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Nicole Vengrove Soffer
When Childbearing Triggers
Trauma: How Obstetric Nurses
Support Sexual Abuse Survivors
Through Pregnancy and Childbirth

ABSTRACT

Survivors of sexual abuse may experience heightened vulnerability and sensitivity during their pregnancies and child birthing processes. This qualitative study explores how Obstetric and Gynecology (OBGYN) nurses understand and respond to the unique needs of this population, and how they partner with social workers to do so. This research highlights OBGYN nurses' attunement to survivors' needs and suggests ways that nurses and social workers can better work together to provide comprehensive care and therapeutic interventions to pregnant sexual abuse survivors. Participants (n=33), who completed an online anonymous survey, are Registered Nurses who have knowingly worked with at least one sexual abuse survivor and are employed at a United States hospital, health clinic, and/or private practice that accepts Medicaid health insurance. Findings indicate that when OBGYN nurses alter care for sexual abuse survivors, they do so in a way that promotes safety, control, and privacy for their patients. However, nurses would benefit from additional training on how to specifically respond to survivors' post-traumatic stress reactions. Social workers are encouraged to share their expertise in trauma treatment and provide obstetric nurses with therapeutic techniques that can help prevent survivors from becoming re-traumatized during prenatal exams and labor and delivery procedures.

WHEN CHILDBEARING TRIGGERS TRAUMA:
HOW OBSTETRIC NURSES SUPPORT SEXUAL ABUSE SURVIVORS
THROUGH 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.

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2011

ACKNOWLEDGEMENTS

This thesis is dedicated to women whose trauma histories cast a shadow on their lives, but whose courage allows them to face both the joys and the struggles of pregnancy, childbirth, and ultimately motherhood.

To the nurses and social workers who are devoted to supporting women through such a transitional and vulnerable experience—this research is also a tribute to you.

A heartfelt thank you to those who helped me accomplish this thesis:

The OBGYN nurses who took time out of their busy lives to participate in this study; and the various professionals, colleagues, and friends who assisted me with recruiting these nurses.

Natalie L. Hill, my research advisor, whose thorough feedback and guidance ensured that I am proud of this piece of research.

My parents, Susan and Marc, and my sister, Sara, whose ever-present support, love, and encouragement has allowed me to embrace life in every way.

And my husband, Matt, who keeps me grounded, makes me laugh, and embodies the definition of a true partner.

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CHAPTER ONE

Introduction

The process of childbearing causes enormous physical, mental, and emotional changes and transitions within a woman's body and life. For a survivor of sexual abuse, pregnancy can be an especially difficult experience. This study explores how Obstetrics and Gynecology (OBGYN) nurses conceptualize and treat pregnant women who are survivors of sexual abuse. Through an anonymous, qualitative, online survey, OBGYN nurses answered questions regarding their work with pregnant, sexual abuse survivors. This research expands upon the existing research on the role that nurses play when working with women who have been abused. This research also highlights gaps where further training and collaboration between nurses and social workers may improve care to this vulnerable population. Social workers may use this research to partner more effectively with nurses to improve patient care and provide adequate support for sexual abuse survivors' unique needs during pregnancy and birthing.

Sexual abuse is loosely defined as "sexual activity where consent is not obtained or freely given" (Centers for Disease Control and Prevention, 2009). Sexual abuse can include sexual violation (touching and/or penetration) of an adult or minor, by a stranger, family member, or intimate partner (Centers for Disease Control and Prevention, 2009; Mannon & Leitschuh, 2002; Squire, 2009). For survivors of sexual abuse, inherent changes that occur within the body and sexual organs during pregnancy and labor and delivery may trigger memories of past sexual traumas (Issokson, 2004; Rose, 1992). Such memories, which may then be associated with the process of pregnancy and labor, may even cause the woman to become re-traumatized.

Re-traumatization can be understood as a recurring cycle “with four interrelated sub processes: hypersensitivity to threats of safety, exposure to triggers, post-traumatic stress reactions, and avoidant coping” (Dallam, 2010, p. iv). A woman who has been sexually abused may become hypersensitive to threats of safety during situations where she is made to feel vulnerable or out of control (Dallam, 2010). Such hypersensitivity may occur during vaginal examinations, which take place during prenatal visits and while the woman is in labor (Coles & Jones, 2009; Dallam, 2010; Leeners et al., 2007). If the health provider then says or does something to make the woman feel unsafe, she may respond with post-traumatic stress reactions that include dissociating, screaming, or fighting the provider (Cole, Scoville, & Flynn, 1996; Dallam, 2010; Parratt, 1994; Rose, 1992; Simkin, 2009; Squire, 2009). This then makes the woman feel that she has been re-traumatized (Cole et al., 1996; Dallam, 2010). In the case of a prenatal visit, such re-traumatization can then lead her to avoid future prenatal appointments; this avoidance puts both her and her fetus at risk for complications (Issokson, 2004; Rhodes & Hutchinson, 1994). In the case that this re-traumatization occurs during labor, the woman may develop Post-Traumatic Stress Disorder (PTSD) symptoms following childbirth (Lev-Wiesel, Daphna-Tekoa & Hallak, 2009).

Given that many women come into contact with OBGYN nurses during pregnancy and the birthing process, survivors of sexual abuse may benefit from supportive nurses who are sensitive to and knowledgeable about the impact that past traumas may have on a woman’s birthing experience (Cole et al., 1996). Such sensitivity may help pregnant survivors of abuse have a more positive and meaningful experience of pregnancy and birthing and also minimize the risk of re-traumatization (Rhodes & Hutchinson, 1994). Therefore, the current study explores and analyzes how OBGYN nurses assess for a sexual abuse history, adjust their care to meet a

survivor's needs, and engage social workers in caring for pregnant patients who have a sexual abuse history. This research highlights the importance of social workers and nurses working as a team to address survivors' potential vulnerabilities during pregnancy and childbirth.

CHAPTER TWO

Literature Review

Defining Sexual Abuse

Sexual abuse tends to be an umbrella term for more specific types of sexual abuse including: childhood sexual abuse, incest (sexual contact between an adult and child family member), stranger rape (forced intercourse where the perpetrator is a stranger), and partner rape or intimate partner violence (sexual assault between partners; Rape, Abuse, and Incest National Network, n.d.). Researchers, however, continue to disagree on a universal definition of sexual abuse (Haugaard, 2000; Mannon & Leitschuh, 2002; Squire, 2009). Sexual abuse definitions tend to differ around and be based on the age of the victim at the time the abuse occurs, the victim's relationship to the perpetrator, and the age difference between the victim and perpetrator (Mannon & Leitschuh, 2002; Squire, 2009). These age and relationship differentials attempt to distinguish between sexual abuse and sexual exploration (Squire, 2009).

Many researchers, however, use the terms *childhood sexual abuse* and *sexual abuse* interchangeably, suggesting that only children can be victims of sexual abuse (Mannon & Leitschuh, 2002). This is especially problematic since 54% of sexual abuse victims are over the age of 18 (U.S. Department of Justice, 2004). In fact, in 2008, the rate of sexual abuse victims ages 20-24 years old was higher than the rate of sexual abuse victims who were ages 12-15 years old (U.S. Department of Justice, 2008).

In defining sexual abuse, researchers also disagree over the type of sexual activity and the context that the sexual activity needs to take place in. For example, some researchers argue that

sexual contact needs to occur, while others argue that contact is not required (such as child pornography or forcing someone to look at sexual anatomy; Ghate & Spencer, 1995; Haugaard, 2000; Johnson, 2001; Mannon & Leitschuh, 2002; Squire, 2009). Other researchers highlight cultural differences and familial norms which influence how behavior is categorized as sexual abuse; for example, in some cultures it is normal for children and adults to be nude in front of each other (Mannon & Leitschuh, 2002; Squire, 2009). Researchers also differ in their definitions of informed consent; some researchers argue that children have the ability to give consent, while others argue the opposite (Squire, 2009).

For the purpose of this study, sexual abuse will be defined as occurring when a partner, family member, or stranger forcefully touches a child or adult in her sexual and/or genital organs, without informed consent; when the victim is a child, it is assumed that the child is not mature enough to give informed consent (Centers for Disease Control and Prevention, 2009). Since women are sexually abused at a higher rate than men, victims/survivors will be referred to in the feminine (U.S. Department of Justice, 2008).

Sequelae of Sexual Abuse

Physical and psychological effects of sexual abuse. Sexual abuse, whether it occurs in childhood or adulthood, can have long-term negative effects on women's physical and psychological health as well as their social lives and overall behaviors (Kendell-Tackett, 2003; Steel, Sanna, Hammond, Whipple, & Cross, 2004). Childhood sexual abuse survivors experience more health problems such as headaches, gastrointestinal problems, pelvic pain, chest pain, shortness of breath, and obesity than non-childhood sexual abuse survivors (Hulme, 2004). Childhood sexual abuse survivors are more likely to consider suicide and are about three times more likely to suffer from depression than women with no sexual abuse history (Hulme, 2000;

Zuravin & Fontanella, 1999). Women who have a history of childhood sexual abuse are more likely to report a higher number of physical and psychosocial complaints and are 1.33 times more likely to visit a primary care clinic than women without a childhood sexual abuse history (Hulme, 2000, 2004).

While every abuse survivor copes differently, victims of childhood sexual abuse report higher levels of psychological distress than individuals who are survivors of other forms of abuse (Brayden, Deitrich-MacLean, Dietrich, Sherrod, & Altemeier, 1995; Steel et al., 2004; Weinberg, 2008). The severity of psychological distress in adulthood largely depends on the number of offenders involved and the duration of the abuse, mediated by how the victimized individual understands the causes of the abuse (Steel et al., 2004). The longer the abuse occurs and the older the individual is during the time of abuse, the more likely the individual will blame herself and even accept responsibility for the abuse. Adults who blame themselves for the abuse often suffer from a high level of psychological distress (Steel et al., 2004).

Dissociation. Individuals who have experienced sexual abuse may employ the unconscious, psychological defense of dissociation, which Schamass and Shikret (2008) define as occurring when:

...a painful idea or memory is separated from the feelings attached to it, thereby altering the idea's emotional meaning and impact. It is the core defense among incest survivors and among adults who were abused as children..." (p. 81).

Dissociation is an alternative to the flight or fight response. When the victimized individual is so overpowered that fighting back or running away is not an option, the individual may dissociate in order to numb the emotions (Allen, 2001). Dissociation can be defined on a continuum that spans

from detachment to compartmentalization (Allen, 2001; Brown, 2006). Detachment includes becoming unresponsive, a self-observer (feeling outside one's body), and absorbed in one specific detail so as to detach from the other details that are occurring in the moment; detachment creates a change in the individual's emotional experience of what is occurring in reality (Allen, 2001; Brown, 2006). Compartmentalization, on the other hand, is the ability to separate reality from consciousness (Allen, 2001). While detachment may lead to PTSD, compartmentalization may lead to somatoform disorders, dissociative amnesia, and even dissociative identity disorder (Allen, 2001; Brown, 2006). Employing dissociation can put survivors at risk for taking part in future high-risk behaviors.

Substance abuse. Childhood sexual abuse survivors are more likely than individuals who were not sexually abused as children to abuse substances (Briere & Runtz, 1993; Rotheram-Borus, Mahler, Koopman, & Langabeer, 1996; Wilsnack, Vogeltanz, Klassen, & Harris, 1997). In fact, women who have been sexually abused as children are at a high risk for abusing substances as adults (Briere & Runtz, 1993; Wilsnack et al., 1997). This risk for substance abuse may be a way for survivors to emotionally avoid and dissociate from the psychological pain that such abuse caused (Briere & Runtz, 1993; Messman-Moore & Long, 2003).

Adolescent pregnancy. Researchers have also found a relationship between childhood sexual abuse and adolescent pregnancy (Boyer & Fine, 1992; Francisco et al., 2008; Stock, Bell, Boyer, & Connell, 1997). Adolescent girls who were sexually abused display more high-risk, sexual behaviors than adolescent girls who were not sexually abused. These high-risk behaviors result in adolescent girls becoming pregnant at higher rates than girls who were not sexually abused (Stock et al., 1997). Adolescents who have been sexually abused are more likely to have sex at an earlier age, have more sexual partners, and not use contraception regularly compared to

pregnant adolescents who were not sexually abused (Boyer & Fine, 1992; Rotheram-Borus et al., 1996; Stock et al., 1997).

Relationship struggles. Sexual abuse survivors experience problems in their interpersonal relationships due to issues related to trust, safety, and need for control (DiLillo, 2001; Messman-Moore & Long, 2003). Sexual abuse survivors tend to have more difficulties sustaining their self-esteem, adjusting socially, maintaining friendships, and parenting (DiLillo, 2001; Messman-Moore & Long, 2003). In addition, survivors tend to focus on others' needs before their own (Messman-Moore & Long, 2003). Such interpersonal struggles put survivors of sexual abuse at risk of being re-victimized in the future (Classen, Field, Koopman, Nevill-Manning, & Spiegel, 2001).

Risk of sexual re-victimization. Alarmingly, 59% of women with childhood sexual abuse histories are sexually re-victimized as adults (Roodman & Clum, 2001). One reason that childhood sexual abuse survivors are at such a high risk of being sexual re-victimization in adulthood has to do with survivors' likelihood for developing PTSD (Arata, 2000; DiLillo, 2001; Messman-Moore & Long, 2003; Roodman & Clum, 2001; Weinberg, 2008). PTSD often causes survivors to dissociate and numb themselves when they are feeling threatened, rather than fighting or fleeing (Arata, 2000; Messman-Moore & Long, 2003; Roodman & Clum, 2001). In addition to developing PTSD, self-blame for the abuse and risky sexual behavior often results in re-victimization (Arata, 2000). Messman-Moore and Long (2003) further explain:

...women with a history of childhood sexual abuse are more likely to have permissive attitudes about participation in sexual behavior and are more likely to label themselves promiscuous...such self-perceptions may be apparent to potential perpetrators and may influence the decision to target these women for sexual coercion. (p. 552)

As sexual behavior is the only behavior that can predict re-victimization relatively accurately, survivors' self-perceptions may put them at risk for re-victimization (Arata, 2000; Messman-Moore & Long, 2003). Since childhood sexual abuse survivors are at risk for being re-victimized as adults, survivors may have a complex sexual abuse history that includes numerous sexual abuse encounters throughout the lifespan.

Sexual Abuse Survivors' Experiences of Pregnancy

Survivors' physical and mental health during pregnancy. Women with sexual abuse histories often avoid vaginal and gynecological exams as the exams may remind the women of past sexual abuse encounters (Burian, 1995; Dallam, 2010; Leeners et al., 2007; Squire, 2009). During prenatal visits, doctors and nurses physically touch and examine women's genitalia. Such touch, as well as being asked to lie down, spread their legs, and undress, can feel like a reenactment of past sexual abuse (Coles & Jones, 2009). Women may re-experience past sexual abuse during a prenatal visit as a result of the medical provider being in control of what goes on during the visit and examination (Coles & Jones, 2009). The examinations may heighten women's vulnerability and bring up feelings of shame, guilt, and blame that are associated with past sexual abuse. In fact, 43.5% of women who were sexually abused as children recall memories of abuse during a gynecological appointment (Leeners et al., 2007). This suggests that pregnant women who are survivors of sexual abuse may find prenatal appointments especially traumatizing, and thus possibly avoid regular prenatal check-ups during pregnancy. The lack of regular visits may then lead to increased risk of prenatal complications.

Women who have experienced sexual abuse, whether as a child or as an adult, are at a higher risk for health problems during pregnancy than women who have not experienced such abuse (Kendall-Tackett, 2007). They are hospitalized at higher rates than women without sexual

abuse histories and experience higher rates of prenatal complications including miscarriages, premature contractions, premature births, and cervical problems (Heimstad, Dahloe, Laache, Skogvoll, & Schei, 2006; Lev-Wiesel & Daphna-Tekoa, 2007; Leeners, Stiller, Block, Gorres, & Rath, 2010; Möhler et al., 2008). Women with a sexual abuse history are also more likely to partake in behaviors during their pregnancies that put the fetus at risk and thus increase chances for prenatal complications (Grimstand & Schei, 1999).

Women with sexual abuse histories are more likely to report discomfort during their pregnancies, including common physical and medical complaints that relate to being pregnant, than women without sexual abuse histories (Grimstand & Schei, 1999; Lukasse, Schei, Vangen, & Øian, 2009). Reports of discomfort in pregnancy may relate to sexual abuse survivors general tendency to experience high amounts of physical pain and body dissatisfaction (Gatti, 2001; Hulme, 2004; Murray, Macdonald, & Fox, 2008; Sahay, Piran, & Maddocks, 2000).

Survivors of sexual abuse often experience an increase in their mental health needs during their pregnancies. For example, women with sexual abuse histories experience higher levels of depressive symptoms during their pregnancies than non-sexual trauma survivors who are pregnant (Benedict, Paine, Paine, Brandt, & Stallings, 1999; Nayak & Al-Yattama, 1999). Prenatally, pregnant women who are victims of childhood sexual abuse are more likely to be suffering from PTSD than pregnant women who have suffered from other, non-sexual traumas (Lev-Wiesel & Daphna-Tekoa, 2007; Lev-Wiesel et al., 2009). Therefore, the process of pregnancy may heighten memories of *sexual* abuse specifically, compared to other forms of abuse.

Sexual Abuse Survivors' Experiences of Labor and Delivery

Although sexual abuse survivors' experiences of childbirth differ, there is clearly research that highlights some of the extreme, traumatic reactions to labor and delivering a baby (Issokson, 2004; Rhodes & Hutchinson, 1994). Some sexual abuse survivors' extreme reactions to the painful labor and delivery process may include fighting, trying to gain control over the pain, surrendering to the pain, and/or retreating from the overall experience (Rhodes & Hutchinson, 1994; Squire, 2009). Such extreme reactions may be the result of the woman feeling powerless over the pain and powerless to control the multiple procedures and intrusive vaginal exams that occur during labor and delivery (Rhodes & Hutchinson, 1994; Squire, 2009). Especially in hospitals, where the environment may be "hierarchical, paternalistic and scientific," women may feel especially powerless (Squire, 2009, p. 262). Researchers have hypothesized that the level of satisfaction that sexual abuse survivors feel with their childbirth experience largely depends on the women's sense of safety and level of privacy, control, and touch (Burian, 1995; Parrett, 1994).

For some women, memories of past abuse can be triggered during childbirth (Parratt, 1994; Rose, 1992; Squire, 2009). The language that doctors and nurses use during labor may also resemble the language used during the sexual abuse encounter; for example, women are told to take their clothes off, spread their legs, that they are doing a good job, etc. (Squire, 2009). Such language can trigger memories of past abuse (Squire, 2009). This vulnerability of experiencing childbirth as a trauma helps to explain why pregnant women with sexual abuse histories are more at risk for developing PTSD symptoms following childbirth, compared to women with no trauma history or non-sexual trauma histories (Lev-Wiesel et al., 2009; Soet, Brack & Dilorio, 2003).

When memories of sexual abuse are triggered, survivors may employ dissociation as a way to defend against feeling threatened and overwhelmed with helplessness. Since dissociation for many sexual abuse survivors is a reaction to extreme stress and pain, pregnant sexual abuse survivors may employ dissociation as a way of coping with the pain of labor and delivery (Cole, et al., 1996; Simkin, 2009). Such dissociation during labor and delivery may then cause the woman to feel that her childbirth was an act of sexual trauma, since her reaction to birthing mirrored her reaction to being sexually abused (Cole et al., 1996).

Fear seems to impact sexual abuse survivors' experiences of childbirth more strongly than pregnant women who have not been sexually abused. Survivors have a stronger fear of childbirth than women without such histories (Heimstand et al., 2006). Eberhard-Gran, Slinning, and Eskild (2008) surveyed women on their amount of fear during labor. Out of 414 women, 84% reported no fear, 13% reported some fear, and 3% reported extreme fear. Since a high percentage of the extreme fear category included women who had been sexually abused, Eberhard-Gran et al. (2008) concluded that there is a relationship between extreme fear during labor and a sexual abuse history. As survivors may associate pain in their sexual organs with sexual abuse, survivors seem to be especially vulnerable to fear prior to and during childbirth.

Alternatively, sexual abuse survivors may experience childbirth as an emotionally healing experience that reconnects a woman to her body (Issokson, 2004). Chambers (2010) found that survivors who had positive child-birthing experiences were given: (1) therapeutic space to process the past trauma, (2) space to reflect on their fears of pregnancy and labor, (3) an environment that was physically and emotionally sensitive to the woman's needs, and (4) a sense of respect for the woman's physical and emotional needs. Few researchers, however, have fully explored the potential for childbirth to be a corrective experience for sexual abuse survivors.

How Prenatal Providers Identify and Respond to Survivors of Sexual Abuse

While there is a dearth of literature on providers' response to sexual abuse survivors in the US, a number of studies have been conducted on this topic outside the US. These studies are included here as the basis for hypotheses on nurses in the US. Worldwide, women are most likely to seek health care services when they become pregnant (Nayak & Al-Yattama, 1998). Since sexual abuse survivors' experiences of childbirth cannot be generalized, individualized obstetric care is extremely important throughout pregnancy (Parratt, 1994). Obstetric providers must take reports of past sexual abuse seriously as such trauma histories can have effects on women throughout their pregnancies (Leeners, Richter-Appelt, Imthurn, & Rath, 2006). Lev-Wiesel et al. (2009) eloquently explain:

It is important that health care providers as well as practitioners recognize and address the psychological state of pregnant women who have been sexually abused during childhood. Identifying these women early in their pregnancy and establishing a risk assessment will lead to increased monitoring, which may significantly reduce delivery complications and consequently mitigate postpartum [Post-Traumatic Stress] outcomes. (p. 886)

Obstetric providers' awareness of a pregnant patient's sexual abuse history may also help the provider to be especially sensitive in terms of how the provider examines and works with the patient.

The research and literature on prenatal providers' abuse assessment tends to focus on providers' assessment of abuse that is *currently* occurring—rather than abuse that may have taken place in the past (Glass & Sharps, 2008; Häggblom & Möller, 2006; Moore, Zaccaro, & Parsons, 1998). D'Avolio et al. (2001) found that prenatal care providers' failed to screen their

patients for domestic violence for various reasons including: wanting to avoid difficult conversations, lacking knowledge about what to do if their patients were experiencing abuse, and believing that their patient population did not experience domestic violence. Even when prenatal providers are encouraged to screen for active domestic violence, many clinicians fail to do so (Renker, 2006). Such research tends to highlight the gaps in assessment and offers suggestions for how health care providers can better screen for current abuse. Suggestions for improved screening techniques include training providers on the importance of screening for abuse and integrating abuse assessment into prenatal visits (D'Avolio et al., 2001; Glass & Sharps, 2008; Wiist & McFarlane, 1999).

Webster, Stratigos, and Grimes (2001) highlight that women find being screened for domestic violence within health care settings to be beneficial. However, when prenatal providers do perform an abuse assessment, some patients still do not disclose that they are being abused. Teenagers, for example, tend to deny that they are in a violent relationship even if they are in fact in one (Renker, 2006). Renker (2006) found that teenagers denied such relationships as a result of needing to feel that they were in control of who knew their story. A teenager may have also denied as a result of not trusting the provider, feeling that the abuse was over, and/or or worrying about the consequences of disclosing such information. Lastly, teenagers denied being in a violent relationship if they felt that they either had the situation under control or felt that there was no way out of the relationship (Renker, 2006). Such research highlights the complexities surrounding how providers screen for abuse and additionally, reminds providers to remain sensitive and aware that a patient may be experiencing abuse even if the patient initially denies current abuse.

How Nurses Partner with Sexual Abuse Survivors

Nurses have the ability to offer both physical care and emotional support to patients. One example of nurses providing such care is the Sexual Assault Nurse Examiner (SANE). This national program was created to provide 24-hour support to sexual assault victims. SANE is staffed by Registered Nurses and Nurse Practitioners who support the victim's physical and emotional needs (Campbell, 2004). The goals of SANE focus on addressing the trauma that has occurred as well as supporting victims through the physical examination and collection of evidence for a rape kit; this program was created out of a need to prevent victims from feeling like there were being "re-raped" during this physical exam (Campbell, 2004). This program seems to be effective as a result of emotional support being intertwined into the physical exam.

There appear to be few comprehensive prenatal health care models that specifically address sexual abuse survivors' needs during pregnancy. Cole et al. (1996) describe a unique obstetric care model where a psychiatric nurse evaluates all women who attend a Utah health clinic for past and present physical and sexual abuse. The same nurse then follows each woman throughout her pregnancy, in order to help the patient develop coping skills to handle any difficulties and/or triggers that occur during the pregnancy and childbearing process (Cole et al., 1996). Although this obstetric care model exemplifies ways in which nurses are able to assess for and provide therapeutic care to survivors of abuse, this program is not representative of most obstetric models in the United States.

In order for sexual abuse survivors to feel safe with their health care providers, providers need to make concerted efforts to work with patients in a way that respects their needs and vulnerabilities. Health care professionals can make their interactions with sexual abuse survivors feel safer by creating a trusting relationship where the provider can respond to the patient's

emotional cues (Coles & Jones, 2009). Understanding the long-term effects of trauma and helping patients to access services that support them during the transition of becoming a parent may also sustain a trusting and safe patient-provider relationship (Coles & Jones, 2009).

Research Objectives

A history of sexual abuse can have an especially profound effect on a pregnant woman's mental, emotional, and physical health as well as her overall pregnancy and birthing experience. In order to provide a high quality of care, OBGYN nurses need to be sensitive to the impact that a past sexual abuse history may be having on a woman's pregnancy. Given that much research focuses primarily on nurses' abilities to screen for abuse that is *currently* taking place in patients' lives and there are few prenatal models that are designed to address pregnant sexual abuse survivors' specific needs, this research explores how OBGYN nurses respond to women's *past* sexual trauma(s) that might be triggered during the pregnancy and birthing processes. This thesis analyzes if and how OBGYN nurses assess for a history of sexual abuse, alter their care for sexual abuse survivors, and involve social workers in caring for pregnant patients who have been sexually abused.

CHAPTER THREE

Methodology

The purpose of this study is to explore how OBGYN nurses respond to and alter obstetric care for sexual abuse survivors. This research will provide social workers with a practical understanding of how nurses support the emotional needs of their patients and how social workers might be able to partner with nurses to provide comprehensive care to this vulnerable population. Since little to no research has been conducted on this topic, a qualitative research method is most appropriate.

Sample

Participants in this study are required to be Registered Nurses, 18 years of age or older, who work in obstetric care and have knowingly worked with a patient who is a sexual abuse survivor. Participants are currently employed at a hospital, health clinic, or medical practice in the United States. In order to ensure that the sample works with underserved and mixed income populations, the place of employment must accept Medicaid health insurance. Nurses who work *solely* in Neonatal, Post-partum, and/or Gynecology units are to be excluded, since nurses in these units do not work with pregnant patients.

Participants were recruited using snowball sampling through email. The Massachusetts's chapter of the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) emailed a recruitment advertisement about this study to their members and also posted the information on their website. I networked with various obstetric nurses, doctors, and other health

care professionals, who agreed to email the survey on to their own contacts. The sample for this study is made up of thirty-three participants.

Data Collection

The Smith College School for Social Work Human Subjects Review Board approved this study (See Appendix A). Participants filled out an anonymous, online survey (see Appendix B) designed through Survey Gizmo (www.surveygizmo.com). The recruitment email (Appendix C) included an advertisement for the survey, which briefly described the research study, and included a direct link to the survey. Participants filled out required questions to confirm their eligibility and were then directed to give informed consent. Prior to answering the main survey questions, participants were also asked to provide basic information about themselves, including race, ethnicity, and educational history. The entire survey was designed to take a maximum of fifteen minutes to fill out.

Ethics and Safeguards

Sexual abuse can be an emotionally charged and troubling subject to think about and discuss. The informed consent letter detailed the risks of participation, the voluntary nature of this study, and the ability to withdraw from the survey at any time. Since nurses who have worked with survivors of sexual abuse may have experienced some stress or discomfort while reflecting upon their experiences with such patients, participants who completed the survey were provided with suggested ways of seeking mental health support. In case participants were interested in learning more about the services available for sexual abuse survivors, participants were encouraged to visit the website of the Rape, Abuse, and Incest National Network (RAINN).

Participants were also informed of the benefits of participating in this study. This survey offered participants the opportunity to share their professional experiences working with patients

who are pregnant sexual abuse survivors and may have provided participants with a new insight into how they work with this population. This study may also contribute to an overall understanding of how nurses respond to pregnant sexual abuse survivors.

In order to ensure anonymity, the survey did not include questions that ask for participants' identifying information. In addition, Survey Gizmo has an anonymous response option, which disables IP tracking and thus does not allow the researcher to see where the survey was filled out. If participants accidentally included identifying information in the narrative sections of the survey, I deleted the identifying information before sharing the findings with my research advisor. I downloaded all data from the surveys into a password-protected document.

Data Analysis

In some surveys, participants did not answer all questions. As long as at least five out of the eight main survey questions (numbers eighteen through twenty-five) were answered, the survey was included in the analysis. For demographic questions, the ranges, frequencies, and percentages were calculated in order to describe the overall characteristics of the participants. For the multiple choice questions, I calculated the frequencies and percentages of participants who chose each response.

For open-ended questions, which included questions that had multiple parts, the data were manually analyzed thematically using open coding strategies, an inductive coding method that allows themes to derive from the data, rather than from hypotheses made prior to starting the research (Rubin & Babbie, 2007). I grouped all of the answers to each question together. I analyzed the answers as one group and then split them up into different thematic categories. I then compared and contrasted these categories in order to come up with additional themes. I repeated this process for each question in the survey. I also briefly analyzed full, individual

surveys. First, I identified themes within the surveys and then I grouped together and compared surveys that shared similar themes. Finally, I compared and contrasted each grouping of surveys to one another.

CHAPTER FOUR

Findings

To explore how OBGYN nurses respond to survivors of sexual abuse, a link to the survey was sent out using the snowball sampling method discussed in Chapter 3 (see Appendix C). Eighteen people were disqualified for not meeting the eligibility requirements; twelve of these people were disqualified because they chose “yes” to the eligibility question that asked them if they worked solely in the neonatal, post-partum, and/or gynecological units. Thirty-three people began the survey, but exited the survey before completing and submitting it. Thirty-three participants submitted the survey with at least five of the eight survey questions answered; their responses make up the sample for analysis. This chapter presents the results of data analysis, beginning with information on the demographics of the participants and then going on to describe findings from the survey questions.

Demographic Data

All thirty-three participants identified themselves as female and 66% of participants have given birth. Thirty participants (91%) identified themselves as White or Caucasian; one participant (3%) identified herself as Black; and two participants (6%) did not answer. The sample ranges in age from 25-57 years old, with a mean of 42.9, median of 45.5, and mode of 54 years of age. The mean length of time participants have been working as RNs is 18.8 years, with a range of 2-35 years, median of 21, and modes of 5 and 32 years. Participants’ highest professional degrees are Master of Science in Nursing (27%) or Bachelor of Science in Nursing (42%); one participant (3%) earned a PhD. Participants work in a total of thirteen states (see

Table 1). Currently, thirty participants (91%) work on the labor and delivery unit, nineteen participants (58%) work on the ante-partum unit, twelve participants (36%) work in outpatient OBGYN settings; one participant (3%) did not specify which unit she works on. Twelve participants (36%) currently work on one of these units, thirteen participants (39%) work on two of these units, and seven participants (21%) work on all three of these units. In the past, all participants have worked on the labor and delivery unit.

Demographic limitations. This sample is primarily made up of female, Caucasian OBGYN RNs and thus fails to represent RNs who identify as male or part of a racial minority. The recruitment for this study was based on a snowball method, which included contacting nursing associations, professionals in the health care field, and health clinics. Therefore, recruitment did not specifically target nurses based on demographic characteristics. However, a high majority of the RN population in the United States is White and female: the U.S. Department of Health and Human Services, Health Resources and Services Administration (2010) surveyed RNs in 2008 and found that 83.2% identify as White, Non-Hispanic, and under 10% of RNs licensed identify as male.

Table 1
Which State(s) Participants Currently Work In

State	Number of Participants per state	Percentage (%)
California, Idaho, Maine, Michigan, Ohio, Texas, Washington, D.C., Wisconsin	1	24
Massachusetts	10	30
New Hampshire, Vermont	2	12
New York	3	9
Pennsylvania	8	24
Did not answer	1	3

Part One: Survey Question Analysis

As discussed in Chapter 3, the initial and primary part of the data analysis consisted of analyzing all of the responses to each survey question in order to identify themes within the responses. The findings from this analysis are presented below.

Defining sexual abuse. Thirty-one participants (94%) answered the open-ended survey question, which asked them to define sexual abuse. The percentages below were calculated based on the number of participants who responded to this question.

Of those who responded, 94% define sexual abuse as non-consensual, unwanted, sexual contact; their descriptions of sexual contact include touching, fondling, and/or penetration. Forty-five percent of the sample states that sexual abuse is forceful in nature. When describing their understanding and definition of non-consensual contact, 13% of the sample mentions the vulnerable populations that are unable to give consent due to age, mental ability, and drug and alcohol intoxication. Sixteen percent of the sample notes that sexual abuse may cause distress or

emotional trauma to the victimized individual, while 10% indicate that the perpetrator may gain sexual pleasure from the encounter.

How a patient's past history of sexual abuse informs obstetric care. Participants were asked to rate, using a Likert scale, how often they ask new patients if they have ever been sexually abused, and how often they alter care for sexual abuse survivors (see Table 2); all thirty-three participants responded to both of these questions. Participants who report that they alter care were then asked to describe how they change their care for sexual abuse survivors.

Thirty participants (90%) report that they ask patients about sexual abuse history at least some of the time, and 31 participants (91%) report that they alter the care they provide sexual abuse survivors at least some of the time. Several themes emerged from their descriptions of how they adjusted care to meet the needs of sexual abuse survivors:¹

Facilitate clear verbal and non-verbal communication between nurse and patient (73%). Participants facilitate clear communication by explaining what procedures may be done and why, checking-in with the patient to see how she is coping, and encouraging the patient to ask questions. One nurse exemplifies this when she states, “I explain what I am going to do in great detail and ask for her permission to do so, and I check in with her throughout the event to be sure she is okay.” Nurses also provide space for the patient to vocalize her needs and desires about the physical care she would like to receive. To promote a sense of safety and control, nurses may also ask the patient permission to examine her. Nurses also mention giving extra attention to the language and words they use to support the patient or to explain what will

¹ The percentages calculated below were based on the thirty participants who report that they alter care.

happen. Nurses mention that they especially pay attention to the patient's non-verbal cues, such as how a patient reacts when she is being touched.

Make efforts to protect patient's privacy (33%). Nurses often limit the number of people in the room during labor, delivery, and/or examinations. Nurses also help the patient stay covered during exams and/or speak to patients about how they want to be exposed during delivery. Nurses may also knock before coming into the room to help ensure a sense of privacy. For example, one subject wrote: "I ask permission to touch first and respect their privacy by always knocking and or announcing that I am at the door [and] may I come into the room."

Demonstrate sensitivity during physical exams (40%). During vaginal, cervical, and/or other physical examinations, nurses alter how they perform such exams in order to make the patient feel as comfortable and safe as possible. One nurse explains that she "always give[s] them the option of stopping or waiting to proceed if they are uncomfortable or feel overwhelmed." Sometimes, nurses limit the number of vaginal and other physical examinations. One nurse explains that she "limit[s] vaginal exams in labor to the bare necessity."

Advocate for patients (23%). Nurses advocate for survivors of sexual abuse in a variety of ways, including attempting to have female providers examine the patient and asking a social worker to meet with the patient to address the sexual abuse history. If a sexual abuse survivor declines an exam or procedure, nurses may then advocate to other medical providers for this patient's decision to be respected.

Provide extra emotional support, sensitivity, and compassion (23%). Nurses explain that they are more understanding of patients' adverse behaviors during examinations if they have a sexual abuse history. One participant explains that she is "more patient of their needs and more forgiving of behaviors caused by [the abuse] history."

Table 2

How Past History of Sexual Abuse Informs Obstetric Care

	How often do you ask new patients if they have ever been sexually abused?		When working with a pregnant patient who has a sexual abuse history, how often do you change your care for her in any way?		If you are working with a pregnant patient who is experiencing emotional difficulties during her pregnancy, how often do you call on a social worker for assistance?	
Response	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
Always	15	45	17	52	12	36
Often	11	33	8	24	7	21
Sometimes	4	12	6	18	8	24
Never	3	9	2	6	6	18

Survivors' reactions during labor and delivery. Participants were asked whether or not they had worked with a sexual abuse survivor who had an emotionally difficult time during the process of labor and delivery. Those participants who have worked with such a patient were then asked to describe their experience. Twenty-six participants (79%) have knowingly worked with a sexual abuse survivor who had an emotionally difficult experience during labor and delivery. These twenty-six participants describe patients' various struggles and reactions with the labor and delivery processes as follows:²

Physical pain. Participants describe numerous ways that sexual abuse survivors experience a higher amount of physical pain and discomfort during labor and delivery compared to patients who are not sexual abuse survivors. Survivors may especially experience extreme discomfort during vaginal and cervical exams (46%), labor processes such as pushing, contractions, and pelvic floor sensations (42%), and even when being touched in non-genital

² The percentages calculated below were based on the twenty-six participants who report that they have worked with a patient who had an emotionally difficult time during labor and delivery.

areas (8%). As a result of the intense pain and discomfort, some participants (8%) even report that patients elect to have a cesarean section.

Clinicians' gender. Participants also highlight ways that patients struggle with issues related to lack of physical privacy during labor and delivery (8%), which often includes patients' preferences to work with female, rather than male, health providers (17%).

Emotional and psychological responses. Twenty-nine percent of participants report that sexual abuse survivors often become highly emotional during labor and delivery, including crying, screaming, and are often unable to be comforted; one participant describes a patient who screamed "mommy, mommy." Participants highlight specific psychological reactions that seem to be trauma-related responses. For example, this participant appears to be describing the differing needs between patients who dissociate and those who become hyper-aroused:

I find people with abuse to be either non-emotional, or overly emotional. Many have a flat affect and do not engage normally. These are "easy" to care for, but require extra sensitivity and awareness as they will not ask for anything but obviously have emotional needs to be paid attention to. More emotional patients, require over communication, assuring education about reason[s] for procedures, what they involve, how they will help the patient and baby. These patients usually cooperate if they are allowed time to prepare for procedures, given reassuring communication, and allowed to set the pace as much as possible.

In addition, 21% of participants describe how patients have flashbacks related to the past abuse during labor, and 25% of participants report that patients dissociate during labor and delivery.

One participant explains:

Throughout it all, she kind of separated herself from the process. She would pretend that she didn't hear you or continuously ask questions that you had already explained just to keep you focused on something other than the fact that she was in labor. Others seem to retreat into themselves...

Furthermore, 13% of participants report patients have trouble accepting their loss of control during labor and delivery. One nurse explains, "They appear to resist surrendering themselves to the labor process."

How nurses respond to survivors during labor and delivery. When asked how they do or would respond to patients who are having an emotionally difficult time during labor and delivery, twenty-seven participants responded with detailed explanations. These participants list various ways that they help to support such patients:³

Communication. Sixty-three percent of participants describe ways that they take additional steps to ensure that they are communicating with patients clearly and comprehensively. This includes spending more time with patients to provide explanations about procedures, initiating discussions about patients' needs and desires, exploring with the patient how her history of abuse might impact the labor and delivery process, and being aware of patient's non-verbal cues. One nurse explains, "[I] try to ask the patient what may be best for her to cope with the situation...what things are acceptable and what are not...try to find ways to ease the anxiety as much as possible." In order to prevent sounding like a past perpetrator, participants also describe how they are more selective and sensitive in terms of their usage of

³ The percentages calculated were based on the twenty-seven participants who responded to this question.

language. For example, one participant explains, “I will sometimes change the language I use to try to avoid sounding too familiar...in Spanish, I will stop myself from referring to the patient as ‘*mi amor*’ because I’m afraid it might be triggering.”

Physical comfort. Thirty-three percent of participants identify ways that they help to make patients more comfortable and at ease during the labor and delivery process. This includes limiting the number of people in the room as well as the number of vaginal/cervical examinations.

Emotional support. Fifty-nine percent of participants offer emotional support to the patient such as speaking calmly, holding the patient’s hand, and coaching the patient through labor and delivery.

Grounding techniques. Eleven percent of participants help keep patients present in the moment as a way to protect patients from experiencing flashbacks to past abuse. One nurse describes how she helped a woman “to remember where she was and that this situation was a positive one (having a baby) and that she was in a safe place.”

Sense of control. When appropriate, 15% of participants offer patients choices about how to proceed with labor. Participants do this as a way to help the patient feel more in control of her labor. For example, a nurse “reminded [a patient] that the option of her getting a cesarean was available if she was unable to deal with the emotional stress of the labor.”

Privacy. Eleven percent of participants mention ways that they may help patients feel less physically exposed during labor and delivery. This includes ensuring that the patient’s privacy is protected by “covering [her] with linens, gowns, [and] closing curtains and doors.”

Training on sexual abuse. Out of 33 participants, 32 participants provided responses about the number of years they have been working as an RN and if they have received training

on the long-term effects of sexual abuse. Fifty-eight percent of participants (18 participants) report that they have not received training on the long-term effects of sexual abuse.

Participants' experience collaborating with social workers. When working with a patient who is a sexual abuse survivor and is struggling emotionally during labor and delivery, participants request assistance from social workers to varying degrees (see Table 2). When asked to further describe their experience working with a social worker, 24 participants responded with the following information:⁴

Overall experience. When describing their experience working with a social worker, 33% of participants describe their experience as positive; one nurse reports, "I have high regard for the social workers at the hospital where I work." In addition, 13% of participants report that their experience with social work largely depends on the specific social worker; one nurse states, "some social workers are better than others. Some are condescending to the nurses." None of the participants described their experiences with social workers as negative. Twenty-five percent of the respondents report that after they requested a social work consultation for the patient, they had no contact with the social worker; some nurses highlight that if a labor and delivery nurse requests a social work consultation for the patient, this consultation often occurs when the patient is on the post-partum unit and thus has a different nurse. In place of a social worker, 17% of participants explain that another non-nursing professional (psychiatrists, midwives, Clinical Nurse Specialists) either provides emotional support to patients or requests a social work consultation.

⁴ The percentages calculated were based on the twenty-four participants who responded to this question.

Team approach. Twenty-nine percent of participants describe their experience with social workers as a team-oriented approach where social workers guide nurses in working with a patient who has a sexual abuse history. This team approach may include having a social worker conduct an individual assessment of the patient and then relay the social worker's concerns/insight to the nurse. Sometimes, social workers are able to meet with a patient prior to going into labor and help the patient think through and predict difficulties that may arise during the labor process. In such instances, this allows the social worker and nurse to work together ahead of time to prepare for the patient's labor needs and struggles:

Our social worker was well prepared. She had been contacted by the patient's physician at least a month before delivery and was prepared for what our patient wished to occur and made sure that we had the tools we would need in case any problems developed during her labor if it happened on an off shift.

Resources and referrals. Twenty-nine percent of participants report that social workers provide resources to patients such as a list of homeless shelters and referrals to counseling services.

Assessments. Eight percent of participants describe ways that social workers conduct safety and psychosocial assessments for patients, including assessing for a "risk of depression and the mother's ability to care for herself and her newborn."

Helpful ways social workers can collaborate with nurses. Participants were asked about the kind of support that social workers might offer nurses while they are working with a

pregnant sexual abuse survivor. Thirty participants responded with multiple ways social workers could assist them:⁵

Team approach. Fifty-seven percent of participants suggest a collaboration where social workers can help nurses understand the patient’s psychosocial stressors and how to address the patient’s specific needs: “[The social workers] are wonderful and help me understand what might be going thru the patient’s mind.” Working with the patient prior to labor and delivery is preferable. A few nurses even suggest creating a prenatal and a labor and delivery plan at the start of pregnancy that could help providers be sensitive and respond to the patient’s needs. One of the nurses describes this plan as, “a plan for labor and for the course of the pregnancy and postpartum that covers different labor/prenatal visit situations that could potentially occur and cover them in detail—like cervical exams, male physicians/nurses, etc.” Participants also encourage social workers to provide therapeutic support and assessment during the patient’s hospital admission, during labor, and/or after delivery.

Resources and referrals. Upon discharge, 47% of participants recommend that social workers provide resources and referrals to therapy, community programs, and support groups.

Educate nurses. Seventeen percent of participants would like social workers to provide information to nurses about the parts of labor and delivery that may be most difficult for patients, ways that nurses can help respond to and support the patient, and information on the impact of abuse on individuals. Examples of this include:

⁵ The percentages calculated were based on the thirty participants who responded to this question.

How to talk to a woman and to let her know we are her advocate and will do everything we can to ease her suffering during labor, even though we do not know all the history...[helping us make] sure that we know how to comfort or calm a patient if they begin to relive their sexual assault or parts of it...information about forms of abuse and how victims respond.

Difficult to assist nurses during labor and delivery process. Seven percent of participants are skeptical about how social workers could be helpful during labor. One participant explains this ambivalence:

In the atmosphere of labor and delivery it would be difficult to have assistance from a social worker during active labor when you are unable to leave the patient's bedside.

However, if a patient is in early labor or just admitted it'd be great to meet with a social worker and discuss ways to support the patient throughout the labor process.

Part Two: Individual Survey Analysis

The second part of the data analysis involved analyzing full, individual surveys, which included demographics and survey questions, in order to identify overlapping themes and patterns within surveys. The findings from this secondary analysis elaborate on the impact that sexual abuse training has on the care participants provide to sexual abuse survivors:

When in their careers do nurses receive training on the effects of sexual abuse? Two out of nine participants (29%) who have been working as an RN for 10 years or less have received training. Of the five participants who have been working as an RN for 11-20 years, two (40%) have received training. Six out of eleven participants (55%) who have been working as an RN for 21-30 years have received training and four out of seven participants (57%) who have worked for 31 or more years have received training.

How sexual abuse training impacts nurses' likelihood to assess new patients for a sexual abuse history. Of the 14 participants who have received training on the sequelae of sexual abuse, 43% always, 50% often, and 7% sometimes ask new patients if they have ever been sexually abused. None of the participants who have received training report never asking new patients about their sexual abuse history. Out of the 19 participants who have not received such training, 47% always, 21% often, and 16% sometimes ask new patients about their sexual abuse histories. In contrast to participants who have received training, 16% of participants who have not received training report that they never assess new patients for a sexual abuse history. Overall, 93% of participants who have received training and 68% of participants who have not received this training always or often ask new patients about such histories.

How sexual abuse training impacts obstetric nursing support to survivors. When analyzing how participants care for sexual abuse survivors during prenatal visits or labor and delivery, participants who have received training in sexual abuse tend to offer more informed support than those participants who do not have training. In general, participants who did not receive training provide patients with detailed explanations about physical examinations, ask permission to touch patients, and are aware of the way they speak to the patient. They also help to maintain the patient's physical privacy, state that they are extra compassionate with such patients, especially during vaginal examinations, and initiate conversations with the patient about her needs and desires for labor and delivery. Some of these participants mention that they engage the patient in making choices about her plan of care. Participants who have received training offer all the support that participants without training provide. In addition to this support, participants with training are more aware of how the birthing process can, at times, remind the patient of past sexual abuse. Participants with training notice how patients dissociate and

experience flashbacks during labor and delivery, and also implement grounding techniques in order to help the patient stay present and feel safe. They give patients a sense of control by allowing them to take an active part in creating a birthing plan. Such participants also advocate for patients' decisions and needs to be respected by other health care providers.

How sexual abuse training impacts nurses' likelihood to request a social work consultation. Of those who have not received training,⁶ 22% of participants always, 39% often, and 17% never request a social work consultation for a sexual abuse survivor who is experiencing emotional difficulty during labor and delivery. Fifty percent of participants who have received training always request a social work consultation for such a patient and 14% often request a consultation. Twenty-one percent of participants who have received training never request a social work consultation; participants' explanations for this include that psychologists are called instead of social workers, social workers do not work during the evening nursing shifts, and the social workers available do not specialize in sexual abuse.

Summary

This chapter presented the various ways that nurses support and respond to patients who have sexual abuse histories and also explored how nurses partner with social workers to care for sexual abuse survivors. The impact of training nurses on the long-term effects of sexual abuse was also discussed in the context of how such training may inform obstetric care. The next chapter will further explore the implications of such findings and how the findings from this study might be used to improve the quality of care provided to pregnant sexual abuse survivors.

⁶ 14 participants have not received training on the long-term effects of sexual abuse

CHAPTER FIVE

Discussion

This chapter discusses what can be learned from this research study about how OBGYN nurses respond to and support pregnant sexual abuse survivors during their prenatal and labor and delivery experiences. Suggestions for how both nurses and social workers might use these findings to inform and improve care for this population are included in this chapter. These suggestions incorporate ways that social workers and nurses can partner together to provide comprehensive obstetric and mental health care.

Overall Assessment of How Nurses Respond to Sexual Abuse Survivors

Nurses' attunement to survivors' needs. Overall, the nurses in this study have a comprehensive understanding of what survivors of sexual abuse often struggle with during their pregnancy and labor and delivery processes. Participants' descriptions of these struggles include: difficulty with vaginal examinations, high levels of physical discomfort, and extreme emotional reactions during labor and delivery. Such observations are consistent with researchers' findings (Burian, 1995; Dallam, 2010; Grimstand & Schei, 1999; Lukasse, Schei, Vangen & Oian, 2009; Rhodes & Hutchinson, 1994; Squire, 2009). In terms of patient care, nurses adjust care for pregnant sexual abuse survivors in a way that promotes safety, control, privacy, and open dialogue about the patient's needs. Researchers suggest that these factors help to ensure that a survivor has a positive child-birthing experience (Burian, 1995; Parrett, 1994).

Nurses' ability to prevent re-traumatization. While nurses are attuned to patients' reactions and able to provide sensitivity, patience, and compassion to such patients, it is unclear

if nurses connect or equate patients' emotional and physical struggles with traumatic responses. For example, while participants recognize that survivors often experience heightened pain during gynecological exams, they may not realize that some survivors actually experience flashbacks during such exams (Leeners et al., 2007). Vaginal exams or painful contractions can act as triggers that start off the cycle of re-traumatization, which was described in Chapter 1 (Dallam, 2008). Since many participants seem to lack knowledge about the cycle of re-traumatization, they are unable to *deliberatively* make efforts to stop post-traumatic stress reactions, such as dissociation and flashbacks, from occurring. For example, one participant identifies how a patient dissociated during labor: "She began to be less present in the moment...she drifted to another place as the contractions continued...I observed her and stayed present. She cried still, but seems as though she was coping." In this example, helping the patient to stay present—rather than drifting—may have emotionally benefited the patient and potentially may have prevented the patient from becoming re-traumatized during labor.

As described in Chapter 2, the goal of the Sexual Assault Nurse Examiner (SANE) program is to have RNs and Nurse Practitioners offer emotional support while performing rape kit examinations in order to ensure that victims do not become re-traumatized during this collection of evidence (Campbell, 2004). This study, however, suggests that even though OBGYN nurses' intentions might be to offer emotional support, nurses may lack knowledge about the traumatic responses and the therapeutic skills necessary to prevent re-traumatization from occurring. Alternatively, OBGYN nurses in this study may not be applying their knowledge about how to respond to a rape victim to a similar patient's later prenatal and labor and delivery experiences. In contrast, psychiatric nurses, who staff the Utah obstetric clinic described in Chapter 2, may have expertise and additional knowledge in trauma and traumatic responses; such

nurses may have more insight into the techniques needed to appropriately prevent re-traumatization from occurring during prenatal exams and labor and delivery processes.

Implications for Practice: Training Nurses on the Effects of Sexual Abuse

If nurses are trained to understand survivors' reactions within a framework of trauma, nurses may be more likely to consistently and appropriately address patients' traumatic reactions. Training nurses about how sexual abuse can negatively affect a patient's experience of her pregnancy and birth process will help survivors to have a positive birthing experience and may even help the rate of birthing-related PTSD to decline (Lev-Wiesel, Daphna-Tekoah, & Hallack, 2009).

Strengths of training. Nurses in this study who received training on the long-term impact of sexual abuse were more likely to assess new patients for a sexual abuse history than nurses who did not have such training. In fact, 16% of participants who did not receive training report that they never assess new patients for a sexual abuse history; all participants who have received training report that they assess for sexual abuse at least some of the time. This suggests that such training teaches nurses the importance of assessing patients for a sexual abuse history.

Compared to participants without training, participants who have received training often become their patient's advocate and communicate their patient's desires and needs to other medical providers. Therefore, such training provides nurses with a context in which to understand a patient's behavior. This likely has implications for how the patient experiences her pregnancy and birthing process.

Gaps in training. Most of the participants who have training have been working as an RN for over 10 years. This suggests that participants received such training on their own and were not required to have such training in order to get their RN licensure. In addition, throughout

the surveys, participants assume that the patient's perpetrator is male. For example, participants often noted that, if possible, they try to have only female providers in the labor and delivery room. Training programs need to educate nurses that although men commit most sexual assaults, perpetrators can be female (U.S. Department of Justice, 2006).

In order to benefit their patients, OBGYN nursing units should require—or at least offer—training on how to address the needs of pregnant sexual abuse survivors. This training should not only educate nurses about the typical reactions survivors may have during prenatal examinations and labor and delivery procedures, but should also provide nurses with training on how to interrupt the re-traumatization cycle.

Implications for Clinical Social Workers

Collaborative partnership with nurses. This study highlights the opportunity for nurses and social workers to partner with one another to provide comprehensive and quality care to sexual abuse survivors. Social workers can help nurses further assess and understand patients' needs and desires, and offer suggestions to nurses about the best ways to work with a specific patient. While 57% of participants encourage this team-oriented approach, only 29% of participants report that they have actually worked with social workers in such a way.

One theme that arose in participants' responses was the need for social workers to meet with survivors prior to labor and delivery. Participants highlight the benefit of having a social worker create a birthing plan with the patient prior to labor and delivery. This process, ideally, may be most beneficial if both a social worker and a nurse are present. That way, the nurse can go over the various scenarios that may occur during labor and delivery, and the social worker can help address or anticipate difficulties the patient may face.

In addition, a few participants mentioned that their experience with social workers is often dependent on who the social worker is; one participant described some social workers as “condescending.” This study highlights nurses’ insight into sexual abuse survivors’ physical and emotional difficulties. Social workers should help nurses expand their knowledge about trauma and reactions to trauma while also honoring the unique expertise that nurses offer.

Training nurses on the long-term effects of sexual abuse. Social workers can share their expertise in trauma treatment by offering educational opportunities where nurses can learn and ask questions about how to work with sexual abuse survivors prenatally and during the labor and delivery process. Specifically, social workers can teach nurses about the cycle of re-traumatization and offer training in techniques that can help to prevent re-traumatization from occurring. For example, social workers can teach grounding, meditation, breathing, and visualization techniques to help keep the patient calm and present. Since participants mention that having a social worker present during more advanced labor would be difficult, these are techniques that nurses can implement on their own. In addition, social workers can also train nurses on how to speak with survivors about their needs and desires. For example, it may be triggering and/or inappropriate, at times, for nurses to specifically bring up the patient’s sexual abuse history.

Psychosocial sequelae of sexual abuse. Besides patients’ emotional and physical reactions during prenatal exams and labor and delivery procedures, none of the participants mentioned any psychosocial and behavioral issues that often face survivors of sexual abuse and may cause health providers to identify such patients as difficult to work with. Such issues include substance abuse (Briere & Runtz, 1993; Rotheram-Borus et al., 1996; Wilsnack et al., 1997), teenage pregnancy (Boyer & Fine, 1992; Francisco et al., 2008; Stock et al., 1997), interpersonal

struggles (DiLillo, 2001; Messman-Moore & Long, 2003), and mental health problems (Brayden et al., 1995; Hulme, 2000; Steel et al., 2004; Weinberg, 2008; Zuravin & Fontanella, 1999). It is unclear whether participants in this study failed to mention such difficulties because there was no explicit question on the survey about these issues, because they are unaware of the connection between sexual abuse and such behaviors, or because within the context of labor and delivery, patients' primary behavioral struggles are with the labor and delivery process.

A sexual abuse history may be one of the many issues facing patients, but may not be presented as the primary concern. For example, if 25 year old, active substance abusing woman comes for an outpatient prenatal exam, providers' primary concern will be her substance abuse; even though she was sexually abused as a child, that history is not going to be as apparent or as much of an immediate concern. Ideally, social workers can help to assess for a sexual abuse history during the first few prenatal visits—even when this history may not be the identifying psychosocial issue facing the patient. Social workers can also help to educate nurses about such psychosocial sequelae and encourage nurses to assess for a sexual abuse history when patients display such behaviors; however, social workers should be careful to highlight that not all patients who present with difficult behaviors were necessarily sexually abused. Given that these behaviors, such as substance abuse during pregnancy, can be especially challenging for nurses to witness and address, providing psycho-education to nurses may help nurses to be even more sensitive and empathic to such patients.

Limitations

There are a number of factors that limit the scope of this study. To participate in this study, the OBGYN nurses had to knowingly have worked with a sexual abuse survivor. The sample in this study represents a comparatively informed population of nurses and therefore, this

study does not represent OBGYN nurses who have been unaware that they have worked with sexual abuse survivors. In addition, participants may have been subject to social desirability bias when answering the Likert scale questions. This may have caused them to overestimate the frequency with which they assess for a sexual abuse, adjust care for sexual abuse survivors, and involve social workers in caring for this population. It would have been helpful to know if any participants were sexual abuse survivors, and how this experience impacts their understanding of and care for sexual abuse survivors.

Lastly, this study did not ask specific questions about other psychosocial factors and behaviors that often plague sexual abuse survivors such as substance abuse, teenage pregnancy, and mental health struggles. Such questions would have provided a deeper look into how nurses' understand such psychosocial issues in the context of a sexual abuse history.

Future Research

Future studies may broaden the sample requirements and survey OBGYN nurses who have not knowingly worked with sexual abuse survivors, in order to evaluate such nurses' understanding of this subject. Besides nurses, exploring how other health professionals, including physicians and midwives, who likely work with the same patient on a consistent basis, support such patients may also provide further insight into the care that survivors receive. Further research is needed on the kind of sexual abuse training that is provided to OBGYN nurses and also how sexual abuse survivors are identified within OBGYN units/clinics. In addition, analyzing how nurses assess patients for a sexual abuse history would provide further insight into how effectively such assessments are performed. Lastly, future research might study under what conditions nurses refer or do not refer sexual abuse survivors to the social work department.

Conclusions

While many obstetric providers' primary focus is to physically and medically assist a patient with delivering a healthy baby, the *process* of pregnancy and childbirth also deserves special attention. This is especially true for sexual abuse survivors, who face additional struggles during this process and are at-risk for developing PTSD following childbirth. Working as an obstetric support team, nurses and social workers can partner with each other to provide informed, sensitive, and focused care to sexual abuse survivors that helps to ensure that survivors have positive—and maybe even healing—birthing experiences.

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Appendix A

Human Subjects Review Committee Approval Letter

January 30, 2011

Dear Nicole,

Your revisions have been reviewed and they are fine. Your Consent is shorter and the tone less formal and your email is more inviting. I hope you get lots of response. We are happy to give final approval to your study. However, there is one small but important thing to correct. In the Application, you say you won't include any accidentally noted identifying information. You have to delete it. You want to keep this anonymous and the data is available to your RA. I note that you did say you would delete it in the Consent (which was the most important place). Just correct that page and send it to Laurie Wyman for your file so it is accurate.

Please note the following requirements:

Consent 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.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Natalie Hill, Research Advisor

Appendix B

Online Survey

Eligibility, Informed Consent and Survey Questions
(designed through www.surveygizmo.com)

Nurses' Response to Working with Pregnant Survivors of Sexual Abuse

CRITERIA NEEDED TO PARTICIPATE IN SURVEY

Thank you for your interest in this research study. In order to participate, you must meet certain eligibility criteria. Please answer the questions below to determine if you qualify to continue with this survey.

1.) Are you a Registered Nurse?

- Yes
- No

2.) Are you employed at a hospital, medical practice, and/or health clinic in the United States?

- Yes
- No

3.) Does your place of employment accept Medicaid health insurance?

- Yes
- No

4.) Do your nursing responsibilities include obstetric care?

- Yes
- No

5.) Do you work ONLY in the Neonatal, Post-partum, and/or Gynecological units?

- Yes
- No

6.) Have you ever worked with a woman who is a survivor of sexual abuse?

- Yes
- No
- Unsure

INFORMED CONSENT

YOU ARE ELIGIBLE TO PARTICIPATE IN THIS SURVEY!

Dear Participant,

My name is Nicole Vengrove and I'm a Master of Social Work (MSW) student at Smith College. As part of this program, I am conducting a research study that explores how nurses who

work in obstetric care respond to women with sexual abuse histories during the pregnancy and birthing processes. The data will be used for my MSW Thesis, related publications, and presentations.

Participation in this study includes filling out an online, anonymous survey that should not take longer than 15 minutes. To participate in this study, you must be a Registered Nurse who has worked with a female sexual abuse survivor during her pregnancy. You must be currently employed on an obstetric unit at a United States hospital, health clinic, or medical practice that accepts Medicaid health insurance. If you work solely on Neonatal, Post-partum, and/or Gynecology units, you are not eligible to participate.

If you decide to participate, you will be asked a number of questions regarding how you work with pregnant patients who are survivors of sexual abuse. Since sexual abuse can be a troubling subject to think about, you may experience some emotional discomfort while filling out the survey. You will be provided with mental health resources at the end of the survey. Your participation in this study will contribute to an overall understanding of how nurses respond to pregnant, sexual abuse survivors. Social workers may use this research to more effectively partner with nurses to provide additional support to this population.

The online survey that you will fill out is conducted through Survey Gizmo. No information about your identity or location will be provided to me. If you accidentally write any identifiable information in your responses, I will delete the identifying information before sharing the findings with my research advisor or in publications and presentations. All data, including notes and survey responses, will be kept in a secure location for a period of three years as required by Federal guidelines, and data stored electronically will be password protected. Should I need any of the materials beyond this three year period, the data will continue to be kept in a secure location and will be destroyed when no longer needed.

Participation in this study is voluntary. Since I won't be able to identify participants' surveys, I cannot withdraw your survey once you've submitted it; however, you can choose not to answer any question on the survey, or you can exit the survey without submitting your answers at any time. If you have any questions, please contact me via email at _____ or phone at _____. Should you have any concerns about your rights or about any aspect of this study, you may also contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

BY SELECTING "YES, I WOULD LIKE TO CONTINUE WITH THE SURVEY," YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THIS STUDY.

7.) Have you read the informed consent and agree to continue?

- Yes, I would like to continue with the survey
- No, I do not want to continue with the survey

INFORMATION ABOUT YOU

These questions are meant to collect information about our participants. They are not required:

8.) Age

9.) What college/graduate degrees do you hold?

10.) How many years have you worked as a Registered Nurse?

11.) Which state(s) do you currently work in?

12.) Race:

13.) Ethnicity (ies):

14.) Gender:

15.) Have you ever given birth?

Yes

No

16.) Which nursing unit(s) do you currently work in? Please check all that apply.

Outpatient OB/GYN

Labor and Delivery

Ante-Partum

Women's Health (general)

Other

17.) Please check all nursing units you have worked on in the past:

Outpatient OB/GYN

Labor and Delivery Unit

Ante-partum Unit

Post-partum Unit

Neonatal Unit

Women's Health (general)

Other

SURVEY QUESTIONS

18.) How do you define sexual abuse?

19.) How often do you ask new patients if they have ever been sexually abused?

Always

Often

- Sometimes
- Never

20.) When working with a pregnant patient who has a sexual abuse history, how often do you change your care for her in any way?

- Always
- Often
- Sometimes
- Never

) Please explain

21.) To your knowledge, have you ever worked with a woman who has a sexual abuse history AND who had an emotionally difficult time while she was in labor and giving birth?

- Yes
- No
- Unsure

) Please describe your experience with this person(s)

22.) How would you respond in this situation?

23.) Have you ever received training on the long-term effects of sexual abuse?

- Yes
- No

24.) If you are working with a pregnant patient who is experiencing emotional difficulties during her pregnancy, how often do you call on a social worker for assistance?

- Always
- Often
- Sometimes
- Never

) Please describe your experience(s) working with a social worker on such a case.

25.) When you are working with a pregnant patient who has a sexual abuse history, what kind of support or assistance from social workers would be helpful to you?

MENTAL HEALTH REFERRALS

Thank you for your participation.

In case filling out this survey and/or working with sexual abuse survivors causes you distress, here are suggestions for how to seek support for yourself:

Call the number on the back of your health insurance card and ask for referrals to behavioral health specialists.

Contact your employee health department and/or the mental health departments (such as social work or psychiatry departments) at your place of employment for local referrals.

For more information regarding services for survivors of sexual abuse:

Please visit the Rape, Abuse, and Incest National Network (RAINN) at **www.rainn.org**.

Appendix C

Recruitment Email

Hello,

My name is Nicole Vengrove and I'm a Masters of Social Work student at Smith College. I am conducting a research study that explores how nurses who work in obstetric care respond to women with sexual abuse histories during the pregnancy and birthing processes. I am seeking obstetric nurses who would like to share their experiences working with this population and would be willing to fill out an anonymous, online survey that takes no more than 15 minutes to fill out.

To participate in this study, you must be a Registered Nurse who has worked with a female sexual abuse survivor during her pregnancy. You must be currently employed on an obstetric unit at a United States hospital, health clinic, or medical practice that accepts Medicaid health insurance. If you work solely on Neonatal, Post-partum, and/or Gynecology units, you are not eligible to participate.

Please click on this link to complete the survey:
(<http://www.surveymoz.com/s3/407597/Working-with-Pregnant-Survivors-of-Sexual-Abuse>).

Please feel free to forward this email to anyone you think might be interested in this study. For any questions, please contact me via email _____ or phone _____.

Thank you for your time!

Nicole Vengrove

Master of Social Work Candidate