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Child Sexual Abuse and Prenatal Care: Understanding Screening, Modifications, and Proper Care

Wendy Abbott-Egnor
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Walden University

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Walden University
2018

Abstract

Child Sexual Abuse and Prenatal Care:
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by

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MA, Walden University, 2009

BS, University at Albany, SUNY, 2005

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Research has shown that 1 in 9 women in prenatal care have a history of childhood sexual abuse. Pregnant women with a history of childhood sexual abuse are at increased risk of depression, somatization, preterm contractions, posttraumatic stress symptomology, and re-traumatization. The purpose of this study was to bridge the gap in literature between research and practice. Data was collected from practitioners regarding the care and treatment of pregnant women with a childhood sexual abuse history. It was hypothesized that screening practices and modification to care and treatment based on practitioner knowledge of prior sex abuse history will vary by provider type and provider title. A quantitative, online-based survey design was used to gather data from prenatal and birthing practitioners regarding their treatment of female patients who have a history of childhood sexual abuse. Data was analyzed via multiple regression analysis. The data analysis did not lead to any significant results and therefore was unable to support any findings regarding the research questions and hypotheses. The results of this study can be used to encourage practitioners to seek education regarding childhood sexual abuse and its effects on the health and wellbeing of pregnant women. Further, this study brings awareness to the importance of screening for childhood sexual abuse and modifying care during pregnancy and childbirth.

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Chapter 1: Introduction to the Study

The purpose of this chapter is to introduce the reader to research about standard practices used by prenatal and birthing practitioners to care for women who have a history of childhood sexual abuse. In the chapter, I present general information regarding the increased risk factors that a history of childhood sexual abuse can have on pregnancy and childbirth, recommended care practices according to literature, and whether these best care practices are being utilized in care. I then present the problem statement via a discussion of the gap in the literature about increased risks in pregnancy and childbirth due to childhood sexual abuse history and how prenatal care and birthing practitioners tailor their treatment to women with this history. In this discussion, I also offer background information regarding risks a history of child sexual abuse has for pregnancy and childbirth. The purpose of the study and its potential for social change is delineated, as are the research questions and the nature of the study. Next is a brief discussion of the theoretical framework, followed by definitions of key concepts and terms. Finally, I address my assumptions and the scope, delimitations, and limitations of the study.

Background

Studies (Grimstad & Schei, 1999; Hobbins, 2004; Monahan & Forgash, 2000) have indicated that the estimated incidence of women who have experienced child sexual abuse ranges from 6% to 62%. Childhood sexual abuse is a unique trauma. According to Finkelhor and Browne (1985), childhood sexual abuse is the only trauma that affects all four traumagenic dynamics, including chronic and acute developmental, behavioral, psychological, and health issues. In Chapter two, I offer detailed discussions of these

dynamics. Numerous researchers have explored the link between child sexual abuse and factors such as mental health (Chartier, Walker, & Naimark, 2009; Nelson, Baldwin, & Taylor, 2012; Sigurdardottir, 2012), teen pregnancy (Butler & Burton, 1990; Papamicheal, Pillai, & Yoong, 2009; Roosa, Tein, Reinholtz, & Angelini, 1997), substance abuse (Dilorio, Hartwell, & Hansen, 2002; Lev-Wiesel & Daphna-Tekoa, 2007; Monahan & Forgash, 2013; Sartor et al., 2013; Schiff, El-Bassel, Engstrom, & Gilbert, 2002), and sexual dysfunction (Jacobs, 1992; Zwickl & Merriman, 2011). With a history of childhood sexual abuse affecting multiple facets of an individual's life, it follows that this history could also be a risk factor during the prenatal period.

Leeners, Neumaier-Wagner, Quarg, and Rath (2006a), and Roller (2012) estimated that one in nine pregnant women who seek prenatal care have child sexual abuse in their history. Research, albeit limited, has shown that this history can have adverse effects on the prenatal health of both mother and baby (Leeners et al., 2006a; Roberts, O'Connor, Dunn, & Golding, 2004; Yampolsky, Lev-Wiesel, and Ben-Zion, 2010). For example, Yampolsky et al. (2010) found that pregnant women with a history of sexual abuse tended to have higher rates of depression and avoidance behaviors compared to their counterparts with no history of sexual abuse. Studies have also shown that women with a history of childhood sexual abuse are at higher risk for health issues during pregnancy such as somatization (Nelson et al., 2012), preterm contractions (Roller, 2012), increased complaints of discomfort (Grimstad & Schei, 1999; Weinstein & Verny, 2004), increased complaints of nausea and vomiting (Roller, 2012), and an overall increase in prenatal visits and ultrasounds (Grimstad & Schei, 1999; Leeners, et

al., 2006b; Yampolsky et al., 2010). Likewise, pregnant women with a history of childhood sexual abuse also tend to have a higher instance of post-traumatic stress symptoms (PTSD; Benedict, Paine, Paine, Brandt, & Stallings 1999; LaCoursiere, Hirst, & Barrett-Connor, 2012; Leeners et al., 2006b; Mohler et al., 2008; Yampolsky et al., 2010) compared to their non-abused counterparts. These issues are not unique to pregnancy; a history of childhood sexual abuse has been shown to increase risk factors associated with childbirth as well (Clark & Smythe, 2011; Grimstad & Schei, 1999; Issokson, 2004; Noll et al., 2007; Roseth et al., 2011).

Childbirth can bring about a new set of issues for women with a history of childhood sexual abuse. Roseth, Bongaardt, and Binder (2011) speculated that a history of childhood sexual abuse could be associated with increased fears of childbirth. In their research, Roseth et al. (2011) found that women with a history of childhood sexual abuse are at increased risk of being re-traumatized during childbirth due to associating the sensation of these events with events from their abuse history. Not surprisingly, Hotelling (2012) noted that women who feel in control and cared for by their healthcare providers tended to have a more positive birth experience compared to their counterparts who have been unable to establish such a relationship with their providers.

Women with a history of childhood sexual abuse may see standard care procedures used during childbirth as intrusive (Coles & Jones, 2009; Hobbins, 2004). There are many potential triggers that could upset, remind, or re-traumatize women with a history of child sexual abuse, such as vaginal exams (Issokson, 2004), being under the care of someone in a position of power (Hobbins, 2004; Monahan & Forgash, 2013),

nakedness (Issokson, 2004), pelvic/genital pain (Issokson, 2004), and phrases or sayings that may also have been used during the woman's abuse history (Gutteridge, 2001).

Education and training about treating and caring for women with a history, or suspected history, of sexual trauma could assist prenatal and childbirth caregivers in displaying the care and consideration that would best suit such women, thereby reducing the risk of complications associated with childbirth (McGregor, Glover, Gautam, & Jülich, 2010).

Since spontaneous disclosure is a relatively rare occurrence, the burden to ask about childhood sexual abuse history lies on the prenatal and birthing practitioners (Read, McGregor, Coggan, & Thomas, 2006).

Prenatal care providers may be the first line of defense in helping pregnant women with a history of childhood sexual abuse, especially those who have never disclosed their history. Yet, few prenatal care providers take a full sexual case history, let alone ask pregnant patients about their childhood sexual abuse history (Diaz & Manigat, 2000; Leeners, Stiller, Block, Gorres, Imthurn, & Rath, 2007; McGregor, Glover, Gautman, & Jülich, 2010).

Problem Statement

The estimated incidence of women who have experienced child sexual abuse is large enough to warrant research regarding their prenatal care and the childbirth experiences. Research, albeit limited, has shown that this history can have adverse effects on the prenatal health of women (Leeners et al., 2006a; Roberts et al., 2004; Yampolsky et al., 2010). Prenatal health care providers such as obstetricians/gynecologists (OB/GYNs), midwives, doulas, birthing coaches, and prenatal nurses are in a unique

position to identify and manage the problems that may arise during this period for women who have a history of childhood sexual abuse (Leeners et al., 2006a; Yampolsky et al., 2010). According to research on the desired obstetrician/gynecologist (OB/GYNs) care for women with a history of childhood sexual abuse, modification of procedures and treatment methods during prenatal and birthing care can lessen the risk that pregnant women with a history of childhood sexual abuse will be re-traumatized (Gutteridge, 2001; Hobbins, 2004; Issokson, 2004; McGregor et al., 2010; Monahan & Forgash, 2013).

The adverse effects of childhood sexual abuse on pregnancy and childbirth are well documented (Leeners et al. 2006; Roberts et al., 2004; Yampolsky et al., 2010). Nevertheless, there is little to no evidence that this information is reaching prenatal and childbirth practitioners and informing them about how to treat women with a childhood sexual abuse history. Researchers to-date have focused on recommended best practices in the prenatal and childbirth field when working with pregnant women with a history of childhood sexual abuse, but not on whether these recommendations have, in fact, been implemented. In this study, I worked to bridge the gap between what is known about the adverse effects of childhood sexual abuse on pregnancy and childbirth, and the best practices associated with treating survivors during the pregnancy experience. Specifically, I sought to understand what methods, if any, prenatal and labor and delivery health care providers use to identify the sexual abuse history of their patients, what interventions and/or modification of treatment and procedures they use, and, finally, what resources would they like to see within their practice to benefit this clientele. The main

purpose of this study was to determine the methods of identification and interventions that prenatal and birthing practitioners use with their patients who have a history of childhood sexual abuse.

Purpose of the Study

The purpose of this study was to gather information regarding the care and treatment of pregnant women with a history of childhood sexual abuse. Research has shown that a history of childhood sexual abuse can adversely affect pregnancy and childbirth (Benedict et al., 1999; Cort et al., 2012; Diaz & Manigat 2000; Dilorio et al., 2002; Farley & Keaney, 1997; Jacobs, 1992; Leeners et al., 2007; Lev-Wiesel & Daphna-Tekoah, 2007; Lev-Wiesel, Daphna-Tekoah, & Hallak, 2009; McMahon et al., 2000; Monahan & Forgash, 2013; Murray, MacDonald, & Fox, 2008; Nelson et al., 2012; Sartor et al., 2013; Schiff, El-Bassel, Engstrom, & Gilbert, 2002; Wilson, 2010, Yampolsky et al., 2010; Zwickl & Merriman, 2011). For example, women with a history of childhood sexual abuse tend to have more complaints of discomfort (Grimstad & Schei, 1999; Weinstein & Verny, 2004), nausea and vomiting (Roller, 2012), and number of prenatal visits and ultrasounds than women without this history (Grimstad & Schei, 1999; Leeners et al., 2006b; Yampolsky et al., 2010). Research has also indicated that screening for abuse by prenatal care providers (McGregor et al., 2010; Wilson, 2011) and modification of treatment during pregnancy and childbirth can lead to a more positive and less traumatic experience for these women (Clark & Smythe, 2011; Coles & Jones, 2009; Gutteridge, 2001; Hobbins, 2004; Hotelling, 2012; Monahan & Forgash, 2013;

Prescott, 2002). However, there is no research to indicate if prenatal practitioners are taking such steps to properly care for women with a history of childhood sexual abuse.

In this quantitative study, I explored whether or not prenatal and birthing practitioners screen for a history of childhood sexual abuse (response variable) and if, based on this information, they modify care, treatment, and procedures (response variable). I used practitioner type (predictor variable) and demographic information to explore whether patterns, themes, and relationships were identified in the collected data. Themes, patterns, and relationships identified can bring awareness to deficits in the care for pregnant women with a history of childhood sexual abuse, if, as imagined, it exists. This may allow medical practitioner and administrators to implement policy changes within their agencies to better serve these clients.

The results of the study added to the existing literature about the treatment and care of pregnant women with a history of childhood sexual abuse. My intent was to contribute to the literature and bring about change in prenatal and birthing care for the benefit of women with a childhood sexual abuse history. Finally, practitioners may use information from this study to petition their agencies for greater funding, additional education, and/or time allowances with their prenatal patients to allow for screening and modification of care.

Research Questions and Hypotheses

This study was guided by the following research questions:

Research Question 1: Does practitioner type, age, sex, and/or years in practice predict whether they think childhood sexual abuse history affects their pregnant and/or birthing population?

H_01 : Practitioner type, age, sex, and/or years in practice does not predict whether they think childhood sexual abuse history affects their pregnant and birthing population.

H_{a1} : Practitioner type, age, sex, and/or years in practice does predict whether they think childhood sexual abuse history affects their pregnant and birthing population.

Research Question 2: Does practitioner type, age, sex, and/or years in practice predict whether pregnant and/or birthing patients are screened for a history of childhood sexual abuse?

H_02 : Practitioner type, age, sex, and/or years in practice does not predict whether pregnant and/or birthing patients are screened for a history of childhood sexual abuse.

H_{a2} : Practitioner type, age, sex, and/or years in practice does predict whether pregnant and/or birthing patients are screened for a history of childhood sexual abuse.

Research Question 3: If practitioners screen for childhood sexual abuse history, does practitioner type, age, sex, and/or years in practice predict whether there is modification of treatment and procedures during prenatal and/or childbirth care?

H_03 : Practitioner type, age, sex, and/or years in practice does not predict whether there is modification of treatment and procedures during prenatal and/or childbirth care.

H_{a3} : Practitioner type, age, sex, and/or years in practice does predict whether there is modification of treatment and procedures during prenatal and/or childbirth care.

Research Question 4: Does practitioner type, age, sex, and/or years in practice predict the training received regarding screening and modification of care regarding patients with a childhood sexual abuse history?

H₀4: Practitioner type, age, sex, and/or years in practice does not predict the training received regarding screening and modification of care regarding patients with a childhood sexual abuse history.

Ha4: Practitioner type, age, sex, and/or years in practice does predict the training received regarding screening and modification of care regarding patients with a childhood sexual abuse history.

For all hypotheses, I collected data to determine whether there was a relationship between the opinions of practitioner participants on the following response variables: (a) effect of childhood sexual abuse on pregnancy and childbirth; (b) screening, (c) modification of care, treatment, and procedures; and (d) desired additional resources to better work with pregnant and birthing patients with a history of childhood sexual abuse. I looked at the response variables to see if there were any relationships, themes, or patterns in regard to the practitioner variables: practitioner type (predictor variable-lead/primary practitioner, support staff, and optional/hired practitioners), and demographic characteristics (practitioner title, participant's age, participant's sex, and years in practice).

Conceptual Framework

In this study, I assumed that there is an association between a history of childhood sexual abuse and acute and chronic psychological, behavioral, and health consequences

(Benedict et al., 1999; Hulme, 2004). Finkelhor and Browne (1985) suggested that their traumagenic dynamics theory helps researchers understand the link between a history of childhood sexual abuse and increased risks of psychological and behavioral manifestations. This framework helped in the understanding of how a childhood sexual abuse history can increase risk factors for health problems throughout life, as well as during the pregnancy and childbirth phase of a woman's life.

Finkelhor and Browne (1985) identified four traumagenic dynamics:

sexualization, betrayal, powerlessness, and stigmatization. These lay the basis for developing an individual's cognitive and emotional foundation. Any form of trauma adversely affects one or more of these dynamics. Disruptions in life, such as trauma, tend to lead to distorted self-concepts, cognitions, affect, sense of control, and worldview (Finkelhor & Browne, 1985). According to the authors, sexual abuse survivors are unique in that their trauma affects all four aspects of the traumagenic dynamics. The traumagenic dynamic framework holds that childhood sexual abuse shapes one's sexuality at a developmentally inappropriate time within an unsuitable, dysfunctional relationship (*sexualization* dynamic). This experience also teaches that someone who a child thought they could trust can also hurt them (*betrayal* dynamic). The victim of childhood sexual abuse also learns they do not have total control over their body, their will, their desires, and their self-efficacy (*powerlessness* dynamic). Finally, this experience can also lead to internalizing of negative connotations conveyed both directly and indirectly by individuals and society (*stigmatization* dynamic). In Chapter 2, I offer a more in-depth

discussion about Finkelhor and Browne's (1985) traumagenic dynamic conceptual framework.

With the traumagenic dynamic framework, Finkelhor and Browne's (1985) attempted to create a methodological foundation that would allow for a concise way to assess childhood sexual abuse survivors. This framework also helps researchers to understand physical, psychological, and somatic ailments survivors commonly complain about (Finkelhor & Browne, 1985). For this study, I used this theory as a base to understand and make a connection between the increased somatic complaints and psychological distresses, such as flashbacks, dissociation, and PTSD symptomology, which are reported by pregnant women with childhood sexual abuse histories

Nature of the Study

I used an online survey to collect data and recruited participants through a Research Now participant pool that I accessed for a nominal fee to locate prenatal and child birthing practitioners. Examples of practitioners include licensed OB/GYNs, midwives, prenatal nurses, labor and delivery nurses, and other prenatal and birthing support staff that has direct contact with patient care. All participants were asked to complete the online questionnaire. Participants submitted their questionnaire anonymously. The demographic data that I collected from participants included sex, age, years of practice, and professional title.

Definitions

Body memories: According to Hobbins (2004), bodies remember feelings and activities. Researchers (see Hobbins, 2004) have speculated that parallels in the delivery

room to the childhood sexual abuse experiences such as pressing physical boundaries, exposure and touching of sexual body parts, and a sense of helplessness and powerlessness can cause the body to react and remember abusive experiences. Simply, sensory triggers, in this case touch, can elicit intrusive memories for both the mind and body of a childhood sexual abuse survivor. In these cases, the childhood sexual abuse survivor's body may re-experience an event, complete with sensations, from the abuse history (Weinstein & Verny, 2004). These sensations typically seem to present with no immediate physical reasons for them to happen. It is theorized that body memories can manifest as somatizations (Hobbins, 2004).

Childbirth: For the sake of this study, I have used the terms *labor and delivery*, *birthing*, *birth*, and *labor* interchangeably.

Child sexual abuse: For the sake of this study, I defined childhood sexual abuse as the use by someone in a position of power (usually power due to age differential or maturity) of a child for sexual gratification. For an in-depth discussion regarding the varying definitions of childhood sexual abuse, see Chapter 2.

Dissociation: Dissociation is typically described as feelings of having a separation of the body and the self (Gutteridge, 2001). The experience can be described as a disconnect between an individual and their experiences, events, or surroundings. This is a coping strategy or survival technique often used by individuals when presented with traumatic experiences (Gutteridge, 2001).

Flashbacks: Flashbacks are vivid memories or re-experiencing of abuse as if it is occurring at this moment (Clark & Smythe, 2011). Flashbacks are often triggered by sensory perceptions, such as a smell, sound, or image.

New England: For the sake of this study the New England area of The United States consists of six states: Maine, Massachusetts, New Hampshire, New York, Rhode Island, and Vermont.

Practitioners/providers: For the sake of this study, the term *practitioner/provider* will encompass numerous medical care providers and support professionals who assist in the care of pregnant women. These practitioners/providers can include: OB/GYNs, Midwives (CNM), physician assistants (PA), nurse practitioners (NP), nursing staff in the prenatal care setting, labor and delivery nurses, birthing instructors, and doulas/birthing coaches. I have used the terms *practitioner(s)/provider(s)* interchangeably with the terms *medical healthcare provider/practitioner*, *healthcare provider/practitioner*, and *prenatal care provider/practitioner*.

Somatization: According to So (2008), somatization is described as “an individual suffering from psychological issues expresses distress in the form of physical symptoms” (p. 168). Simply put, somatization is a physical manifestation of psychological distress. Common somatic complaints include, but are not limited to: nausea, vomiting, muscle aches, headaches, abdominal pain, fatigue, and dizziness (So, 2008).

Spontaneous disclosure: For the sake of this study, spontaneous disclosure is defined as a person admitting or telling of a childhood sexual abuse history to another without being prompted or asked about said experiences (Read et al., 2006).

Assumptions

For the sake of this study, childhood sexual abuse history was determined by the disclosure of a childhood sexual abuse history by the patient to the medical care provider. Given this reasoning, I used the most inclusive definition: childhood sexual abuse is the use by someone in a position of power (usually power due to age differential or maturity) of a child for sexual gratification. I assumed that the identification of a history of childhood sexual abuse is adequate. Specific definitions vary (see Chapter 2 for a discussion on varying definitions of childhood sexual abuse).

I also assumed that medical care providers only ask about a childhood sexual abuse history and not about details of the history. A formal definition was not used as each practitioner would be required to ask for specifics of the abuse, that, at a minimum would include what type of acts were committed and age difference. Therefore, personal identification by the patient as having a childhood sexual abuse history, disclosing to a practitioner, sufficed and I did not require that the patients met certain criteria regarding one of many definitions. Finally, I assumed that a history of childhood sexual abuse is associated with acute and chronic psychological, health, behavioral, and developmental complications that in turn are risk factors for complications during pregnancy and childbirth (see Benedict et al., 1999).

Scope and Delimitations

Research shows that a history of childhood sexual abuse is a risk factor during pregnancy and childbirth (Benedict et al, 1999; Cort et al., 2012; Diaz & Manigat 2000; Dilorio et al., 2002; Farley & Keaney, 1997; Jacobs, 1992; Leeners et al., 2007; Lev-

Wiesel & Daphna-Tekoah, 2007; Lev-Wiesel, Daphna-Tekoah, & Hallak, 2009; McMahon et al., 2000; Monahan & Forgash, 2013; Murray, MacDonald, & Fox, 2008; Nelson et al., 2012; Sartor et al., 2013; Schiff, El-Bassel, Engstrom, & Gilbert, 2002; Wilson, 2010, Yampolsky et al., 2010; Zwickl & Merriman, 2011). Research also shows there is the potential for re-traumatization when women with a history of childhood sexual abuse go through standard prenatal and birthing treatment and care (Leeners et al., 2007). In this study, I explored whether prenatal and birthing practitioners screen for a history of childhood sexual abuse, and if they do, what, if any, modifications to care, procedures, and treatment do practitioners make for these women.

According to Creswell (2003), a quantitative survey design is an effective for exploring opinions of the population under study. Most often, survey data, through randomized selection, can be used to generalize to a population as a whole. I conducted a power analysis to determine that I needed a minimum of 43 of medical practitioner participants. Participants were recruited through Research Now's participant pool from the New England area of The United States. Due to the heterogeneity within this study, data is not generalizable; however, I have still identified and discussed themes and patterns.

Limitations

The main limitation of this study was the lack of randomization. According to Creswell (2003), randomization allows for a representative sample of a population. This sample would then allow results to be generalized to the population. Creswell (2003) noted that a convenience sample, the type of sample that I used in this study, is less

desirable because it does not allow results to be generalized to the population as a whole. I did not intend for study results to be generalized to the population; results from data were only to be used to infer practices within the New England area of The United States.

Another major limitation to survey design was the limited response by potential participants. According to Garson (2013), web survey design yields the lowest response rate compared to other methods of collecting survey data. However, Garson (2013) noted highly educated respondents tend to have a higher response rate to online surveys than other methods of survey data collection. Garson (2013) also found data quality was much higher on online surveys than other type of surveys, with fewer missing items and more comprehensive responses to open-ended questions. The survey for this study was easily accessed and took about 5-10 minutes to complete. Given these reasons, combined with the busy schedules of medical practitioners, I determined that a web-based, quantitative survey method was the best choice for gathering data from this chosen population. I did not attempt to generalize data or information; because of the variance among the participants, I only explored and discussed themes and patterns. Finally, I ensured the reliability of this study by presenting the complete method of participant and data collection in order to allow others to replicate this study (Rudestam & Newton, 2007).

Significance

This study was unique because in it I attempted to identify, from the practitioner's perspective, the physical and emotional complications a patient's history of sexual abuse has on the pregnancy and birthing experience. I also attempted to identify what steps, if any, practitioners use to identify and alleviate potential complications associated with

their survivor patients' pregnancies. The insights from this study bring to light the discrepancies between suggested best practices and actual practices for care when working with prenatal and birthing women with a history of childhood sexual abuse.

Summary

Studies (Leeners et al., 2006a; Roller, 2012) have indicated that one in nine women who seek prenatal care will have childhood sexual abuse in their history. Researchers (Leeners et al., 2006a; Roberts et al., 2004; Yampolsky et al., 2010) also have suggested that a history of childhood sexual abuse can increase risk factors during pregnancy and childbirth for both mother and baby. Prenatal care providers are in a unique position to help identify and treat women with a childhood sexual abuse history in an effort to reduce possible harm to this population (Leeners et al., 2006b). In this study, I sought to bridge the gap between research showing that prenatal and birthing care practitioners should screen for childhood sexual abuse history and should modify treatment and care with their patients with childhood sexual abuse history, and actual practices of screening and modification of care throughout the prenatal and birthing care of patients.

In this chapter, I introduced the background and basis of the study. I also presented the problem statement and an overview of the study's scope, delimitations, limitations, and significance. This chapter also included the definitions of key terms that I have used throughout the study. In Chapter 2, I discuss, in detail, the methods used and results of my extensive literature review. An in-depth discussion of the theoretical

framework, Finkelhor and Browne's traumagenic dynamics (1985) framework, and how it relates to pregnant women with a childhood sexual abuse history is also included.

Chapter 2: Literature Review

The purpose of this chapter is to review the literature on the relationship between childhood sexual abuse and pregnancy and childbirth. I discuss the methods used for searches of databases to gather materials. I also offer a summary and critique of the current literature, discuss its limitations, and then discuss the theoretical framework that I used as the basis of the study.

Literature Search Strategy

I conducted an extensive literature review using Academic Search Complete, CINAHL Plus with full text, EBSCO ebooks, Education Research Complete, ERIC, Health & Medical Complete, MEDLINE with full text, ProQuest Central, PsycARTICLES, PsycBOOKS, PsycCRITIQUES, PsycEXTRA, PsycINFO, SAGE, Science Direct, and SocINDEX with full text databases. I searched these databases because of their focus on psychology, medicine, or both. Two databases were of particular interest to me: MEDLINE with full text, and CINAHL Plus with full text. Keyword searches included a combination of *child sexual abuse*, *childhood sexual abuse*, *incest*, or *molest* in conjunction with *pregnancy*, *prenatal*, *maternity*, *women's health [womens health]*, *childbirth [child birth]*, *labor [labour]*, and *expectant mother*. For information regarding current estimates of abuse, I used the National Center for Victims of Crime (2012) and the advocacy group Parents for Megan's Law and the Crime Victims Center (2013).

In the field of psychology, I assessed research on the effects of childhood sexual abuse on things such as mental health (Cort et al., 2012; Nelson et al., 2012), sexual

health (Colangelo & Keefe-Cooperman, 2012), teen pregnancy (Francisco et al., 2008), and drug/alcohol abuse (Dilorio et al., 2002; Schiff et al., 2002). Few studies in psychology have explored the relationship between childhood sexual abuse and the maternal pregnancy experience. I retrieved a majority of psychological research from academic journals such as *Child Abuse & Neglect*, *Journal of Childhood Sexual Abuse*, *Journal of Consulting and Clinical Psychology*, *Journal of Psychosomatic Research*, and *Psychological Trauma*.

Medical professionals, especially those affiliated with midwifery and nursing care and practice, have explored the connection between a history of childhood sexual abuse and the maternal pregnancy experience. However, most of these studies were conducted in European nations (Clark & Smythe, 2011; Gutteridge, 2001; Leeners et al., 2006b; Lev-Weisel & Daphna-Tekoah, 2007; Lev-Weisel et al., 2009; Marriot, 2012; Rouf, 1999; Yampolsky et al., 2010). Of the articles from the medical field, the majority were descriptive rather than research-based. I found a majority of these articles in academic journals such as *Journal of General Internal Medicine*, *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, *Australian and New Zealand Journal of Mental Health Nursing*, *Women & Health*, *Maternal and Child Health Journal*, and *Acta Obstetrica et Gynecologica*.

Overall, my search of the literature revealed a limited amount of published research about the relationship between childhood sexual abuse and the survivor's later experience with pregnancy and childbirth, especially within the field of psychology and

within the United States. I found no research that explored whether screening and modification of care were used in the prenatal care community.

The Relationship Between Child Sexual Abuse and Pregnancy and Childbirth Prevalence, Background, and Definitions

Studies have shown that the prevalence of women with a history of childhood sexual abuse ranges from 6% to 62% (Grimstad & Schei, 1999; Hobbins, 2004; Monahan & Forgash, 2000). The variance in this data is due to differences in definitions of childhood sexual abuse, where the study was conducted, and type of study conducted. The National Center for Victims of Crime (2012) has estimated that 1 in 5 females and 1 in 20 males will be a victim of childhood sexual abuse, while Parents for Megan's Law and The Crime Victims Center (2013) estimated that 1 in 3 females and 1 in 6 males will be a victim of sexual abuse before they are 18 years old. Following a period of greater awareness of childhood sexual abuse in the United States in the 1990s, Diaz and Manigat (1999) noted there was a 322% increase in reported cases of childhood sexual abuse in the United States between 1980 and 1990. Accurate numbers are difficult to estimate because they are based solely on reported cases (London, Bruck, Ceci, & Shuman, 2005).

The extreme ranges found when estimating the prevalence of childhood sexual abuse can be seen both in the literature and in research reports. There is lack of agreed upon definitions regarding what constitutes childhood sexual abuse, which makes it difficult to properly compare and contrast data and to calculate accurate statistics (Grimstad & Schei, 1999; Monahan & Forgash, 2000). Some definitions in the literature are similar, with just a detail or two differing (Clark & Smythe, 2011; Diaz & Manigat,

1999; Wilson, 2010). Other researchers (Monahan & Forgash, 2000; Simkin, 1996) have used widely divergent definitions. For example, definitions of childhood sexual abuse have generally included some sort of touching, which can range from fondling to intercourse (Leeners et al., 2006b). More comprehensive definitions included actions such voyeurism, exposure, and child pornography (Hotelling, 2012) or any act committed against a child used to bring the perpetrator sexual arousal (Hobbins, 2004).

Apart from the acts committed, definitions of childhood sexual abuse most commonly include the age of both victim and perpetrator. Maximum age for the victim, as well as the age of the perpetrator, is also different across studies. Ages of victims, as mentioned in the literature, have ranged from abuse occurring in childhood and mid-adolescence (Leeners et al., 2006b), abuse occurring before the age of 16 years (Hobbins, 2004), and abuse occurring before the age of 18 years (Grimstad & Schei, 1999). Ages of the perpetrators also varied by definition, such as being at least 5 years older than the victim (Grimstad & Schei, 1999) or more loosely defined as having a “large age or maturational advantage” over the victim (Weinstein & Verny, 2004, p. 314), or as being “sexually mature” (Hobbins, 2004, p. 486). Due to this lack of agreed upon definitions of what constitutes childhood sexual abuse, it is difficult to compare data and information from one study to the next.

It is important to remember that since all studies require the consent and cooperation of volunteers, there cannot ever be a truly random study (Wright, Crawford, & Sebastian, 2007). Therefore, the data is skewed, although researchers do not know in what specific ways. Wright et al. (2007) speculated that female survivors who are willing

to participate in studies could very well be a small subset who may have a less difficult time dealing with their sexual abuse history than their more reluctant counterparts.

Therefore, there is a lack of information from those who have refused to discuss their childhood sexual abuse histories or who do not remember their childhood sexual abuse histories (Wright et al.). Still, despite varying definitions, widely reported differences in prevalence, and methodological issues, there is a common theme in the literature regarding childhood sexual abuse: It is the use by someone in a position of power (usually power due to age differential or maturity) of a child for sexual gratification.

Read et al. (2006) conducted a study of 191 women between the ages of 20 and 74 in New Zealand who were participating in therapy regarding their childhood sexual abuse experiences. Read et al. reported that the literature has indicated that childhood sexual abuse survivors are very hesitant to spontaneously disclose abuse. It also indicated that instances of childhood sexual abuse were not usually identified by mental health care providers (Read et al.). Read et al. sought to explore details regarding the disclosure of childhood sexual abuse. The authors asked participants a series of questions regarding their childhood sexual abuse history, such as whether and when the abuse was disclosed, to whom, and whether the abuse was reported to authorities. Read et al. analyzed the age of abuse onset, the length of abuse, the severity of abuse, the participant's relationship to perpetrator, and whether these factors influenced disclosure. Read et al. found participants hesitant to disclose their childhood sexual abuse history regardless of their relationship to perpetrator, the severity of abuse, their age at onset, or the length of abuse.

The authors concluded that this lack of spontaneous disclosure shows the importance of health care providers asking their clients about their childhood sexual abuse history.

Age of onset, seriousness of abuse acts, and relationship to the abuser seem to be correlated with increased risk of biological, psychological, and social issues for the women who experienced abuse (Lundqvist et al., 2004). Lundqvist et al. conducted a study of 45 women who were participants in different long term therapy groups focused on childhood sexual abuse history. The participants were active in these therapy groups between 1993 and 2001. The aim of the study was to determine whether characteristics of childhood sexual abuse experience (age of onset, type, duration, and relationship to perpetrator) had an influence on the women's health. The researchers were also interested in collecting information about why the women had not disclosed the abuse when it was happening. Participants were administered several questionnaires to measure psychiatric symptoms (Symptom Check List-90), social integration (Interview Schedule of Social Interaction), and social adjustment (Social Adjustment Scale). Age of onset, severity of abuse, relationship to perpetrator, and length of abuse were also assessed. Lundqvist et al. found that the participants who had early age of onset (≤ 6 years old) were significantly more likely than those with later onset (7-18 years old) to have increased psychiatric symptomology ($p < 0.001$). According to Lundqvist et al., the victim's relationship to the perpetrator, specifically when the perpetrator was a relative to the victim, affected interpersonal sensitivity ($p < 0.05$). Derogatis (2105) explained that interpersonal sensitivity measures feelings of inferiority and inadequacy, especially how people

compare themselves to others. Severity of abuse, namely penetration, was significantly related to having a score that indicated poor social interaction in later life ($p < 0.05$).

Read et al. (2006) also discussed several studies in which researchers estimated the average number of years in the United States and New Zealand between the cessation of abuse and disclosure; they found the average time span to be approximately 9.5 years. Using this information, the authors conducted a study that explored disclosure rates. The average time of disclosure among Read et al.'s participants was approximately 16.3 years. The researchers suggested that the differences in disclosures between their study and other findings from their analysis might be due to level of abuse experienced by the participants in their study. Read et al. noted that their participants tended to have especially severe levels of childhood sexual abuse. The majority of the participants in this study suffered and dealt with their childhood sexual abuse trauma by themselves throughout their childhoods and did not seek therapeutic interventions. More shocking was the finding that 82% of the participants never reported their abuse to authorities (Read et al.).

In Read et al.'s (2006) study, participants were recruited via media advertisements, which means that participants self-selected for the study. This, coupled with self-reporting, could have led to distortions in the data obtained. However, the authors attempted to limit these distortions by comparing their results with similar studies. Read et al. concluded that their results were comparable to those in other studies; therefore, they felt comfortable generalizing their results to female childhood sexual abuse survivors in general.

Read et al.'s (2006) research is of particular interest to me for several reasons. The authors explained that the childhood sexual abuse survivors were unlikely to spontaneously disclose their abuse histories. This helps in the understand of the importance of screening for childhood sexual abuse histories by practitioners (see The Practitioner section in this chapter for further discussion). According to Read et al., simply asking about an abuse history increased the chance of disclosure. The Read et al. study also showed that not all childhood sexual abuse survivors will disclose their history whether they are asked. The researchers urged use of respectful, trust-based, and compassionate care (see the Screening and Modification of Treatments and Procedures section in this chapter for a more detailed discussion) for all women in prenatal and childbirth care to help lessen potential trauma for pregnant women with a history of childhood sexual abuse.

A cursory glance at prior research regarding the long term effects of childhood sexual abuse history reveals findings that include an increased risk of substance abuse (Dilorio et al., 2002; Lev-Wiesel & Daphna-Tekoa, 2007; Monahan & Forgash, 2013; Sartor et al., 2013; Schiff et al., 2002), high risk sexual behavior (Dilorio et al., 2002; McMahon, Goodwin, & Stringer, 2000; Zwickl & Merriman, 2011), sexual dysfunction (Jacobs, 1992; Zwickl & Merriman, 2011), self-injurious behaviors (Monahan & Forgash, 2013; Murray et al., 2008), somatization (Leeners et al., 2007; Monahan & Forgash, 2013; Nelson et al., 2012; Yampolsky et al., 2010), posttraumatic stress disorder (PTSD) (Lev-Wiesel et al., 2009; Schiff et al., 2002), dissociation (Farley & Keaney, 1997; Jacobs, 1992), eating disorders (Diaz & Manigat, 2000; Monahan & Forgash,

2013; Murray et al., 2008), and higher rates of depression (Benedict et al., 1999; Cort et al., 2012; Jacobs, 1992; Wilson, 2010).

Research has shown that a history of childhood sexual abuse can adversely affect the biological, psychological, and social realms aspects of a survivor's life (Benedict et al., 1999; Cort et al., 2012; Diaz & Manigat 2000; Dilorio et al., 2002; Farley & Keaney, 1997; Jacobs, 1992; Leeners et al., 2007; Lev-Wiesel & Daphna-Tekoah, 2007; Lev-Wiesel et al., 2009; McMahon, Goodwin, & Stringer, 2000; Monahan & Forgash, 2013; Murray et al., 2008; Nelson et al., 2012; Sartor et al., 2013; Schiff et al., 2002; Wilson, 2010, Yampolsky et al., 2010; Zwickl & Merriman, 2011). It is not difficult to imagine that a history of childhood sexual abuse may have a negative influence on pregnancy and childbirth, given its relationship to sexual functioning, intimacy, and privacy.

Pregnancy

Studies indicate that approximately one in nine women seeking prenatal care will disclose a childhood sexual abuse history (Leeners et al., 2006a). Leeners et al., (2006a) conducted a study of 226 women who were within three to eight months postpartum regarding their childhood sexual abuse history. They looked at the medical and psychological wellbeing of the mother throughout pregnancy, childbirth, and postpartum period. Leeners et al., (2006a) found that about 12%, or about one in nine, of their participants admitted to a history of childhood sexual abuse. The authors also analyzed other studies and concluded that this, indeed, was a conservative estimate.

In another study conducted by Leeners et al., (2006b), a meta-analysis of 43 articles with a focus on the effect of childhood sexual abuse, pregnancy, childbirth, and

early postpartum period, published between 1992 and 2005, was conducted. Based on their review, Leeners et al., (2006b) concluded that about 74% to 96 % of women with a history of childhood sexual abuse presented to health care providers with physical and emotional issues, such as somatization, depression, and anxiety.

Prenatal care brings women into contact with numerous individuals, many of whom are strangers (Rouf, 1999). According to Coles (2009), women with a history of childhood sexual abuse are at greater risk of unintentional traumatization via obstetric and gynecological care. There is no way of knowing if and when memories of abuse will be triggered or how these memories will present (Leeners et al., 2006b). Leeners et al., (2006b) noted that pregnancy and labor and delivery can each present potential triggers for such women.

Pregnancy may be considered a joyous time in some women's lives, but for the child sexual abuse survivor, this time can be riddled with anxiety and fear. Studies show that pregnancy and childbirth can be difficult experiences for the childhood sexual abuse survivor to go through (McMahon et al., 2000). Hobbins (2004) explained that pregnancy is a time of physical, emotional, and social changes. Pregnancy is also typically a time of dependency and vulnerability (Simkin, 1996), as well as a time of physical, mental, and emotional growth and change (Issokson, 2004). The changes that pregnancy brings about can affect every aspect of a woman's life and can lead her to feeling vulnerable (Issokson, 2004). The nature of these changes may trigger both physical and mental memories of the childhood sexual abuse history.

The combination of fear and anxiety regarding interaction with a provider and the knowledge that frequent vaginal exams will be required may be a reason this population is more likely to delay or avoid prenatal care (Issokson, 2004; Yampolsky et al., 2010). Roseth et al. (2011) conducted an in-depth case study of a woman in her middle-20s who was sexually abused by her father to explore how incest may correspond with postpartum depression. Roseth et al. (2011) found that this woman had concerns regarding privacy, touching, and lack of control. The authors (Roseth et al., 2011) found that their subject connected her pregnancy and childbirth experiences with her childhood sexual abuse memories. This is an interesting article that gives some evidence similar to what other authors (Hobbins, 2004) have found. However, being a case study, it can only be considered as an anecdotal account. Hobbins (2004) noted there might be similarities between the abuse experience and childbirth examination experiences such as being asked to disrobe, restraint or entrapment by tubes and monitors, bodily fluids, and fear. Childbirth can also bring to light concerns regarding privacy and control (Roseth et al., 2011).

According to Benedict et al. (1999), having had negative life events and traumas are associated with having increased stress during pregnancy. Increased stress during pregnancy is associated with adverse outcomes during pregnancy. Studies have correlated a history of childhood sexual abuse with increased complications during pregnancy and childbirth (Benedict et al., 1999; Hobbins, 2004; Issokson, 2004; McMahon et al., 2000; Monahan & Forgash, 2000; Nelson et al., 2012; Simkin, 1996; Weinstein & Verny, 2004)).

Depression

Numerous studies have found that pregnant women with a history of childhood sexual abuse had a much greater prevalence of depression and posttraumatic stress disorder (PTSD) symptoms than their non-abused counterparts (Benedict et al., 1999; LaCoursiere et al., 2012; Leeners et al., 2006b; Mohler et al., 2008; Yampolsky et al., 2010). Benedict et al. (1999) found that frequency of depression in prenatal patients could range from 4% to 38% depending on the population being studied.

Benedict et al. (1999) conducted a study of 357 women who were pregnant for the first time in order to determine if there was an association between a history of childhood sexual abuse and depressive symptomology during pregnancy. These women were given both the Center for Epidemiologic Studies Depression Scale (CES-D) and the Life Events Questionnaire (LEQ) to measure depressive symptomology and life stressors, respectively. The LEQ results allowed the authors (Benedict et al., 1999) to control for current life stressors as a factor on the depressive scale. The study found those with a history of childhood sexual abuse had significantly higher levels ($M=20.9$, $SD=10.7$) ($p < 0.000$) of depressive symptoms when controlling for current life stressors than their non-abuse counter parts ($M=15.09$, $SD=8.9$).

According to LaCoursiere et al. (2012), women with a history of childhood sexual abuse who reported stressful life events are at a substantial risk for developing depression during their pregnancy and postpartum depression after birth. LaCoursiere et al. (2012) conducted a study of 1,038 women who delivered live, single infants between 2005 and 2007 in order to determine whether there was an association between having a history of

childhood sexual abuse and having postpartum depression (PPD). The researchers administered two questionnaires to measure PPD and stressors; the Edinburgh Postnatal Depression Scale and Center for Disease Control and Prevention's Pregnancy Risk Assessment Monitoring System, respectively. LaCoursiere et al. (2012) found that women with a history of childhood sexual abuse were significantly more likely to admit to a history of depressive symptomology ($p < 0.001$) and two and a half times more likely to admit to a history of PPD ($p < 0.001$). The authors also found the more life stressors the participants reported, the higher the likelihood they would report a history of PPD.

A history of childhood sexual abuse seems to be related to a greater chance of developing depression, in general, and postpartum depression, more specifically. When controlling for life stressors, Benedict et al., (1999) found a considerable increase in chances of depression. According to LaCoursiere et al. (2012), when taking life stressors into account, women with a history of childhood sexual abuse are considerably more likely to experience depression and postpartum depression.

Posttraumatic Stress Disorder

Roller (2012) suggested that about 3 to 24% of women entering the prenatal care system present with PTSD. According to Seng et al. (2013), women who were sexually victimized as children and teenagers were more likely to report clinically significant symptoms of PTSD, dissociative symptoms, and affect dysregulation. Affect dysregulation occurs when an individual has a difficult time regulating and/or controlling their emotional responses and reaction (Psychological Care & Healing Treatment Center, 2013). Seng et al. (2013) conducted a study of 1,581 women who had sought prenatal

care between 2005 and 2008 in order to determine whether there was an association between interpersonal trauma and mental health problems during pregnancy. Numerous variables were measured including reported life history of trauma, dissociation, somatization, and PTSD symptomology. Roller (2012) found that those women with a history of childhood sexual abuse were more likely to report comorbid PTSD symptomology. PTSD symptomology was also found to present along with major depressive disorder (2%) and affect/relational dysregulation (24%).

Ullman (2007) conducted a study to determine what effects the relationship to the perpetrator may have on victims of childhood sexual abuse. Ullman (2007) recruited and surveyed 733 college students regarding their childhood sexual abuse history, the relationship to their perpetrator, disclosure, and reactions to disclosure and their PTSD symptomology. Ullman (2007) found that childhood sexual abuse survivors were more likely to experience PTSD symptomology if their perpetrator was a relative. According to Ullman (2007) several factors increased PTSD symptomology; relationship to perpetrator (specifically perpetrator being a family member), delayed disclosure, and when the victim received negative reactions from those they disclosed to. While the Ullman (2007) study did not look at how this relates to pregnant women, one can still see that the relationship to the perpetrator can correlate with the likelihood of having PTSD symptomology.

It has been posited (Lev-Wiesel & Daphna-Tekoah, 2007) that pregnancy can reactivate or exacerbate PTSD symptoms in women who have a history of childhood sexual abuse. The authors suggested that the combination of PTSD's anxiety laden state

and the intimate and sexual nature of pregnancy and childbirth might result in activating memories of abuse. These memories can be seen in intrusive thoughts, flashbacks, and nightmares, as well as body memories (Hobbins, 2004; Weinstein & Verny, 2004).

Somatization

Women with a history of childhood sexual abuse have tended to use health care services at a much higher rate than their non-abused counterparts (Grimstad & Schei, 1999; Leeners et al., 2007). These women reported a lower rate of overall health and an increased number of physical symptoms and complaints. Nelson et al. (2012) conducted a meta-analysis that found that women with a history of childhood sexual abuse were at an increased risk to suffer from medically unexplained conditions such as chronic pelvic pain, fibromyalgia, chronic fatigue, gastrointestinal pains, and neurological and gynecological issues.

According to Leeners et al. (2007), women with a history of childhood sexual abuse were also at increased risk for such gynecological issues such as chronic pelvic pain, premenstrual dysphoric disorder, pelvic inflammatory disease, menorrhagia, and dysmenorrhea, among other gynecological concerns. Women with a history of childhood sexual abuse also tended to present with more complaints and problems throughout their pregnancy (Grimstad & Schei, 1999; Leeners et al., 2006b, Mohler et al., 2008; Seng et al, 2013). These women tended to report higher levels of pain regarding common pregnancy discomforts than their non-abused counterparts (Weinstein & Verny, 2004). Hotelling (2012) explained that common pregnancy discomforts such as morning sickness and joint pain were more likely to be severe, even debilitating, in this

population. This means that pregnant women with a history of childhood sexual abuse are more likely to require additional visits and ultrasounds than their non-abused counterparts (Grimstad & Schei, 1999; Leeners et al., 2006b; Yampolsky, et al., 2010).

Monahan and Forgash (2013) noted that pregnant women with childhood sexual abuse histories tended to have more complications during their pregnancies than their non-abused counterparts. Roller (2012) found that women with a history of childhood sexual abuse were more likely to seek care for symptoms such as nausea/vomiting and preterm contractions. Other common complaints among this population were back pain, pelvic joint pain, or Symphysis Pubis Dysfunction (SPD) (Weinstein & Verny, 2004).

Overall, the literature seems to suggest that women with a history of childhood sexual abuse are at greater risk for health issues, especially somatization, depression, and PTSD, during pregnancy. However, as with much of the information collected regarding childhood sexual abuse and its increased risk factors for pregnancy, studies have been limited. Much of the information that has been presented is based on meta-analyses (Leeners et al., 2006b), case studies (Roseth et al., 2011), descriptive studies (Hobbins, 2004; Issokson, 2004; McMahon et al., 2000; Monahan & Forgash, 2000; Nelson et al., 2012; Simkin, 1996; Weinstein & Verny, 2004), and anecdotal accounts (Rouf, 1999). The nature of these studies gives information regarding the adverse effects childhood sexual abuse history can have on pregnancy, but it is clear that more exploration is needed.

Childbirth

Roseth et al. (2011) explained that a history of childhood sexual abuse could increase a woman's fear of childbirth. This increased fear could result in complications during labor and delivery. According to Issokson (2004), it is common for women to prepare, physically and mentally, for their upcoming childbirth experience. For the sexual abuse survivor, it may be beneficial for them to prepare by learning about the childbirth process, as well as to identify and address any specific concerns or fears they may have (Issokson, 2004). Roseth et al. (2011) found that women who believed they lacked control or had been victimized were more likely to associate their childbirth experience with experiences from their sexual abuse history.

Noll et al. (2007) conducted a study to explore the link seen in literature between mothers with a history of childhood sexual abuse and preterm labor. They looked at 67 women who were sexually abused in childhood and compared them to a control group of 56 non-abused women. Permission to access labor and delivery records was granted. Noll et al. (2007) found that the women with a history of childhood sexual abuse were at greater risk for preterm labor (Odds ratio [OR] = 2.80 ± 1.44 , $p < 0.05$). The authors (Noll et al., 2007) linked this increased risk to higher basal cortisol levels in this population. Another possibility discussed by the authors for increased preterm labor in this population could be the increase in risk taking behaviors, such as continued alcohol consumption; this was more likely to be seen in those women who had a history of childhood sexual abuse (Noll et al., 2007). Increased risk taking behaviors during pregnancy by women with a history of childhood sexual abuse could also be a reason

why a link between these women and low birth weight newborns has been found (Grimstad & Schei, 1999).

Grimstad and Schei (1999) conducted a quasi-experimental, case controlled study of 173 postpartum women in an effort to determine whether women with a history of childhood sexual abuse were at greater risk of birthing newborns with a lower birth weight. Among all participants, 82 gave birth to low birth weight infants (<2,500 g) and 91 had infants who were normal weight (the control group). Participants were interviewed regarding their history of childhood sexual abuse. Participants were also asked to rate their pregnancy discomfort using an interval scale of one (never) to seven (always) regarding twelve specific discomforts (heartburn/regurgitation, nausea/vomiting, leg cramps/aching legs or feet, insomnia, headache, feeling faint/fainting, fatigue/tiredness, swelling, Pelvic Joint Syndrome, uterine contractions, back pain, and numbness or tingling of fingers/hands). The scores to all these answers were summed up to determine total discomfort (range= 12 to 84). The researchers (Grimstad & Schei, 1999) found that 76% of the women in their study who had a history of childhood sexual abuse had at least one unscheduled visit to the hospital or clinic. Women with a history of childhood sexual abuse also rated themselves higher on the discomfort scale than their non-abused counterparts (discomfort scale score $M=3.03$ versus $M=2.050$, $p = .01$). However, having a history of childhood sexual abuse was not a predictor of low birth weight (no significant results OR = 1.03, 95% Confidence interval (CI).44-2.40). One limitation of this study (Grimstad & Schei, 1999) was that participants were not matched by demographic characteristics in addition to the birth weight and abused/non-abused

classification. In this study, abused women tended to be less well educated, more likely to be unemployed, and to have lower socioeconomic status than the non-abused participants.

Childbirth can be an arousing experience (Gutteridge, 2001). According to Roseth et al. (2011) the act of childbirth, as well as factors surrounding childbirth, may cause the woman to recall her sexual abuse history. Issokson (2004) explained that there are numerous triggers during childbirth that may result in trauma or re-traumatization to the mother. These triggers include “nakedness, vaginal exams, and pain in the pelvic and genital areas of the body, the presence of blood and other bodily secretions, body odors, changes in breathing, crying, and moaning” (Issokson, 2004, p. 205). In addition to all of this, the mother-to-be is exposed, mentally and physically, to numerous people, and most of these are people in authority who are strangers.

A feeling of lack of control is common during childbirth (Issokson, 2004). Hotelling (2012) explained that, while the act of childbirth can be somewhat prepared for, the process in itself involves little control by the prospective mother. The author (Hotelling, 2012) noted that it is almost impossible to determine how or when a natural labor will start, how long it will last, how much pain one will be in, and how it will feel. Some women may choose to use anesthesia or medication as a way to take control of their body and the sensations. Still others may refuse these interventions because they may fear it will be a loss of control (Issokson, 2004). The act of pushing and the movement of the baby going through the vagina may remind the child sexual abuse survivor of forcible touching, penetration, and mutilation (Issokson, 2004). Clark and

Smythe (2011) explained that within their own prenatal practices, it was not uncommon for childbirth to be associated with flashbacks or dissociation in this population.

Women with a history of childhood sexual abuse are more likely to have their childbirth end with having a Caesarean section (Clark & Smythe, 2011). In the majority of the cases Clark and Smythe (2011) came across while practicing prenatal medicine, the choice of Caesarean section was due to failure to progress in women with a history of childhood sexual abuse, as opposed to fetal malposition, the main reason for caesarean section in their non-abused counterparts.

Research (Clark & Smythe, 2011; Grimstad & Schei, 1999; Issokson, 2004; Noll et al., 2007; Roseth et al., 2011) has shown that a history of childhood sexual abuse increases risk factors during childbirth. Issokson (1999) explained that women with a history of childhood sexual abuse were more likely to parallel their child birthing experience to their sexual abuse experience. This may be one reason for women with a history of childhood sexual abuse having higher instances of Caesarean section due to failure to progress.

The Practitioner

Survivors of childhood sexual abuse may have a more difficult time trusting those in a position of authority (Simkin, 1996). McGregor et al. (2010) suggested that women who have a difficult time disclosing their child sexual abuse history to their health care providers could have negative experiences during medical examinations. According to the authors, pelvic exams used in gynecological and prenatal care can be considered to be a more traumatic and negative experience in those individuals who have a sexual abuse

history who do not disclose. Leeners et al. (2007) found that about 43% of the women who had a history of childhood sexual abuse experienced memories of their abuse during gynecological exams.

Practitioner training regarding patient care for those with a history of childhood sexual abuse has traditionally been limited. Courses that look at screening and care for those with a history of childhood sexual abuse have only begun to be added to the curriculum in the past twenty years (Monahan & Forgash, 2013). According to Diaz and Manigat (2000), health care providers have admitted to being uncomfortable discussing this topic. Still others have admitted to having a basic knowledge of this topic but are unsure of how to broach this topic in their practices (Monahan & Forgash, 2013).

Prenatal care providers are seen as authority figures by patients (Hobbins, 2004; Monahan & Forgash, 2013). Marriott (2012) cautioned practitioners to remember that sexual abuse is about control as well as sexual pleasure; powerlessness is imbedded deeply in these women. Health care providers are usually older than their patients. Pregnancy and childbirth can remind these women of their lack of control, powerlessness, and bring fear of authority figures back to the forefront of their mind. McGregor et al. (2010) explained that the power imbalance between the patient and prenatal care provider can make the patient believe they have no say or control over their care. Marriott (2012) also noted these women most likely have a difficult time trusting, and developing trust of, strangers. These factors, coupled with lack of knowledge regarding pregnancy and labor, and intrusive exams, could remind the pregnant mother of her sexual abuse history (Hobbins, 2004).

According to Hobbins (2004), it is not uncommon for women with a history of childhood sexual abuse to seek care providers who are of the opposite sex than their perpetrator(s). This means most of these women will seek care with a female provider (Hobbins, 2004). Regardless of the provider, the relationship may be associated with increased anxiety and fears, disappointment with the birthing experience, and postpartum difficulties such as PPD and attachment difficulties in this population (Hobbins, 2004).

Screening and Modification of Treatments and Procedures

McGregor et al. (2010) found that most patients with a history of childhood sexual abuse want to be asked about this history so they could discuss it with their provider. However, only a small number of health care providers admit to taking a full sexual case history, including a full abuse history (Diaz & Manigat, 2000; Leeners et al., 2007; McGregor et al., 2010). Wilson (2011) suggested that women with a history of childhood sexual abuse should be encouraged to disclose this history to health care providers, especially those who will care for them during their pregnancy and childbirth. Hobbins (2004) suggested that questions regarding physical, emotional, and sexual abuse or victimization be included in the standard case history form used for each and every patient (Hobbins, 2004).

According to Hobbins (2004), a practitioner's response to a disclosure of childhood sexual abuse has the potential to open or close lines of communication. Wilson (2011) suggested that the best reaction for a practitioner to portray is that of calm concern. The practitioner should also acknowledge both how difficult and important disclosure is. Jacobs (1992) warned that practitioners should be extremely cautious when

women disclose childhood sexual abuse for the first time during their prenatal period as disclosure can increase stress on the mother. In these situations, the practitioner may wish to observe the patient a bit more closely over a period of time to ensure minimal complications due to increased stressors.

McGregor et al. (2010) explained that health care providers could better serve women with a history of childhood sexual abuse if they were educated about how to be sensitive and competent when asking and discussing childhood sexual abuse histories. If a sexual abuse history is disclosed, practitioners should ask the patient if it acceptable to make a note of this in their chart (Hobbins, 2004; McGregor et al., 2010; Prescott, 2002). Before the end of the visit, literature (Hobbins, 2004; McGregor et al., 2010; Prescott, 2002) suggests that practitioners should offer referrals and resources to the patient. Support and lack of judgment will be needed for rapport to be built (Hobbins, 2004).

Trust is necessary for a healthy relationship between the practitioner and the patient. As has been noted several times, intimate, intrusive procedures can cause distress in women with a history of childhood sexual abuse (Hobbins, 2004). Hobbins (2004) suggested practitioners introduce themselves by name and title (i.e. Nurse-Midwife, Doctor, and Registered Nurse). Numerous resources recommend limiting the initial meeting to the taking of history. This will allow the first visit to be conducted in street clothes (Hobbins, 2004; Monahan & Forgash, 2013).

Several sources (Clark & Smythe, 2011; Hobbins, 2004; Monahan & Forgash, 2013; Prescott, 2002) have suggested that caregivers attempt to make all patients as comfortable as possible. This includes knocking and asking for permission to enter exam

rooms, explaining procedures prior to conducting them, asking permission to touch, and taking time to discuss the events at the end of the meeting (Clark & Smythe, 2011; Hobbins, 2004; Monahan & Forgash, 2013; Prescott, 2002). Clark and Smythe (2011) noted that consent should never be assumed and permission should be asked prior to each and every examination. Several sources (Clark & Smythe, 2011; Coles & Jones, 2009; Prescott, 2002) recommended that permission to continue should be asked several times throughout the exam process to ensure patient comfort. Health care providers should explain each course of treatment, each examination, and every procedure they plan to use. Research also suggests that the mother to be asked prior to care providers having any contact with the baby and all procedures be fully explained before they start. (Clark & Smythe, 2011; Coles & Jones, 2009; Prescott, 2002).

McGregor et al. (2010) echoed these sentiments, and added that examinations and procedures should be conducted in a careful and unhurried manner. The authors also suggested that the health care provider and patient might want to develop a care plan that limits intrusive examinations to the minimum amount necessary for the circumstances of the particular individual patient. Conrad (2012) suggested that prenatal care providers encourage and help this population to develop their own personal and comprehensive birth plan that lays out all of the mother's-to-be specific concerns and planned strategies. Coles and Jones (2009) and Clark and Smythe (2011) noted that while conducting procedures can become habitual, medical care providers should never assume the patient knows what is going to happen and to expect; all steps should be discussed prior to

starting with the patient being reminded that she the right to refuse treatment (Clark & Smythe, 2011).

Gutteridge (2001) explained that phrases and terms of endearment that are commonly used could bring back memories of the abuse. For example, “Lie still it won’t hurt.” “I’m just going to put my fingers inside,” “Open your legs wider,” and “That’s a good girl” (Gutteridge, 2001, p. 314) may very well be phrases the woman’s attacker used. Care should be used when explaining procedures, asking for access to the women’s body, and trying to soothe and comfort her, according to this author.

While practitioners cannot negate all the risks that a history of childhood sexual abuse causes to increase during the prenatal and childbirth periods, there are still steps that can be taken to lessen patient discomfort and distress. Screening for a history of abuse is the first and most important step in this process (Diaz & Manigat, 2000; Leeners et al., 2007; McGregor et al., 2010). Respect, sensitivity, kindness, and patience should be used with all patients, but is of utmost importance when working with women with a history of childhood sexual abuse (McGregor et al., 2010).

Theoretical Considerations

Hulme (2004) stated that research has found that those women with a history of childhood sexual abuse are at increased risk for suffering from a wide range of health problems. Childhood sexual abuse has been found to be associated with increased complications during pregnancy and childbirth (Benedict et al., 1999). The complications include, but are not limited to, depression, postpartum depression, childbirth complications, poor health, and emotional deregulation. Many medical based models

touch on the connection between trauma and somatization but are unable to explain it (Finkelhor & Browne, 1985).

Finkelhor and Browne's (1985) Traumagenic Dynamics Conceptual Framework

Finkelhor and Browne (1985) developed a conceptual framework that explores four traumagenic dynamics they suggest are the foundation of psychological inquiry when assessing child sexual abuse survivors. According to the authors, trauma survivors can be affected on any or all of the traumagenic dynamic spectrums; however, childhood sexual abuse tends to encompass all four. A history of childhood sexual abuse is associated with acute and chronic developmental, psychological, behavioral, and health consequences (Benedict et al., 1999). Finkelhor and Browne (1985) suggested that the ailments survivors suffer from could be explained by exploring where an individual falls on each of the traumagenic dynamic spectrums

There are four traumagenic dynamics: *sexualization*, *betrayal*, *powerlessness*, and *stigmatization* (Finkelhor & Browne, 1985). The authors suggested these dynamics lay the groundwork for the development of cognitive and emotional foundation. Trauma adversely affects the development of these underpinnings. When a child goes through a trauma distorted cognitions, self-concepts, affect, worldview, and sense of control are all effected, negatively (Finkelhor & Browne, 1985). Finkelhor and Browne (1985) suggested their theoretical framework could be helpful in both the research and practice venues.

According to Finkelhor and Browne (1985), *traumatic sexualization* occurs when an individual's sexuality is shaped at a developmentally inappropriate time, within a

dysfunctional interpersonal relationship. In their view, an individual's sexuality is cultivated during childhood and includes sexual feelings and sexual attitudes. The authors suggested the inappropriate rewards, such as privileges, affection, and attention, for sexual behaviors teach the child they can use sexual behaviors to manipulate (Finkelhor & Browne, 1985). Sexual misconceptions, confusions regarding sexual behaviors, fetishes, and sexual morality can be shaped during these interactions. Those with a history of childhood sexual abuse tend to associate fear with sexual activity, as well as have confusion and misconceptions regarding their sexual self-concepts. These all lead to the development of maladaptive emotions that become associated with sexual activity (Finkelhor & Browne, 1985).

Betrayal is the dynamic in which the child learns someone they trusted has caused them harm (Finkelhor & Browne, 1985). The majority of reported childhood sexual abuse acts are committed by family members, family friends, or acquaintances (Ullman, 2007). According to Craven, Brown, and Gilchrist (2006), approximately 80% of reported cases of childhood sexual abuse are committed by someone the child knows. Betrayal can be felt when a child realizes that someone they trusted manipulated and lied to them. However, Finkelhor and Browne (1985) noted this betrayal is not just limited to the perpetrator, children are also frequently betrayed by other trusted adults. This can be a true betrayal, in cases in which the child discloses the abuse and is not believed or perceived betrayal, in cases where the child feels the adult should have known and protected them (Finkelhor & Browne, 1985). According to Finkelhor and Browne (1985), the betrayal dynamic can manifest in disenchantment and disillusionment leading to

extreme dependency, usually seen in children, and in adults, either an extreme distrust of others or a desperate need for the perfect relationship. However, anger and aggression, as well as isolation and avoidance of relationships can also be seen (Finkelhor & Browne, 1985).

Powerlessness is the process by which the child loses control over multiple facets: their body, their will, their desires, and their sense of self efficacy (Finkelhor & Browne, 1985). Powerlessness, much like betrayal, is not experienced as being limited to the perpetrator alone. The child is disempowered by the perpetrator's use of manipulation and coercion and frequent invasions of personal space and body throughout the course of the abuse. However, powerlessness is also forged as the child is trapped in the abusive relationship. Finkelhor and Browne (1985) explain being stuck in the abusive relationship is a huge factor in the loss of power. The reality of being trapped, either due to lack of disclosure or lack of believers, is the crux of powerlessness and fear-there seems to be no way out or no escape. Difficulty with coping, fear, and anxiety are common issues childhood sexual abuse survivors complain about and tend to manifest as depression, anxiety, dissociation, and somatization in adult childhood sexual abuse survivors (Kallstrom-Fuqua et al., 2004). A need to regain control may manifest through aggressive and delinquent behaviors.

Stigmatization is the dynamic in which the child internalizes negative connotations expressed either implicitly or explicitly by individuals and society (Finkelhor & Browne, 1985). Common sources of stigmatization are the perpetrator, family, community, and society. Shame and guilt are common feelings that are

internalized by victims of childhood sexual abuse. These feelings are cultivated by the perpetrator through their push for secrecy, as well as when they blame and degrade the victim to keep in control over the abusive relationship (Finkelhor & Browne, 1985). Attitudes regarding sexual abuse, victims, and perpetrators from family, community, and society can also reinforce the shame and guilt the sexual abuse survivors feel. Reactions by people when they learn of the abuse, such as shock, pity, hysteria, and even, blame, can reinforce these feelings. Finkelhor and Browne (1985) explained that childhood sexual abuse survivors are well aware of the taboo and deviant ideals that surround the act of abuse. These may lead childhood sexual abuse survivors to internalize feelings that they are damaged, tainted, or even responsible because of their history (Finkelhor & Browne, 1985).

Finkelhor and Browne (1985) noted there is much research that shows that survivors of childhood sexual abuse tend to have long-term issues including, but not limited to, difficulty or dysfunctionality regarding sexuality and sexual behaviors, flashbacks, psychological, and somatic complaints. Edwards and Hendrix (2001) conducted a study of 125 female sexual abuse survivors and 60 adolescent male sexual offenders and administered the Trauma-Related Beliefs Questionnaire (TRBQ) to assess beliefs corresponding to Finkelhor and Browne's (1985) traumagenic dynamic framework. Edwards and Hendrix (2001) found female childhood sexual abuse survivors consistently reported high levels on all four traumagenic dynamics (Betrayal: $M = 2.17$, $SD = 1.04$; Powerlessness $M = 1.96$, $SD = 1.08$; Stigmatization $M = 2.02$, $SD = .99$; Traumatic Sexualization $M = 1.98$, $SD = 1.25$; $p > .05$). Female victims also tended to

have maladjusted emotional and behavioral symptoms. Edwards and Hendrix (2001) suggest that Finkelhor and Browne's traumagenic dynamic framework is useful when attempting to understand the link between childhood sexual abuse and emotional, psychological, behavioral, and somatic manifestations.

Finkelhor and Browne's (1985) traumagenic dynamic framework helps to understand the effects trauma may have on biopsychosocial realms. Finkelhor and Browne's (1985) framework is the only theoretical model that attempts to explain the connection between trauma and somatization as well as other aspects of an individual's life. Finkelhor and Browne (1985) explained that childhood sexual abuse was a unique form of trauma that affects all four traumagenic dynamic spectrums. While this theory does not discuss pregnancy or childbirth specifically, one can see how the adverse effects of childhood sexual abuse shown along these traumagenic dynamic spectrums would also aid in understanding the psychological, behavioral, and health issues that can arise during pregnancy.

Summary

An extensive literature review resulted in locating numerous descriptive and analytical studies that determined that a history of childhood sexual abuse could adversely affect the pregnancy and childbirth experiences (Benedict et al., 1999; Cort et al., 2012; Diaz & Manigat 2000; Dilorio et al., 2002; Farley & Keaney, 1997; Jacobs, 1992; Leeners et al., 2007; Lev-Wiesel & Daphna-Tekoah, 2007; Lev-Wiesel et al., 2009; McMahon et al., 2000; Monahan & Forgash, 2013; Murray et al., 2008; Nelson et al., 2012; Sartor et al., 2013; Schiff et al., 2002; Wilson, 2010, Yampolsky et al., 2010;

Zwickl & Merriman, 2011). Recommendations for screening and modification of care were presented from studies that used personal experience and descriptive study methods (Clark & Smythe, 2011; Hobbins, 2004; Monahan & Forgash, 2013; Prescott, 2002).

Taken together, it can be concluded that childhood sexual abuse is a risk factor for pregnancy and childbirth. However, no research was located to determine whether screening and modification of care are commonly practiced during the prenatal and birthing periods. Chapter three describes the methodology for the qualitative and phenomenological study to be used to explore whether prenatal and childbirth health care providers screen and modify procedures for their pregnant patients with a history of childhood sexual abuse.

Chapter 3: Research Methodology

The purpose of this chapter is to describe the methodology of this study. In it I discuss the research design and my rationale for it. Next, I present an in-depth discussion about the methodology, including participant selection, recruitment, participation, method of data collection, and data analysis plan. A discussion of trustworthiness and ethical considerations concludes the chapter.

Research Design and Rationale

Quantitative methodology enables researchers to explore relationships and patterns through statistical methods of analysis (Rudestam & Newton, 2007). According to Creswell (2003), the survey-based quantitative research design provides a framework that can relay trends, opinions, and attitudes through statistical, numerical explanations. Both Creswell and Rudestam and Newton noted that this method allows the researcher to be able to present information through inferential and descriptive statistics. Presenting statistics in both inferential and descriptive terms is a great strength, as the researcher can determine probabilities, generalizations, patterns, and relationships. I used a quantitative survey-based research design to determine whether there are patterns and relationships between numerous variables such as practitioners, demographics of practitioners, and the care given to women with a history of childhood sexual abuse in the prenatal and birthing care fields.

Garson (2013) explained that online survey designs tend to have the lowest number of respondents among all methods of data collection. While this could have been an issue for this study, Garson suggested that online surveys tend to be more popular and

more likely to garner responses when targeting participants with higher levels of education. Online surveys seem to elicit a better response from these more highly educated participants compared to other methods of data collection (Garson).

Methodology

As I stated in the previous section, I used a quantitative online-based survey design to gather data from prenatal and birthing practitioners regarding their treatment of female patients who have a history of childhood sexual abuse. Participants were recruited through Research Now. Research Now is an online marketing research and data collection company (Research Now Group, Inc., 2017). The use of Research Now's participant pool added an extra layer of anonymity and confidentiality because I did not know details of the participants.

Participant Selection Logic, Sampling, and Sampling Procedures

I used convenience sampling to recruit participants from a Research Now participant pool. I hired this online research company to recruit participants and aid in development of this survey. The survey was disseminated to potential participants within Research Now's participant pool. I selected participants if they were identified as individuals working in the healthcare field and living or working in the New England area. Once the participant entered the survey, I used certain demographic information to include or exclude them from the survey. Convenience sampling is a method that is used for preliminary studies because it allows the researcher to get an estimation of themes and patterns without incurring the nominal and time costs associated with random sampling (StatPac, 2014). Members of the population of prenatal and birthing practitioners were

recruited in the New England area. I chose this area in order to limit geographical differences in an attempt to aid in generalization. Research Now compensates its participants with electronic currency for each survey they complete based on the length of the survey.

I chose practitioners as participants for this study because they have a unique perspective on this topic. Practitioners are trained and educated in the care, procedures, and treatments of their patients. Patients were not chosen, mainly for this reason. The majority of patients will be unaware if their practitioner has used standardized or modified approaches of care. Additionally, for the patient perspective to be of added value to this particular study, patients of each practitioner would need to be polled. This would make guaranteeing the confidentiality of both the patient and the practitioner difficult. Finally, HIPAA regulations would not allow for practitioners to reveal their client base (Fisher, 2012), making it difficult to match patient and practitioner responses.

To determine the number of participants that I would need to detect differences between variables, I conducted a power analysis with $\alpha = 0.05$, $1-\beta = 0.80$ and an effect size $f^2 = 0.15$. According to Zint (2013), these values are commonly used to determine adequate power and sample sizes in social science studies. This study had a $k = 3$, as there were three categories (lead/primary practitioner, support staff, and optional/hired practitioners) for practitioner type. Practitioner type and demographic variables were used as the predictor variables for the study. Sample size was calculated using G*Power (Faul, Erdfelder, Buchner, & Lang, 2009) and the previous values. According to G*Power (Faul et al., 2009), for there to be enough data collected to detect significant

differences between categories, a minimum of 43 participants was needed, and I collected a total of 50 complete surveys. In the next section, I present procedures for recruitment, participation, and data collection.

Procedures for Recruitment, Participation, and Data Collection

I used convenience-sampling procedures to recruit participants to the study. Participants were recruited through Research Now's participant pool. Research Now aids researchers in finding participants, disseminating surveys, and collecting data. I hired this company for a monetary fee to aid in this process. This company finds participants based on the specified population within their established participant pool. According to Research Now, members who complete the survey process are compensated with electronic currency, per the agreement the member has with Research Now. Once potential participants were identified, the survey was disseminated, data was collected, and once the requested number of completed surveys were reached, all data was sent to me.

Research Now sent an email to all members who were identified as working in the healthcare field and living or working in the New England area. The solicitation letter (Appendix A) and survey link were a part of this email. Participants logged onto the survey via an emailed link. The survey took 5-10 minutes to complete. This timeframe was determined by Research Now's research department.

Informed consent was the first screen participants viewed. Participants were prompted to either *accept* or *decline* via a click. According to Bersoff (2008), in situations when there is minimal risk of participation to the participants, as well as little

documentation to link participants to data, accepting terms of informed consent via a click prompt is acceptable for data collected through online means. Participants who declined were not admitted to the survey. Participants could discontinue the survey at any time.

Next, demographic information (Appendix B) was gathered using multiple-choice questions. I used this demographic information as some of the variables to compare data and find themes and patterns in this study. Demographic information collected included: practitioner type, professional title, age, sex, years in practice, and percentage of patients who are prenatal or labor and delivery.

It was necessary to develop a survey for this because there have been no similar studies and therefore no other researchers have developed usable surveys. I wrote questions at an eighth-grade reading level, which I determined by using Microsoft Word's Readability Statistic feature. The Readability Statistic feature determined the readability of this study's survey to be Flesch-Kincaid grade level of 8.4. All questions in the survey were developed on the basis of the variables selected for analysis. I used anecdotal and descriptive studies (Clark & Smythe, 2011; Diaz & Manigat, 2000; Hobbins, 2004; Issokson, 2004; Leeners et al., 2007; McGregor et al., 2010; McMahon et al., 2000; Monahan & Forgash, 2000; Nelson et al., 2012; Prescott, 2002; Rouf, 1999; Simkin, 1996; Weinstein & Verny, 2004) that described practitioners' preferred practices when working with pregnant and birthing women with a history of childhood sexual abuse as the basis for developing these questions. My goal was to explore whether suggested practices discussed by these researchers were being used in the prenatal and

child birthing venues. All questions in the survey were based on the suggested practices for screening, prenatal care, and child birthing care described in Chapter 2.

The first questions in the survey collected demographic information and also asked the practitioner whether they had direct patient contact and were responsible for patient care during prenatal and/or child birthing periods. If the answer was *no* to either of these questions, the participant was exited from the survey. Some questions allowed for an *other* or *please specify* open-ended question option while the majority used a seven point Likert-type scale. Likert-type choices ranged from 0-Never, 3-Sometimes, 6-Always, to 7-Not applicable.

Data Analysis Plan

Research Question 1: Does practitioner type, age, sex, and/or years in practice predict whether they think childhood sexual abuse history affects their pregnant and/or birthing population?

H_01 : Practitioner type, age, sex, and/or years in practice does not predict whether they think childhood sexual abuse history affects their pregnant and birthing population.

H_a1 : Practitioner type, age, sex, and/or years in practice does predict whether they think childhood sexual abuse history affects their pregnant and birthing population.

Research Question 2: Does practitioner type, age, sex, and/or years in practice predict whether pregnant and/or birthing patients are screened for a history of childhood sexual abuse?

H_02 : Practitioner type, age, sex, and/or years in practice does not predict whether pregnant and/or birthing patients are screened for a history of childhood sexual abuse.

H_{a2}: Practitioner type, age, sex, and/or years in practice does predict whether pregnant and/or birthing patients are screened for a history of childhood sexual abuse.

Research Question 3: If practitioners screen for childhood sexual abuse history, does practitioner type, age, sex, and/or years in practice predict whether there is modification of treatment and procedures during prenatal and/or childbirth care?

H₀₃: Practitioner type, age, sex, and/or years in practice does not predict whether there is modification of treatment and procedures during prenatal and/or childbirth care.

H_{a3}: Practitioner type, age, sex, and/or years in practice does predict whether there is modification of treatment and procedures during prenatal and/or childbirth care.

Research Question 4: Does practitioner type, age, sex, and/or years in practice predict the training received regarding screening and modification of care regarding patients with a childhood sexual abuse history?

H₀₄: Practitioner type, age, sex, and/or years in practice does not predict the training received regarding screening and modification of care regarding patients with a childhood sexual abuse history.

H_{a4}: Practitioner type, age, sex, and/or years in practice does predict the training received regarding screening and modification of care regarding patients with a childhood sexual abuse history.

For all hypotheses, I collected data to determine whether there was a relationship between the opinions of practitioners on the following response variables: (a) effect of childhood sexual abuse on pregnancy and childbirth; (b) screening; (c) modification of care, treatment, and procedures; and (d) desired additional resources to help better work

with pregnant and birthing patients with a history of childhood sexual abuse. I studied the response variables to ascertain whether there were any relationships, themes, or patterns in regard to the practitioner variables: practitioner type (predictor variable-lead/primary practitioner, support staff, and optional/hired practitioners), and demographic characteristics (practitioner title and years in practice, and participant age and sex).

Raw data analysis was guided by the research hypotheses. Multiple linear regression analysis was conducted using SPSS software. This data analysis allowed me to identify and predict relationships between variables. I used the variables to see if they predicted whether practitioners screen for a history of childhood sexual abuse in their patients and if they modify their care and procedures based on their patient's childhood sexual abuse history. For example, the analysis may be able to determine if there is a difference between practitioner types, practitioner sex, practitioner age, and years of experience, and if this difference can help predict whether or not a practitioner will screen for childhood sexual abuse history and/or modify care. Given that there are no previous studies on the topic, I attempted to find if there is any relationship among these variables.

Threats to Validity

I maintained thorough records for all aspects of the study. I kept records regarding recruitment details and procedures, copies of written correspondence to agencies and potential participants, informed consent, data collection procedures, and data collection strategies. I also saved all raw data. All of this information was saved on a flash drive and the flash drive is stored in a locked safe that only I have access to. All data will be stored

for 5 years in accordance with code 45 CFR 46.115(b) regarding protecting human test subjects (Bersoff, 2010).

Due to the limited locale and number of participants, the themes, patterns, and relationships that were found are unable to be generalized beyond the area in which the study. This limited attempt at generalizations helps to ensure external validity (Creswell, 2003; Rudestam & Newton, 2007). I developed the survey questions in order to explore information from a snapshot in time. Specifically, I asked practitioners about current behaviors and opinions. I do not plan to re-question these participants in any repeat study; therefore there I have no concern about internal validity threats such as maturation or selection maturation interaction.

Ethical Procedures

IRB approval for this study was granted on March 31, 2017. The IRB approval number for this study is 12-27-16-0075448. Due to the nature of data collection of an online survey, there was little to no risk to participants. Since Research Now was the agency that recruited participants and collected data, there was little concern that the act of participation would cause difficulties within any realms of the participant's life, such as employment. Collecting participants through this agency also ensured anonymity and confidentiality. Finally, there was no risk to participants choosing not to participate in the survey from Research Now.

I collected demographic variables; however, the information gathered was not enough information to identify participants. My questions focused on behaviors and practices participants used as a practitioner. I did not use specific questions regarding

patients in order to honor HIPAA (Fisher, 2012). As an added step of protection, I did not ask participants to identify their place of employment.

Summary

I used a quantitative, online survey design to collect data based on questions developed to determine if there are any patterns regarding screening and care given by prenatal and birthing practitioners to their pregnant patients with a history of childhood sexual abuse. I collected 50 complete surveys from participants, more than the minimum 43 participants determined by power analysis. There was little to no risk for those participating in this study, and anonymity and confidentiality was fully ensured. I collected raw data and analyzed the data via SPSS. I conducted a multiple linear regression analysis in order to determine if there were any patterns regarding care. I discuss the results of this study in the next chapter.

Chapter 4: Data Collection and Results

The purpose of this study was to gather information from medical practitioners about their care and treatment of pregnant women with a history of childhood sexual abuse. Researchers have shown that a history of childhood sexual abuse has adverse effects on pregnancy and childbirth (Benedict et al., 1999; Cort et al., 2012; Diaz & Manigat 2000; Dilorio et al., 2002; Farley & Keaney, 1997; Jacobs, 1992; Leeners et al., 2007; Lev-Wiesel & Daphna-Tekoah, 2007; Lev-Wiesel, Daphna-Tekoah, & Hallak, 2009; McMahon et al., 2000; Monahan & Forgash, 2013; Murray, MacDonald, & Fox, 2008; Nelson et al., 2012; Sartor et al., 2013; Schiff, El-Bassel, Engstrom, & Gilbert, 2002; Wilson, 2010, Yampolsky et al., 2010; Zwickl & Merriman, 2011). Research has also shown that screening for childhood abuse history (McGregor et al., 2010; Wilson, 2011), as well as modification of care by medical practitioners for this population, can lead to a less traumatizing and, overall, more positive pregnancy and birthing experience for these women (Clark & Smythe, 2011; Coles & Jones, 2009; Gutteridge, 2001; Hobbins, 2004; Hotelling, 2012; Monahan & Forgash, 2013; Prescott, 2002). While research has shown that there are best practices that should be used with this population, it is unclear if practitioners are using these practices in the treatment and care of pregnant and birthing women. Therefore, the purpose of this study was to explore whether or not practitioners screen for a history of childhood sexual abuse and if, based on this information, they modify care, treatment, and procedures.

In this chapter, I discuss the data collection process, including changes to the original data collection plan. Next, I discuss the study's external validity and generalizability, and then present the results.

Data Collection

Data collection required three separate attempts and several changes in procedures. In this section, I discuss all changes in data collection methods and the reasons for these changes. Finally, I discuss the final, successful data collection process.

Data Collection, First Attempt

The original data collection plan was to use SurveyMonkey to administer the survey. I planned to send this survey to administrators and department heads of birthing units in hospitals within the Capital Region of New York State. Outreach began in September 2016. Conditional IRB approval was granted by Walden University on December 27, 2016. In January 2017, I contacted five hospitals. Only two hospitals returned voicemails. Both hospitals required submission of my research proposal to their institutional IRB for approval. I was able to complete application process at one hospital. At the second hospital, I was able to complete all parts of the application process (i.e., proposal, ethics training, and within-agency liaison), but the birthing department did not respond about whether or not it would participate. Despite my numerous attempts to reach out to the birthing department and the IRB department, my communications were unanswered. With no indication that this attempt at data collection would be successful, I decided in March 2017 to cease this method of collection and develop another plan.

Data Collection, Second Attempt

My second data collection attempt was to create a survey via SurveyMonkey to collect data from members of professional organizations in the Capital District of New York State. Approval was received from Walden University's IRB before beginning. I asked administrators of these organizations to disseminate the solicitation letter with survey link to their members and social media pages. I also directly contacted publicly posted members via posted email and Facebook pages. This phase of data collection began April 2017. By May 2017, only four participants had entered the survey.

Data Collection, Final Attempt

In June 2017, I contacted Research Now and made an agreement to use its participant pool for a nominal fee. Give the availability of Research Now participants and this study's specific participant pool; I broadened the area of residency for inclusion in the study from Capital District, New York, to all of the New England states including Connecticut, Maine, Massachusetts, Vermont, New Hampshire, and New York.

The research agency requested changes in the wording of some survey questions, as well as changes in both the solicitation letter and consent form to aid in clarity. For example, the time to complete the survey was changed from 10-15 minutes to 5-10 minutes. Language about compensation was added and a change to the format of some survey questions was made to aid in understanding. All changes were approved by Walden University's IRB prior to implementation. On August 2, 2017, the study was disseminated to targeted participants within Research Now's participant pool. On August 5, 2017, the study was closed upon reaching the agreed upon 50 fully completed surveys.

Research Now then sent an Excel document of the completed survey data to me on September 16, 2017.

Demographics, Descriptive, and Response Rates

In this section, I discuss recruitment and response rates and provide descriptive and demographic information regarding the survey participants. Finally, I discuss the external validity of this study.

Research Now disseminated the survey to 185 potential participants who were identified as working in the medical field. Of these potential participants, 57 were eliminated from the survey. Eighteen were eliminated because they chose not to consent to participate, and 39 were eliminated because they did not meet inclusion criteria. The inclusion criteria for this survey were that participants were practicing and residing in one of the seven states in the Northeast, had patient contact, and were responsible for patient care. Due to the inclusion/exclusion criteria and drop out, 78 participants partially completed the survey. Because of Research Now's policies, partial survey data was not saved or given to me. This study had a 58% participation rate. Table 1 shows all demographic information from the participants in this study.

Table 1.

Demographic Information for Participants

Demographic category	Frequency	Percent
<u>Sex</u>		
Male	2	4%
Female	48	96%
Total	50	100%
<u>Age</u>		
18-30 years old	6	12%
31-40 years old	8	16%
41-50 years old	7	14%
51-60 years old	19	38%
61 or older	10	20%
Total	50	100%
<u>Title</u>		
OB/GYN	2	4%
CNM	1	2%
NP	8	16%
RN	36	72%
LPN	2	4%
General Birth Coach	1	2%
Total	50	100%
<u>Practitioner Type</u>		
Lead/Primary	11	22%
Support	38	76%
Hired	1	2%
Total	50	100%
<u>Years in Practice</u>		
0-5 years	11	22%
6-10 years	7	14%
11-15 years	4	8%
16-20 years	3	6%
21-25 years	5	10%
26-30 years	5	10%
More than 30 years	15	30%
Total	50	100%
<u>State</u>		
CT	10	20%
ME	3	6%
MA	14	28%
NH	3	6%
NY	20	40%
VT	0	0%
Total	50	100%

The majority of participants in this sample were female, making up 96% of the study's participants. The majority of the participants were support staff. Specifically, 72% were RNs and 4% were LPNs. Only 11 participants, or 22%, were within the lead/primary practitioner category. As stated previously, practitioners in the lead/primary category includes OB/GYNs, CNM, PAs, and NPs, or those practitioners who are primarily responsible for the care of the patient. More specifically, two participants were OB/GYNs, one was a CNM, and eight were NPs. The median age of participants was 51 to 60 years old. The number of years in practice was skewed toward the poles, with 22% of participants in practice from 0-5 years and 30% of participants in practice for more than 30 years. Finally, 40% of participants practiced within the state of New York, followed by 28% in Massachusetts, 20% in Connecticut, and 6% in both Maine and New Hampshire.

Results

As I noted in the previous section, the majority of participants in this study were female nurses who lived or practiced in New York State. The data from these participants gave some ideas as to the treatment of pregnant and birthing women from a nursing perspective, but I do not have data regarding the treatment of this population by other medical treatment providers. Based on the composition of the sample, findings are generalizable only to nursing practitioners and not to other medical practitioners, whether within this geographic region or as a whole. In the next section, I discuss the findings.

Findings

For ease of understanding, I present each research question and hypothesis before discussing the statistical analysis and findings associated with that item. Of all results, there were no statistically significant results to support any hypotheses.

Research Question 1 was: Does practitioner type, age, sex, and/or years in practice predict whether they think childhood sexual abuse history affects their pregnant and/or birthing population? To answer this question, I conducted a multiple linear regression analysis of data from participants' responses to the survey question "Do you think that a history of childhood sexual abuse affects women during pregnancy and childbirth?" Participants were given the option to choose *Yes* or *No* and explain their choice, if they chose to. For a list of these comments, please refer to Table 2.

Demographic variables (years in practice, title, age, and sex) as well as practitioner type were used as predictor variables. I used the variable measuring whether or not practitioners believe that a history of childhood sexual abuse effects pregnancy and childbirth or Q6CSAAffectsPrenatal as the dependent variable in this analysis. No significant results were found to support this research question or the hypothesis, $F(5, 45) = .343, p > .05$. Therefore, practitioner type, age, sex, and/or years in practice does not predict whether they think childhood sexual abuse history affects their pregnant and birthing population and the null hypothesis was rejected.

Table 2.

Practitioner's Thoughts on CSA Affecting Pregnancy and Childbirth

Do you think that a history of childhood sexual abuse affects women during pregnancy and childbirth?			
Childhood sexual abuse affects	Frequency		Percent
Yes	48		96%
<ul style="list-style-type: none"> • Need more attention, compassion, and gentle care for special needs • Depends on overall findings • Mental Health/Coping • Additional community support • Sensitive to all patients-individualized treatment • Unsure how-need extra awareness 		10	
		1	
		3	
		1	
		3	
		1	
No	2		4%
<ul style="list-style-type: none"> • Never thought of it • Not a simple 'yes' or 'no'-numerous factors. 		1	
		1	
	Total	50	Total 100%
			21

Research Question 2 was: Does practitioner type, age, sex, and/or years in practice predict whether pregnant and/or birthing patients are screened for a history of childhood sexual abuse? The hypotheses developed for this question were: H_02 : Practitioner type, age, sex, and/or years in practice does not predict whether pregnant and/or birthing patients are screened for a history of childhood sexual abuse and H_a2 : Practitioner type, age, sex, and/or years in practice does predict whether pregnant and/or birthing patients are screened for a history of childhood sexual abuse.

Two questions were asked regarding this research question: "Do you screen your prenatal patients for a history of childhood sexual abuse?" and "Do you screen your labor and delivery patients for a history of childhood sexual abuse?" Participants could choose

either *Never*, *Always*, *Only those with a suspected history*, or *Other-Please Specify*. For a more detailed look at these answers, refer to Table 3. Again, I conducted a multiple linear regression analysis of data from participants' responses to the survey questions.

Demographic variables (years in practice, title, age, and sex) as well as practitioner type were used as predictor variables. The variables screen labor and delivery patients or ScreenDelivery and screen prenatal patients or ScreenPrenatal were used as dependent variable in this analysis. No significant results were found to support this research question or the hypothesis, with the results being $F(5, 36) = 1.657, p > .05$ and $F(5, 42) = 1.147, p > .05$, respectively. Therefore, fail to reject H_02 : Practitioner type, age, sex, and/or years in practice does not predict whether pregnant and/or birthing patients are screened for a history of childhood sexual abuse and the null hypothesis was rejected.

Table 3

Screening for Child Sexual Abuse History

Area of practice	Frequency	Percent
Prenatal		
• Never	1	2%
• Always	26	52%
• Only with a suspected history	21	42%
• Other-Not an option	1	2%
• No response	1	2%
Total	50	Total 100%
Labor and Delivery		
• Never*	5	10%
• Always	17	34%
• Only with a suspected history	17	34%
• Other-Does not work with L&D	3	6%
• No response	8	16%
Total	50	Total 100%

*Responses to 'Never' were: "Not required within practice", "Not part of assessment tool", "No labor and delivery patients", and "Not one of screenings".

Research Question 3 was: If practitioners screen for childhood sexual abuse history, does practitioner type, age, sex, and/or years in practice predict whether there is modification of treatment and procedures during prenatal and/or childbirth care? The hypotheses developed for this question were: H_03 : Practitioner type, age, sex, and/or years in practice does not predict whether there is modification of treatment and procedures during prenatal and/or childbirth care and

H_a3 : Practitioner type, age, sex, and/or years in practice does predict whether there is modification of treatment and procedures during prenatal and/or childbirth care.

For a detailed list of the questions asked regarding Research Question #3, refer to Table 4. Again, I conducted a multiple linear regression. As with the last analyses ran, demographic variables (years in practice, title, age, and sex) as well as practitioner type were used as predictor variables. The variable should prenatal and birthing patients with a history of childhood sexual abuse be treated differently or CSATreatedDifferently was used as dependent variable in this analysis. No significant results were found to support this research question or the hypothesis, with the results being $F(5, 36) = .87, p > .05$. Therefore, H_03 : Practitioner type, age, sex, and/or years in practice does not predict whether there is modification of treatment and procedures during prenatal and/or childbirth care and the null hypothesis was rejected.

Table 4:

Practitioner's Thoughts on Treating Patients Differently

Do you think that women with a history of childhood sexual abuse need to be treated and cared for differently than your non-abused patients?		
Area of practice	Frequency	Percent
Prenatal		
• Yes	34	68%
• No	2	4%
• Maybe/Unsure	10	20%
• No Response	1	2%
• All patients deserve tailored care	3	6%
Total	50	Total 100%
Labor and Delivery		
• Yes	38	76%
• No	4	8%
• No Response	8	16%
Total	50	Total 100%

Research Question 4 was: Does practitioner type, age, sex, and/or years in practice predict the training received regarding screening and modification of care regarding patients with a childhood sexual abuse history? The hypotheses developed for this question were: H_04 : Practitioner type, age, sex, and/or years in practice does not predict the training received regarding screening and modification of care regarding patients with a childhood sexual abuse history and H_a4 : Practitioner type, age, sex, and/or years in practice does predict the training received regarding screening and modification of care regarding patients with a childhood sexual abuse history. As with all other analyses run, demographic variables (years in practice, title, age, and sex) as well as practitioner type were used as predictor variables. I conducted numerous multiple linear regressions to coincide with different survey questions used. A summary of questions and answers can be found in Table 5.

The first survey question to be explored was “Have you had any training regarding screening patients for childhood sexual abuse history?” The variables continuing education for childhood sexual abuse screening or CSATrainingCE, elective course(s) for degree on childhood sexual abuse screening or CSATrainingElective, no trainings for childhood sexual abuse screening or CSATrainingNone, required course(s) for degree on childhood sexual abuse screening or CSATrainingRequired, and professional conference/seminar on childhood sexual abuse screening or CSATrainingSeminar were used as dependent variables in this analysis. No significant results were found to support this survey question, with the results being $F(5, 44) = 2.248, p > .05$, $F(5, 44) = .430, p > .05$, $F(5, 44) = 2.140, p > .05$, $F(5, 44) = 1.045, p > .05$, and $F(5, 44) = 1.731, p > .05$, respectively.

The second survey question to be explored was “Have you had any training regarding how a history of childhood sexual abuse can adversely affect women during pregnancy and childbirth?” The variables continuing education on adverse effects of childhood sexual abuse history on prenatal and birthing patients or AdverseCE, elective course(s) for degree on adverse effects of childhood sexual abuse history on prenatal and birthing patients or AdverseElective, no trainings on adverse effects of childhood sexual abuse history on prenatal and birthing patients or AdverseNone, required course(s) for degree on adverse effects of childhood sexual abuse history on prenatal and birthing patients or AdverseRequired, and professional conference/seminar on adverse effects of childhood sexual abuse history on prenatal and birthing patients or AdverseSeminar were used as dependent variables in this analysis. No significant results were found to support

this survey question, with the results being $F(5, 44) = 0.508, p > .05$, $F(5, 44) = 0.441, p > .05$, $F(5, 44) = 0.908, p > .05$, $F(5, 44) = 0.802, p > .05$, and $F(5, 44) = 1.067, p > .05$, respectively.

The third survey question to be explored was “Have you had any training regarding special considerations when working with patients for childhood sexual abuse history?” The variables continuing education on special considerations when working with prenatal and birthing patients with a history of childhood sexual abuse or ConsiderationsCE, elective course(s) for degree on special considerations when working with prenatal and birthing patients with a history of childhood sexual abuse or ConsiderationsElective, no trainings on special considerations when working with prenatal and birthing patients with a history of childhood sexual abuse or ConsiderationsNone, required course(s) for degree on special considerations when working with prenatal and birthing patients with a history of childhood sexual abuse or ConsiderationsRequired, and professional conference/seminar on special considerations when working with prenatal and birthing patients with a history of childhood sexual abuse or ConsiderationsSeminar were used as dependent variables in this analysis. No significant results were found to support this survey question, with the results being $F(5, 44) = 1.216, p > .05$, $F(5, 44) = 0.365, p > .05$, $F(5, 44) = 1.884, p > .05$, $F(5, 44) = 0.919, p > .05$, and $F(5, 44) = 1.691, p > .05$, respectively.

The final survey question to be explored was “Have you had any training regarding modifying care, treatment, and/or procedures for women during pregnancy and childbirth with a childhood sexual abuse history?” The variables continuing education on

the modification of care when working with prenatal and birthing patients with a history of childhood sexual abuse or ModificationCE, elective course(s) for degree on the modification of care when working with prenatal and birthing patients with a history of childhood sexual abuse or ModificationElective, no training on the modification of care when working with prenatal and birthing patients with a history of childhood sexual abuse or ModificationNone, required course(s) for degree on the modification of care when working with prenatal and birthing patients with a history of childhood sexual abuse or ModificationRequired, and professional conference/seminar on the modification of care when working with prenatal and birthing patients with a history of childhood sexual abuse or ModificationSeminar were used as dependent variables in this analysis. No significant results were found to support this survey question, with the results being $F(5, 44) = .868, p > .05$, $F(5, 44) = .135, p > .05$, $F(5, 44) = .454, p > .05$, $F(5, 44) = .714, p > .05$, and $F(5, 44) = 1.046, p > .05$, respectively. No significant patterns or themes were found. Therefore, in all cases, H4₀: Practitioner type, age, sex, and/or years in practice does not predict the training received regarding screening and modification of care regarding patients with a childhood sexual abuse history and the null hypothesis was rejected.

Table 5

Training

Trainings Attended	Frequency	Percent
<u>Attended trainings regarding screening patients for CSA history:</u>		
• None	11	22%
• Continuing Education	29	58%
• Required course(s) for degree	17	34%
• Elective course(s) for degree	9	18%
• Professional conference/seminar	16	32%
• Other-Hospital	2	4%
<u>Attended training regarding how a history of CSA adversely affect women during pregnancy and childbirth</u>		
• None	16	32%
• Continuing Education	23	46%
• Required course(s) for degree	11	22%
• Elective course(s) for degree	5	10%
• Professional conference/seminar	9	18%
• Other-Hospital	2	4%
-Practice experience	1	2%
<u>Attended training regarding special considerations when working with patients for CSA history:</u>		
• None	20	40%
• Continuing Education	23	46%
• Required course(s) for degree	8	16%
• Elective course(s) for degree	3	6%
• Professional conference/seminar	12	24%
• Other-Hospital	2	4%
<u>Attended training regarding modifying care, treatment, and/or procedures for women during pregnancy and childbirth with a CSA history?</u>		
• None	25	50%
• Continuing Education	20	40%
• Required course(s) for degree	9	18%
• Elective course(s) for degree	2	4%
• Professional conference/seminar	10	20%
• Other-Hospital	2	4%
-SANE	1	2%

In summary, this study required several major changes in order to be able to collect participants. This study was unable to find data to support any of the research questions and their hypotheses. However, there were two tending responses that were found and these findings will be discussed in the next chapter.

Summary

After numerous attempts at data collection, Research Now recruited the necessary participants for this study. Of the 185 identified potential participants, 50 met all criteria to continue and complete the survey. Once the data was given to me, it was entered into SPSS and analyzed through multiple regression analysis. After extensive data analysis, no significant results were found to support any of the research questions or their hypotheses for this study. The next and final chapter will discuss these findings more thoroughly.

Chapter 5: Interpretation and Discussion

In this study, I sought to gather information regarding medical practitioners' treatment and care of prenatal women with a history of childhood sexual abuse. The purpose of this study was to gather information regarding the care and treatment of pregnant women with a history of childhood sexual abuse. While I found no significant results to support any of the hypotheses, two trending results emerged that I discuss in this section. In the conclusion of this chapter, I make recommendations and discuss implications of this study.

Interpretation of the Findings

As just noted, I found no statistically significant results to support any of this study's hypotheses. The majority of study participants were nurses (RN and LPNs). Therefore, the information gathered for the study is mainly from a nursing perspective.

The first trending result was that as practitioner type code increased; the less likely the practitioner was to have training regarding screening patients for childhood sexual abuse history. Simply put, this means that the more education a participant had, the more likely it was that they had not attended trainings regarding screening patients for a history of childhood sexual abuse. The second trending result was as age category decreases; the less likely the practitioner was to have training regarding screening patients for childhood sexual abuse history increases. Again, according to these trending results, the younger the participant was the more likely they were not to have attended trainings regarding screening patients for a history of childhood sexual abuse. In both cases, further studies are necessary to determine if this trend continues to be found.

Read et al.'s (2006) research showed that childhood sexual abuse survivors are unlikely to spontaneously disclose their abuse history. These findings underline the importance of practitioners screening for a history of childhood sexual abuse in their patients. Read et al. found that simply asking about a history of abuse increases the likelihood of disclosure. More interesting, McGregor et al. (2010) found that most patients with a history of childhood sexual abuse want to be asked about this history so that they could discuss it with their provider.

The practitioner is the first line of defense in assisting pregnant and birthing patients with a history of childhood sexual abuse. However, studies (i.e. Diaz & Manigat, 2000; Leeners et al., 2007; McGregor, Glover, Gautman, & Jülich, 2010) have shown that few healthcare practitioners conduct a full sexual case history, and even fewer ask their patients about their childhood sexual abuse history. The results of this study echoed results of these previous studies on the topic.

Ninety-six percent of the participants in this study reported that they thought a history of childhood sexual abuse affects women during pregnancy and childbirth. When participants were asked if they thought that prenatal patients with a history of childhood sexual abuse need to be treated and cared for differently than non-abused patients, 68% reported *yes*, while 20% reported *maybe/unsure*. I found that 52% the participants reported that they always screened their prenatal patients for a history of childhood sexual abuse. I also found that 42% of the participants in this study only screened for sexual abuse history in their prenatal patients when there was a suspected history of childhood sexual abuse.

Regarding labor and delivery, only 34% of participants reported that they always screened for a history of childhood sexual abuse. Another 34% reported that they only screened their labor and delivery patients for childhood sexual abuse history when past victimization was suspected. Even more interesting are these numbers when take in light of the fact that 76% of participants reported that they thought labor and delivery patients with a history of childhood sexual abuse need to be treated and cared for differently than their non-abused counterparts. Several practitioners noted that they do not screen their labor and delivery patients because it is “not required within practice,” “not part of the assessment tool,” and “not one of the screenings.”

Screening for a history of abuse is the first and most important step in this process. However, few health care providers admit to asking about a childhood sexual abuse history, let alone administering a full sexual case history (Diaz & Manigat, 2000; Leeners et al., 2007; McGregor et al., 2010). Treating all patients with kindness, respect, and sensitivity should be a given, but it is of particular importance in developing a trusting relationship with the survivor of childhood sexual abuse (McGregor et al., 2010). Studies (Clark & Smythe, 2011; Hobbins, 2004; Monahan & Forgash, 2013; Prescott, 2002) indicated the way in which prenatal and childbirth care providers best to interact with their patients.

Literature has indicated that prenatal care practitioners to should explain procedures, ask permission frequently throughout the procedure to see if it is alright to touch and continue, and be willing to stop or slow down at the patient’s request (Clark & Smythe, 2011; Hobbins, 2004; Monahan & Forgash, 2013; Prescott, 2002). Pregnancy

and childbirth, with frequent intrusive examinations and numerous care providers, can lead to unintentional traumatization by care providers (Coles, 2009). Childbirth may become a traumatic experience resulting in dissociation, flashbacks, and/or PTSD symptomology (Clark & Smythe, 2011). Coping strategies used by childhood sexual abuse survivor can range from dissociation to anxiety attacks, passivity to belligerence, even counter-dependence (Issokson, 2004). Whether or not medical care providers use care and caution, there is still a chance that women with a history of childhood sexual abuse will have adverse reactions to the whole pregnancy (LaCoursiere et al., 2012; Lev-Weisel & Daphna-Tekoa, 2007; Roller, 2012) and childbirth process (Clark & Smythe, 2011; Issokson, 2004; Roseth et al., 2011).

Such best practice suggestions seem to be based on individual practices and descriptive studies. While this is a limitation of the extant literature, taken together, these practices seem to be the preferred approach when consulting midwifery and nursing academic journals. In Table 6 I offer a complete list of best practices for prenatal and labor and delivery care. Practitioners were able to choose answers on a Likert-type scale from 0-Never to 5-Always, with 6-Only with a suspected history, and 7-N/A. The majority of the participants in this study reported that they *always* follow the best practices discussed in literature.

Table 6

Modification of Treatment and Procedures in Prenatal Care

Recommended Best Care Practices	M	SD	Mode
• Knock prior to entering?			
• Ask permission to enter?	4.86	0.57	5
• Introduce yourself by name and title?	3.98	1.67	5

• Conduct first visit with patient in street clothes, only take case history, and discuss future course of care?	4.83	0.49	5
• Develop a care schedule with limited internal and invasive exams?	3.64	2.16	5
• Explain what will happen during the visit?	4.12	1.68	5
• Explain all processes and procedures prior to conducting them?	4.83	0.62	5
• Ask permission to conduct each and every exam and procedure?	4.90	0.53	5
• Explain that patient can stop procedure/exam at any point in time?	4.59	0.86	5
• Ask permission to touch prior to contact?	4.24	1.48	5
• Ask permission to continue/touch at each step of the exam?	4.17	1.38	5
• Ensure procedures and exams are conducted in a careful, unhurried manner?	3.88	1.61	5
• Discuss/recap visit events at the end of the appointment?	4.76	0.66	5
• Allow time for any questions or concerns to be voiced at the end of the visit?	4.83	0.99	5
•	4.81	0.59	5

Table 7

Modification of Treatment and Procedures in Labor and Delivery

Recommended Best Care Practices	M	SD	Mode
• Knock prior to entering?	4.95	1.50	5
• Ask permission to enter?	4.74	1.75	5
• Introduce yourself by name and title?	5.31	1.02	5
• Explain what will happen during visit?	5.26	1.01	5
• Attempt to minimize the number of internal exams conducted?	5.14	1.39	5
• Develop a care schedule with limited internal and invasive exams?	5.07	1.33	5
• Explain all processes and procedures prior to conducting them?	5.40	0.94	5
• Ask permission to conduct each and every exam and procedure?	4.81	1.63	5
• Explain that patient can stop procedure/exam at any point in time?	4.74	1.81	5
• Ask permission to touch prior to contact?	4.93	1.58	5
• Ask permission to continue/touch at each step of the exam?	4.67	1.78	5
• Ensure procedures and exams are conducted in a careful, unhurried manner?	5.28	1.02	5
• Allow time for any questions or concerns to be voiced prior to exiting the room?	5.21	1.12	5
• Use terms of endearment (such as “Honey”, “Sweetie”, “Good Girl”, etc.)?	2.43	2.84	0
• Fully explain all exams and procedures to be conducted on baby?	5.40	0.96	5
• Ask permission to touch baby each time?	4.55	1.89	5

• Offer to conduct exams and procedures in mother's room (when able)?	4.90	1.36	5
• When exams and procedures cannot be conducted in the room, ask mother, or a person designated by mother, to accompany you to procedure room?	4.79	1.55	5

Even the most attentive practitioner cannot negate all the risks that a history of childhood sexual abuse causes during the prenatal and childbirth periods. However, there are steps that can be taken to lessen the patient's discomfort and distress. Screening for a history of abuse is the first and most important step in this process (Diaz & Manigat, 2000; Leeners et al., 2007; McGregor et al., 2010). The discrepancy between the awareness of the adverse effects of child sexual abuse history on pregnancy and delivery and the practices of screening and modification of care is interesting. Participants reported they were aware of the issues that this history can have on their patients but there is still limited screening and modification. This finding is consistent with prior research. Respect, sensitivity, kindness, and patience should be used with all patients, but is of utmost importance when working with women with a history of childhood sexual abuse (McGregor et al., 2010).

Limitations of the Study

The main limitation I have identified regarding this study is the limited number of participants and the limited types of providers who participated. While, according to the power analysis, there were enough participants to achieve significant results, the trending responses found indicates that with more participants, significant results could have been likely. The majority of the participants were nurses, this means the data gleaned from this study more represents the nursing viewpoint. It is my opinion that the small number of

primary care providers (i.e. OB/GYNs, CNMs, PAs, and NPs) that participated in this study resulted in a large gap of information on this topic. The same is true for hired support (i.e. Doula and birth coaches). The limited number of participants in these categories resulted in little, if any, information for these groups. Another limitation of this study is the geographical area in which this study pooled participants from. If I recruited participants nationally, the data would be more generalizable.

A major limitation I identified in current literature is that there is no agreed upon theory or theories to explore the relationship between a history of childhood sexual abuse and biopsychosocial issues. McMahon et al. (2000) noted the lack of a comprehensive theoretical framework makes it difficult to explore the relationship between childhood sexual abuse and reproductive health. With the proper theoretical framework, one would be able to help the researcher identify and control for variables that may also be influencing findings, such as other forms of abuse, behavioral factors, personality factors, and other risk taking behaviors (McMahon et al., 2000). McMahon et al. (2000) also pointed out the lack of an agreed upon theoretical framework leads to an inability to standardize methodology. The inability to use standardized methodology makes it difficult for researchers to compare findings and apply information gathered to larger populations.

Recommendations

I explored practices and procedures within the prenatal and childbirthing venues. While I was unable to find significant results regarding patterns and themes within

variables, I was able to explore whether screening and best care practices are being used within the field.

I did find two trending results. I found that practitioner type and practitioner age were found to have possible connection with not participating in trainings regarding screening patients for a history of childhood sexual abuse. I recommend that additional or future studies explore this relationship more fully. A larger sample size and a sample that included other types of providers should confirm or disconfirm these findings.

My main recommendation regarding this study is to encourage future researchers to explore the identified relationships with a study of larger sample size. It would be interesting to see what, if any, significant results could be found with a larger sample that is reflective of prenatal and labor and delivery practitioner population demographics. I am interested in seeing if a larger sample size would allow for results that are more reflective of the population and more able to generalize.

Implications

Ideally, I would like prenatal care providers to be able to use the results of this study to request additional support and funding for prenatal and childbirth clinics. Creedy, Nizette, and Henderson (1998) explained access to mental health care providers can help medical care practitioners to give more holistic treatment and care to their patients. Additional funding could also allow for education of identification and interventions with this population. In addition to education, additional funding could allow these departments to allocate more time and resources to obstetric patients, allowing for an increase in the identification and intervention for these patients.

I asked participants what additional resources they would like to see in their work environment that would better help them serve their patients who have a history of childhood sexual abuse. The majority of participants reported they would like to see additional resources within their offices. Sixty-four percent of participants reported that they would like the ability to spend more time with their patients. Sixty-eight percent of participants reported they would like to have access to onsite mental health providers. Regarding trainings they would like to see available, 68% of respondents would like training for childhood sexual abuse screening available, 70% of participants reported they would like trainings available regarding the adverse effects that childhood sexual abuse can have on pregnancy and childbirth. Next, 66% of respondents reported they would like trainings that would help them understand and help them with their reactions to the disclosure of childhood sexual abuse by their patients. Finally, 58% of the participants reported that they would like to have trainings regarding different ways to modify care during prenatal and/or labor and delivery care. For a more detailed look at the responses, refer to Table 7.

Table 8

Additional Resources Practitioner Would Like

Additional resources	Frequency	Percent
• Ability to spend more time with patients.	32	64%
• Access to mental health care providers' onsite.	34	68%
• Training for screening for childhood sexual abuse history.	34	68%
• Training for overall awareness regarding the adverse effects that childhood sexual abuse can have on pregnancy and childbirth.	35	70%
• Training to help with understanding and reactions to disclosure of childhood sexual abuse history.	33	66%
• Training regarding different ways to modify care during prenatal and/or labor and delivery care.	29	58%

Prenatal and childbirth medical care providers are in a unique position to assist pregnant women with a history of childhood sexual abuse. Screening for a history of abuse is the first and most important step in this process, however, few health care providers admit to asking about a childhood sexual abuse history, let alone administering a full sexual case history (Diaz & Manigat, 2000; Leeners et al., 2007; McGregor et al., 2010). I propose that a simple change in agency policy and assessment tools regarding screening could increase the number of patients screened for a history of childhood sexual abuse in prenatal and childbirth patients. Numerous participants noted their lack of screening was due to screening not being a part of policy or not being a part of assessment tools. The majority of participants reported they would like to see more resources available regarding screening, disclosure, and care.

Summary and Conclusion

The limited number of participants in this study effected results. I recommend that an in future study, a larger participant pool is used. Matching the characteristics of participants to the demographic variables of the population may also yield interesting results. Most specifically, matching practitioner titles with the characteristics of the population of prenatal and birthing practitioners within the field may help understand differences within the practices between primary care providers, support staff, and hired practitioners. This may be a difficult task to accomplish, as those within the medical field tend to have rigorous schedules with little to no downtime.

According to Hotelling (2012), women were more likely to have a positive birth experience when they feel in control, accomplished, and well cared for by their health

care providers. For the proper care of this population, practitioners must know what effects a child sexual abuse history can have on their patients and how to identify these issues (Coles & Jay, 2009; Leeners et al., 2006a).

Prenatal and childbirth medical care providers are in a unique position to assist pregnant women with a history of childhood sexual abuse. Screening for a history of abuse is the first and most important step in this process, however few health care providers admit to asking about a childhood sexual abuse history, let alone administering a full sexual case history (Diaz & Manigat, 2000; Leeners et al., 2007; McGregor et al., 2010). Treating all patients with kindness, respect, and sensitivity should be a given, but it is of particular importance in developing a trusting relationship with the childhood sexual abuse survivor (McGregor et al., 2010). Studies (Clark & Smythe, 2011; Hobbins, 2004; Monahan & Forgash, 2013; Prescott, 2002) indicate the way in which prenatal and childbirth care providers are best to interact with their patients. Literature indicates that prenatal care practitioners should explain procedures, ask permission frequently throughout the procedure if it is alright to touch and continue, and be willing to stop or slow down at the patient's request (Clark & Smythe, 2011; Hobbins, 2004; Monahan & Forgash, 2013; Prescott, 2002). I was unable to locate literature to determine whether these techniques are used in the care for pregnant women with a history of childhood sexual abuse.

I attempted to fill this gap in the literature. While I was unable to find significant results, I was able to identify two trending results while analyzing the data. The first trending result was, as practitioner education increase, the likelihood on not receiving

training regarding screening patients for a history of childhood sexual abuse. The second trending result was, the younger the participant was the more likely they were to not have attended trainings regarding screening patients for a history of childhood sexual abuse. In both cases, further studies are necessary to determine if this trend continues to be found. Even though I was unable to find significant results, a majority of participants reported they would like to see one or more additional resources available within their agencies to help them improve on their treatment and care of prenatal and birthing patients with a history of childhood sexual abuse.

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Appendix A: Solicitation Letter

Dear Practitioner,

My name is Wendy Abbott-Egnor and I am a PhD Clinical Psychology student at Walden University. For my dissertation, I am exploring the treatment and care of women with a history of childhood sexual abuse throughout their prenatal and childbirth experience. Since you are a health care practitioner who has been identified as working with pregnant and/or birthing women, I would like to invite you to participate in this research study by completing the online survey found at <<Research Now Link>>.

The online survey should take approximately 5-10 minutes to complete. There will be no compensation for responding. There is also no known risk for participation. This survey is confidential and anonymous. At the completion of the study, you will have the option to submit contact information, should you be interested in receiving the study results. Your contact information *will not* be linked to your survey answers. If you choose to participate in this study, please answer all questions honestly and to the best of your ability. Participation is completely voluntary and you may stop the survey at any time.

Whether you chose to participate or not, it would be greatly appreciated if you could forward the survey link to your colleagues and associates. This study is interested in receiving feedback from all health care providers that come in contact with pregnant and birthing women. Health care providers, for the sake of this study include, but are not limited to: OB/GYNs, CNMs, PAs/NPs, RNs/LPNs, Doulas/Birthing coaches, and other staffers who participate directly in the care and treatment of pregnant and birthing women.

Thank you for taking the time to consider this study. Your participation will be invaluable. The data collected in this study will help in understand what types of screening and modification practices are used in the care of women with a history of childhood sexual abuse, if any, in the prenatal and labor and delivery arenas. If you require any further information regarding this study, please feel free to contact me at wendy.egnor@waldenu.edu.

If you have any problems with this study or the manner in which it is being conducted, you may report any complaints to Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is 612-312-1210.

Sincerely,

Wendy Abbott-Egnor

wendy.egnor@waldenu.edu

Appendix B: Demographic Survey

Please indicate for each section what applies to you by checking the appropriate item.

Sex

-Male/Female

Age

-Under 20

-41-50 years old

-21-30 years old

-51-60 years old

-31-40 years old

-61 or older

Practitioner Title

-Obstetrics/Gynecologist (OB/GYN)

-Doula

-Certified Nurse Midwife (CNM)

-Birthing Coach-General

-Physician's Assistant (PA)

-Birthing Coach-Lamaze

-Nurse Practitioner (NP)

-Birthing Coach-Bradley

-Registered Nurse (RN)

-Birthing Coach-Alexander

-Licensed Practical Nurse (LPN)

-Birthing Coach-Hypnobirthing

-Other-Please specify.

Years in Practice

-0-5 years

-21-25 years

-6-10 years

-26-30 years

-11-15 years

-more than 30 years

-16-20 years

Focus of Practice

Percentage of patients/practice prenatal

Percentage of patients/practice labor and delivery

Appendix C: Survey Questions

1. Are you in direct patient contact with patients?
 -Yes (continue) -No (exit survey)

2. Are you responsible for the patient's care during prenatal and/or child birthing periods?
 -Yes (continue) -No (exit survey)

3. Are you a lead care provider (i.e., OB/GYN, Midwife), member of the support staff (i.e. RN, LPN), or hired support person (i.e. birth coach, doula) to your prenatal and/or birthing patients?
 -Lead care provider -Support staff -Optional/Hired support

4. Have you had any training regarding screening patients for childhood sexual abuse history? Check all that apply.
 -None -Continuing Education
 -Required course(s) for degree -Professional conference/seminar
 -Elective course(s) for degree -Other. Please Specify

5. Have you had any training regarding how a history of childhood sexual abuse can adversely affect women during pregnancy and childbirth? Check all that apply.
 -None -Continuing Education
 -Required course(s) for degree -Professional conference/seminar
 -Elective course(s) for degree -Other. Please Specify

6. Have you had any training regarding special considerations when working with patients for childhood sexual abuse history? Check all that apply.
- None
 - Continuing Education
 - Required course(s) for degree
 - Professional conference/seminar
 - Elective course(s) for degree
 - Other. Please Specify
7. Have you had any training regarding modifying care, treatment, and/or procedures for women during pregnancy and childbirth with a childhood sexual abuse history? Check all that apply.
- None
 - Continuing Education
 - Required course(s) for degree
 - Professional conference/seminar
 - Elective course(s) for degree
 - Other. Please Specify
8. Do you screen your prenatal patients for a history of childhood sexual abuse? Please skip this question if you do not work with prenatal patients.
- Never
 - Always
 - Only those with a suspected history
 - Other-Please Specify
9. Do you think that a history of childhood sexual abuse affects a woman during pregnancy and childbirth?
- Yes (explain how)
 - No (explain why)
10. Do you believe pregnant women with a history of childhood sexual abuse need to be treated and cared for differently than your non-abused patients?

11. Do you screen your labor and delivery patients for a history of childhood sexual abuse? Please skip this question if you do not work with prenatal patients.
- Never
 - Always
 - Only those with a suspected history
 - Other-Please Specify
12. If you do not screen patients for a history of childhood sexual abuse, how come?
(Feel free to explain)
13. Do you think women with a history of childhood sexual abuse need to be treated and cared for differently during childbirth than your non-abused patients? Please skip this question if you do not work with prenatal patients
- Yes (Feel free to explain why)
 - No (Feel free to explain why)
14. When a patient discloses a history of childhood sexual abuse during a prenatal visit or labor and delivery care, do you: Check all that apply.
- Schedule a few visits at closer intervals to have the ability to observe for potential stressors and complications that could be brought on by disclosure?
 - Automatically add this information to the patient's chart
 - Ask the patient's permission to add this abuse history to her chart and respect her wishes either way.
 - Offer to give the patient information, resources and referrals.
 - Automatically give the patient a packet that includes information, resources and referrals.
15. Please skip this section if you do not work with prenatal patients.

Regarding prenatal care, do you:

-Knock prior to entering? [Likert scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]

-Ask permission to enter? [Likert scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]

-Introduce yourself by name and title? [Likert scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]

-Conduct first visit with patient in street clothes, only take case history, and discuss future course of care? [Likert scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]

-Develop a care schedule with limited internal and invasive exams? [Likert scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]

-Explain what will happen during the visit? [Likert scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]

-Explain all processes and procedures prior to conducting them? [Likert scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]

-Ask permission to conduct each and every exam and procedure? [Likert scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]

-Explain that patient can stop procedure/exam at any point in time? [Likert scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]

-Ask permission to touch prior to contact? [Likert scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]

-Ask permission to continue/touch at each step of the exam? [Likert scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]

-Ensure procedures and exams are conducted in a careful, unhurried manner? [Likert scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]

-Discuss/recap visit events at the end of the appointment? [Likert scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]

-Allow time for any questions or concerns to be voiced at the end of the visit? [Likert scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]

-Other-Please specify.

16. Please skip this section if you do not work with labor and delivery patients.

Regarding Labor and delivery care. Do you:

-Knock prior to entering? [Likert scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]

- Ask permission to enter? [Likert scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]
- Introduce yourself by name and title? [Likert scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]
- Explain what will be happening during the visit? [Likert scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]
- Attempt to minimize the number of internal exams conducted? [Likert scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]
- Develop a care schedule with limited internal and invasive exams? [Likert scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]
- Explain all processes and procedures prior to conducting them? [Likert scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]
- Ask permission to conduct each and every exam and procedure? [Likert scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]
- Explain that patient can stop procedure/exam at any point in time? [Likert scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]

-Ask permission to touch prior to contact? [Likert scale: 0-Never 5-Always 6-

Only with patients with a history of childhood sexual abuse 7-N/A]

-Ask permission to continue/touch at each step of the exam? [Likert scale: 0-

Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]

-Ensure procedures and exams are conducted in a careful, unhurried manner?

[Likert scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]

-Allow time for any questions or concerns to be voiced prior to exiting room?

[Likert scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]

-Use terms of endearment (such as “Honey”, “Sweetie”, “Good Girl”, etc.)?

[Likert scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]

-Fully explain all exams and procedures to be conducted on baby? [Likert scale:

0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]

-Ask permission to touch baby each time? [Likert scale: 0-Never 5-Always 6-

Only with patients with a history of childhood sexual abuse 7-N/A]

-Offer to conduct exams and procedures in mother’s room (when able)? [Likert

scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]

-When exams and procedures cannot be conducted in the room ask mother, or a person designated by mother, to accompany you to the procedure room? [Likert scale: 0-Never 5-Always 6-Only with patients with a history of childhood sexual abuse 7-N/A]

-Other-Please specify.

17. What additional resources would you like to see in your work environment that would help you better serve patients with childhood sexual abuse history?

-Ability to spend more time with patients.

-Access to mental health care providers on site.

-Training for screening for childhood sexual abuse history.

-Training for overall awareness regarding the adverse effects that childhood sexual abuse can have on pregnancy and childbirth.

-Training to help with understanding and reactions to disclosure of childhood sexual abuse history.

-Training regarding different ways to modify care during the prenatal and/or labor and delivery care.

-Other. Please specify.

18. Please use this section to make any comments and/or add any information you think was missed:

Thank you for taking time out of your busy schedule to help with this study. If you have any questions or would like more information, please contact the researcher at

wendy.egnor@waldenu.edu.