protective of them and not that I didn't think any body else could take care of them but I needed to know what was going on. I think that's just definitely part of the abuse, I mean definitely and I just always followed my gut. (198)	6. The survivor understood that others could take care of her children, but because of her past sexual abuse, she was very protective of her children and always followed her gut.
7. I definitely cope with things by compartmentalizing, you know that happened to me in the past, this is here. (192)	7. The survivor coping mechanism is to compartmentalize her past history of sexual abuse as separate from her current experiences.
8. So she was my trigger. When she was born, it was shear joy and happiness and also 'oh no.' (211)	8. The survivor experienced joy and happiness as well as feeling triggered to her past abuse when her daughter was born.
9. But because you have so many check ups and exams in the beginning it felt a little invasive only because outside of my husband that was the next time I was actually being touched down there and I guess it was just more uncomfortable. (265)	9. The survivor felt that during her pregnancy vaginal exams were invasive, since outside of her husband and her abuser, this was the next time her vagina was being touched. I made her feel uncomfortable.
10. And your body, even though you're thinking you're okay, your body reacts automatically and it even surprised me because I didn't really think I was going to have any trouble at all. (301)	10. A survivor did not believe she would have any difficulty with having a vaginal exam. However, when she was actually touched during the exam she was surprised that she was triggered to her past history and stated her body reacted automatically.

Table 3. Examples of Two Theme Clusters with Their Formulated Meanings

Theme 1: An emotional roller coaster: From excitement, to grief for what could have been a better experience

a. A survivor expressed that in her mind she had done something wrong to be abused. Later in life when she became pregnant, she again felt this guilt, feeling that she had done something wrong. (2)

b. A survivor kept both her past history of sexual abuse and her pregnancy to herself. She always felt guilty that she should be telling her family and friends about these two events in her life. (41)

c. A survivor who worked in the healthcare setting experienced grief for what could have been a better experience during her labor and delivery. She had witnessed births as a nursing student and knew they could be beautiful, but hers was not beautiful. (79)

d. During her fourth pregnancy, a survivor recalled she was clean and sober and felt settled in her life. At this time she truly enjoyed her pregnancy. (108)

e. A survivor discussed that as a survivor of sexual abuse she actually loved the physicality of being pregnant. (205)

f. A survivor was very nervous and very scared when she was pregnant. She was worried about committing to having a child and questioned if she could raise a child, that maybe she had made a mistake getting pregnant. (224)

g. A survivor recalled she was happy and had no negative feelings about delivering her baby. Physically she delivered the baby without any assistance from forceps or a vacuum and she had no problems physically delivering the baby. (288)

h. For a survivor, the different trimesters of pregnancy were very enjoyable for her. (291)

Theme 7: Overprotection: Keeping my child safe.

a. A survivor expressed how difficult it was when her son was born because the family member who sexually abused her was still present in her life. She worried that he may hurt her son too. (21)

b. A survivor stated that even though her son is 20 years old, she is still worried and stressed about him. She often calls him to ask if he is doing alright and if he made it to school safely. (31)

c. A survivor recalled that beginning even in the hospital after birth, she wouldn't let her son leave the room or be out of her sight. (136)

d. A survivor expressed that the protectiveness that she felt over her children once they were born is unique to survivors of sexual abuse. (167)

e. A survivor felt that daycare was not an option she could consider for her children because she was a survivor of sexual abuse. Her job allowed her to arrange her schedule so that either her or her husband was the one home with the kids. (194)

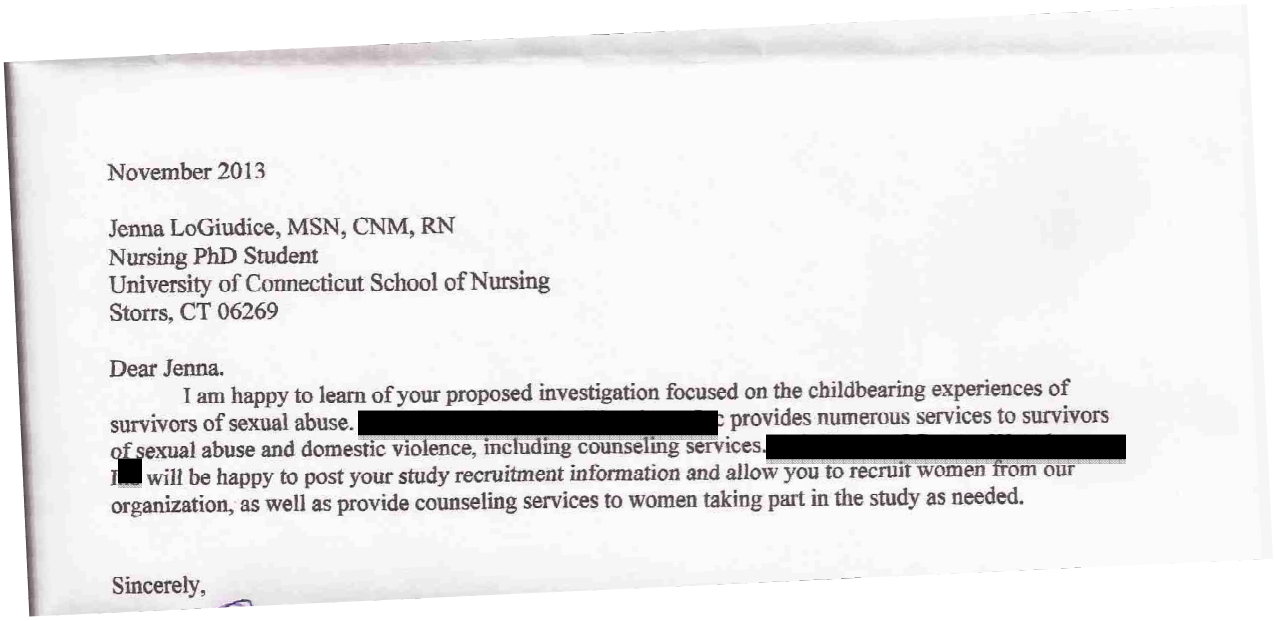
f. Despite not knowing the gender of her child during her pregnancy, a survivor convinced herself that she was going to have a boy. She did this because she was terrified of what would happen if she had a little girl. (206)

g. A survivor described her parenting style as a "helicopter mom" because she was very strict with her daughter. She was open with her daughter as well but overall recalled always hovering around her to ensure she was safe. (230)

h. For one survivor, raising her children was a trigger to her past history of sexual abuse. (255).

(#) indicates the number assigned to the significant statements from which the formulated meaning was derived

Appendix A



November 2013

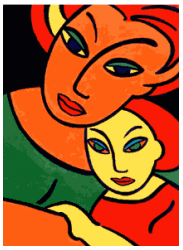
Jenna LoGiudice, MSN, CNM, RN
Nursing PhD Student
University of Connecticut School of Nursing
Storrs, CT 06269

Dear Jenna.

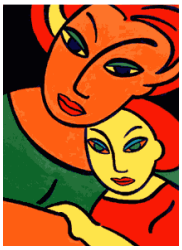
I am happy to learn of your proposed investigation focused on the childbearing experiences of survivors of sexual abuse. [redacted] provides numerous services to survivors of sexual abuse and domestic violence, including counseling services. [redacted] will be happy to post your study recruitment information and allow you to recruit women from our organization, as well as provide counseling services to women taking part in the study as needed.

Sincerely,

Appendix B



University of Connecticut



Volunteers Wanted for a Research Study

The Experience of Childbearing from Survivors of Sexual Abuse

I am a Certified Nurse Midwife looking for women to participate in my research at the University of Connecticut School of Nursing. I am studying the childbearing experiences of survivors of sexual abuse. I am interviewing women about being a survivor, and being pregnant and giving birth. You may share your experience(s) either in writing or during an interview at a time convenient for you. Your participation and responses will be kept confidential and take approximately 30-60 minutes of your time

If you have had at least one childbearing experience and are a survivor of sexual abuse, you are eligible to participate in this research study.

Participants will receive a $20 gift card to Target for completing the study.

To learn more about this research, contact,
Jenna LoGiudice, MSN, CNM, RN at
jenna.logiudice@uconn.edu
or 203-437-2624

This research is conducted under the direction of Dr. Cheryl Beck, School of Nursing

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Appendix C

Call for Participants

I am a Certified Nurse Midwife studying the childbearing experiences of survivors of sexual abuse. I am interviewing women about being a survivor, and being pregnant and giving birth. This understanding may lead to improvements for women who are also survivors during their pregnancy and childbirth experiences. You may share your experience(s) either in writing or during an interview at a time convenient for you. Your participation and responses will be kept confidential and take approximately 30-60 minutes of your time to complete. You will receive a $20 gift card to Target for your participation. If you or someone you know is interested in participating, please contact:

Jenna LoGiudice, MSN, CNM, RN
University of Connecticut
jenna.logiudice@uconn.edu
203-437-2624

This research study was approved by the UConn IRB, Protocol #H13-326.
This research is conducted under the direction of Dr. Cheryl Beck at the University of Connecticut, School of Nursing.

Appendix D

Participant Profile Form

1. Current Age:_____

2. Race: ___American Indian or Alaska Native
___Asian
___Black or African American
___Hispanic
___Native Hawaiian or Other Pacific Islander
___Multiracial
___White (Non-Hispanic)

3. Highest level of education: ___Some High School
___High School/Diploma
___Associate
___Bachelors
___Masters
___Doctorate

4. Are you currently: ___Single
___In a committed relationship
___Married
___Divorced

5. Age(s) at which the sexual abuse occurred _____

6. Relationship to the perpetrator(s) of abuse_____

7. Number of pregnancies you have experienced (regardless of pregnancy outcome) _____

8. Number of living children _____

9. Your age at the time of your first delivery_____

10.Who cared for you during your pregnancies?: ___Doctor/ Obstetrician
___General/Family Practice Physician
___Nurse Midwife
___Both Certified Nurse Midwife and Doctor
___Other (please specify)_____

11. Have you had:
____Vaginal delivery(s)
If yes, did it involve a vacuum? _____
If yes, did it involve forceps? _____
_____Cesarean delivery(s)

If yes, was it an emergency or planned?_____

_____Both vaginal and Cesarean

If both please specify how many of each: _____

12. Have you ever been specifically or directly asked about a history of sexual abuse during your pregnancy or labor and delivery experience?

___Yes

___No

13. Have you ever received counseling related to your past sexual abuse?

___Yes

___No

If yes, Are you still receiving counseling?: _____

14. Your age you when you first disclosed your history of sexual abuse _____

Appendix E

Consent Form for Participation in a Research Study

University of Connecticut

Principal Investigator: Cheryl Beck, DNSc, CNM, FAAN
Student Researcher: Jenna LoGiudice, MSN, CNM, RN
Study Title: The Lived Experience of Childbearing from Survivors of Sexual Abuse

Introduction

You are invited to participate in a research study to understand the childbearing experiences of survivors of sexual abuse. Childbearing includes both your pregnancy and labor and delivery experiences. Few research studies have addressed this topic. This research is needed in order to understand the needs of survivors during childbearing and to potentially improve the healthcare experiences of survivors during childbearing.

Why is this study being done?

The purpose of this research study is to better understand the childbearing experiences of survivors of sexual abuse. The study aims to understand how being a survivor may have affected your pregnancy and labor and delivery experiences.

What are the study procedures? What will I be asked to do?

If you agree to take part in this study, you will be asked to either submit a written response to a statement or to have a one on one interview. The decision to submit a written response or to have an interview will be yours to make. Both the written response and the interview will have one statement to which you will be asked to respond. You will also be asked to provide some information about yourself, such as your age, marital status, educational level, and childbearing history.

The written response can be completed at any time that is convenient for you. This response can be collected at a time and place that is convenient for you, or you can mail it back to the researcher in a pre-stamped, pre-addressed envelope. If you are unable to meet in person or mail the response, you may email your response to the researcher. Similarly, the interview will be scheduled at a time and place that is convenient for you. The interview will be audio recorded. Both the written response and the interview will require approximately 30-60 minutes of your time. When the project is complete, if you would like, the researcher will send you a copy of the findings for your review to see if you agree with them or not. If you decline, you will not be contacted again in the future.

What are the risks or inconveniences of the study?

While we believe this study does not involve any risk to you, you may feel uncomfortable or become emotionally upset as you recall events while you write a response or speak during an interview. If at any time you feel uncomfortable or upset you are free to stop writing or stop the interview. The only inconvenience is the amount of time (30-60 minutes) to participate in this study.

What are the benefits of the study?

You may not directly benefit from this research; however, we hope that your participation in the study may help clinicians provide better care to survivors.

Will I receive payment for participation? Are there costs to participate?

There are no costs to participate in this study.

You will receive a $20 gift card to Target for participating in this study. The gift card will be given to you at the completion of the interview or upon receiving your written response.

How will my personal information be protected?

The following procedures will be used to protect the confidentiality of your data. The researchers will keep all study records (including any codes to your data) locked in a secure location. Research records will be labeled with a code. The code will be derived from a number (sequential 2 digit code) that reflects how many people have enrolled in the study. A master key that links names and codes will be maintained in a separate and secure location. The master key and audio recordings will be destroyed after 2 years. The researchers and/or a professional transcriptionist will transcribe the audio recordings. No identifying information will be provided to the professional transcriptionist. All electronic files (e.g., database, spreadsheet, etc.) containing identifiable information will be password protected. Any computer hosting such files will also have password protection to prevent access by unauthorized users. Only the members of the research staff will have access to the passwords. Data that will be shared with others will be coded as described above to help protect your identity. At the conclusion of this study, the researchers may publish their findings. Information will be presented in summary format and you will not be identified in any publications or presentations.

We will do our best to protect the confidentiality of the information we gather from you but we cannot guarantee 100% confidentiality. Since email is not anonymous and not a secure transmission method, your confidentially cannot be guaranteed. For example, emails can be monitored by employers. Also emails are not encrypted. If your email is somehow diverted or lost in transmission, your response with your identification attached through your email address can be exposed.

You should also know that the UConn Institutional Review Board (IRB) and the Office of Research Compliance may inspect study records as part of its auditing program, but these reviews will only focus on the researchers and not on your responses or involvement. The IRB is a group of people who review research studies to protect the rights and welfare of research participants.

Can I stop being in the study and what are my rights?

You do not have to be in this study if you do not want to. If you agree to be in the study, but later change your mind, you may drop out at any time. There are no penalties or consequences of any kind if you decide that you do not want to participate.

Whom do I contact if I have questions about the study?

Take as long as you like before you make a decision. We will be happy to answer any question you have about this study. If you have further questions about this study or if you have a research-related problem, you may contact the principal investigator, (Cheryl Beck, DNSc, CNM, FAAN 860-486-0547) or the student researcher (Jenna LoGiudice, MSN, CNM, RN, (203) 437-2624). If you have any questions concerning your rights as a research participant, you may contact the University of Connecticut Institutional Review Board (IRB) at 860-486-8802.

Documentation of Consent:

I have read this form and decided that I will participate in the project described above. Its general purposes, the particulars of involvement and possible risks and inconveniences have been explained to my satisfaction. I understand that I can withdraw at any time. My signature also indicates that I have received a copy of this consent form.

_____	_____	_____
Participant Signature:	Print Name:	Date:

Relationship (only if not participant):_____

_____	_____	_____
Signature of Person Obtaining Consent	Print Name:	Date: