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## "I know that I'm strong" : survivors of sexual violence and their experiences with pregnancy and childbirth

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Gretchen J. Davidson  
“I Know that I’m Strong”: Survivors  
of Sexual Violence and their  
Experiences with Pregnancy and  
Childbirth

## **ABSTRACT**

The purpose of this exploratory study was to gain a deeper understanding of how women with a history of sexual violence experience pregnancy and childbirth. The study used semi-structured phone interviews with eleven women to gather qualitative data about their experiences with pregnancy and childbirth and their reflections on the relationship between past sexual violence and childbearing.

The findings suggest that most women experience negative effects of past sexual violence at some point in the childbearing year and that these effects manifest as emotional, physical, and relational trauma reactions. When these reactions occur women may have the opportunity to process past trauma and experience increased growth and healing. Growth and healing was a prominent theme in this study, with all participants identifying some ways in which pregnancy, childbirth, or being a mother promoted psychological growth and healing. The data also suggests that how women cope with these trauma reactions and the relationships they have with their care providers impact their experiences with pregnancy and childbirth. In fact coping and relationships with care providers may mitigate trauma reactions and promote growth or can contribute to negative childbearing experiences. This study presents a framework of four intersecting themes: *negative effects of sexual violence*, *coping*, *relationships with care providers*, and *growth and healing*, meant to guide social work and maternity care practice with childbearing women with a history of sexual violence.

**“I KNOW THAT I’M STRONG”: SURVIVORS OF SEXUAL VIOLENCE AND THEIR  
EXPERIENCES WITH PREGNANCY AND CHILDBIRTH**

A project based upon an independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work.

Gretchen J. Davidson

Smith College School for Social Work  
Northampton, Massachusetts 01063

2014

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## **CHAPTER I**

### **Introduction**

Some sources estimate the rate of women who have experienced sexual violence in the United States to be as high as one in every four women (Sperlich & Seng, 2008). Twenty five thousand women in the United States become pregnant each year as a result of a sexual assault (Stewart & Trussell, 2000), and pregnant women have a 60.6% higher risk of being physically abused than non-pregnant women, with overall rates of violence against pregnant women between 7 and 11%, depending on the source (Gazmararian, Lazorick, Spitz, Ballard, Saltzman, Marks, 1996). Given how common violence against women is it only stands to reason that many women who present for maternity care or for mental health care during the childbearing year are survivors of sexual violence.

Anecdotally many women have reflected on the interplay between the lived experiences of both sexual violence and childbearing (Simkin & Klaus, 2004; Sperlich & Seng, 2008) and maternity care providers have worked to articulate best practices for childbearing women with a history of sexual violence (Simkin & Klaus, 2004; Sperlich & Seng, 2008). Though a connection between these two phenomena has been noted, research into this dynamic interplay has just gotten off the ground in the past two decades.

The existing literature provides evidence that prior sexual trauma can have a direct effect on how women experience pregnancy and childbirth by both contributing to negative birth outcomes and by triggering trauma responses (Eberhard-Gran, Skilling, & Eskild, 2008; Jacobs,



1992; Rhodes & Hutchinson, 1994; Seng, Low, Sparbel, & Killion, 2004; Simkin & Klaus, 2004; Sperlich & Seng, 2008). Additionally, trauma research over the past several decades has illuminated the connection between psychological trauma and physiological processes (Felitti, Anda, Bremner, Walker, Whitfield, Perry, Dube, & Giles, 2006; Rothschild, 2000), leading to the necessity for more research about the connection between past trauma and the lived experiences of basic biological processes.

This study explores how women who have a history of sexual violence experience the physiological processes of pregnancy and childbirth and asks the participants to reflect on the connection between prior sexual violence and their childbearing experiences. The research question guiding this study is: How do women with a history of sexual violence experience pregnancy, labor, and childbirth? This study explores the research phenomena through an inductive, qualitative research method. One of my aims in this research is to remain close to women's voices by using qualitative research methods.

For the purpose of this study sexual violence has been defined along a continuum of behaviors created by the United States Centers for Disease Control (Leeb, R., Paulozzi, L., Melanson, C., Simon, T., Arias, I., 2008) as a suggested uniform definition of sexual violence. This continuum of sexual violence includes non-contact sexual abuse, abusive sexual contact, attempted sex act, and completed sex act. Using this continuum-based definition allows participants to identify with varied experiences of sexual violence without having to share details of the violence.

Eleven women with a living, biological child at least twelve weeks or older participated in semi-structured interviews for this study and reflected on their perceptions of the impact that sexual violence did or did not have on their experiences of childbearing. The participants also

reflected on the maternity care they received and what aspects of that care were helpful or not helpful in addressing sexual trauma.

This study is needed to inform how maternity care and mental health care are practiced with childbearing women with a history of sexual violence. Though other studies have examined this phenomenon from other angles, there is a dearth of qualitative research that examines women's reflections on past experiences. Interviewing women who have already given birth allows the research to benefit from the women's self-reflection.

Though this study is inductive, leading to the creation of a framework, I have been informed by Feminist theories (Mardorossian, 2002; Sachs, Sa'ar, & Aharoni, 2007) and Intersectionality Theory (Townsend, 2008) in designing this study. These theories situate sexual violence as a gendered experience that happens more commonly to women because of sexism. These theories also recognize how other forms of oppression, particularly racism, heterosexism, and class oppression interact with gender to make women more vulnerable to violence and to the negative repercussions of violence. Finally, trauma theory (Rothschild, 2000) that makes a connection between past psychological trauma and current physiological functioning fundamentally influences the forming of this research project by suggesting that a connection between psychological trauma and physiological processes may exist.

There are several limitations to this study. There is a sample bias due to the non-probability convenience sample methods used to recruit participants. The racial and ethnic homogeneity of the participants (100% identify as white) makes exploring the intersection of oppression and its impact on women's experience less complex. Also this study is not generalizable, but instead provides an in-depth examination of the research question. Finally because this study only minimally defines sexual violence along a spectrum of behaviors, the

degree to which severity of violence, repetition of violence, or relationship between victim and perpetrator affect the relationship between sexual violence and childbearing is not examined.

The following chapters describe the basis for this study and its relationship to the current literature, the methodology used for this study, the demographic and qualitative findings of the study, and finally a discussion that makes meaning of the research findings.

## **Chapter II**

### **Literature Review**

#### **Introduction**

In this section I will review several major themes in the literature about women with a history of sexual violence and their experiences with pregnancy and childbirth. The literature outlines the association between maternal sexual violence history and pregnancy and birth outcomes, and includes a review of women's subjective experiences with pregnancy and childbirth. This review will also introduce the positive and healing dimensions of pregnancy and childbirth for women who have experienced sexual violence.

The existing literature finds that a history of sexual violence can negatively impact women's experiences with pregnancy and childbirth, though a maternal sexual violence history has not been proven to cause particular birth outcomes (Grimstad & Schrei, 1998; Rhodes & Hutchinson, 1994; Schwerdtfeger & Wampler, 2009). The literature also finds the effect that sexual violence has on childbearing is impacted by several factors in women's lives, including psychosocial stressors, individual traits, socioeconomic status, and social location, in particular race (Rauchs, Oetting, Defever, Graham-Bermann, & Seng, 2013; Seng, Kohn-Wood, L., McPherson, & Sperlich, 2011).

This review will also examine theoretical literature that can be used to frame and understand the experiences of pregnancy and childbirth for women with a sexual violence history. The theories reviewed are Feminist Security Theory, Intersectionality Theory, Postmodern Feminist Theory, The New View Theory, Psychodynamic theories of psychological development

in pregnancy, and Posttraumatic Growth Theory (Hall, 2008; Joseph & Linley, 2006; Madorossian, 2002; Notman & Lester, 1988; Sachs, et al., 2007; Smith, 1999; Tedeschi, 1999; Townsend, 2008; Winnicott, 1960). Feminist Security Theory explores how prior trauma creates vulnerability in women exposed to stressful situations (Sachs, et al., 2007). Intersectionality Theory and Postmodern Feminist Theory situate sexual violence, pregnancy, and childbirth as experiences that occur within a patriarchal and racist framework and are impacted by intersecting societal oppressions (Madorossian, 2002; Townsend, 2008). The New View Theory challenges the assumption of normalized sexuality or normal responses to sexual violence (Hall, 2008). Psychodynamic Theory presents pregnancy as a time of inherent psychological development, often triggering past relational and developmental issues (Notman & Lester, 1988). Posttraumatic Growth Theory purports that through rumination and cognitive processing that often manifest as symptoms of Posttraumatic Stress Disorder (APA, 2000), most people are able to manifest long-term personal growth in the aftermath of trauma (Joseph & Linley, 2006; Tedeschi, 1999).

This review begins with an overview of the empirical literature and five themes that emerged from this data set. These themes, *psychological experiences in pregnancy, long-term sequelae of sexual violence, effects of prior sexual violence on pregnancy and childbirth, internal and external factors that affect traumatic stress responses, and maternity care provider relationships*, will each be reviewed separately. The review is followed by critiques of the empirical and theoretical literature and a final summary of the studies and theories that have informed this research study.

## **Empirical Literature**

This section reviews the quantitative and qualitative literature related to sexual violence and pregnancy and childbirth. Five themes emerging from the literature are covered in the following order in this section: *psychological experiences in pregnancy, long-term sequelae of sexual violence, effects of prior sexual violence on pregnancy and childbirth, internal and external factors that affect traumatic stress responses, and finally, maternity care provider relationships.*

**Psychological experiences in pregnancy.** The empirical literature describes a variety of psychological experiences for women during pregnancy. These experiences include self-reflection, psychological growth, connection to spirituality, identity development, and psychological distress (Furber, Garrod, Maloney, Lovell, McGowan 2009; Keating-Lefler & Wilson, 2004; Levy, 2006; Reed, Miller, & Timm, 2011; Schneider, 2012; Smith, 1999).

Identity development was a common theme in several studies (Ethier, 1995; Reed, et al., 2011; Smith, 1999). Smith (1999), in a qualitative study of four women's pregnancies, posited that pregnancy can be seen as psychological preparation for mothering. The researcher describes several themes of development including self-reflection in early pregnancy, a shift in focus from public to private spheres, a dynamic relationship between psychological regression and progress, and a shift in priorities and identity that occurs throughout the process of childbearing.

Reed, et al. (2011) also discussed parental identity development in their study of young, black lesbians and found pregnancy to denote positive identity development. In this study pregnancy "affirmed sexual identity... as well as garnered sexual and reproductive agency" (p. 571) in their sample of young mothers. For example, the young women in this study valued being pregnant and parenting their children as a way of being recognized as lesbian. As Reed et al. (2011) state, pregnancy, for these mothers, "provided a declaration of identity, a way to make

salient aspects of their developing selves that were all too often delegitimized and stigmatized” (p. 578).

Ehtier (1995) studied identity development longitudinally across the transition to motherhood and found that women strengthened their identity as a mother concurrently with the transition to having a child. In this study women describe inhabiting a “threshold identity” through pregnancy that marked the change to motherhood. The researcher also found that women lessened their connection to external identities and non-familial roles as they transitioned to motherhood.

One study emphasized the spiritual aspects of pregnancy and childbirth. Schneider (2012) found, in a study examining narrative data from 119 online surveys, that many women describe spiritual dimensions of normal pregnancy and childbirth, including experiencing the liminal qualities of these events, emphasizing the normalcy of these processes, and seeing themselves as “miracle bearers” (p. 220).

Many women in the literature recount psychological growth during the process of becoming a mother (Keating-Lefler & Wilson, 2004; Reed, Miller, & Timm, 2011; Scheider, 2012; Smith, 1999). Pregnancy and birth are conceptualized in a variety of ways by the women in these studies as normal experiences that involve some degree of psychological development. Concepts related to childbearing include experiencing these events as normal and natural, as spiritual experiences, and as opportunities for “reformulating life” (Keating-Lefler & Wilson, 2004).

Single, unpartnered, low-income, new mothers were found to be grieving multiple losses associated with the transition to motherhood by Keating-Lefler and Wilson (2004) in qualitative study of 20 women’s experiences. The women in this study coped with these losses through

psychological growth. The theme of “reformulating life” emerged from the interviews and encompassed such strategies as believing in the future, submerging in motherhood, dreaming, and developing a new identity.

Nicolson (1999) also found women to be grieving numerous losses after pregnancy in a study of British women in the postpartum period. The losses women described included loss of their former appearance, occupational status, sexuality, and autonomy. Nicolson (1999) found these losses triggered symptoms of postpartum depression, which has been conceptualized as a pathological response to motherhood. The researcher recommended normalization of the experience of loss and facilitating grieving as therapeutic measures for the symptoms of depression and to facilitate psychological growth. In fact Sawyer, Ayers, Young, Bradley, and Smith (2012) propose that psychological distress in pregnancy may be necessary for psychological growth to occur. In their study of posttraumatic growth after childbirth, PTSD symptoms in pregnancy predicted psychological growth after childbirth, leading the researchers to theorize that distress may be a necessary part of growth.

Several studies point to psychological distress as a common experience in pregnancy, especially for women who have experienced traumatic events (Furber, et al., 2009; Levy, 2006). Furber, et al., (2009) studied pregnant English women experiencing “mild to moderate psychological distress” (p.669) and found that even mild or moderate psychological distress “can be extremely debilitating” (p.669) and interferes with women’s functioning. Only one woman in this study reported being a survivor of sexual violence, but she did draw a connection to the prior violence and her psychological distress in pregnancy.

Women in the Furber, et al. (2009) study experienced symptoms varying from crying alone and feeling panicked to isolation and relationship troubles. The researchers found that



some women used constructive coping strategies such as swimming, resting, and talking about their feelings. Some of the women in the study used coping strategies that led to greater distress such as isolating themselves, compulsive cleaning, and over reliance on books and internet searches about possible pregnancy-related problems. This study indicates that psychological distress may be under-addressed in prenatal care, and that women may benefit from receiving psychological support even when they are not experiencing severe levels of distress.

Levy (2006) found significant psychological distress and posttraumatic stress in a sample of eight Israeli mothers who had survived terrorist attacks. The women in this study described experiencing flashbacks, extreme fear for their children, and doubt about their ability to maintain their pregnancies. The women in this study also described extreme loss related to the trauma they experienced, finding that this loss affected their experiences with pregnancy.

The reviewed research studies indicate that during normal reproductive events women experience different psychological states including growth, identity development, and distress. Psychological distress in pregnancy has the potential to negatively impact women's functioning, though some sources propose that this distress has the potential to lead to long-term psychological growth.

**Long-term sequelae of sexual violence.** Sexual violence has been clearly established in the literature as a traumatic event with the potential to cause psychological distress consistent with the symptoms of Posttraumatic Stress Disorder (Hermann, 1997). Interpersonal trauma such as sexual violence has been associated with many long-term effects such as “increased rates of psychopathology, more frequent health problems, and negative health behavior (ie. behavior with a known negative impact on health outcomes)” (Rodgers, Lang, Twamley, Stein, 2003, p. 961). Interpersonal trauma has also been shown to impact many areas of functioning, development,

and relating to others. As D'Andrea, Stolbach, Ford, van der Kolk, and Spinazzola (2012) state, “numerous studies have shown that exposure to interpersonal trauma can chronically and pervasively alter social, psychological, cognitive, and biological development” (p. 187).

Rodgers, et al. (2003) conclude in their review of the quantitative literature that “trauma-related symptoms and behaviors put traumatized women at risk for poorer pregnancy outcomes” (p.964).

The following studies review various findings about how women are impacted by sexual violence.

The Adverse Childhood Experiences Study found rates of child sexual abuse comparably high with those of overall sexual violence quoted earlier. In this study of over 17,000 adults, 25% of adult women and 16% of adult men reported having experienced “contact child sexual abuse” (Dube, Anda, Whitfield, Brown, Felitti, Dong, & Giles, 2005, p. 430). Men and women who experienced contact sexual abuse as children were more than twice as likely to have attempted suicide and had a 40% increased risk of marrying an alcoholic and of reporting marriage problems (Dube, et al., 2005).

Vigil, et al. (2005), through applying Life History Theory in their study, found that child sexual abuse (occurring before 14 years old) spurred hastened sexual development including earlier menarche, earlier reproductive debut, and earlier subjective assessment of readiness to become a parent among their sample. Reed, et al. (2011) report that earlier reproductive debut is associated with adolescent pregnancy (p.571), which may put women at risk for greater socioeconomic stress.

Another analysis of the Adverse Childhood Experiences study (Felitti, Anda, Bremner, Walker, Whitfield, Perry, Dube, & Giles, 2006) explores how traumatic experiences that occur in childhood may manifest in disruptions of adult biological processes. These researchers found

that adverse childhood experiences, including sexual abuse, are correlated with increased illness in adulthood, negative health behaviors, and early death (Felitti, et al., 2006). These findings demonstrate the connection between trauma and negative physical health outcomes and may show how sexual trauma negatively affects birth outcomes through interfering with biological processes.

Survivors of child sexual abuse demonstrate higher levels of psychological distress in adulthood overall than adults who do not report having experienced child sexual abuse (Steel, Sanna, Hammond, Whipple, & Cross, 2004). Steel, et al. (2004) found when studying non-patient, psychiatric outpatient, and psychiatric inpatient populations that number of perpetrators of sexual abuse and duration of sexual abuse were both positively correlated with psychiatric symptoms in all populations. They also found that inpatient psychiatric participants were more likely to report a history of sexual violence than non-patients and psychiatric outpatient participants (Steel, et al., 2004).

Liang, Williams, and Siegel (2006) found that severe sexual trauma in childhood was correlated with adult marital dissatisfaction in their study of primarily African-American women who were survivors of child sexual abuse. In this study women with a history of child sexual abuse and poor maternal attachment were more likely to be married or cohabitating as adults than women with secure maternal attachment. Finally they found that secure maternal attachment buffered the relationship between child sexual abuse and adult marital dissatisfaction.

One study describes the benefits perceived by survivors of childhood sexual abuse. This quantitative study used qualitative data to discover four categories of benefits perceived by adult women who had experienced sexual abuse as children. These categories, protecting children from abuse, self-protection, increased knowledge of child sexual abuse, and having a stronger

personality, demonstrate some of the positive outcomes associated with sexual trauma (McMillen, Rideout, & Zuravin, 1995).

Most of the empirical research demonstrates negative sequelae of sexual trauma, including increased suicidality, psychological distress, and health problems that last throughout the life span and may effect normal physiological processes such as pregnancy and childbirth (Dube, et al., 2006; Felitti, et al., 2005; Hermann, 1997; Rodgers et al., 2003; Vigil, 2005). However, it is important to note that survivors of sexual violence also point to positive personal growth as one of the dimensions of the aftermath of trauma (McMillen, et al., 1995; Schwerdtfeger & Wampler, 2009).

**Effects of sexual violence on pregnancy and childbirth.** The existing literature finds that a prior history of sexual violence is associated with negative birth outcomes such as increased discomfort and longer labors (Eberhard-Gran, et al., 2008; Jacobs, 1992; Seng, et al., 2004). The literature also finds evidence of trauma reactions and symptoms of PTSD occurring throughout the childbearing year in women with a history of sexual violence, causing psychological distress, physical reactions in labor, and a distraction from the normal psychological development of pregnancy (Lev-Wiesel, Daphna-Tekoah, & Hallak, 2009; Rhodes & Hutchinson, 1994; Schneider, 2012; Schwerdtfeger & Wampler, 2009; Seng, et al., 2011; Seng, Sparbel, Low, Killion, 2002). For some women sexual violence is a current reality, compromising maternal and fetal health in numerous ways (Hussain & Khan, 2008). In addition, this review examines the evidence that pregnancy and childbirth may play healing or normalizing roles for women with a history of sexual violence and their experiences of their bodies (Levy, 2006; Schwerdtfeger & Wampler, 2009; Simkin & Klaus, 2004).

Jacobs (1992) found many negative reproductive outcomes in survivors of child sexual abuse such as longer labors, more pregnancy terminations, and greater reported stress in a study of women participating in a mental health support group in Maine. Eberhard-Gran, et al. (2007) discovered a connection between adult sexual abuse (occurring after age eighteen) and extreme fear of childbirth in their study examining Norwegian mothers. Only extreme fear of childbirth was correlated with a history of sexual violence, with moderate and mild fear of childbirth not related to maternal trauma history. In this study, maternal depression was more highly correlated with fear of childbirth than previous adult sexual abuse, though it was unclear whether maternal depression was related to prior sexual trauma.

Though many studies indicate that prior sexual trauma can negatively impact how women experience childbearing, the empirical literature also offers mixed findings about whether a history of sexual violence is always associated with negative birth outcomes (Lev-Wiesel, et al., 2009; Grimstad & Schei, 1999; Van Der Hulst, et al., 2006). A Norwegian study (Van Der Hulst, et al., 2006), found survivors of sexual abuse experienced increased pelvic pain and emotional distress during birth, but also reported higher levels of autonomy and were less likely to receive episiotomies (p.59). This study also found no significant difference between technological birth interventions between women who had experienced sexual violence and those who had not.

Grimstad and Schrei (1999) found no association between prior sexual abuse in the mother and low birth weight among infants, though a sexual abuse history was correlated with increased reported discomfort and more unscheduled clinic visits. Together these studies illustrate the complicated relationship between a sexual violence history and childbirth outcomes. While women who have a sexual violence history may be at risk for increased discomfort, fear,

and psychological distress associated with pregnancy and childbirth, there are not clear predictors of how a history of sexual violence may manifest in the childbearing year.

Many studies report the manifestation of trauma reactions in the childbearing year for women with a history of sexual violence. Seng, et al. (2002) state, “women with trauma histories, including those who have survived childhood abuse and those experiencing abuse as an adult, present for health care with a wide range of trauma-related sequelae” (p. 360). They described clinically significant somatic symptoms associated with PTSD in their qualitative study of fifteen women interviewed about their experiences of childbearing and abuse-related post-traumatic stress. Seng, et al., (2002) also found that women described their psychological symptoms during the childbearing year in ways that correlated with the PTSD diagnosis (APA, 2000) and they encouraged maternal health care providers to screen for symptoms of post-traumatic stress and implement care practices that support women experiencing psychological distress.

Lev-Wiesel, et al. (2009) studied the connection between a history of child sexual abuse (occurring before age fourteen) and postnatal symptoms of posttraumatic stress in Israeli mothers. They found a connection between higher levels of dissociative processes and increased likelihood for posttraumatic stress symptoms in women who reported being sexually abused as children. They also found that women who were survivors of child sexual abuse experienced higher levels of arousal and intrusion, but not higher overall posttraumatic stress disorder scores. In addition, survivors of child sexual abuse were found to have experienced more long-term post-traumatic stress symptoms than survivors of other forms of trauma.

Survivors of sexual violence may also experience the physical sensations of labor as reminiscent of sensations associated with sexual abuse, according to Rhodes and Hutchinson (1994) in their qualitative study of survivors of sexual violence and birthing styles. The

researchers outlined four birthing styles indicative of a sexual abuse history: fighting, taking control, surrendering, and retreating. These birthing styles were linked to Posttraumatic Stress Disorder in the study. Rhodes and Hutchinson (1994) discussed how these birthing styles were sometimes evident in women who had not disclosed a history of sexual violence, which the researchers indicate may point to repressed memories of abuse being triggered during childbirth.

Hussain and Khan (2008), studying women in Pakistan, found many nuanced ways that exposure to sexual violence compromises maternal health, including having a larger family than desired, being exposed to unprotected sex during pregnancy, and experiencing physical violence during pregnancy. These factors have the potential to lead to direct negative outcomes for women and babies. Hussain and Khan's (2008) qualitative interviews indicate the complex interaction between sexual violence and reproduction in the context of ongoing abuse, where childbirth is not only a trigger of past violence, as Rhodes and Hutchinson (1994) describe, but a direct result of it as well.

Schwerdtfeger and Wampler (2009) found a correlation between sexual violence history and psychological distress in pregnancy, but also highlighted the healing potential of pregnancy and the positive growth that can occur as a result of trauma in their qualitative study of pregnant women who had experienced prior sexual trauma (Schwerdtfeger & Wampler, 2009). The researchers found three of the four themes in their study focused on growth: “becoming a survivor, pregnancy: a new beginning beyond sexual trauma, and the integration of sexual trauma and motherhood” (Schwerdtfeger & Wampler, 2009, p.100). Though women in this study reported many negative effects of sexual trauma on pregnancy, they also described aspects of growth after sexual trauma, including finding an inner strength and gaining a new perspective. These participants also described directly positive associations with pregnancy that facilitated

integration of the sexual trauma. These pregnancy-related themes include a new found hope, a new beginning, and the importance of a new relationship. Schwerdtfeger & Wampler (2009) emphasize the “bi-directional” experience of childbearing women who have experienced prior sexual trauma, where they must attend to their psychological trauma while at the same time processing the expected physical and psychological changes of this life stage.

The existing empirical literature finds evidence of negative birth outcomes for women with a history of sexual violence including increased discomfort, fear, and longer labors. The literature also provides strong evidence that women with a history of sexual violence commonly experience trauma reactions throughout the childbearing year including emotional distress, symptoms of PTSD, and physical reactions to the sensations of labor. In addition, consistent with the literature on the long-term sequelae of sexual violence, some women experience positive growth following the dual experiences of sexual trauma and childbearing.

**Internal and external factors that affect traumatic stress.** External factors such as socioeconomic status and access to resources appear to affect how women are impacted by sexual trauma and how they experience pregnancy and childbirth. Seng, et al., (2011) found that African American women expecting their first baby “had more trauma exposure, posttraumatic stress disorder symptoms and diagnosis, comorbidity and pregnancy substance use, and had less mental health treatment” (p. 295) than non-African American women in the same study. African American women were exposed on average to more cumulative and more recent trauma than non-African American women and had a threefold increased risk for meeting diagnostic criteria for PTSD (Seng, et al., 2011). These findings suggest that societal oppression, particularly racism has a large impact on likelihood of trauma exposure as well as on what resources women have to address the psychological impacts of trauma.



Rauchs, et al. (2013) found that socioeconomic status was the single largest factor affecting severity of posttraumatic stress symptoms and coping style among a large sample of pregnant women, though number of traumas and personal optimism were found to be independent variables affecting symptom severity as well. Because social location factors such as race and income so sharply affect the severity of pregnant women's posttraumatic stress symptoms, the study may indicate that racial, gender, and economic oppression in society increase women's chances of having experienced violence and inhibits their ability to access positive coping methods.

Optimism was more prevalent in pregnant women who had experienced trauma, but did not develop PTSD, and in women with positive coping skills. The researchers conclude that though socioeconomic status and number of traumas influence the severity of women's posttraumatic stress symptoms, optimism does play a role in buffering women from the impacts of psychological trauma (Rauchs, et al., 2013).

Perrot, Morris, Martins, & Romans (1998) found that coping style impacted long-term effects of sexual violence in their study of women in New Zealand. Repressing reactions to past child sexual abuse was associated with negative long-term mental health outcomes, while externalizing the blame was associated with positive mental health outcomes. Reframing was associated with positive mental health measures, but participants who used reframing as a coping style were significantly more likely to have children who were also sexually abused at some point. The researchers hypothesized whether reframing somehow interfered with participants' ability to protect their children from sexual abuse (Perrot, et al., 1998).

Steel, et al. (2004) found that internalizing attributional style, confrontive coping style, and accepting responsibility were all associated with greater psychological distress in survivors

of child sexual abuse. It is unclear whether these coping styles develop in conjunction with the abuse or not, but their findings indicate the complex interplay between internal and external factors in women's experiences of trauma, pregnancy, and childbirth.

Bryanton, Gagnon, Johnston, and Hatem, M. (2007) studied factors that affect women's perceptions of their experiences with childbirth and found the strongest predictors of perception were "type of birth; degree of awareness, relaxation, and control; helpfulness of partner support; and being with the infant following birth" (p. 24). Though this study did not examine trauma-related symptoms, Bryanton, et al. (2007) note that women's negative perceptions of the birth experience can impact health outcomes for the mother and child including postpartum depression and maternal/infant attachment.

Social location such as race and socioeconomic status appear to be salient factors in women's experiences with trauma and with childbearing (Rauchs, et al., 2013; Seng, et al., 2011), which illustrates the profound impact that external societal oppression has on women's lived experiences. Other factors, such as number of traumas, optimism, experience of childbirth, and coping style all also have an impact on how women experience sexual trauma and the childbearing process.

**Provider relationships.** In therapeutic relationships many survivors of complex trauma revisit issues of safety and begin to form new ways of relating to important people in their lives. The creation of new relationship patterns leads to a changing sense of self that promotes long-term healing (Tummuala-Narra & Kallivayalil, 2012). Throughout pregnancy and childbirth women often engage in numerous professional relationships with various care providers. These patterns may guide professional practice in seeing all relationships as an opportunity to establish safety and provide new models of relating for complex trauma survivors.

Seng, et al., (2002) examined what pregnant women experiencing posttraumatic stress desired from their maternity care providers and found that women fell generally into three categories of trauma healing: far along in recovery, not safe, and women who were not ready to “know” (p. 360). The women in different stages of healing preferred and responded to different types of maternity care. For example, women who were far along in recovery looked for a “collaborative ally”, while women who were characterized as not safe preferred a “compassionate authority figure” in a caregiver, and women who were not ready to “know” benefited most from a caregiver who was a “therapeutic mentor” (Seng, et al., 2002, p.360).

In a similar vein, Gibson (2013) found that women chose maternity care providers based on their perceptions of birth as a natural or a medical event. The researcher hypothesized that when providers and mothers share perceptions of birth, or explanatory models, the relationships are more likely to be experienced positively by mothers. The researcher further stated that positive relationships would foster better outcomes and more positive perceptions of the birth experience.

One study of mothers in Greece characterized the dimensions of positive maternity care provider behavior as cooperation, help/guidance, briefing, and psychological support. Negative provider behavior included non-existent collaboration, insufficient help, unacceptable behavior, insufficient briefing, unwillingness, impersonal confrontation, lack of psychological support, erroneous diagnosis, and bad implementation of techniques (Sapountzi-Krepia, Tsaloglidou, Psychogiou, Lazaridou, & Julkunen, 2011). This study also found that mother's experiences with birth in general were closely related to their interactions with maternity care providers. This is significant because as Sapountzi-Krepia, et al. (2011) state, “a mother's positive perception of the

childbirth experience has been linked to positive feelings towards her infant and adaptation to the mother role” (p. 584).

Maternal choice regarding what model of maternity care to utilize, the medical model or the midwifery model, was found to be important to women in a review of studies from Northern Europe, Australia, and the U.S. (Hadjigeorgiou, E., Kouta, C., Papastavrou, E., Papadopoulos, I., & Martensson, L., 2011). This review discovered that, “women who selected a midwife reported feeling more knowledgeable about birth attendants, more in control over the birth attendant decision, and more satisfied with their delivery decisions” (p. 385). Women who selected a midwife also experienced increased autonomy and personal attention. This study also found that “women’s right to choose is closely related to the availability of information and their relationships with health professionals” (p. 388), with 12 of the studies reviewed indicating that women commonly chose hospital birth due to the assumption that the hospital is the only safe place to give birth (Hadjigeorgiou, et al., 2011).

Levy (2006) found, in a qualitative study of eight Israeli mothers who had experienced trauma from terrorism, that sensitive relationships with prenatal providers could mitigate the effects of trauma in the childbearing process and avoid re-traumatization. Levy (2006) states, “if she receives care that answers her specific needs, she may have a positive and empowering birth experience. The significance of a good birth experience could be far-reaching” (p. 246) by instilling confidence and reconnecting women with their bodies.

The research indicates that women value the psychological and supportive dimensions of their relationships with their maternity care providers and the ability to make decisions regarding their own care. Positive relationships may foster more positive experiences for new mothers, and

increase autonomy and satisfaction with birth outcomes. The following section will review the relevant theoretical literature.

### **Theoretical Literature**

This section reviews several theories relevant to women's experiences with sexual violence, pregnancy, and childbirth. The theoretical review will open with a discussion of two feminist theories: Feminist Security Theory and Postmodern Feminist Theory before moving into a review of Intersectionality Theory and The New View Theory. I will also review normative psychological development during the childbearing year through a Psychodynamic Theory perspective and Posttraumatic Growth Theory, finally hypothesizing how these theories might be applied to women's experiences of sexual violence and how it impacts pregnancy and childbirth.

The review of the theoretical literature will finish with a discussion of how these theories contradict and how they complement each other in offering approaches to the research. Finally, I will explain my use of the theories in the proposed study.

**Feminist Theories.** This section will examine how two variants on feminist theory contribute to conceptualizing women with a prior history of sexual violence and how they experience pregnancy and childbirth. Contextualizing an individual woman's experience with sexual violence and childbirth as occurring within a system of intersecting oppressions offers an important framework through which to view this study (Sachs, et al., 2007; Townsend, 2008; Mardorossian, 2002). Feminist Theory looks critically at how oppression and the dimensions of social location impact women's lived experience. Feminist Security Theory, Intersectionality Theory, and Postmodern Feminist Theory all have this view of society as an underpinning concept.

Feminist Security Theory developed in response to international discourses about security and conflict. Feminist theorists developed Feminist Security Theory to understand the gendered dimensions of civilian experiences during conflict. For example, studies have often shown that women have increased levels of psychological distress following political violence. This data can be shown as proof of women's unfitness for participating in war or as proof of women's weakness. Feminist Security Theory contributes to this discourse by challenging the objectiveness of the data and pointing out how social location, women's position as an oppressed population, and women's access to resources may be impacting their levels of psychological distress (Sachs, et al., 2007). Sachs, et al. (2007) state that in research gender is often treated as a category external to political violence, when in fact political violence is often gendered, as in the case of rape as a tactic of war. Further, Intersectionality Theory, when paired with Feminist Security Theory demonstrates that gender is a heterogenous category and that other aspects of social location such as race, ethnicity, and class combine with gender to protect or exacerbate exposure to violence (Townsend, 2008).

Due to high levels of oppression and lack of access to resources, women who have a history of sexual victimization may be more vulnerable to traumatic reactions to further stress (Sachs, et al., 2007). Sachs, et al. (2007) studied Israeli women's sense of insecurity during the Second Intifada and how that sense is informed by previous experiences of sexual violence and other social factors such as ethnic discrimination and economic distress. The researchers found that women with previous social stress were more likely to feel insecure during war (Sachs, et al., 2007). Though pregnancy and childbirth are not generally seen as traumatic experiences, Feminist Security Theory encourages the question: could prior sexual victimization inhibit a

woman's preparation to cope with the psychological and physical stressors associated with pregnancy and childbirth?

Postmodern Feminist Theory pushes analysis of sexual violence to go beyond the exposure of women's experiences to examine "what the category encompasses in different spaces and time and investigate its relation to other areas of women's lives in the public sphere" (Mardorossian, 2002, p.746). For example, a woman experiencing sexual assault as an adult who has social support and financial means to seek healing opportunities for herself will encounter different issues than a woman who was sexually assaulted as a child and received no support at the time. In addition a woman who faces class oppression or institutional racism when interacting with systems such as the criminal justice system or medical care systems is likely to have different experiences addressing sexual assault than a woman who has class and/or race privilege. Another example of the contextual and political frames that influence women's experiences is sexual orientation and gender expression. Individuals who do not conform to gender norms or lesbian, gay, bisexual, and queer individuals may face discrimination or uninformed care in seeking support for sexual violence or prenatal care (Crespi, 2001).

**Intersectionality Theory.** Intersectionality Theory furthers the contextualization of experience through analyzing the social structures within which experiences take place and especially locating the individual in an intersection of "multiple systems of oppression" (Townsend, 2008, p. 432). Intersecting oppressions are based on different aspects of identity that are privileged or oppressed in our society. For example, white people, men, Christians, the able-bodied, cis-gendered people, and heterosexuals are conferred unearned privileges in the United States. Unearned privileges include access to resources, protection from abuse and mistreatment,

and normalization of experience. Oppression can occur on different levels: individual, community, structural, systemic, and societal (Miller & Garran, 2007).

For individual women the intersecting oppressions they experience can influence how they feel connected to or separate from an aspect of their social identity, for example gender, race, or social class (Townsend, 2008). These intersecting oppressions can also affect women's ability to cope with traumatic or stressful situations, self-esteem and identity, and access to resources.

**The New View Theory.** The New View, a theory described by Hall (2008) asks clinicians to examine the context within which we have sexual experiences and within which survivors of sexual violence attempt to heal from trauma. Hall (2008) writes how trauma models assume pathological responses and focus on the relief of symptoms related to that pathological response. The New View encourages clients to define their response and rejects the idea of a normalized sexuality.

The New View informs my approach to the research, making space for distressed and traumatized responses as well as for feelings of empowerment, healing, and normalization associated with pregnancy and childbirth. In fact, Simkin and Klaus (2004) state that many survivors of sexual violence find their experiences of pregnancy and childbirth normalize their perceptions of their bodies. One mother stated, “becoming pregnant was the highlight of my life. My body felt normal for the first time” (Simkin & Klaus, 2004, p.33).

The New View theory encourages an examination of what is considered normal sexuality and normal responses to sexual violence. When balanced with the theories of development described below, the New View theory allows the research to be open to whatever experiences



the participants describe without rushing to categorize or pathologize their responses and experiences.

**A Psychodynamic perspective.** The psychological tasks of pregnancy have been discussed in the literature, especially from psychodynamic and developmental perspectives. Winnicott (1960) describes an identity shift in mothers leading to “primary maternal preoccupation”, a state of being that fosters mother/infant attachment and infant development in object relations theory. Notman and Lester (1988) present the psychoanalytic proposition that “pregnancy revived developmental conflicts, which influenced women's feelings about motherhood and their attitudes toward their children” (p. 1). From this standpoint pregnancy and childbirth are almost destined to trigger associations with sexual abuse that occurred during the child or adolescent development of the mother.

If Psychodynamic theories have described some aspects of normative maternal development, could a history of sexual trauma interfere with maternal development or identity shift, as Feminist Security Theory might suggest? Moskowitz (2011) found in a study of mothers who suffered losses from September 11, 2001, that primary maternal preoccupation was negatively affected by the process of mourning, and that it was not possible for the psyche to mourn and maintain the preoccupation described by Winnicott (1960).

Psychoanalytic and developmental theories highlight the individual's contributions to their own experiences. These theories rely on theories of normal development or normal psychological functioning, such as are challenged by Hall (2008) with the New View theory. Though when combined they provide an interesting tension that makes rooms for a variety of truths and experiences.

**Posttraumatic Growth Theory.** Many researchers have examined how and when growth and resilience occur after trauma (Joseph & Linley, 2006; Tedeschi, 1999). Joseph and Linley (2006) describe how three main themes of growth have emerged in the literature: enhanced relationships, a changed view of self, and a change in life philosophy (p.1042). Tedeschi (1999) describes how common posttraumatic growth actually is, stating, “in over half of the persons who have experienced traumatic events, the reconstruction of schemas produces a view of the world and related behavior that the survivor perceives as beneficial, not only in managing the trauma, but in living life more fruitfully than it was prior to the trauma” (p.320).

Joseph and Linley (2006) describe the major theories underlining how traumatic growth occurs. These theories include a functional-descriptive model of growth which situates trauma as an event that shatters previously held notions about self, others, and life. These beliefs are rebuilt through necessary rumination and cognitive processing, which may manifest as the symptoms of PTSD.

The person-centered model of posttraumatic growth sees humans as inherently growth-oriented and that this tendency motivates people to accommodate trauma into a comprehensive life narrative. Organismic Valuing Theory describes, from an evolutionary psychology standpoint, how trauma waits in active memory to be processed, where it causes the symptoms associated with PTSD. Through cognitive processing the trauma is assimilated or accommodated by the psyche. Those who accommodate the trauma, or alter their worldview to include the trauma, experience posttraumatic growth.

Finally the Biopsychosocial-Evolutionary View presents growth as the normal outcome of trauma and the trauma response that does not resolve itself as maladaptive. These views are grounded in a biological-evolutionary model of the psyche, but also consider how the external

world impacts individual response. In this model the trauma response is seen as influenced by external factors such as social support (Joseph & Linley, 2006).

Posttraumatic Growth Theory is useful for this study in two important ways.

Posttraumatic Growth Theory encourages an examination of the ways that mothers in the study may have accommodated, integrated, and grown from the trauma they experienced. It also suggests that different participants in the study may be in different stages of posttraumatic growth and may therefore have different experiences and different needs during the childbearing year. Further research of posttraumatic growth may also inform practice by helping us to understand the dimensions of this kind of psychological growth and what kinds of support most readily foster this type of growth.

In this study I combined Psychodynamic theories with Feminist theories, Intersectionality Theory, The New View Theory, and Posttraumatic Growth Theory to provide a balanced analysis that encompasses the dynamic nature of women's experiences. I constructed an analysis, guided by these theories, that both honors women's unique experiences and understands the societal dimensions of those experiences; an analysis that makes space for varied expressions of sexual and psychological development and at the same time, describes the distress that may be an inevitable part of processing trauma.

### **Summary of the Literature**

The empirical literature indicates that women's experiences with pregnancy and childbirth are likely to be affected by prior sexual trauma. Prior sexual trauma may create vulnerabilities for some women in the childbearing year, vulnerabilities that are exacerbated or mediated by socioeconomic conditions such as income level and social support (Seng, et al., 2011). Feminist theories and Intersectionality Theory provide a frame for understanding the socioeconomic

conditions affecting women's lives as part of a web of societal oppressions including racism, sexism, class oppression, and heterosexism (Collins, 2000; Mardorossian, 2002; Sachs, et al., 2007; Townsend 2008). Sexual trauma, negative birth experiences, and negative perceptions of birth may affect mothers' identity formation and maternal/infant bonding. Additionally, psychological distress during pregnancy appears to interfere with functioning even when that distress is only characterized as moderate or mild (Furber, et al., 2011).

Conversely for many women, pregnancy and childbirth, normally times of psychological development and identity shift, may provide an opportunity for healing and normalization after sexual trauma (Schwerdtfeger & Wampler, 2009; Simkin & Klaus, 2004). Pregnancy may also foster a sense of bodily agency in marginalized populations such as sexual minorities and young people (Reed, 2011). Psychological growth in the childbearing year may be explained by normal psychological development in this period of transition or by Posttraumatic Growth Theory, which states that at least half of individuals who experience trauma discover growth, including an increased appreciation for life after the trauma (Tedeschi, 1999).

### **Critique of Literature**

The studies and theories outlined in this review help us understand how women who have a history of sexual violence may experience pregnancy, labor, or childbirth. The empirical studies draw a direct connection between maternal history of sexual violence and women's experiences of childbearing. The literature also alerts us to the ways psychological distress and other trauma reactions manifest in the childbearing year. The theoretical literature offers a framework for designing the study and for examining the data in its context. This critique examines both the theoretical and empirical literature.

The empirical literature finds a connection between maternal history of sexual violence and negative experiences in childbearing including psychological distress, increased discomfort, and fear of childbirth. A concern with focusing on problem responses or increases in negative outcomes is that women presenting for prenatal care may be branded as difficult or problem cases because they have a history of sexual violence. Looking at mothers negatively who have been victimized in the past could constitute a re-victimization (Simkin & Klaus, 2004).

It is important that clinicians who plan to serve this population be aware of the possible factors compounding women's experiences of pregnancy, labor, and birth, and at the same time be awake to the individual's unique experience. Godderis (2010) wrote about "responsibilization" of subjects for problems, such as postpartum depression, in her study, as a gendered process that encourages surveillance and government of oppressed populations. Godderis (2010) stated, "it is important to analyze how these risk discourses are gendered because the subjectivities produced by these discourses responsabilize women and men differently" (p. 454).

The emphasis on distress and problems also may miss stories of resiliency, healing, and empowerment that may be occurring in the study population. Smith (1999) states that an "emphasis on illness or pathology presents a narrow, one-sided picture, neglecting the range of possible experiences of women during pregnancy" (p. 282). A qualitative study, as Smith (1999) suggests, offers the opportunity for women to express their experiences in their own words and for the research to generate meaning from their own insight.

Much of the literature on this population studies international populations (Eberhard-Gran, et al., 2007; Furber, et al., 2009; Hussain & Khan, 2008; Lev-Wiesel, et al., 2009; Sapountzi-Krepia, et al., 2011; Van Der Hulst, et al., 2006), where birth practices differ and

services available to pregnant women also differ from the United States. The only study (Jacobs, 1992) that I found utilizing a population regionally similar to the population I studied, women living in rural New England, used methods that may not be valid, including surveying women who were part of a mental health support group and comparing them to a control sample of women enrolled in a psychology course. Because of the many differences between these groups, it is difficult to establish causality between sexual violence and the many, varied negative pregnancy and birth outcomes outlined by Jacobs (1992).

Many studies failed to locate the study population in a social and political context. Only the Reed, et al. (2011) study and Seng, et al., (2011) analyzed data in its societal context and discussed social location factors that may influence the sample and their experiences. This missing analysis can affect both how the data is analyzed and how study participants are treated. For example, the Vigil, et al. (2005) study surveyed women they recruited by going door to door in two U.S. cities. They described a racially diverse sample population, but did not make meaning of how racism may have affected their populations' experiences.

Using Seng et al.'s (2011) finding that African American women carry such a heavy burden of posttraumatic stress, substance use in pregnancy, and trauma exposure, an understanding of how women's experiences with sexual trauma and with pregnancy and childbirth are affected by external sources such as socioeconomic status, access to resources, and societal oppression is essential.

The theories described in this review have provided useful frames that inform the study design, data analysis, and discussion, however, each theory proposes limitations. While a strength of Feminist theories is highlighting the oppression of women, this focus can also pose some limitations. Intersectionality Theory broadens this focus by examining other forms of

oppression, describing how different forms of oppression can magnify and interact with each other. Many writers through the years have countered the centrality of gender oppression, stating that societal oppression is more complex and nuanced (Moraga & Castillo, 1988).

Feminist Theory may also miss the complex and dynamic relationship that the individual and her unique psychological make-up bring to her experiences. A concentration on the context of women's experiences, focused on oppression, may then overgeneralize this theme and miss the unique biopsychosocial interplay of factors that exist in any woman's experience.

In contrast, psychodynamic theories of psychological development can rely too heavily on the intrapsychic experience to the neglect of the political and social context in which experiences occur. Using these theories, which at times provide opposing frameworks for conceptualizing this research, in a combined approach offers an opportunity to mitigate the limitations of any one theory.

This study contributes to the qualitative literature about women's experiences with pregnancy and childbirth after having experienced sexual trauma. This study helps fill a gap in the literature of women's voices reflecting on and describing their own experiences with sexual violence and its impact on pregnancy and childbirth. This study also fleshes out the dimensions of how survivors of sexual violence interact with their maternity care providers and offers suggestions for social work and maternity care practice with this population.

## **Chapter III**

### **Methodology**

#### **Research Purpose and Question**

The purpose of this study is to gain a deeper understanding of women who are survivors of sexual violence and their experiences with pregnancy, labor, and childbirth. The research question is: How do mothers who are survivors of sexual violence experience pregnancy, labor, and childbirth? From this study I hoped to glean the important themes that surround women's experiences with childbearing after sexual violence, and provide a framework to guide practice for maternity care providers and social workers assisting all families through the childbearing year.

#### **Design**

To answer the research question I conducted a qualitative, exploratory, inductive study. Induction, a research method where theory is generated from the research findings gleaned during the data analysis, allowed a flexible study that deepens understanding of the phenomenon without a formal assumption about the actual nature of the relationship between a history of sexual violence and women's experiences of pregnancy, labor, and childbirth. This study method also allowed me to remain close to women's voices in the generation of a framework that makes meaning of the study findings.

Remaining close to women's voices was an important motivation in this study, as all of the women in this study have experienced sexual violence. Sexual violence is a potentially traumatic experience that necessitates a loss in voice and personal agency. My hope in using



qualitative research methods is that the participants' voices remained central. Also, as discussed in the theoretical literature review, the complex interplay between women's individual, internal experiences and societal context are unique factors that bear out as important themes in the literature. A qualitative approach allowed for subjective, interconnected analysis that quantitative methods can oversimplify. The following sections outline the methodology of this study including the sample, data collection, and analysis, and biases inherent in the methodology.

I conducted eleven telephone interviews with participants using a semi-structured interview guide with open-ended questions. Schwerdtfeger (2009) found that in a study of pregnant women with a previous history of sexual trauma that participants "reported significantly higher 'personal benefit' from participating in personal interview procedures compared to written questionnaires" (p. 39). Though childbearing women appear to tolerate both surveys and personal interviews, the preference for and benefit associated with interviews influenced my research decisions. I recorded the interviews and completely transcribed them for analysis. I analyzed the narrative data for themes and patterns, informing the generation of a framework that encapsulates the research findings, using MAX QDA, a qualitative data analysis software.

For this study I operationalized the term sexual violence using subcategories of sexual violence suggested by the U.S. Centers for Disease Control as a uniform definition of sexual violence (Leeb, et al., 2008). The sub-definitions are outlined in the following table.

Table 3:1

*Operationalized Definition of Sexual Violence*

Non-contact sexual abuse	Abusive sexual contact	Attempted sex act	Completed sex act
Voyeurism; intentional exposure of an individual to exhibitionism; unwanted exposure to pornography; verbal or behavioral sexual harassment; threats of sexual violence to accomplish some other end; or taking nude photographs of a sexual nature of another person without his or her consent or knowledge, or of a person who is unable to consent or refuse	Intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person without his or her consent, or of a person who is unable to consent or refuse	An attempted, but not completed sex act without the person's consent or of a person who is unable to consent or refuse	Contact between the penis and the vulva or the penis and the anus involving penetration, however slight; contact between the mouth and penis, vulva, or anus; or penetration of the anal or genital opening of another person by a hand, finger, or other object without his or her consent, or of a person who is unable to consent or refuse

**Sample**

The sample universe for this study topic is broad: mothers who have experienced sexual violence. The sample population for my study included mothers who came across my recruitment fliers and self-selected for the study. For this study I interviewed 11 cis-gendered<sup>1</sup>, non-pregnant women who have a child who is at least 12 weeks of age and who experienced sexual violence at some point before they became pregnant with their child or children.

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<sup>1</sup> Cis-gendered women are women whose gender identity is congruent with their biological sex.

**Recruitment.** I used snowball sampling methods to obtain a convenience, non-probability sample. I recruited through two key informants, who are home birth midwives in Western and Southern Maine: Brenda Surabian, CPM and Lindsay Bushnell, CPM, co-owners of Sacopec Valley Birthing Services. These key informants reached out to potential participants through their past clients and posted the study recruitment flyer on their Facebook page. Birth Roots, a support center for women in the childbearing year in Portland, Maine, Birthwise Midwifery School in Bridgton, Maine, and MWV Moms, a Facebook group in North Conway, New Hampshire also posted the study recruitment flier. Finally I shared the flier on my own personal Facebook page. The recruitment flier contained the operationalized definition of sexual violence used in the study so that participants could self-identify as having had an experience that fit into one of the sub-categories.

I recruited 13 participants, 11 of whom followed through with returning the consent forms and participating in an interview. All of the mothers in the study gave birth to a live child at least 12 weeks of age, are at least 18 years old, and self-selected for the study, meaning they freely consented to participate in the study.

Once participants learned about the study they contacted me through my confidential e-mail address. Once this e-mail was received participants were contacted and asked for their address and phone number and two copies of the informed consent form were sent to them with a self-addressed stamped envelope and instructions to return one signed copy in the envelope. Once the informed consent form was received, participants were called and an interview time was scheduled.

## **Ethics and Safeguards**

Three major ethical concerns arose during the design of this study: consent, confidentiality, and the potential for psychological distress. To address these ethical concerns I built several measures into the study design and carried them out throughout recruitment, data collection, analysis, and reporting. These measures are outlined in the following paragraphs.

To reduce the likelihood of psychological distress I informed potential participants of the sensitive nature of the study and the possibility that participation could create psychological distress both in the recruitment flyer and in the consent form. Participants chose whether to contact me to participate in the study and the organization or maternity care provider through which they were recruited had no knowledge of who contacted me. I also created a mental health resource sheet that included mental health crisis resources and sexual violence crisis centers for participants to contact should the need arise. This mental health resource sheet was mailed to all participants with the informed consent form.

All participants read and signed informed consent forms approved by Smith College School for Social Work before participating in the study. When the interview phone call began I reminded participants that I was taping the interview and asked if they were ready to proceed.

To address confidentiality I keep all consent forms, interview notes, and any printed transcriptions in a lockable file drawer during the thesis process and for three years after, in accordance with federal regulations. After three years I will either destroy the material described above or maintain it in this secure fashion. The interviews will be saved on my password protected computer, and any copies of the interviews will be saved on a removable drive that will be stored in the above-mentioned lockable file cabinet.

During data analysis I chose a pseudonym for all study participants that could not be connected to the participants actual name or identifying information. The pseudonym will be used to protect the confidentiality of the participants throughout the reporting process.

I collected limited demographic data, but use this data only to describe the sample in the aggregate. I did not connect the demographic data to specific study participants consistent with maintaining participant confidentiality. In this report quotes from participants are used to illustrate the research findings, but these quotes are not connected to the demographic data and are assigned a pseudonym.

Participants may have benefited from this study by having the opportunity to talk about their experiences with childbearing and their experiences with sexual violence. Drawing a connection between these two experiences may have been beneficial for some participants.

### **Data Collection**

In this research study I used semi-structured, in-depth interviews to collect qualitative data about mothers who have a history of sexual violence and how they experience pregnancy, labor, and childbirth from January, 2014 to April, 2014. The interviews were all conducted over the telephone. The interviews were audio recorded for transcription and qualitative analysis. The data was analyzed using MAX QDA, a qualitative data analysis software.

Participant interviews lasted around 45 minutes in length, though some were as short as 25 minutes. I collected demographic data at the start of the interview, including participant current age and age at first birth, race, sexual orientation, number of children, and income level. The interview guide was divided into themes: the experience of pregnancy and birth, which included four questions; the connection between prior sexual violence and childbearing, which included two questions; and maternity care relationships, which included five questions. The

interview began with the participant sharing a brief version of her labor and birth story or stories, a method employed by Seng, et al. (2002). This interview opening offered several benefits: the participant began the interview and is in control of how her story is told, and it oriented me, the researcher, to the main points of what she experienced during childbirth (Seng, et al., 2002).

In addition to the interview transcripts I collected my impressions of the interviews in a notebook that served as both a research log and as a self-reflection journal for bracketing. Bracketing, a process of examining and putting aside researcher subjectivity has been used to increase study validity through reducing the likelihood of researcher bias (Tufford & Newman, 2010). There are several forms of bracketing, and I chose the reflective journal method because I did not have a colleague with whom I could regularly bracket verbally and because I used the reflective journal as a research log as well (Tufford & Newman, 2010). This journal was a place to self-reflexively explore my reactions to the interviews and at the same time keep a log of important events surrounding the interviews. This log uses the participants' pseudonyms, consistent with maintaining their confidentiality. The self-reflective journal, also serving as a research log, combines with records of each step of the study to create an audit trail.

### **Data Analysis**

I used descriptive statistics to analyze the demographic data that I collected to create a demographic frame around the sample. These statistics offer information about the generalizability of the study and the application of its findings to other parts of the sample universe.

I recorded and transcribed in full the semi-structured interviews and analyzed the transcribed data using MAX QDA, a qualitative data analysis software. I used the grounded theory stages of open coding, axial coding, and selective coding to both code the data and

generate a theory or explanation about the phenomenon of survivors of sexual violence and their experiences with pregnancy and sexual violence (Corbin & Strauss, 2008). Grounded theory is a qualitative research methodology used “for the purpose of building theory from data” (Corbin & Strauss, 2008, p.1). This method allows the women's voices in the interviews to guide the creation of a theory about mothers with a history of sexual violence and their experiences with childbearing. Though the findings of this research project will inevitably be constructions and reconstructions, grounded theory helps maintain interplay with and faithfulness to the data, the women's voices.

I used these methods of qualitative data analysis to find methodical and meaningful ways to keep my analysis close to the data and still discover patterns and themes of importance. Grounded theory helps to coalesce these patterns and themes into a meaningful story about the data and the phenomenon (Corbin & Strauss, 2008).

## Chapter IV

### Findings

The purpose of this research project is to explore how women who have a past history of sexual violence experience pregnancy, labor, and childbirth, including the relationship between mothers and their maternity care providers. This chapter outlines the findings of this exploratory, qualitative study based on 11 interviews with mothers who identify as having a past history of sexual violence and explores these findings related to the research question.

The data presented in this chapter was collected through phone interviews which were fully transcribed and then analyzed in an open coding format using MAX QDA, a qualitative data analysis software. The interview was centered around three broad areas of inquiry, with several questions for each area of inquiry. The areas of inquiry are: women's experience of childbearing, the perceived relationship between sexual violence history and the experience of pregnancy and childbirth, and relationships with maternity care providers. Demographic data was also collected during interviews.

Four main themes emerged from the data during analysis, each theme encompassing several subthemes. This section will explain and describe the four main themes and their respective subthemes using examples from the interviews in the service of maintaining fidelity to the participants' voices. The four main themes this section describes are: *negative impacts of sexual violence on childbearing*, *growth and healing*, *coping*, and *relationships with care providers*. This study generated some themes that were not related to the research question about the relationship between past sexual violence and women's experiences with childbearing. This



section will focus specifically on reporting themes related to the research question. Themes not related to the research question will be discussed in the following chapter. This chapter begins with an explanation of the demographic findings.

### **Demographic Data**

A total of 11 individuals participated in telephone interviews and answered all demographic questions. All study participants identified as white and participants who identified their ethnicity reported being English, Irish, Dutch, German, and Russian. Further discussion of the implications of this sample bias can be found in the following chapter.

The participants' current age ranged from 25 to 70, with the age at time of birth ranging from 18 to 36. The average current age for participants was 36.9, with a median age of 35 and a mode age of 38. The average age at time of birth for participants in this study was 28.5, with a median age of 29.5 and a mode of 31. Ten out of 11 participants reside in the Northeast United States, and 1 participant resides in the Midwest. Eighteen percent (n=2) of participants identified themselves as bisexual, and 82% (n=9) participants identified themselves as either straight or heterosexual.

Participants were asked to identify their yearly family income level within four choices: 0-\$25,000, \$25,000-\$50,000, \$50,000-\$75,000, and \$75,000 +. Twenty seven percent (n=3) of participants identified their family income as falling between \$25,000 and \$50,000 a year, 45% (n=5) identified as falling between \$50,000 and \$75,000 a year, and 27% (n=3) identified as having a family income over \$75,000 a year.

Forty five percent of study participants (n=5) had an out of hospital birth, or gave birth at home or in a free-standing birth center, for at least one of their children. Fifty five percent (n=6) of participants gave birth in hospitals. These statistics are vastly different than the general rates

of out of hospital births in the U.S., which has hovered around 1% for the past 20 years (CDC, 2014).

In the interview participants were asked to identify their personal experience on a spectrum of sexual violence created by the U.S. Centers for Disease Control (CDC, 2009). Four types of sexual violence were presented on the spectrum: non-contact sexual abuse, abusive sexual contact, attempted sex act, and completed sex act. Eighteen percent (n=2) of participants identified more than one type of violence. Twenty percent (n=3) of total responses to this question fell into the first category, non-contact sexual abuse. Twenty six percent (n= 4) of responses fell into abusive sexual contact, the second category, 6% (n=1) fell into the third type of violence, attempted sex act, and 46%, the majority of responses, fell into the final type of violence of this spectrum, completed sex act.

The following sections outline the four main themes and their respective subthemes that emerged during qualitative data analysis. In the following sections all participants are given pseudonyms to protect confidentiality.

### **Negative Impact of Sexual Violence on Childbearing Experiences**

All but one of the participants in this study identified ways that having experienced sexual violence in the past negatively impacted their pregnancy and birth experiences, though these effects manifested in different ways and to varying degrees. This section is broken down into subheadings to try and capture the varied ways that the participants saw past sexual trauma as negatively impacting their childbearing experiences. The three main subheadings I will discuss in this section are *affective reactions*, *physical reactions*; and *relational reactions*.

**Affective reactions.** Many mothers in this study reported experiencing affective reactions during the childbearing year that they felt originated with past sexual violence.

Affective reactions occurred in the form of experiencing distressing emotions such as anger and fear, through difficulties with affect regulation, or through engaging dissociative processes to defend against overwhelming stimuli.

Affective reactions that participants felt were due to their history of sexual violence were reported by participants to cause psychological distress and negatively interfere with their experiences of pregnancy and childbirth. Rachel stated the following about her pregnancy:

I would say if I wasn't sexually abused my pregnancy would've been so much smoother for me and I don't think I would've been stressed, as stressed out, which I mean that maybe that added to how bad the labor and delivery went.

Three participants reported that affective reactions manifested in emotional dysregulation, or rapidly vacillating emotional states. In the following passage Rachel describes how emotional dysregulation manifested in her pregnancy.

I thought about it a lot, and I thought about the scenarios, like what if I had to have a C-section, or, you know, what if I started freaking out because of my emotional instability being pregnant and having all these feelings come up, and, you know, they're fresh again after you've done years of therapy. And I think I've been doing therapy for like 11 years. I still do therapy, it saves me and it is, it's like a scab heals over a wound and then it just gets ripped off again, and it makes those feelings fresh and very difficult to deal with when you're pregnant and you have so much other stuff going on.

Linda summed up how labor generated intense emotions for her:

And during the labor I think with the first baby it was like 15 years of therapy in 20 hours. It was amazing. I went through like everything. I was angry to feeling great and being panicked to really, really emotional, a lot of crying.

Anger and fear were common difficult emotions that participants experienced throughout the childbearing year and were reported to be distressing to participants. Anger was an emotion identified by four participants as arising at some point through the childbearing process. Alexa described her anger eloquently in the following passage.

After having a child I was just furious like you [abuser] destroyed my life kind of furious you destroyed my, because I think looking back I realize how much it's just changed my entire life and my entire relationship, relationships with my partners in the past and current partner and then to have it resurface made me even angrier because to think I'm not just angry at myself but also angry to think that that I have a daughter and to think that how furious I am that at the thought that something like that could change her whole teenage years and how she felt about herself you know or adulthood or any part of it.

Rachel also reported feeling anger.

How can these people like let this happen like my mom let it happen, my grandma let it happen, all kinds of people just let it happen and I just like, I hated it even more, I hated them more for it.

Fear was a commonly reported affective reaction based in prior sexual violence with 8 out of 11 participants identifying experiencing fear during the process of childbearing. Fear occurred in different parts of the process for different women and to varying degrees. Reese

experienced profound terror during her labor, which she related directly to her past experience of rape.

When I was triggered like with the, you know, with checking for dilation and definitely with the, the bulb syringe thing with my second, terror, nausea, I was crying uncontrollably, just feeling terror which I knew in my mind was not related to what was happening in the moment I realized that, but it didn't make my reaction any different. It was based on the physical, physical sensation I guess.

Reyna described fear too, though her fear was related to losing control, where she felt that she needed to have her birth unfold in a specific way. This manifested most strongly in a fear of hospital birth and medical interventions.

The idea of me losing control over what happened my body that people were going to do things to me that I didn't want done, I lost my shit and, I was really not okay with that...I was like no I'm not doing this you can't make me do anything I don't want to do nobody's going to touch my body that I don't want to have done, and I lost it.

Alexa reported anxiety related to prior sexual abuse resurfaced during the postpartum period, causing psychological distress.

Anxiety has, that's taken a big toll on my life and a lot of different areas now in ways that it never did before, and I don't know if that's that, but it's definitely kind of re-came into my life, nightmares and that sort of thing, maybe part of it is I have a daughter and you know wanting you know the idea of protecting and worried about protecting somebody.

Linda discussed how anticipatory fear of labor manifested during her pregnancies.

I had these moments when I felt completely, like, I guess terrified like about the labor, that I wouldn't be able to get out of it; that I'd be stuck you know. Stuck in the between 7 and 9 cm for hours, you know, that feeling of being in a nightmare and unable to escape, almost like being trapped in a car going underwater, that sounds kind of crazy, but you know what I mean, that terror feeling I had that every once in a while, that anxiety.

Anger and fear were common psychologically distressing emotions related to past sexual violence that had a negative impact on women's experiences with pregnancy, childbirth, and the postpartum period.

Dissociation, or the urge to dissociate was described by five participants as occurring during childbirth in response to the overwhelming sensations of labor. Dissociation is an unconscious process, generally employed to protect the psyche from traumatic experiences, and the five women who talked about dissociation during labor experienced it as negative. Reese reported how a medical procedure triggered dissociation during labor, "using...a bulb syringe...to try and stretch the cervix, and during my second labor that was actually attempted and I think I dissociated a little bit it was very traumatic".

Bertha noticed a desire to dissociate during her labor.

There was an element of wanting to escape from my body and from the situation you know things like it's kind of like oh my gosh...so this kind of like knowing that I should breathe and stay in my body, but feeling like I wanted to just get out of it as fast as possible I remember that feeling.

Linda realized after giving birth that she had dissociated during her labors.

I guess during my labors, definitely during the first two I went out of my body a whole bunch to the point where I didn't even realize later on when I had my first son that I had been completely naked with just a...blanket wrapped around me. My memory of that was that I was not completely naked, and I never even saw the blanket until I saw it in pictures later.

Almost half of the participants reported feeling a pull to dissociate or actually dissociating during labor, which may suggest that psychological processes engaged during traumatic experiences can recur during childbirth as well.

Affective reactions were a main way that participants described being negatively affected by past sexual violence during the childbearing year. Distressing emotions such as anger and fear, difficulties with regulating emotions, and engaging dissociative processes were all identified by study participants. The many passages above illustrate the varying ways that women experienced different emotional states and responses throughout the childbearing year.

**Physical reactions.** Participants described several physical reactions they experienced throughout the childbearing year that they attributed to past sexual violence. Participants described physical reactions as interfering with the normal processes of pregnancy and childbirth, as causing discomfort with medical procedures, and as causing difficulty with body changes.

Four participants described physical reactions that they felt interfered with their labor or birth processes. Shauna described a physical reaction to past sexual violence that arose during labor. She felt that her difficult labor was due in part to feeling unsafe. She described arriving at the hospital and feeling her body tense up, which she felt led to problems with the delivery.

I just got really scared and I know that's what it was...For someone who I don't know has posttraumatic stress or whatever it is from sexual abuse, but you're just kind of like you're always watching your back and when you're in that state...you don't really know what's going on all around you, so like someone's coming in that door and in my mind I don't know what, I don't really know, but my body knows it, you know what I mean? In my body was something, and it was not responding well...I don't know yet I guess I got to the point where it would be transition for most people, going from late labor to, you know, the final stages of pushing, which is very hard for everyone, and I just I panicked I couldn't handle it and my body froze up and then of course you know the drugs and then that led to everything else to the C-section.

Linda also described how she felt that past sexual violence inhibited her ability to relax during labor and contributed to her getting "stuck" as her cervix was opening.

I felt like because I had a lot of pain from the first two births, just from getting stuck for so long then wondering why my body couldn't do it. I felt like my body couldn't do what I wanted it to do...I think, it's funny I tried not to connect them (sexual violence and labor) definitely during my first pregnancy. I didn't understand how that would have any effect on a pregnancy or on giving birth and I literally didn't even think about it, then after my first delivery my midwife said, 'you know we didn't really talk about this when you were pregnant, but, you know, did something happen? ...If...somebody gets stuck and their cervix won't open in the 7 to 9 cm range, we usually find that they've experience some sort of sexual trauma'. Then I started think about it some more with the second one.



Reese described struggling with not progressing during labor and experiencing difficult physical reactions.

So that was a considerable, I think the labor was 30+ hours and which there were multiple like efforts,...and the nurse or midwife or an MD would need to check and see how dilated I was and if I wasn't making progress. And the first time there was talk of using...like a bulb syringe...to try and stretch the cervix, and during my second labor that was actually attempted, and I think I dissociated a little bit it was very traumatic and even just being checked for to see how I was progressing in terms of dilation, both times was really difficult scary, just unwanted insertion.

Another physical reaction described by four participants was discomfort with medical procedures that they related to their history of sexual abuse. The most common discomfort was caused by pelvic exams, though discomfort with pain relief measures was also mentioned as well as discomfort during suturing and labor induction methods.

Reese described how one procedure was severely triggering for her.

I think that was probably worse than being raped, but yeah I knew I'm sure that it was because of my experience that it was so horrible...I knew that the person doing it was my female doctor and she wasn't hurting me, but it just brought me right back to, to being raped.

Joan also described her discomfort with pelvic exams.

I think it definitely made, I don't know if this connection is appropriate or not, but when I would go in for the exams at my OB's office it was very uncomfortable being touched in that way because it wasn't, wasn't like I had kind of established

relationship with this doctor. It was like an inspection, and it made me very uncomfortable.

Chelsea was appreciative of a lack of pelvic exams performed by her midwives, as she found them uncomfortable.

I will say that I loved it when the midwives they never did any exams so as soon as they I switched to them they never did any exams they never touched me until right before the baby came out. They didn't check for dilation, nothing they just, I mean the first time they checked me I was 9 cm, and I had been with them for hours and so I do, I will say I did appreciate that.

Physical reactions to past sexual violence that manifested in discomfort with medical procedures made it difficult for participants to endure many events during labor such as checking for dilation, suturing, and labor induction.

One participant had a negative perspective on the changes her body went through during the childbearing process. Reese felt a decrease in her self-image following birth, "It was the first probably four months which is also during postpartum time, but I felt absolutely disgusting I mean droopy and flabby and down".

Participants in the study articulated several ways that physical reactions to prior sexual violence manifested in the childbearing year. These reactions were perceived by participants to interfere with the labor and birth processes, to cause discomfort with medical procedures, and to negatively impact body image.

**Relational reactions.** The final type of reaction associated with prior sexual violence was relational reactions, or reactions that affected how women relate to themselves and to others.

The ways that participants identified relational reactions as manifesting were through self-blame, difficulties in romantic partnerships, and secrecy, both about the past abuse and about pregnancy.

Four participants reported blaming themselves for negative birth experiences or for failing to adequately deal with past trauma. Chelsea reported how her feelings of self-blame manifested in relation to the birth.

I felt like I completely crumpled, oh my God, I made a complete mess of my labor. I was in so much pain I cried and screamed I did all those things...I definitely had this feeling of like I'm not good enough I can't get this baby out on my own I am pushing as hard as I can, and she's not coming out and it was definitely hard. All in all the experience was very was pretty hard.

Alexa too, described how she blamed herself for an undesired birth outcome and for not knowing that sexual violence she experienced in the past could affect her birth.

Part of me, I think it's my own disappointment of feeling like, you know, I let myself down or not that I failed, but I just felt like, I almost felt like I let them [care providers] down too in the process of labor...That's one of the reasons like I kick myself too... I wish I had taken more time to really kind of investigate that just kind of how this will affect birth because I just didn't realize the level of how it would affect me just in that being able to let go or not relax.

Linda reported feeling angry at herself for difficulties during her labors.

I had a lot of pain from a first two birth just from getting stuck for so long then wondering why my body couldn't do it. I felt like my body couldn't do what I wanted it to do...like I was getting mad at myself.

Participants also described how sexually violence negatively affected their relationships with others. Alexa reported feeling angry at the person who abused her and noted how much she felt sexual abuse affected her relationships with romantic partners.

I was just furious, like you [abuser] destroyed my life kind of furious...because I think looking back I realize how much it's just changed my entire life and my entire relationship, relationships with my partners in the past and current partner.

Rachel also described how she felt angry at important people in her life because of the sexual violence.

It [pregnancy] made me more disgusted with the people who did it because I don't understand how you do that like I mean I got pregnant...as soon as I got pregnant you know I started feeling the baby move, and it seemed really real, I thought, gosh how can these people like let this happen, like my mom let it happen, my grandma let it happen, all kinds of people just let it happen, and I just like I hated it even more I hated them more for it.

Rachel noted that because she has a history of sexual violence her partner worries about her.

He always worries about me, he worries about me. He's probably worried about me right now. He was really worried cause he knows everything. I have no secrets from him, and he does, he worries that maybe [I'm] having a really bad day because that happens, that happens a lot you know, that's what's not normal about me, you know, I have really bad days.

Charlotte felt that past sexual violence negatively affected her relationships until she learned positive coping skills.

I think that my experience from when I was a kid affected me in every relationship up until I think up until now because before I met [current partner] I'd been married, and I got divorced and I'd kind of gone through a lot of periods of time when I had blowup relationships and had really not great coping skills.

The final way that participants described how a history of sexual violence impacted their experiences with childbearing was secrecy, which manifested mostly in secrecy about the prior abuse, but also extended to secrecy about pregnancies. Three participants discussed secrecy. One participant reported how secrecy about the abuse made it hard to tell her maternity care providers about it. Reyna stated that she didn't feel comfortable telling her providers about her past history of sexual violence, "I definitely wouldn't have intentionally disclosed, because I wasn't feeling comfortable enough with everybody or anybody to open up like that".

Lauren articulated the ways that secrecy about sexual abuse and about her reproductive health impacted her for many years.

I couldn't talk about it, so again it was another way of pushing down. The secrecy of the abuse, the secrecy of the pregnancy, and I and I haven't told people about those pregnancies much less the abuse until the last 10 years or so I've begun really feeling comfortable talking about it.

Joan also described how little she shares about the sexual violence she experienced. She stated, "this is actually probably the first time I've really talked about it in any way shape or form since I told them [midwives]".

Study participants described varied ways that past sexual violence negatively impacted their experiences with childbearing. These impacts occurred in all phases of the childbearing year, through pregnancy, labor, birth, and the postpartum period. The negative impact of sexual

violence was described by the study participants as manifesting in three types of reactions: *affective reactions*, *physical reactions*, and *relational reactions*. Participants perceived these reactions as impacting their ability to birth naturally, generating distressing emotional states, creating discomfort around medical procedures, as triggering dissociation or the desire to dissociate, and interfering with their relationship to self and others. These effects were related to prior sexual violence and reflect how past trauma can manifest in a variety of ways during the pregnancy, birth, and the postpartum period.

### **Growth and Healing**

As an interesting compliment to the first theme, all of the participants described aspects of the childbearing process that fostered growth and healing from sexual violence. As in the previous section growth and healing manifested in different ways and different magnitudes for different women. This section will outline four subheadings of the umbrella theme of *growth and healing*. These four subheadings, *the role of motherhood*, *safety*, *body changes*, and *empowerment* articulate the different ways that women described how growth and change occurred for them.

**The role of motherhood.** The majority of participants, or 8 out of 11 (73%) participants, reported that becoming a mother or parenting their new baby provided aspects of growth and healing from sexual violence. Shauna reported that motherhood increased her self-care and improved how she coped with difficult things.

My whole world has changed you know I don't, I don't hardly drink anymore, I don't take nearly as many pills, I'm just happier just being with (baby) you know and that's amazing for me, like I've been sedating myself for years, mildly,

sometimes not mildly, so I've really just kind of slowed down and am taking time to take care of myself for him and for me, but you know it started out for him.

Alexa also felt that mothering her child helped her to cope with difficult emotions that had been triggered for her.

Just being a parent...that obviously was such an amazing beginning, being busy with that was like I said this blissful life, and then it was teetering on the edge of this other thing going on, that as long as I could get back on and stay focused on this you know that's what definitely pulled me out of it just having my (baby).

Charlotte described how a positive birthing experience helped her to have an appreciative approach to parenting her child.

The kind of experience we've had (natural birth) has made me be a little bit more relaxed, you know, I'm not, I think that we kind of let him be, and, you know, that the world can be sharp and pointy, and what we can do that's under our control is to give him the best little experience in development...a nice part of our kind of slowing down in this whole process and just enjoying that.

Bertha discussed how motherhood helped connect her to her identity as a woman.

I think well particularly motherhood even more so than just pregnancy and labor, helped me to feel more comfortable being a woman. I feel like before I had children it was always like, I'm a woman, but...I didn't feel like I embraced it very much...now something about the prospect of becoming a mother being a mother has help me to be more comfortable in that part of who I am.

Rachel talked about how her child has had a positive influence on her life.

For a long time I've suffered from postpartum depression from how bad it all went, but once I got past that it was amazing. My son is really great, and I don't know what I would do without him, and in every way I have been positively impacted. I feel needed by him and really loved, you know? I have like a lifelong buddy that I get to hang out with.

Linda found that her experiences as a mother have healed many things for her.

Becoming a mother...it was like so much therapy in a day or two days, depending on the situation, and I also feel like having a crazy sexual you know having a past before I had a baby, I thought nothing would make me a mom. It's amazing to me the healing that I've been able to do around that experience of having kids. I honestly never thought that the two would be connected at all and never thought about it.

Participants described different ways that the role of motherhood has been healing for them. The role of motherhood was described as generating healing through creating the experience of unconditional love of their children, through making better choices for the sake of their children, through feeling a greater connection to womanhood, and through offering an experience that the participants may not have thought was possible.

**Safety.** Twenty seven percent (n=3) of participants reported that finding safety in some way through the childbearing process was healing for them. All of the three women that described this theme reported that safety came in the form of some nurturing relationship.

Chelsea found safety in her maternity care providers.

My midwives were wonderful...one of the things they kept saying to me which I never...would've thought that this would be an important thing to say, but during



the labor they kept saying, 'you're safe here, you're safe, you're perfectly safe', and that was such an amazing thing to hear because I did not feel safe in the hospital, but I felt totally safe with them.

Lauren described finding safety in several women who cared for her during her pregnancy.

I was scared and completely paralyzed by the fact that I was pregnant, and then once I got into the home, I was okay I felt safe, and actually for those first two, I felt very much loved I was in a home for mothers that was run by a Catholic...they were nuns, and the two women that I knew most there...were both unconditionally loving.

Joan described how her midwives' care for the baby just after the birth was reassuring.

She came out and I lifted her into my arms and she was very blue because she had the cord wrapped around her so tight, but I felt like in that moment, when I held her, even though she was blue, and I wasn't sure she was going to be okay I knew everything was going to be okay. My midwives gave her a little bit of love and held her and I handed her to (midwife) because I was really scared, and (midwife) gave her a rub and got the oxygen out, and she (baby) pushed the oxygen away and let out a big cry, so I knew everything was fine.

For these participants finding safety in a nurturing relationship challenged anxiety and fear that accompanied some aspect of the childbearing process.

**Body changes.** The vast majority of the participants, 10 out of 11 (91%) described the changes their bodies went through over the childbearing year as healing in some way. Most participants described positive and healing experiences through pregnancy, though some women reported that the feeling of having accomplished something difficult after the birth was healing

too. Because so many women described this theme I have included a variety of quotes articulating the different ways that body changes promoted healing.

Joan described how having the changes in her body reflected back to her in a loving way by her care providers offered some closure to prior sexual violence she had experienced.

I guess I did get a little bit of closure in that moment you know when my three midwives were looking at my, my personal areas and telling me what they saw, and telling me what my body went through and being honest.

Bertha stated that pregnancy and birth helped her to feel more connected to her body.

Having my kids makes me feel more connected...I guess more ownership or more sense of this is my body. I so intimately dealt with the female parts, now I feel like I know those parts of me better and I also feel more deeply like appreciative or connected to them.

Linda reported many ways that having children has healed her connection to her body.

I like my body much more now than I did before I was pregnant I feel much more like connected with myself now and as far as sex stuff, I feel less likely to leave my body, I feel more present, and I feel less shame around it now that I've had three kids.

Charlotte described pregnancy as having a positive impact on her body image.

I think it made me feel definitely more present in my body I felt more beautiful for sure I felt just good.

For Lauren being pregnant offered a positive counter experience to having been sexually abused.

I felt like I could finally relax. I don't know if that makes sense, but it was such an emotional wound in the belly center from the abuse and from the two babies that

having pregnancy out in the open and having people say, ‘oh when is it due?’ and things like that it always felt so life affirming, so rich, and I could breathe, I could let my belly out and let people know that you know I was pregnant, it was okay, so it was very freeing.

The majority of mothers in this study found some part of the body changes associated with pregnancy and birth were healing and “life-affirming”. Body changes were seen as positive through reducing shame, providing closure, connecting mothers with their inner strength and beauty, and through providing a positive experience to counter the negative experience of sexual violence.

**Empowerment.** Seventy two percent (n=8) of participants described some part of the childbearing process as empowering. Empowerment was described as a healing or growth-inducing experience. Joan described how her birth helped her to realize her personal strength.

I know that I’m strong, giving birth at home without, with no drugs definitely showed me that... Birth empowered me, birth definitely gave me the strength to look at myself in a different way.

Reyna echoed a similar sentiment, recognizing her own strength.

It was amazing actually, really I mean it really, really hurts like a bitch, but it was an amazing experience. I felt like a rock star after I had the first one, I was like, ‘holy crap I can do that!’

Linda found that giving birth shifted how she saw herself.

Giving birth without any medicine or medical interference...I feel like that’s given me a lot of strength...especially around my past and I don’t know, where I want to be in the future, it really helps make me feel more connected to being a

woman. I think before I had kids I still sort of identified as a little girl like I was stuck, so going through my hard labors and giving birth three times really made me feel like a mother, a woman, an adult.

For Bertha, the process of having children empowered her to value herself more.

I think that my experience of the sexual violence was connected with my whole history of how I allowed myself to be treated as a person and as a woman and how I felt about myself and my strength in the fact that I didn't have the strength to stand up for myself or get out of that situation, and so in a certain way I feel like what happened to me with this was the culmination of a long time of not respecting myself...I mean I'd already like deal with that to some degree before (babies) were born, but the process of having them I feel like has made me value myself in a new way, and I guess I got more in touch with my instinctual sense of protection in a healthy way that, like, I deserve to protect myself, you know, which I didn't feel when I was a single person.

Many participants described the process of childbearing as empowering in some way. Empowerment was perceived as healing by participants, exemplified in the following quote from Linda about a positive birthing experience: "yeah, it was very healing for me to have the third birth go smoothly because it gave me my power back".

The subthemes of *role of motherhood*, *safety*, *body changes*, and *empowerment* all describe different ways that the childbearing process promoted growth and healing from sexual violence for participants. Though some participants described more profound levels of healing and deeper growth than others, all participants saw some way in which childbearing experiences promoted healing.

## Coping

Coping is the third theme that the study participants described. Participants were asked one direct question about how they coped with difficulties associated with pregnancy and childbirth, but many women described how they coped throughout the interview. This section outlines the ways that the study participants reported coping and includes seven subheadings, or different ways of coping: *trusting the self or the natural process of birth, self-care, planning and educating, support from partner, reframing, helping others, and pain relief.*

**Trusting the self or the natural process of birth.** Sixty four percent (n=7) of participants talked about how they coped with the difficulties of childbearing by trusting in themselves and their innate ability to carry a child or give birth, or trusted in these natural processes themselves. Charlotte described how connecting with her animal nature helped her cope with labor.

I think that I looked at it like this is how we were built, we're mammals... I felt like with the whole birthing experience that you know this is what our bodies were really built to do and that birth was something that just was natural and happened.

Joan talked about trusting the birth process and trying not to overthink what was happening.

I felt like there was a certain point where it was so completely out of my hands and I had to just accept it like there was one point when I reached down and I thought a felt her...I kind of had to embrace the fact that my body was going to do it, you know all those fears that I had, I just felt like my body is going to do this, stop fighting and just accept it, and when I finally did...everything sped up so fast and I felt like she just came into the world once I accepted that.

Lauren also coped with labor by connecting with her body's wisdom.

The labor was like a challenge it was something primal. And, and it was so natural you know I wasn't afraid of it, it just felt like this is what I was here to do.

Participants described how connecting with the natural process of childbearing and trusting in their bodies' ability to carry and birth a child helped them to deal with the struggles that arise during this time. Participants described this coping strategy as helpful, as in the above quote where Joan attributes this attitude to increased speed of labor.

**Self-care.** Sixty four percent (n=7) of participants talked about using self-care throughout pregnancy and birth to cope with difficult feelings that came up. Rachel used self-talk to manage her feelings.

I ...just got to relax. I tell myself that like 100 times a day you got to have a good attitude, if you have a good attitude and you find things to look forward to and keep yourself busy, then it's on the back burner, it's not right in your face all the time.

Bertha described how pregnancy gave her permission to take better care of herself.

I definitely felt more permission to take care of myself, and I was pregnant so I think that helped me cope with it, I felt like I was in charge of very special cargo and it was important that I rest when I needed to, eat what I felt I needed to, and even what I wanted to, and you know take walks and stuff.

Shauna talked about using self-soothing strategies during her labor to help her feel more comfortable at the hospital.

During the birth I used, what helped a little bit, I used some essential oils like on washcloth, and I breathed them in, like aromatherapy type stuff that just

automatically relaxes you when you breathe it in like lavender, lemongrass, that helped a lot when I was in the tub at the hospital...I brought a lot of things from home that helped a little bit...sheets and blankets and things that smell like home, patterns I'm used to seeing from home, that helped for sure.

Participants described using self-care strategies such as self-talk, self-soothing, exercise and rest to manage difficult times throughout the childbearing process. Also, being pregnant validated an increase in self-care for some participants.

**Planning and educating.** Planning and educating was a coping strategy used by 73% (n=8) of participants, primarily during pregnancy to cope with the upcoming labor. Most participants described reading books or articles, some about sexual violence and pregnancy, though the majority were just about labor and birth itself. Other participants described attending a birth preparation class, creating a birth plan, gathering supplies, and enlisting support from others in preparation for birth. Joan described preparing herself mentally by reading lots of books, and preparing herself physically by gathering supplies for the birth.

I was really nervous I read a lot of books I felt like I was really well educated...Reading stories about other women who are going through the process that helped a lot I read...all these labor stories, women giving birth in the back of vans and Amish women giving birth in their homes while fully clothed, you know, and all these different situations where women gave birth naturally...and I kind of felt like this is the reality I can just do it I can accept it and not be so scared... I had totes full of everything we needed; we were super prepared.

Charlotte described a birth class she took on advice from her midwife as very helpful.

We went to a couple of classes, we did like a safety thing...and we did a natural birthing class, and that was actually really, really helpful because it was anatomy and what to expect...I felt fairly aware of a lot of things, and which was just kind of helpful but the natural birthing class was really helpful, and I think our midwife pointed us in the direction of this one specific woman that we took the class from and that was great.

Linda described planning for her birth by reading about sexual violence and its impact on birth, “I did a lot of work on my own... I read the, what is it that Penny Simkin book (*When Survivors Give Birth*), yeah I read that. I was meditating and visualizing that I wouldn’t be stuck”.

Planning and educating was described by participants as helpful in dealing with worries, particularly about upcoming labor and birth. The mothers in the study described reading, attending classes, using visualization, and gathering supplies all as different ways to plan for birth or educate themselves about labor and delivery.

**Support from partner.** Seventy three percent (n=8) of participants described support from their partner as helping them cope with the challenges of childbearing. Partners were described as supportive by listening and being there for the women, by backing up the decisions the participants made, and by advocating for participants with health care providers. Reese told a story about how her husband stood up for her during a difficult moment in the birth.

My husband, and you know I was saying, I was crying and screaming, just saying ‘stop!’ and ‘stop you need to stop!’ and he supported that, and he definitely said, ‘you know we're all done, we have to find a different way’, so his support and his comfort and understanding made all the difference.

Reyna reported that having her partner’s support helped her to feel strong.



I had an insanely supportive partner so... I didn't feel alone or anything. I felt really empowered and whatever decisions I wanted to make were always like backed a hundred percent, so I think that having someone believe in me so intensely like made it so I never doubted myself either.

Lauren talked about how her husband's relaxed attitude towards birth was helpful to her. She stated, "I had my husband and he was so down to earth about pregnancy and delivery that I felt supported I felt grounded, you know, with him and he actually delivered the last one". Rachel also found the presence of her boyfriend helpful during her labor.

I was really relaxed and really calm. I think it really helped having my boyfriend, that having someone who is really special there, whether it's a boyfriend or grandparent or sister, I think that's really what it comes down to.

Supportive partners helped participants cope with many aspects of the childbearing process through offering a grounding presence, through providing emotional support, and through advocating for participants.

**Reframing.** Reframing is a coping strategy used by participants to challenge negative beliefs about the self or about their childbearing experiences. Reframing through changing a negative belief and finding positive in a difficult situation was articulated by 4 out of 11 (36%) participants. Most reframing occurred around less-than-desired birth outcomes, though one participant reframed her own beliefs about the strength she showed during labor. Chelsea reframed self-doubt about how she birthed her baby.

That was the part that was hard, being like that's my story, that's my, that's how I got my baby out, you know? And it doesn't matter if it's wonderful because she's mine and that's my story and it sweet and beautiful for itself.

Rachel reframed her negative feelings about body changes by focusing on the positive outcome of those changes: her healthy child.

It's kind of negative because I have this big scar and then it got infected so now it's like weird...the stretch marks are just now finally starting to disappear, I'm having a hard time losing the baby weight, but really I mean none of that matters too much because my son's really healthy.

Alexa described how validating her difficult emotions and reframing them as normal helps her feel better about her experience. She stated, "this is normal to have these feelings and that this is okay as far as the birth, you know, I do know these things, it's just that doubt, that self-doubt I guess".

**Helping others.** Twenty seven percent (n=3) of participants used helping others as a way to cope, primarily in the postpartum period. The study participants gave back through career changes or through volunteer work. Some participants have particularly focused on giving to others through work with victims of sexual violence or with new mothers. Rachel described how helping others helps her deal with difficult feelings. She stated, "it's really important to give back; it really gives you a lot of soul support, and that's like 100% taken away when you're sexually abused".

Reyna talked about how her personal growth has led her to helping others and how helping others reminds her of how far she has come.

Just to find love for myself and my power back, which I feel like great...I can help other people and see how far I've come and how good I feel about who I am you know... I didn't let someone else take my power for my whole life like they got it for like a little bit, but I got it back.

Shauna also discussed how she made a career change following her birth experience.

Right after I had the baby I just started looking into all kinds of stuff and reading all kinds of books, and I decided I wanted to be a Doula...but I'd really like to help women who are on their own are single, that's a lot of work and it's really tough and I could never imagine being by myself so, so I'm a Doula now. I'm trying to focus on helping women so that they can try to avoid C-sections.

Helping others was an important way that women reported coping with difficult birth experiences or with the ongoing difficult emotions that are a result of past experiences with sexual violence. Through helping others participants describe finding their power, gaining "soul support", and offering something to others that they wished they had had.

**Pain relief.** Thirty six percent (n=4) of participants described using medicine to cope with pain during labor, with mixed results. One participant described medication use as positive and promoting birth progress, while other women found that it made them sick, impeded birth progress and led to cesarean section, or didn't work. One participant reported using a warm bath to cope with pain, and found it promoted relaxation and offered some relief. Bertha talked about her experience with epidural pain relief.

I just kind of like was having a really hard time dealing with it that's when I got an epidural and then it went really quickly after that I think it was like a half an hour until I was fully dilated.

Shauna reported a negative outcome from using medication for pain relief, but that it did help her cope with a difficult time during labor.

I got to a point where I didn't have any breaks. I had one stretch of contractions for over an hour, and I just broke down, and I couldn't take it, and then I asked for the drugs, and then his heart rate dropped and we needed a C-section.

Rachel talked about getting sick after taking medication for pain relief during her labor.

They gave me a drug, that just I told them, don't give me drugs that make me feel like I'm drinking or being high or something, and they did, so I ended up getting really sick, and it was weird.

Joan described using a warm bath for pain relief. "About an hour before I actually gave birth I transitioned into a tub, so I gave birth while in the tub, um, it was a very comfortable environment".

Both medicine and warm water were described by participants as effective for relief of labor pain. Medicine was associated with some negative outcomes, such as sickness and slowed labor, by participants.

Though different participants coped with the challenges of pregnancy and childbirth in different ways, all of the participants used at least one of the strategies described in this section. Some ways of coping such as helping others, self-care, and having a supportive partner were described as helping heal the effects of sexual violence as well as helping cope with difficult sensations associated with childbearing.

### **Relationships with Maternity Care Providers**

The final theme discussed in this section is relationships with maternity care providers. Two subheadings emerged from the data regarding relationships with care providers, *not being listened to or respected* and *support from care providers*. The subheading *not being listened to or respected* captures the negative experiences that participants reported having with their care

providers, including not having enough access to care providers, not having questions answered, and experiencing care providers as impersonal or uncaring. The subheading *support from care providers* outlines positive aspects of the caregiver relationships including listening to clients and offering emotional support, fostering client decision-making, and being available. Participants were asked direct questions about their relationships with their maternity care providers during the interview, and most participants described these relationships as an important part of the overall experience of childbearing.

**Not being listened to or respected.** In the semi-structured interviews participants were directly asked if there were unhelpful things that their maternity care providers did. The majority of participants, 9 out of 11 (82%) reported some aspect of not feeling listened to or respected by their maternity care providers at some point, though the severity and prevalence of these negative experiences varied. Participants described negative experiences through having providers who felt impersonal or uncaring, through wanting more support from providers, through having providers change frequently in a shared practice, and through having specific negative experiences during labor and delivery.

Joan shared a story about not feeling listened to by her doctor.

I was seeing an OB and I was really uncomfortable with the touching in the exams and things like that and he wasn't very cooperative with listening to what my birth plan was, he said things like, 'that's not regulation, that's not procedure'. He was very adamant about requiring me to have an IV upon entering the hospital, and I don't like needles, so I was definitely trying to fight him on that issue, and he wasn't leaving very much room for me to have an actual birth plan.

Four women in the study described wanting more support from their caregivers, mostly during the labor and delivery. Chelsea talked about how she felt more support would have been beneficial for her throughout the whole process.

When I was with the OB and also with the midwives I wanted more help, more of everything, more questions more! During the labor a little more massage or touch. During when I was with the OB more questions, more detail about some of the things that were happening, especially with the OB when we had all the tests I wanted always wanted to know more, more, more, and she never was quite willing to share that.

Reese was specific that more support around being a survivor of sexual violence would have positively affected her experience giving birth.

It would've been helpful...for somebody to have said straight out... labor's going to be triggering, pregnancy might be triggering at times, there might be difficult moments and here's what, what you need to remember, what you need to focus on in those moments, and speak up and let your providers know that these are your issues, that would've been helpful.

Four participants also described their care providers as impersonal in some way, whether it was through seeing multiple providers in a practice or through not feeling connected to the provider. Shauna described her experience of sharing that she was a survivor of sexual violence with her care provider and feeling dismissed.

She asked a series of questions and I told her yes, and I don't know she didn't really have much of a reaction. She just told me there's a book I should think

about reading, and then we were just right onto the next thing. I kind of felt like a number at that office; it wasn't real personal.

Bertha talked about not feeling connected to her providers.

I didn't feel that particularly connected to her she didn't deliver (baby) either, I mean I just saw her throughout the pregnancy and then you know met a stranger the day of the delivery.

Reyna reported not feeling safe enough to disclose her history of sexual violence to a rotating practice of providers.

I left them at 20 weeks, like I said each time I went to see a different person...I saw a different person because they wanted to make sure I met everybody...I definitely wouldn't have intentionally disclosed because I wasn't feeling comfortable enough with everybody or anybody to open up like that.

Three participants reported changing from an obstetrician practice midway through pregnancy to home birth midwives because they felt the obstetrician practices were impersonal or too focused on intervention. Reyna described feeling terror after talking to her care providers about solutions for slow labor. In this passage Reyna identifies negative experiences around both the providers approach to childbirth and from being rushed through her appointments.

I was very excited and she basically said, 'I have other people coming in so we need to hurry this up' and I was like, 'are you joking? This is an amazing moment in my life and you're rushing me out of here?' So I had a question about, I was having some anxiety about whether or not my labor was going to be prolonged and what they would do to support that, and...I stated very clearly...that I didn't want any kind of medical interventions like epidurals...so when I called...I asked

her that question and then she was like, ‘oh then we would give you an epidural’, and that was her first response, and I was like, ‘what are you doing? This is not what I wanted!’ So in that moment I was like panicking, I was telling my husband I’m going to The Farm...I'm going to give birth in the woods if I have to. I was like in panic mode.

Joan also reported changing practitioners from an obstetrician to homebirth midwives halfway through her pregnancy because she wanted more personal care.

He would say, ‘if you’d like to talk to my nurse you can, but I need to see my next patient’, and also I guess he might not have been the person that would’ve delivered my baby either, he had four other doctors working in his office, and he said it would depend on who was on call...that terrified me that was what sealed the deal really at that 20 week visit he said that...it really was the straw that broke the camel's back that particular piece of information. I wanted someone who I trusted there, and I felt like I was starting to be open to this person...I don’t even know Dr.’s first name that’s how impersonal it was.

Participants also reported specific negative experiences during labor and birth that came from their maternity care providers and from other hospital staff. Rachel described being given a narcotic at the hospital after specifically asking not to be given a narcotic.

I specifically said, because I knew I would get sick if they did this; I specifically told them. After like one wonderful nurse left some young lady came in with fancy nails and an attitude and...she said, ‘you want something for the pain?’ and I said, ‘what can you give me?’ And she said, ‘well I can give you Stadol’. Well Stadol, it made me feel like I was on a bunch of narcotics. It was horrible, I felt



like for a split-second I was laughing hysterically and then like the next second I am crying, I'm vomiting, and then I felt so out of it. That was the worst thing I've ever been on in my life, and yeah so it knocked me out yeah it knocked me out and every time that I would try to fall asleep I would stop breathing so I couldn't even fall asleep.

Shauna described feeling neglected by her midwife who had other patients giving birth at the same time.

I just wish she had been there the whole time like she said she was going to be, or at least told me that she wasn't going to call for backup if there was a second delivery, and I would've gotten a doula. I really felt if I'd had somebody with me every second it might've been a little bit better. I didn't like that, and I felt like I might as well have gone to a doctor instead of having a midwife with the way that she was just in and out very blasé about the whole thing it was kind of a bummer.

Participants described many ways that experiences with maternity care providers were negative or upsetting. Participants experienced impersonal or rushed care, including having rotating providers, as unhelpful and even scary. Also some participants described negative experiences during labor and delivery that impacted the quality of those experiences. Finally participants described ways that they weren't listened to by not having their wishes respected, having their birth plans ignored, or feeling their concerns were minimized.

**Support from care providers.** Study participants were asked a specific question about what aspects of their maternity care experiences were helpful. The vast majority, 9 out of 11 (82%) participants, described having positive, supportive experiences with some aspect of their maternity care. Participants described being able and encouraged to make decisions, having

providers offer a hands-off approach to birth, and minimizing medical interventions as helpful and supportive. They also described feeling listened to and being emotionally supported by their care providers as helpful.

Bertha found that having her midwife be hands-off during the delivery was helpful.

Creating space in the way that the midwife was when (baby) was born she really was very present, but not, but just let me do my thing unless it was necessary for her to say something, to give a suggestion.

Reyna also appreciated her care providers giving her space and not intervening unless it was necessary.

They really just let me advocate for myself...I felt empowered from them and even the second time around I felt even so much more empowered. I just wanted minimal involvement like basically I just wanted someone there to help me catch the baby.

Five participants described being listened to and offered emotional support by their maternity care providers, which they experienced as very supportive and helpful. Reese reported that having her sexual violence history taken into consideration helped her cope with difficult procedures.

When they were going to check to see if I was dilating, they would speak very clearly about what they were going to do and asked if that was okay with me, which was very respectful and put me...more in the driver's seat, which is what you don't have at all when you're sexually assaulted.

Bertha also described a positive experience of being listened to and given space to ask questions by her care providers.

The midwives they gave a lot of space for our appointment, a lot of time for questions which I really appreciated, they had kind of a quiet way of listening so that there is room you know, it wasn't kind of like, okay, quickly I'm here let's do such and such and get out of here, they were pretty relaxed about the emotional space in the room, so that was good enough, if there ever was a question that came up they were very you know, not alarmist, but reassuring.

Linda shared a story about a difficult moment in labor when she felt extremely supported by her midwife.

At the very end of my labor with...my second baby, I felt like I couldn't go on go any further, and I was begging for them...I was telling [midwife] that I was done, and I wanted to go to the hospital, and she was just, basically she looked me deep in the eyes and was like, 'you can absolutely do this, you're strong enough to do this, let's have this baby and get this over with and get there'. And I felt like the way that she connected with me, she always tells me that she didn't do this, but my memory of that is that she reached her hand up and pulled the baby out, even though I know that's not what happened, I just felt like she was 100% there for me.

Chelsea illustrated the positive dimensions of getting emotional support in her relationship with her care providers in the following quote.

The midwives checked in a lot with my emotional well-being, which I found helpful, and I loved when they would also check with my husband, that was just the nicest thing that even during the labor they were taking care of both of us, and that's very unusual; I think it was very nice.

Alexa also reported feeling supported by her midwives.

I trusted them and they were supportive and knowledgeable...just having...strong women that know what I'm about to go through and are there to support me was very comforting, and even afterwards...you can't wait to see them again after you had your baby and they've gone home, and you just can't wait to reconnect again, and I definitely felt just felt like I had support from these strong women who knew what I needed and knew, just made me feel secure and comfortable.

Making decisions about the kind of maternity care they needed, about what procedures and tests to undergo, and about how to proceed with many aspects of maternity health care was described as very important for 45% (n=5) of participants in the study. Chelsea articulated the importance of being able to make informed decisions during her maternity care.

I love having options, options, choices, I can make my own decisions. Especially ahead of time because I didn't want to be dealing with them during labor so anything that we could decide on up front was really, really helpful.

Joan also talked about her choice to switch care providers midway through her pregnancy.

He might not have been the person that would've delivered my baby either, he had four other doctors working in his office and he said it would depend on who was on call...that terrified me; that was what sealed the deal really at that 20 week visit... so then I, I kind of made the decision to go with the midwife who's pretty much just supported my entire decisions, any decision I made they supported me in, which was what I was looking for.

Charlotte described how making decisions in the hospital was a positive experience for her. In this passage she also illustrates how her care provider advocated for her when she was having a difficult encounter with hospital staff.

I got there (the hospital) and like in major labor and was asked to put on a Johnny and to get you know and that someone would be in to do my IV, and I said, ‘oh no, no, no, I’m not a patient I’m just having a baby, and I would prefer not to wear that Johnny and I’m not going to be getting an IV’, and I got a little bit of an eye roll, and a ‘fine, everything off from the waist down’,...it took a while to get admitted because they didn’t want to admit me without an IV, but eventually our midwife came and was like, ‘oh geez this is ridiculous!’ And she actually switched out our nurse, which was really lovely.

The women in the study described many ways that their maternity care providers were supportive and helpful through minimizing interventions, through being available, through really listening to participants, through fostering decision-making and through offering emotional support. Women talked about their maternity care providers with whom they had positive experiences with much love and warmth. Charlotte stated, “the midwife that I went to she’s really amazing”. In addition Chelsea talked about how her midwives helped her see her own strength.

My midwife asked me afterwards, they were so wonderful, she said, ‘do you feel like a hero?’...and I was like no, I feel really humbled and defeated and like I was run over by a truck, and she was like, “no, you are superhero really you should feel amazing”, and she kept at that with me for a few weeks afterwards which was very helpful.

Participants also discussed aspects of their maternity care that women experienced as unhelpful or harmful. These aspects of care included not being listened to, disrespecting parents' decisions, not providing sufficient support, and being impersonal. Though some women found negative experiences more distressing than others, a few participants described impersonal experiences as truly terrifying.

The above passages demonstrate the importance that participants put on their relationship with maternity care providers and how impactful positive and negative experiences can be for women with a history of sexual violence. Relationships with maternity care providers are a major feature that emerged from this research study, and I will further discuss the importance of these relationships in the following chapter.

### **Summary**

The four main themes that emerged from the qualitative data in this study exploring how women who have a history of sexual violence experience pregnancy and childbirth are *negative effects of sexual violence, growth and healing, coping, and relationships with care providers*. These themes and the supporting quotes suggest that women may potentially experience reactions related to prior sexual violence at some point during the childbearing year and also that women may find childbearing to promote growth and healing. Finally the findings in this section suggest that how women cope and the relationships they have with their maternity care providers may impact both the negative effects of sexual violence and the potential for growth and healing. The implications of these findings for both social work and maternity care practice follows in the next chapter. The following chapter also contains a further discussion of the interconnectivity of the four themes and an outline of study bias and limitations.

## **Chapter V**

### **Discussion**

The purpose of this research study was to explore how women who have a prior history of sexual violence experience the physiological and psychological changes of pregnancy and childbirth. The framework outlined in this discussion arose through analysis of qualitative data collected during semi-structured telephone interviews with 11 women who identified as mothers and as survivors of sexual violence.

The major findings of this research project are that most women who are survivors of sexual violence may find that trauma reactions manifest in some way during the childbearing year, that pregnancy and childbirth are commonly experienced as promoting growth and healing from sexual violence, and that how mothers cope and the relationship they have with their care providers can impact trauma reactions that arise during the childbearing process and can promote or inhibit the potential for growth and healing. These main findings are generally supported in the literature, however the universality of growth and healing as a major theme for childbearing women who have experienced sexual violence is surprising when compared to the existing literature.

This study contributes to the literature by fleshing out the dimensions of growth and healing through childbirth, by articulating how women can be negatively affected by sexual violence in the childbearing year, and by describing a framework of themes that identifies how coping style and provider relationships can impact how women experience childbearing. The following sections highlight how the four themes from this study compare with the existing

literature on the connection between sexual trauma and childbearing, psychological distress during pregnancy, the long-term effects of sexual violence, and post-traumatic growth. The *negative impact of sexual violence on women's experiences of childbearing* is considered first, followed by *coping* and *relationships with care providers*, which are examined together, and finally *growth and healing*.

Following comparison with the existing literature I will present a framework of intersecting themes that arose from the research as a guide for social work and maternity care practice with childbearing women who are also survivors of sexual violence. In this chapter I will also discuss the study's strengths and limitations and offer recommendations for further research.

### **Negative Impact of Sexual Violence on Women's Experiences with Childbearing**

A key finding of this research study is the ubiquity of women feeling negatively impacted by prior sexual violence at some point during their experiences of childbearing. Almost all women (10 out of 11) who participated in this study identified some negative impact of sexual violence on their experiences with childbearing, though these impacts varied in intensity and in manifestation. The negative impacts of sexual violence were described as occurring through affective, physical, and relational reactions throughout the childbearing process.

In the literature, sexual trauma is associated with trauma reactions, including psychological distress during the childbearing year (Lev-Weisel, et al., 2007; Rhodes & Hutchinson, 1994; Schneider, 2012; Schwerdtfeger & Wampler, 2009; Seng, et al., 2002; Van der Hulst, et al., 2006), which supports findings in this study of affective or emotional reactions to sexual trauma arising throughout pregnancy and childbirth. Seng, et al. (2002) found high levels of psychological distress correspondent with the symptoms of PTSD in their study of



pregnant women with a history of sexual violence, which reflects how intensely emotional reactions can manifest. Findings of emotional reactions including affective dysregulation, anger, and fear are also consistent with findings about the long-term effects of sexual violence on emotional regulation and emotional distress (Rodgers, et al., 2003; Steel, 2004). As the literature suggests that even mild to moderate psychological distress in pregnancy has negative impacts on mothers, affective reactions during the childbearing year warrant attention (Furber, et al., 2011).

Rhodes & Hutchinson (1994) described physical reactions from sexual violence in their study examining birthing styles of women who had previously been sexually abused. They found prior sexual abuse to impact birthing style and experience, supporting the finding in this study of physical trauma reactions arising during childbearing. The empirical literature shows a relationship between prior sexual violence and negative birth outcomes, though causal relationships between sexual violence and specific birth events such as low birth weight cannot be drawn (Grimstad & Schei, 1999; Lev-Wiesel, et al., 2009; Van Der Hulst, et al., 2006). It is important to acknowledge that women in this study felt the relationship between prior sexual violence and birth complications such as stalled labor and cesarean section was genuine. They attributed these unwanted birth outcomes to past experiences of sexual violence causing physical trauma reactions that interfered with the physiological processes of birth.

The discussion of relational reactions to prior sexual violence in the present study relates to Liang's, et al. (2006) finding of a correlation between severity of sexual trauma in childhood and adult marital dissatisfaction. Marital satisfaction was not examined in the present study however, and the negative relational experiences that participants described were focused on past abusers, on care provider relationships, and on the self. The literature also points to long-term relational impacts of complex trauma, such as child sexual abuse, finding that prior trauma can

impact therapeutic relationships with care providers (Tummuala-Narra & Kallivayalil, 2012). My finding of relational reactions in the childbearing year combined with Tummuala-Narra & Kallivayalil's (2012) findings suggests that prior trauma can interfere with, or put greater importance on, the creation of provider relationships.

The existing literature supports the findings of my research that emotional and physical trauma reactions can arise during the childbearing year for women who are survivors of prior sexual violence. The relational reactions found in my research could be connected to findings in the existing literature that complex trauma impacts the creation of provider relationships. However, relational reactions in the childbearing year were described by only a few participants, which limits the generalizability of this finding.

### **Coping and Relationships with Care Providers**

Coping style as a moderating factor in how women experience the negative effects of sexual violence in the childbearing year is supported in the literature. Steel, et al. (2004) found that coping style impacted people's levels of psychological distress after sexual abuse. Rauchs, et al. (2013) found personal optimism to play a role in positive coping strategies and in lower levels of posttraumatic stress symptoms after sexual violence.

Also Perrot, et al., (1998) found that coping style impacted psychological outcomes, with repressed reactions to childhood sexual violence associated with negative mental health outcomes and externalized blame associated with positive mental health outcomes. Reframing as a coping style was associated with positive mental health measures in mothers, however there was a correlation between maternal use of reframing and an increase in children of those mothers being sexually abused themselves. These findings are interesting when compared with the theme of self-blame that arose in my study. Self-blame could be both a negative outcome from sexual

violence and contribute to negative perceptions of birth. These findings also relate to reframing as a coping strategy which was seen as positive by mothers in my study.

In the framework outlined in this discussion coping plays a moderating role in how women experience the negative effects of sexual violence and in the potential for growth and healing. This idea is supported by the literature, which finds that coping style can influence long-term effects of sexual violence.

The existing literature also supports the concept of relationships with care providers as important to women's experiences with childbearing and with healing from sexual violence. Sperlich & Seng (2008) describe the important role that relationships play in healing in their book, *Survivor Moms: Women's Stories of Birthing, Mothering, and Healing after Sexual Abuse*:

This is the key to healing: being able to risk making connections with others and forming trusting relationships...being pregnant and giving birth has provided many survivor moms with opportunities to make connections with a variety of people, including childbirth educators, doctors, midwives, doulas, nurses, La Leche League leaders, lactations consultants and parent educators. These relationships have been significant and important (p. 189).

Levy (2006) also found that through personal and sensitive maternity care, mothers who had experienced trauma from terrorism could avoid experiencing birth as a re-traumatizing event. Sapountzi-Krepia, et al. (2011) found that women's experiences with childbirth in general were closely tied to their feelings about their care providers, and that providers who offered information, options, and emotional support were viewed most favorably.

The finding that decision-making regarding aspects of maternity care is an important part of how women experience childbearing is supported by Hadjigeorgiou's, et al., (2011)

conclusion that women value autonomy and informed choice in childbirth. Their finding of satisfaction with a home-birth midwifery model of care is also reflected in some of the women's stories in my study, particularly the three women who switched from a medical model to a homebirth model seeking a higher level of autonomy and greater personal care (Hadjigeorgiou, 2011).

Tummuala-Narra & Kallivayalil (2012) conceptualized provider relationships as opportunities for complex trauma survivors to reconstruct how they relate to other important relationships in their lives. The women in my study described many ways that their relationships with providers were healing, which when combined with Tummuala-Narra and Kallivayalil's (2012) findings support the importance of care provider relationships in shaping women's experiences.

An important theme from the existing literature that is touched upon in my study is the influence of external factors such as societal oppression and access to resources (Seng, et al., 2011). My findings are consistent with the empirical literature and with the theoretical models guiding this research, suggesting that societal factors such as oppression affect how women experience childbearing and how they experience the aftermath of sexual violence.

Seng, et al. (2011) and Rauchs, et al. (2013) found that external factors such as socioeconomic status and racism had a bearing on how women respond to sexual trauma, including levels of posttraumatic stress during pregnancy. Postmodern Feminist Theory and Intersectionality Theory both endorse this concept that individual experiences are necessarily impacted by external societal forces such as oppression. In addition the meaning that individuals make of their experiences can be impacted by these forces as well.

External factors such as societal oppression did not arise as an overarching theme in this study, which may be due to limitations in the study sample and to sample bias. All participants in this study identified as white, and the majority were middle income. Because most of the study participants inhabit positions of privilege in relation to race and income few may have reflected on how these external forces impacted their experiences. Though this concept did not generate enough response to constitute a theme, two participants did remark on how their social location influenced their experiences with childbearing. Shauna noted that her income level influenced the kind of maternity care she could access.

At the time I was going to the hospital, and I was completely covered by my insurance, and staying at home would've meant you know a big out-of-pocket expense that I just didn't have at that time, which I think would've made a huge difference to me. I would've felt much more comfortable at home. I still would've panicked, I probably would've panicked a little bit, but I think it would've been able to handle a little bit better.

Charlotte reported that her race and income allowed her access to what she felt was superior maternity care.

I have access, as a white educated woman I have access to these resources that in other parts of the country and in other neighborhoods in my backyard you just don't have that. So I also know as part of this experience that I'm really fortunate because of who we are and where we live.

As this study and the theoretical and empirical literature finds that social location impacts women's experiences with childbearing and with addressing and healing from sexual violence, this is an area of study that should be further explored. It is also essential that care providers

consider social location and societal oppression such as racism and class oppression as factors that may affect how women experience childbearing and recovery from sexual trauma.

### **Growth and Healing**

The present study found a surprising ubiquity in the experience of growth and healing from sexual violence through the process of pregnancy and childbirth. The existing literature is limited in regard to examining the dimensions of growth and healing from sexual violence in the childbearing year. Levy (2006), Schwerdtfeger and Wampler (2009), Simkin and Klaus (2004), and Sperlich and Seng (2008) all note pregnancy and childbirth as having the potential to foster growth and healing, but the dimensions of growth and healing are not deeply examined. The present study offers an exploration of the dimensions of growth and healing from sexual violence through the process of childbearing and the factors that may influence the potential for psychological growth and healing.

The existing empirical literature offers evidence of perceived growth after sexual violence and evidence of pregnancy and childbirth as having the potential to promote healing from trauma. Three sources even identify relationships with maternity care providers as having the potential to foster growth and healing (Levy, 2006; Simkin & Klaus, 2004; Sperlich & Seng, 2008). The theoretical literature augments these findings with the concept of posttraumatic growth, which can be applied to findings of the present study.

Participants in the present study articulated many ways they experienced greater connection to self, increased sense of strength and empowerment, and increased resolution of negative effects of past trauma. These findings are consistent with McMillen's, et al. (1995) finding that some people experience positive benefits after sexual violence, with Schwerdtfeger & Wampler's (2009) finding that pregnancy can provide an avenue for healing from sexual

violence, and with Levy's (2006) finding that birth can offer healing from past trauma. As Levy (2006) states, "a positive, empowering birth can be the experience that helps a woman to discover her power and her capabilities, and can change her forever" (p. 223).

Posttraumatic Growth Theory purports that through processing traumatic material survivors of trauma can experience increased growth and connection (Joseph & Linley, 2006; Tedeschi, 1999). This study's finding of growth and healing occurring in some form for all participants is supported by Posttraumatic Growth Theory and offers the possibility that childbearing presents an opportunity for processing traumatic material.

This idea is related to the trauma reactions women described experiencing during the childbearing year. These reactions, such as experiencing emotions associated with past trauma and having physical reactions to the sensations and procedures associated with childbirth, are described as distressing. Looking at these trauma reactions through the lens of Posttraumatic Growth Theory, the reactions can be seen as presenting opportunities to process past trauma and promote growth and healing. As Linda suggested, "it [birth] was like 15 years of therapy in 20 hours. It was amazing. I went through like everything I was angry to feeling great and being panicked to really, really emotional, a lot of crying". As described in the framework below, how women cope with these reactions and the support they have from care providers may impact whether these reactions are processed and transform into growth.

Evidence in the literature and this study suggest that childbearing can present an opportunity for emotionally, physical, and relationally processing past traumatic material. Participants in this study felt that the growth and healing arrived at through the childbearing process was specifically tied to the triumphs of reproduction: growing a baby, giving birth in an empowered way, and parenting a child.

## Other Factors

Two other themes were discussed with sufficient significance by participants to merit reporting, though they have no clear connection to the research query. These themes: *pain during labor* and *anxiety and nervousness* are discussed below.

Though fear was an emotional trauma reaction noted in the Findings section, some participants reported experiencing anxiety and nervousness that was not related to past sexual violence. Some participants tied their anxiety to other events in their lives, and others did not report the source of their worry. Anxiety and nervousness that was not clearly related to prior sexual violence was discussed by three participants. Joan described how anxiety at times felt difficult to manage.

In the middle of everything [labor] I felt so nervous like I thought I would never, I was never going to get the baby outside of me. I felt like I would be in labor forever, which is kind of a funny thing to say, but I definitely felt like that was true; like I was going to be pregnant forever and knowing it was never going to end, and I had a lot of fears and worries.

Charlotte also described anxiety related to a difficult birth she had witnessed in the past. She stated, “I was much more afraid of things like Pitocin and epidurals and things like that than I think other people might be because [relative]’s birth was really traumatic”.

Four participants talked about pain during labor, specifically struggling to cope with pain. These mentions of labor pain were not related by the participants to prior sexual trauma. The following quote illustrates Chelsea’s experience of pain in labor. “I would describe it as shock and horror. It was shocking, and there was some, I wouldn’t call it traumatic, but wow! It was horror”.



Bertha echoed a struggle to cope with intense labor pain, stating, “I just remember some really intense pain around that time where it was just overwhelming and then I just kind of like was having a really hard time dealing with it”. Though the literature demonstrates that women who have a history of sexual violence report more discomfort and pain during labor (Grimstad & Schrei, 1999; Van der Hulst, et al., 2006), the participants in this study did not relate their experiences with extreme pain to their past sexual trauma.

These two themes of anxiety and nervousness and pain during labor do not necessarily tie back to the research phenomena of how prior sexual violence effects women’s experiences with pregnancy and childbirth, but they offer insight into possible other queries about how women experience childbearing.

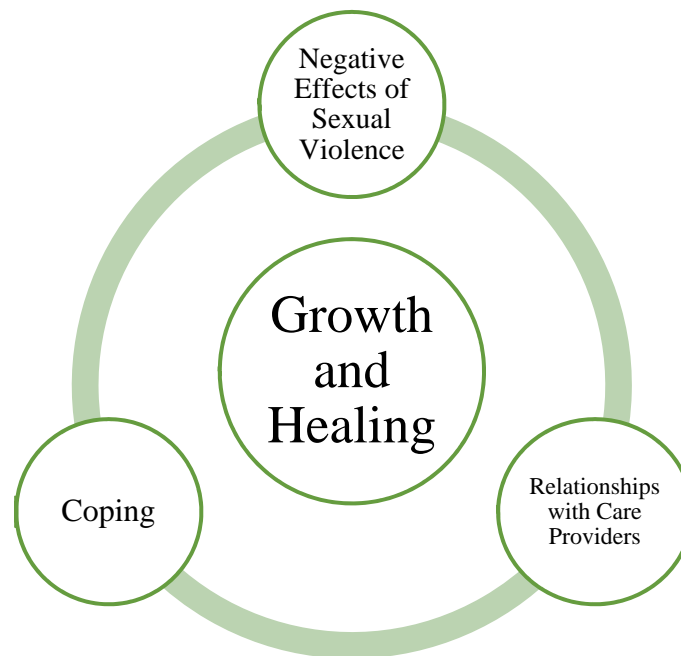
The following section outlines a framework that describes how the four main themes, related to the research query, found in this study interact to shape women’s experiences with childbearing after sexual violence. This framework is a way of understanding the relationship between the four themes found in this study. It can also be used to guide social work and maternity care practice and offer childbearing women a way to conceptualize their individual experiences. Though each woman has her own path and will experience childbearing in a unique way, the framework described here presents her with information that can help empower decisions she makes throughout that process.

### **Framework of Intersecting Themes**

This study led to the generation of a framework encompassing the four main themes found in the data: *negative impacts of sexual violence*, *coping*, *care providers*, and *growth and healing*. This framework, explained pictorially below, captures the dynamic relationship between these four themes and proposes that they interact with and impact each other throughout the

childbearing process, influencing the unique experiences that women have around dealing with past sexual violence during the childbearing year. I will overview the dynamics of this framework here and then make suggestions for social work and maternity care practice.

Figure 5. 1 Framework of intersecting themes.



As almost all participants in the study identified some way that past sexual violence impacted their experiences with childbearing this theme is at the top of the framework, illustrating that this may be something that many women carry into the childbearing experience. The positioning of this theme is also influenced by the psychodynamic theoretical supposition that pregnancy is a time of inherent psychological growth, which may include the re-experiencing of past relational and developmental traumas (Notman & Lester, 1988). At one side is the important theme of *coping*, which may mitigate or exacerbate to some extent how intensely

women experience the negative effects of sexual violence. For example, Charlotte explained how she felt that learning positive coping skills helped her to have a positive birthing experience.

I can recognize that if I wasn't in the place that I'm in now that would be a really I think it would've been a very different feeling, like I feel like feeling the kind of safe and comfortable in my own self now is what gave me the ability to have the kind of authentic, nice, good, you know, pregnancy and birth experience that I had, without having all of the just really awful feelings that I had before all the time. And I think that I couldn't have had this birth experience if I didn't do the work that I did, you know, all those years ago. I think my pregnancy and my birth would've been really different.

At the other side of the framework is *relationships with care providers*, another important factor that may play a moderating role in both how women experience the negative effects of sexual violence during pregnancy and childbirth and in the potential for finding growth and healing during the process of childbearing. A quote from Joan articulates how a positive experience with maternity care providers promoted growth and healing from sexual violence.

I felt nurtured you know after my birth, [my midwife] brought me strawberries and yogurt because that was what I wanted. They let me go upstairs. I received one kind of a vaginal inspection then to see you know what the birth had done, and you know they talked to me about what they saw. They were more calm. I guess I did get a little bit of closure in that moment you know when my three midwives were looking at my, my personal areas and telling me what they saw and telling me what my body went through and being honest.

Finally at the center of the framework is *growth and healing*, a ubiquitous theme that all participants touched upon in some way. Growth and healing may be arrived at through the processing and confronting of negative effects of sexual violence. This processing or confrontation can occur in the context of the care provider relationship as described by Joan, through coping methods, as described by Charlotte, through the processes of childbearing, or in some other way not captured in this framework. Linda described how childbearing promoted healing from sexual violence for her.

Birth is an amazing and powerful process. It's amazing to me that it has, obviously the power to bring another life into the world, but it's also, it has the ability to change, you know, my perception of the world through, you know, becoming a mother, and I always think it was like so much therapy in a day or two days, depending on the situation, and I also feel like having a crazy sexual, you know, having a past before I had a baby, I thought nothing would make me a mom, it's amazing to me the healing that I've been able to do around that experience of having kids.

As Wampler and Schwerdtfeger (2009) articulated a “bi-directional” experience for pregnant sexual trauma survivors of attending to the tasks and changes of childbearing while at the same time attending to the psychological resurfacing of trauma reminders, the framework proposed here attempts to shine light on the dynamic interplay of many factors. For some women coping may mitigate trauma-related reactions and promote growth and healing. For others having a positive care provider relationship can play that role. Conversely, negative experiences with care providers can be disempowering and reinforce negative beliefs and trauma reactions, causing further traumatization or inhibiting the growth and healing potential of childbearing.

Shauna articulated how she felt unsupported during her labor when she was struggling with feeling unsafe, a feeling that she attributed to her past experiences of sexual violence.

If I had surrounded myself with a little more of that [support] it really, maybe had I told someone what happened to me and that might have affected it, it might've gone better. I just got really scared, and I know that's what it was [trauma reaction] I didn't really have anyone there, my midwife was, I don't know there was like another women giving birth down the hall, so she was back and forth, she's kind of like a doctor that way...I didn't have anyone right there with me kind of helping me through and I really needed that extra support.

Shauna's experience points to the importance of care providers to birth outcomes and to women's perceptions of the birth experience. It illustrates the relationships described in the framework. For Shauna birth was not experienced as empowering, but was instead scary and isolating. The way her midwife interacted with her reinforced the physical and emotional trauma reactions she was experiencing. Had she felt emotionally and physically supported during her birth, as she suggests in the quote above, "it might've gone better".

Simkin and Klaus (2004) and Sperlich and Seng (2008) both identify many of the same themes found in this framework as important aspects of women's experiences with childbearing after sexual violence. Sperlich and Seng (2008) describe how sexual trauma manifests in the different phases of childbearing: preconception, pregnancy, labor and birth, postpartum, and in mothering. They also identify "healing and survivorship" as an overarching theme in all the above phases (p. vii). Simkin and Klaus (2004) identify negative effects of sexual trauma that arise in the childbearing year and also present the care provider relationship as central to women's experiences with childbearing.

Vancouver Coastal Health (2009) offers a Framework for Girls' and Women Centered Health that is not specific to maternity care, but is meant to guide care providers promoting health for girls and women. This framework is presented as a 12-petaled flower, describing many aspects of caring for girls' and women's emotional, physical, mental, and spiritual health. Several of the themes presented in my framework are also mentioned the Vancouver Coastal Health (2009) model, including empowerment and safety (facets of growth and healing in this framework) and decision-making (a facet of care providers in this framework).

The framework I have presented here is unique in its focus on the connection between past sexual trauma and reproductive health. It encourages providers and mothers to consider how trauma reactions might manifest, to promote positive coping and empowering relationships with maternity care providers, and to focus on childbearing as carrying the potential for growth and healing. It is an empowering tool for mothers who often described themselves as wanting more information, support, and knowledge. Access to this framework could help women feel more knowledgeable about and in control of the experiences they have with childbearing.

This framework helps to better understand the multi-directional relationships between women's trauma reactions, how they cope, their relationships with care providers, and their experiences of growth and healing through pregnancy and childbirth. In the following section I will describe how this framework can be used to inform social work and maternity care practice.

### **Considerations for Practice**

The findings in this study suggest that relationships with care providers are an important theme for childbearing women who are survivors of sexual violence. The data in this study also suggests that positive relationships with maternity care providers can promote *empowerment*, a facet of *growth and healing*. This study's findings emphasize the importance of listening to

women, offering emotional support, and allowing women to make decisions about their own care. As Simkin and Klaus (2004) state, “when the relationship between the woman and her caregiver is strong and positive, physical outcomes improve from the resulting increase in openness...for the abuse survivor, there is enormous potential for healing” (p. 111). They go on to state, “the most helpful caregivers...are honest, empathic, and respectful in their dealings with [women]” (p. 136).

Social workers can promote these positive aspects of the maternity care provider relationship by encouraging childbearing women to find providers who offer long appointments, emotional support, and informed choice. Social workers can also help women understand their choices and advocate for their wishes to be respected whenever possible. Finally social workers can play a role acting as liaisons for childbearing women with their maternity care providers, advocating for their needs to be accommodated whenever possible.

Maternity care providers can incorporate the same principles, focusing on listening, providing emotional support, and offering informed decision-making opportunities to their clients. Because not all women will disclose whether they have a history of sexual violence applying these principles to all childbearing clients can ensure that survivors of sexual violence receive care that meets their needs.

Maternity care providers and social workers can both normalize the affective, physical, and relational reactions that survivors of sexual violence may experience during the childbearing year. They can also promote positive coping, such as planning and educating, self-care, and engaging partners in providing emotional support, all of which may be associated with improved childbearing experiences.

The framework of intersecting themes described in this study can be a guide for practitioners and for women who are survivors of sexual violence during the childbearing year. This framework can guide attention to the four themes, encouraging positive coping and supportive relationships with providers to reduce negative effects of sexual violence and increase opportunities for growth and healing.

Because *empowerment* is described as a main avenue for *growth and healing* in childbearing women with a history of sexual violence, this framework should be made available to women. Mothers may find the information in this framework can guide decision-making about maternity care and can influence the coping and support that women utilize and seek in the childbearing year.

Though social work and maternity care practice are all impacted by structural constraints such as insurance reimbursement and clinic protocols, increasing women's access to information, normalizing trauma-related reactions, supporting decision-making, and providing emotional support can all foster improved maternity care experiences for women with a history of sexual violence.

### **Study Strengths and Limitations**

The research question and study design were successful in collecting women's reflexive thoughts about how their histories of sexual violence negatively impacted their experiences with childbearing. This study remains close to the participant's voices, an important part of the study design, and emphasizes the meaning that participants made of their experiences.

The interview guide prompted responses that were tied to the research question, however the interview guide appeared to greatly impact the themes generated from the data analysis. The interview guide contained specific questions about coping and about relationships with care



providers, which affected the generation of these themes as central to the data analysis. Also, participants were asked to reflect on both the positive and negative dimensions of their experiences, which impacted the development of those themes as well.

The major limitations of this study come through in the sample bias, including a small sample size, self-selection, and lack of sample diversity. There are a number of sample biases in this study, which can indicate problems with validity and reliability. The validity of the theory generated from this inductive study is limited by the nature of the sample such that it may be particular to the sample. The framework outlined in this study offers a suggestion for using this data. Further study could discover whether this framework holds up in other study samples or in other contexts. However, given the practical nature of the findings and recommendations, they stand as good social work practice consistent with the field.

All study participants self-selected for the interviews, which may indicate increased self-reflection on the part of participants about the connection between prior sexual violence and childbearing. Also people who self-selected for the study may be more likely to have experienced a connection between these two events. The study is quite regionally discrete with ten out of eleven participants living in Northern New England. The study participants all identified as white or of European descent, demonstrating an extreme racial sample bias. White women in the U.S., as Seng, et al. (2011) state are more likely to have access to resources to address negative effects of sexual trauma and to have access to choices regarding maternity care when compared with African American women in the U.S., which may affect the findings of this study and their applicability to other racial or ethnic populations.

Belonging to an oppressed population may have an impact for some women on birth outcomes, access to empowering maternity care, and other factors. The racial homogeneity of

this study and the lack of lesbian-identified study participants means that many important themes may be missed that could have emerged were the study sample more diverse. For example, Reed, et al. (2011) found that women who belong to sexual minorities may create a different meaning of childbearing and motherhood than heterosexual women. Also Collins (2000) states that mothering is an identity-affirming experience for black women, infused with Afro-centric values. It is possible that were this study replicated with a different population the themes generated would differ, which points to a lack of reliability for this study.

Economic status may influence the level of support and services available to different women in my sample. Prior therapeutic encounters, widespread community support, the ability to pay for childcare or have a safe place to live are all factors that could influence women's experiences of pregnancy and childbirth.

Finally, this study population is more likely to have chosen a home birth than the general U.S. population, with 5 out of 11 participants having home births for at least one child. A higher home birth population introduces several biases, including low-risk pregnancies, and may indicate increased empowerment over making decisions regarding maternity care. All of these biases in the sample are concerning because the sample universe is a very diverse population, which the study sample does not represent. As discussed above, further study should be done to examine whether the framework derived from this study applies to other populations, other contexts, and other regions.

### **Researcher Bias**

Corbin and Strauss (2008) stress the importance of researcher reflexivity in data collection and analysis in qualitative research. As they state, "due to this reciprocal influence

[between researcher and participant], the researcher and the participants co-construct the research” (p. 31).

My social location as a researcher has a bearing on the study biases, including the use of personal connections for recruitment. I am a white-identified researcher living in the Northeast, which contributes to the homogeneity of the sample. I also had a home birth, which may contribute to the extreme sample bias in this regard. I used convenience sampling methods, recruiting through one homebirth midwifery practice, which contributed to the skewed sample regarding home birth. Finally, I identify as a mother who has a history of sexual violence. This shapes the research in several important ways. First, I would not have considered this research question if I did not first believe that my personal history with sexual violence impacted how I experienced pregnancy and childbirth. This may cause me to look for other women to reflect that same experience.

I used my research journal for bracketing throughout the research process, including after every interview to examine what personal emotions I experienced through the research process. I was very moved by the stories that study participants shared with me, and those emotional reactions are reflected in the research journal. My feelings about participant interviews most likely were communicated to participants through the interview process, and may have impacted their responses. Also in data analysis, these emotions could cause me to look for responses that resonate with my personal experience or to put greater gravity in responses that reflected my own. Conversely, my experiences as a mother and survivor of sexual violence may positively contribute to the study by promoting an intimate attunement and attention to participants’ emotional experiences.

My social location and membership in my own sample universe offer unique challenges and opportunities to the research design, data collection, and data analysis. Further study should be done with different locations and populations to compare these findings and search for reliability in themes or in the framework suggested here.

### **Areas for Further Research**

As mentioned previously there are many areas for further research that could provide wider knowledge about the research question. Further research should be conducted with different populations than the sample in this study and in different regions to discover whether the themes identified here retain their validity. It would be interesting to discover what different themes may arise in a different population.

The framework presented here to guide practice with childbearing women who are survivors of sexual violence could be tested to see if it resonates with women's experiences and whether it offers a positive contribution to social work and maternity care practice. Such testing could further refine how social workers and maternity care providers approach work with mothers who have a history of sexual violence.

Further research could be conducted as well into the dimensions of women's relationships with their maternity care providers, including comparing and contrasting different birth settings and maternity care models. This study provided positive support for homebirths and for the midwifery model of care, however, as previously stated the sample was not representative of the general population. It would be interesting to see what the positive and negative dimensions of birth experiences for survivors of sexual violence in an obstetric practice are compared with midwifery practice. I also recommend further research examining maternity care providers' perceptions of their clients with a history of sexual violence. This research query

could help illuminate whether women with a sexual trauma history are treated differently in maternity care than women without such a history and what issues doctors and midwives bring to the client/provider relationship.

I also recommend further research into how variables in type of trauma, severity of trauma, and relationship to perpetrator impact women's experiences with childbearing. This research could offer insight into some of the specific issues that may come up for women as they begin to mother their own children. I did not examine the relationship of the character of the sexual trauma participants experienced and its effect of childbearing in this study at all. Other studies have found that number of traumas, severity of trauma, and relationship to perpetrator all play a role in the long-term effects that survivors of sexual violence experience (Felitti, et al., 2006). These findings suggest that studies controlling for these factors could further illuminate the complicated relationship between sexual trauma and childbearing.

Though this research study increases the literature about how women with a history of sexual violence experience childbearing, there are many more aspects of this topic that could be studied, contributing to a greater depth of knowledge on this topic.

## **Conclusion**

Sexual violence is, tragically, an enormous problem in U.S. society. Because it affects so many, understanding how sexual violence can impact and interfere with how women experience pregnancy and childbirth is important both for mothers and for care providers working with childbearing women.

This study provides important information about how women who have a history of sexual violence experience childbearing. The findings and discussion offered here are meant to maintain fidelity to the participants' voices and at the same time draw connections in the data.

The framework presented here distills the findings into four intersecting themes that can impact how women with a history of sexual violence experience pregnancy and childbirth. This framework is meant to guide social workers and maternity care providers in caring for these women throughout the childbearing year. It is also meant to provide information to childbearing women who have experienced prior sexual violence.

This study is limited by sample bias and sample homogeneity, prompting further research to continue to probe the research question. Though this study and the resulting framework are not generalizable, this research deepens our understanding of how women can be negatively affected by past sexual trauma in the childbearing year, how coping methods and relationships with care providers affect women's childbearing experiences, and of the growth and healing potential of pregnancy, childbirth, and becoming a mother.

The growth and healing that study participants describe experiencing through the process of having and mothering their children is inspiring and powerful. These women illustrate how triumph over past trauma can lead to long-term personal growth. One study participant, Lauren, explains beautifully how childbearing empowered her to stand up to an abuser and begin to see herself differently. She describes both psychological and spiritual development in this passage, summing up many of the voices in this study.

It [childbearing] gave me courage, it gave me some kind of strength to actually tell my father to get out of my life, to know that my body was mine, that it didn't belong to somebody else, and there was a feeling of just really strong, some kind of interconnection with the divine. I can't explain it any more than that, just a feeling of this is a miracle, and this is what's supposed to be, not what happened back then [abuse].

All of us are changed as we walk through life. We are shaped by societal forces, by those around us, by our individual selves, and by the things that happen to us along the way. This study examines and connects two aspects of the participants' lives: sexual violence and childbearing and shows the varied and complex ways that the women in this study confront, cope with, and learn from experience. It is my hope that the information and the framework presented in this study will be of use to care providers and families in the childbearing year.

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## Appendix A: Recruitment Letter and Facebook Post



Greetings!

My name is Gretchen Davidson, and I am a graduate student at Smith College School for Social Work. I am currently conducting a research study to fulfill the thesis requirement of my graduate program. This study, titled: *Survivors of Sexual Violence and their Experiences with Pregnancy, Labor, and Childbirth* will explore how women who have a sexual trauma history experience pregnancy and childbirth. Participation in this study is confidential.

**As part of the study, you would be asked to participate in a 45-minute interview in-person or over the phone that will be audio recorded. In order to be part of the study you must:**

- be a woman who has experienced unwanted sexual contact prior to becoming pregnant
- have at least one living, biological child who is over 6 weeks old
- be able to complete the interview in English
- be willing to participate in the study

**Your participation in this study will be kept confidential.** You will not be monetarily compensated for participating in this study. Some study participants find they benefit from talking about their experiences. Participation in this study also carries the risk of causing psychological distress due to talking about difficult past experiences. The results of this study may be published or used in presentations, though individual identities will be disguised. Participants have the right to withdraw from the study at any time.

**If you are interested in participating in this study you may contact me by email at or by phone at .** If someone you know would be interested in being interviewed for this study, please forward this message to them.

**Thank you for your time and consideration and I look forward to hearing from you!**

Appendix B: Informed Consent Form



Consent to Participate in a Research Study  
Smith College • Northampton, MA

.....

**Title of Study:** Survivors of Sexual Violence and their Experiences with Pregnancy, Labor, and  
Childbirth

**Investigator(s):**

Gretchen Davidson

.....

**Introduction**

- You are being asked to participate in a research study examining how mothers who have a history of unwanted sexual contact experience pregnancy and childbirth.
- You were selected as a participant because of you have experienced unwanted sexual contact and are a mother who has given birth to a child who is at least 6 weeks old.
- I ask that you read this form and ask any questions that you may have before agreeing to be in the study.
- I have completed the CITI on line training course prior to HSR approval. The certificate of completion is on file at the SSW

**Purpose of Study**

- The purpose of the study is to gain a deeper understanding of the relationship between unwanted sexual contact and women’s experiences with pregnancy and childbirth. The purpose of conducting in-depth interviews is to gain this understanding through women’s own words.
- This study is being conducted as a thesis requirement for my master’s in social work degree.
- Ultimately, this research may be published or presented at professional conferences.

**Description of the Study Procedures**

- If you agree to be in this study, you will be asked to do the following things: Participate in a one-time 45 minute interview with the researcher. This interview will be audio recorded and transcribed. This interview will discuss your experiences with pregnancy and childbirth and may involve discussion of your experiences with sexual violence. During this interview I will also ask the following demographic questions: your current age, age at first birth, race, sexual orientation, and income level.

**Risks/Discomforts of Being in this Study**

- The study has the following risks. First, the interview questions may elicit distressing memories about the sexual violence you experienced and about your previous pregnancies and labors. Second, these memories could cause psychological distress. Before the interview I will mail to

you a mental health resource sheet that describes how to access mental health resources, including crisis services in your area. These resources are available should you experience psychological distress as a result of participation in this study.

### **Benefits of Being in the Study**

- The benefits of participation in this study are that many women find it helpful to discuss issues that are important to them, such as pregnancy and birth experiences and even negative experiences such as sexual violence. You may gain insight into your own past experiences as a result of participating in this study.

### **Confidentiality**

- The records of this study will be kept strictly confidential. Research records will be kept in a locked file, and all electronic information will be coded and secured using a password protected file. Only the researcher and a paid transcriber who has signed a confidentiality agreement will have access to the audio recordings. I will not include any information in any report I may publish that would make it possible to identify you.
- The data will be kept for at least three years according to Federal regulations. They may be kept longer if still needed for research. After the three years, or whenever the data are no longer being used, all data will be destroyed.
- Your information will be identified by a pseudonym, and any quotes from your interview that appear in the report will be represented by this pseudonym that has no connection to your actual name.

### **Payments**

- You will not receive any financial payment for your participation.

### **Right to Refuse or Withdraw**

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely at any point during the study. If you choose to withdraw, the researcher will not use any of your information collected for this study. You must notify the researcher of your decision to withdraw by email or phone by January 5, 2014. After that date, your information will be part of the thesis, dissertation or final report.

### **Right to Ask Questions and Report Concerns**

- You have the right to ask questions about this research study and to have those questions answered by me before, during, or after the research. If you have any further questions about the study, at any time feel free to contact me, Gretchen Davidson at or by telephone at . If you like, a summary of the results of the study will be sent to you. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

### **Consent**

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep, along with any other printed materials deemed necessary by the study researcher.

.....

Name of Participant (print): \_\_\_\_\_

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Researcher(s): \_\_\_\_\_ Date: \_\_\_\_\_

.....

**[if using audio or video recording, use next section for signatures:]**

**1. I agree to be [audio or video] taped for this interview:**

Name of Participant (print): \_\_\_\_\_

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Researcher(s): \_\_\_\_\_ Date: \_\_\_\_\_

**2. I agree to be interviewed, but I do not want the interview to be taped:**

Name of Participant (print): \_\_\_\_\_

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Researcher(s): \_\_\_\_\_

## Appendix C: Interview Guide

### Demographic Questions

What is your current age? Age at time of birth(s)?

What is your income level?

- \$0-25,000
- 26,000-50,000
- 51,000-75,000
- 75,000 +

How do you identify your race or ethnicity? Please check all that apply.

How do you identify your sexual orientation? Please check all that apply.

### Overview of pregnancy and birth

Please provide a brief orienting overview of your birth experience.

What emotions do you remember experiencing in pregnancy? Labor? During the birth?

What helped you cope with your pregnancy, labor, and birth?

Did pregnancy affect how you felt about your body or your sexuality?

### The relationship between sexual violence and childbearing

Now I would like to shift into talking about the impact that having experienced unwanted sexual contact might have had on your experience of pregnancy and birth.

Looking back do you think having experienced unwanted sexual contact influenced your pregnancy, labor or birth? How?

Did the pregnancy or birth change how you felt about any earlier unwanted sexual experiences?

### Maternity care

Now I would like to ask you about your relationship with your maternity care provider.

Did you ever share your history with your provider or was there a way that your provider knew about it?

What influenced your decision to share or not share that information?

How did your maternity care provider address this history in your treatment?

What was helpful or unhelpful about what your maternity care provider did to support you?

Is there anything you wish your maternity care provider had said or done around this information?

**Follow-up question**

Is there anything more you would like to say about how these experiences have positively impacted you?

## Appendix D: HSR Approval Letter



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**School for Social Work**  
Smith College  
Northampton, Massachusetts 01063  
T (413) 585-7950 F (413) 585-7994

December 31, 2013

Gretchen Davidson

Dear Gretchen,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.  
Co-Chair, Human Subjects Review Committee

CC: William Lusenhop, Research Advisor



## Appendix E: HSR Amendment Approval Letter



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**School for Social Work**  
Smith College  
Northampton, Massachusetts 01063  
T (413) 585-7950 F (413) 585-7994

January 21, 2014

Gretchen Davidson

Dear Gretchen,

I have reviewed your amendment and it looks fine. This amendment to your study is therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.  
Co-Chair, Human Subjects Review Committee

CC: Will Lusenhop, Research Advisor