

**UNDERSTANDING THE CHILDBIRTH EXPERIENCES OF CHILDHOOD SEXUAL  
ABUSE SURVIVORS: A PHENOMENOLOGICAL STUDY**

By

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**Abstract**

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This study describes the childbirth experiences of survivors of childhood sexual abuse using an interpretative phenomenological approach. Data collection involved in-depth, semi-structured interviews of four women who gave birth to a baby within the last five years. Using Interpretative Phenomenological Analysis, three superordinate themes emerged: control, anxiety, and detachment. This contributes to the current body of research by extending knowledge on what it means to experience childbirth for survivors of childhood sexual abuse, told by the woman herself. These findings are especially important in understanding what is required in providing safe, sensitive care for all childbearing women, and has important implications for practice, education, and further research.

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## **The Social Context of Birth**

Inherent to interpretative phenomenology is the examining of preunderstandings. Important to these preunderstandings is the situation of the research to the historical, socio-cultural, and political context in which the research is taking place. As such, a brief historical account of childbirth in Western society is captured, explicating the relevance to the research question below.

Birth in Western society has a turbulent history and a problematic current state. It has functioned largely under a paternalistic approach, with the hierarchy clearly understood. This hierarchy still exists today, arguably perpetuated by a history of male dominance (Squire, 2009). During the twentieth century, birth moved from female-nurtured environments to the hospital setting. This movement largely impacted the way birth was experienced from a socio-cultural perspective. Inside the walls of the hospital the medicalization of birth began to occur, as did the movement of traditional birth attendants (midwives) outside of the birth experience. This transition supported some positive birth outcomes with use of technology, however technology also divided the woman from the experience of birth. Over the next several decades birth was managed almost exclusively by male physicians, with little room for negotiations by the woman herself (McCaffery & Porter, 2011).

More recently, Western society has recognized the disadvantages that come with a paternalistic approach to healthcare and unnecessary interventions. The Province of Ontario has begun to adopt a more holistic approach to perinatal care (SOGC, 2008). Part of this change occurred with the reintroduction of midwifery care over the past several decades. Indeed, midwifery care in Ontario became an acknowledged, regulated profession in 1993 (College of Midwives of Ontario, 2015).

The Society of Obstetricians and Gynecologists of Canada (2008) recently issued a ‘Call to Action’, where they outlined Canada’s current obstetrical state, specifically suggesting better supports need to be in place to nurture the needs of women and children. With the increasing physical and emotional complexities of many Canadian women, coupled with the shortage of obstetrical care providers, a National Birthing Initiative was developed to address these concerns (SOGC, 2008). Foremost on this list of priorities was the call to “listen to women’s voices”. Listening to women’s voices is integral in providing holistic, person-centered obstetrical care. It is in this context that this thesis is titled: *Understanding the Childbirth Experiences of Survivors of Childhood Sexual Abuse: A Phenomenological Study*.

## **Chapter 1: Introduction**

Society perpetuates the notion that birth is a joyous occasion. For some women though, pregnancy and birth is not as joyous and may lead to the experience of significant emotional and psychological trauma. One group of women that may be at increased risk for such adverse sequelae are childhood sexual abuse (CSA) survivors. CSA perpetrated against females is a pervasive global issue and is a significant concern in Ontario, as up to 1 in 5 women have a history of CSA (MacMillan et al., 1997). The negative effects of CSA may surface for the first time or be re-triggered throughout the perinatal period due to the intimate nature of pregnancy, birth, and childrearing. As such, healthcare providers need to be equipped with the knowledge to sensitively care for these women, beginning with an understanding of how birth is experienced for survivors of CSA. In this research study I seek to understand childbirth experiences for survivors of childhood sexual abuse.

Although definitions can vary, CSA may be broadly defined as inappropriate activity between an adult and child that leads to sexual gratification (Baker & Duncan, 1985). The prevalence of childhood sexual abuse is difficult to estimate. Due to the secrecy, shame, and intimidation that accompanies childhood sexual abuse, many survivors choose not to report to authorities or disclose to anyone else for that matter. Some women who have experienced childhood sexual abuse may not remember it. While no amount of abuse is acceptable, estimates from Ontario suggest that it is a relatively common problem in our society (MacMillian et al., 1997).

Although CSA and its sequelae have only begun to be explored in the literature in the last few decades, what is clearly established is the significant impact CSA has on overall health and life quality (Finkelhor, Hotaling, Lewis, & Smith, 1990). CSA has been linked to elevated risks

of self-destructive behaviours including intentional self-injury and self-harm (Kendall-Tackett et al., 1993), posttraumatic stress disorder (PTSD) (Kendall-Tackett et al., 1993; Lev-Wiesel, Daphna-Tekoah, & Hallak, 2009), health problems including obesity, cardiovascular disease (Romans, Belaise, Martin, Morris, & Raffi, 2002) and autoimmune disorders (Cromer & Sachs-Ericsson, 2006), and difficulties in relationships and social functioning (ACOG, 2011; Heritage, 1998; Hobbins, 2003; Simkin, 1992).

The perinatal period is a significant time in a woman's life with high emotional and physical demands. During this period, the consequences and adverse effects of CSA may surface for the first time or be re-triggered. Some of these effects include: fertility issues, unplanned pregnancies, less prenatal care, frequent visits to emergency departments, and pregnancy loss (Clarke, 1998). Childhood sexual abuse exposure has also been linked to a fear of childbirth (Melender, 2002; Nerum, Halvorsen, Sorlie, & Oian, 2006; Ryding, Wijma, Wijma, & Rydhstrom, 1998), increased length of labour, higher rates of intervention (Nerum, Halvorsen, Straume, Sorlie, & Oian, 2012; Nerum, Halvorsen, Sorlie, & Oian, 2006), and pain, among other undesirable experiences (Clarke, 1998; Leeners, Richter-Appelt, Imthurn, & Rath, 2006; Parratt, 1994; Rhodes & Hutchison, 1994). Qualitative literature suggests that childbirth can be a distressing time for survivors of CSA. Experiences such as dissociation, detachment, and a fight for control have been present in several studies (Montgomery, 2013; Palmer, 2004; Rhodes & Hutchison, 1994). Furthermore, survivors of CSA often experience emotional distress from interventions involving touch (Coles & Jones, 2009).

These negative childbirth experiences can affect a woman in a variety of ways including feelings of revictimization, emotional trauma (Coles & Jones, 2009; Palmer, 2004; Rhodes & Hutchison, 1994), and the resurfacing of postpartum post-traumatic stress disorder (Lev-Wiesel,

Daphna-Tekoah, Hallak, 2009; Seng, Low, Sparbel, & Killion, 2003). Despite knowledge of the impact of CSA on childbirth and the associated outcomes, there remains limited understanding on the childbirth experiences told by the survivor herself. This is especially important in understanding how to best care for survivors during pregnancy and childbirth. Understanding how CSA survivors experience childbirth can assist healthcare providers in providing sensitive, informed care to all women during the perinatal period.

### **Problem Statement**

Childbirth may remind CSA survivors of their abuse experiences. This can be related to involuntary physical changes that occur during pregnancy, the intimate nature of childbirth, difficulty with trust and in relationships involving a power difference, and/or the pain that occurs in body areas that remind survivors of their abuse. Furthermore, childbirth can feel like or be an uncontrolled event, where birth plans are not fully realized and quick decisions and interventions may need to be employed for the safety of the mother and the baby.

Emotional trauma associated with obstetrical interventions and interventions involving touch (Coles & Jones, 2009; Palmer, 2004) may be especially difficult for CSA survivors, particularly cervical checks, epidural anesthesia, blood work, intravenous insertion, episiotomies, catheterizations, pushing during labour, male care providers, and infant physical examinations (Burian, 1995; Grant, 1992; Hobbins, 2004; Montgomery, 2013; Rhodes & Hutchison, 1994). For these reasons, childbirth can be a particularly difficult time for CSA survivors.

The majority of the literature available on CSA survivors and childbirth is quantitative in nature with few studies adopting a qualitative approach. Of the qualitative studies that exist, two focused broadly on the maternity care experiences of women (Coles & Jones, 2009; Palmer, 2004). Rhodes and Hutchison (1994) focused on the childbirth experiences told from the

perspective of the healthcare provider, Parratt (1994) completed a phenomenological study investigating the childbirth experiences of incest survivors specifically, and Seng, Low, Sparbel, and Killion (2003) conducted a secondary analysis which focused on abuse-related posttraumatic stress disorder (PTSD) and childbirth. There remains a significant gap in research seeking to *understand* the childbirth experiences of CSA survivors in the Canadian context.

Perinatal healthcare providers may not be meeting the needs of CSA survivors during pregnancy and childbirth (Burian, 1995; Coles & Jones, 2009; Rhodes & Hutchison, 1994). Research points to birth as not only having the potential to be a negative experience for women, but can also be a healing and empowering experience for survivors of CSA. In order for this to occur however, healthcare providers must be aware of what is needed during labour and how to provide sensitive obstetrical care (Heritage, 1998).

This thesis will outline a review of the extant literature, including available qualitative and quantitative sources, the methodological approach of this study, a synthesis of results, and implications to practice, education, and further research.

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

The purpose of this phenomenological study was to understand the childbirth experiences of survivors of childhood sexual abuse. The research question that guided this phenomenological approach is: *How do childhood sexual abuse survivors experience childbirth?*

## Chapter 2: Review of the Literature

The purpose of this chapter is to review the extant literature on childbirth for survivors of childhood sexual abuse (CSA). The search strategies employed will be highlighted, followed by childhood sexual abuse, its definitions, historical and theoretical perspectives, its prevalence, and its sequelae. Although limited research has examined associations between childbirth and CSA specifically, I will examine the dominant themes identified from the literature including fear of childbirth, increased rates of cesarean section, the intrapartum experience, including pain, disassociation, and flashbacks, triggers and suppression of memories, trust and mistrust, control, birth outcomes, and the relationship between practitioner and client/patient.

The following electronic databases were searched using indexing terms where applicable: CINAHL, Medline, Proquest, OVID, and Scopus. Combinations of key terms were searched: “childbirth”, “child sexual abuse”, “child abuse survivors”, “sexual abuse”, “child abuse, sexual” “labour, obstetric”, and “abuse sexual”. In addition to the online searches through the above databases, reference lists were hand-searched to yield all available literature on this topic of study. In total, the search yielded 1134 abstracts, of which 53 were selected. Many of the articles retrieved were excluded due to lack of relevant content and lack of empirical significance. Articles dated over 5 years were still included in this literature synthesis because of their seminal importance and their contribution to conceptual understanding of this understudied topic.

### Definitions

**Child Sexual Abuse.** Baker and Duncan (1985) define CSA in the following way:

A child (anyone under 16 years) is sexually abused when another person who is sexually mature, involves the child in any activity which the other person expects to lead to their sexual arousal. This might involve intercourse, touching, exposure of the sexual organs, showing pornographic material or talking about sexual things in an erotic way. (p. 458)

The American College of Obstetricians and Gynecologists (ACOG) (2011) provides a more detailed definition as they include both: circumstances where deception occurs and circumstances where the child “understands” the nature of the activity/act. The Canadian Incidence Study of Reported Child Abuse and Neglect (2005) defined CSA as being one of the following: (1) penetration, (2) attempted penetration, (3) oral sex, (4) fondling of the genitals, (5) adult exposure of genitals to child, (6) sexual exploitation, (7) sex talk, or (8) voyeurism. Abuse may occur within a family (intra-familial) or outside of family unit (extra-familial) (Palmer, 2004). Although the definition of CSA in the literature ranges from broad to specific, and differs on its exact criteria, for the purpose of this thesis a broad definition was chosen. It was important to allow flexibility in the definition to include any/all forms of sexual activity (Fergusson & Mullen, 1999). As such, this study’s definition of CSA is the following, informed by Baker and Duncan (1985): *Self-reports of involvement of a child before the age of 16 or exposure to sexual contact, activity or behavior by another youth or adult.*

**Survivor and Victim.** The words and terms that are used in the context of CSA are important to consider because of the power they hold. Certain words may serve to perpetuate further victimization, while others may promote resilience and strength. In the past, individuals who experienced abuse were often referred to as victims. The term victim refers to helpless individuals, in positions of vulnerability. The term survivor is used to acknowledge the resilience and strength of individuals who have experienced abuse (Dunn, 2005; Schachter, Staker, Teram, Lasiuk, & Danilkewich, 2008). Referring to a female adult as a ‘victim’ may serve to perpetuate the power differential she may feel with others around her. Some authors suggest terms such as victim may also serve to keep the individual in a psychological place of being broken and damaged (Dunn, 2005; Murray & Graves, 2012). Rather, the term survivor

implies conquering, strength, and life-after-abuse (Dunn, 2005). However, it is important to note, the term victim is still largely used in the political and judicial context, where commonly used phrases include ‘victim testimony’, or ‘victim statements’ (Murray & Graves, 2012). It is understood that there is some variability in how individuals self-identify, but for the purposes of this thesis, the term survivor will be used for those who have experienced childhood sexual abuse.

### **Historical Perspectives of Childhood Sexual Abuse**

Societal acceptance of and response to childhood sexual abuse has undergone a turbulent evolution. Understanding the prevalence and sequelae of CSA is still problematic, but our current understanding has evolved a great deal since the turn of the nineteenth century (Scott, 1992; Scott, 1995; Smart, 2000). Parton (1979) acknowledges that the history of child abuse has followed a natural sequence. He classifies its history in society as occurring in four stages: discovery, diffusion, consolidation, and reification. Discovery relates to the initial diagnosis or acknowledgement by one or more people that ‘something’ is problematic. The discovery, or “re-discovery” as acknowledged by Scott (1995), occurred primarily from 1970-1980, where survivors were first acknowledging their history of abuse, gaining momentum from the recent surge of the North American feminist movement during the 1960s and 1970s (Scott, 1995). Diffusion refers to the mutual concern and the dissemination of like-messages as it relates to the problem. Public and scientific diffusion of knowledge about child sexual abuse occurred primarily during the 1980s where more survivors began to tell their stories, acknowledging their histories of abuse as children. Agencies began to form, such as the International Society for the Prevention of Child Abuse and Neglect, providing a platform for knowledge translation and dissemination, the stage Parton (1979) refers to as consolidation. Consolidation refers to the

stage in which one or more agencies or organizations control and take some responsibility over the problem (Scott, 1995). Lastly, reification refers to child sexual abuse as a societally recognized problem, with lasting effects and consequences (Palmer, 2004; Parton, 1979).

### **Theoretical Perspectives on Childhood Sexual Abuse**

Prior to the 1950s, one prominent ideology existed to understand affectional bonds. Individuals were thought to bond with others based on their innate desire for food (as babies) and for sex (as adults). These desires were primal and necessitated another individual to fulfill them (Bowlby, 1977). “This type of theory postulates two kinds of drive, primary and secondary: it categorizes food and sex as primary and ‘dependency’ and other person relationships as secondary” (Bowlby, 1977, p. 202). Psychologists and theorists empirically tested these prominent ideologies, primarily in animal studies and eventually Attachment Theory was developed (Bowlby, 1977).

### **Attachment Theory and Sexual Abuse**

**Attachment behaviors.** Attachment behaviors are present across one’s lifespan and are defined as affectional bonds or connections between two individuals where one individual cannot be wholly transplanted with another (Ainsworth, 1989). Attachment Theory is based on the premise that children must feel secure in their relationship with a caregiver so that they can safely explore their environments and thrive (Alexander, 1992). Usually developing in infancy toward a preferred caregiver, attachment behaviors may change toward the initial caregiver and may later be directed towards others involved in significant relationships. These attachment behaviors are most evident in adulthood particularly in distressing or difficult situations (Bowlby, 1977).

When mother is present or her whereabouts well-known and she is willing to take part in friendly interchange, a child usually ceases to show attachment behavior and, instead, explores his environment. In such a situation mother can be regarded as providing her child with a secure base from which to explore and to which he can return... (Bowlby, 1977, p. 204)

Starting from a young age, the child constructs an internal working model of their world, a series of constructs and truths around being parented and parenting. Children learn how and where they are situated in their family structure and in the broader context of society. Concepts such as trustworthiness, self-worth, and caring behaviours are learned and help the child construct meaning about themselves and what parenting is about (Alexander, 1992).

**Attachment theory and childhood sexual abuse.** Altered or broken attachment can have long-term adverse consequences including diminished or altered emotional development, impaired neurological development, and difficulties with socialization and relationships (Duncan, 2005). Alexander (1992) acknowledges the reciprocal relationship between CSA and altered attachment, whereby altered attachment may precipitate some of the aforementioned consequences, increasing the child's vulnerability to falling victim to maltreatment. Conversely, maltreatment in the form of sexual abuse impacts the way the child views themselves, their security, family, and worldview. This may impact their attachment toward caregivers and others, and may affect interactions with their own children in the future. "The interpersonal models adapted by those abused in childhood assume that relationships are essentially adversarial, that vulnerability leads to exploitations, and that intimacy leads to pain and betrayal" (Cloitre, Cohen, & Koenen, 2006, p. 25). Children who have been abused demonstrate maladaptive internal models of attachment, which causes impaired attachment with other children and demonstrated aggression and fear. Affects of impaired attachment extend to adolescence where survivors become sexually active earlier, demonstrate aggression more often, and have difficulty in social

situations. In adulthood, these impaired early internal models of attachment impact social and romantic relationships, sensitivity to criticism, and the ability to effectively manage relationships in the workplace (Cloitre et al., 2006). Cloitre et al. (2006) furthers this by explaining that children, when raised in positive, non-abused environments learn when and how they should behave and when it is appropriate or not appropriate to exhibit different emotions (for example: aggression on a basketball court versus in the classroom). As a result of maladaptive models of attachment, adult survivors seem to demonstrate less sensitivity to these social norms.

### **Finkelhor's Precondition Theory**

Theories on attachment behaviors may serve to explain the increased prevalence of childhood abuse for children who experience altered early attachment. Relevant to childhood sexual abuse, D. Finkelhor proposed a theory in which certain manifestations must be present in the perpetrator. Finkelhor's Precondition Theory explains that four preconditions need to be present in a perpetrator in order for child sexual abuse to occur. These factors are: emotional congruence (sexual activity with a child is emotionally satisfying), sexual arousal (sexual activity with a child promotes sexual arousal), blockage (fulfilling a sexual need that they cannot meet in a societally acceptable way), and disinhibition (they become disinhibited and behave in ways they would not normally otherwise) (Ward & Siegert, 2002).

### **Prevalence of Child Sexual Abuse**

Childhood sexual abuse, underpinned in shame, secrecy, trickery and guilt, has been problematic to universally define and is significantly underreported. Many survivors minimize the event(s) or experience(s) to escape shame, protect the perpetrator, or as a way to cope and move on in their lives. Survivors may also forget or suppress memories of abuse entirely [*see Flashbacks, Triggers, and Suppressed Memories, p.18*] (Garratt, 2008; Hobbins, 2004). The

literature expresses vastly different statistics, and this may be due to differing definitions of CSA and of what constitutes a child (Garratt, 2008), varying methods of assessment and differences in the study sample, and sampling and reporting errors (Fergusson & Mullen, 1999). The ACOG (2011) estimates the prevalence of CSA in the United States to be between 12-40%. According to Statistics Canada, in 2008, 201 out of 100,000 (0.2%) of children in Canada were involved in some kind of sexual assault. Children were defined in this case as less than 18 years of age (Statistics Canada, 2008) and included only those that reported to authorities during 2008. As many do not report sexual abuse, these statistics likely vastly underrepresent the prevalence of CSA in Canada. In a meta-analysis to determine international rates of CSA, it was found that 19.7% of women had been sexually abused before the age of 18 (Pereda, Guilera, Forns, & Gomez-Benito, 2009) though Heritage (1998) quotes rates as high as 27%. Fyfe (2005) and Leeners, Richter-Appelt, Imthurn, and Rath (2006) estimate rates in New Zealand and Germany as being 20-30% and 20% respectively. In 1997, MacMillan and Wong reported CSA rates in Ontario as being 21.1% for females.

### **Sequelae of Child Sexual Abuse**

In 1986, Browne and Finkelhor completed one of the first reviews on the effects of CSA on children. It was widely cited and continues to be, but since their publication there has been a surge in research on CSA and its short and long-term consequences (Kendall-Tackett, Meyer Williams, & Finkelhor, 1993). Methodological concerns do exist in the current literature on CSA, particularly as it relates to the retrospective nature of CSA reporting that many studies utilize, as questioning children on this subject matter may carry a good deal of risk. Other difficulties include the lack of a consistent definition of CSA and the comorbidities that exist

among families where sexual abuse is occurring. Also variable is the length and severity of abuse that took place (Neumann, Houskamp, & Pollock, 1996).

Nevertheless, there is strong evidence to support that the effects of CSA can be lasting and profound. Some of the most consistent effects include: depression and anxiety (Brown & Finkelhor, 1986; Burian, 1995; Courtois, 1992; Kendall-Tackett et al., 1993; Neumann et al., 1996), anger and delinquent behaviour, sexualized behaviours including sexualizing child activities such as drawing pictures of sexual acts or positioning dolls into sexually suggestive positions (Kendall-Tackett et al., 1993; Neumann et al., 1996), self-destructive behaviours such as substance abuse and self-injury (Kendall-Tackett et al., 1993; Neumann et al., 1996), post-traumatic stress disorder (PTSD; Kendall-Tackett et al., 1993; Lev-Wiesel, Daphna-Tekoah, & Hallak, 2009), and difficulty in trusting relationships, such as intimate partner relationships (ACOG, 2011; Heritage, 1998; Hobbins, 2003; Simkin, 1992).

As discussed in detail below, child sexual abuse has considerable impacts on other significant life events such as pregnancy and childbirth (ACOG, 2011; Burian, 1995; Clark & Smythe, 2011; Coles & Jones, 2009; Courtois & Riley, 1992; Grant, 1992; Grimstad et al., 1999; Heimstad et al., 2006; Heritage, 1998; Hobbins, 2004; Holz, 1994; Leeners et al., 2006a; Leeners et al., 2006b; Lev-Wiesel, Daphna-Tekoah, & Hallak, 2009; Lukasse et al., 2010; Montgomery, 2013; Palmer, 2004; Rhodes & Hutchinson, 2004; Rose, 1992; Simkin, 1992; Waymire, 1997; Weinstein & Verny, 2004; Welch, 2013; Wilson, 2011).

### **Child Sexual Abuse and Childbearing Women**

**Fear of childbirth.** Fear of childbirth has become a widely documented phenomenon among women. Fear of childbirth may adversely affect labour outcomes and lead to elevated rates of operative deliveries and cesarean sections (Melender, 2002; Nerum, Halvorsen, Sorlie, &

Oian, 2006; Ryding, Wijma, Wijma, and Rydhstrom, 1998). Ryding, Wijma, Wijma, and Rydhstrom (1998) found an association between fear in the third trimester of pregnancy and increased cesarean section rate, and in another study it was found that fear of childbirth was most severe for those who have experienced sexual violence (Schroll, Tabor, & Kjaergarrd, 2011). Women who displayed extreme fear of childbirth (FOC) also reported experiencing unbearable pain more often. These authors made the interesting observation that despite women in the sexual violence (SEV) group reporting effective pain relief measures, their fears were not diminished as it was in other groups. The authors stated that: “this finding is clinically highly relevant as it indicates that pain relief in itself during delivery is not sufficient to avoid severe FOC” (Schroll et al., 2011, p. 24).

Heimstad et al. (2006) examined fear of childbirth among CSA survivors. Fear of childbirth was measured using two validated scales: the Wilma Delivery Expectancy Questionnaire (W-DEQ) and the State –Trait Anxiety Inventory (STAI). Women who reported higher levels of fear required vacuum extraction more often. No correlation was found between increased fear of childbirth and caesarean section, induction of labour, preterm labour, and asphyxia in the newborn. Among those who reported higher pain scores were women with a history of childhood sexual abuse. It was found that childhood sexual abuse was also a significant risk factor for instrumental delivery in the form of vacuum or forceps use. The work of Grimstad, Schei, Backe, and Jacobsen (1999) confirmed that CSA survivors presented with higher anxiety levels when assessed during the postpartum period. Eberhard-Gran, Slinning, and Eskild, (2008) found an association between extreme fear of childbirth and a history of sexual abuse in adult life. A longitudinal study by Lukasse, Vangen, Oian, and Schei (2010) also sought to examine the association between childhood abuse (emotional, physical,

and/or sexual abuse) and fear of childbirth. They completed a longitudinal study in which they followed participants from their first pregnancies to the birth of their second baby. These authors included participants who experienced emotional, sexual and physical abuse during childhood. Overall, their results suggested that women who experienced childhood abuse preferred cesarean sections more often expressed with an odds ratio of 2.14 (95% CI 1.18-3.89).

**Increased rates of cesarean section.** The proportion of women who request a caesarean section is increasing in the general population (Nerum et al., 2006). “Fear of birth with a concurrent request for a cesarean delivery may be understood as a crisis reaction in which the impending birth activates previously unprocessed life events and problems” (Nerum et al., 2006, p. 222). A crisis-oriented counseling service was developed out of a large University hospital in Norway, where the established goal was to reduce fear of delivery as evidenced by women expressing an openness and a desire to deliver vaginally after a crisis-oriented intervention. This intervention involved clearly capturing participants’ significant life events involving “traumatic experiences tied to reproductive health, abuse, and other difficult issues that could be activated by the impending birth” (Nerum et al., 2006, p. 223). The counseling aimed to further explore fears about the impending birth, working through past life events, and providing education to help in clarifying misinformation about birth. Of the participating women, 63% had a history of abuse, and 76% of these indicated a severe fear of birth. Of the women who reported a severe fear of birth, 67% requested cesarean section before the intervention. After the intervention “86% [of women] changed their thinking about mode of birth, and prepared themselves for a vaginal birth” (p. 224), and most of the women that changed their mind went on to have a vaginal delivery. In a follow-up questionnaire, almost all of whom had a vaginal delivery indicated that they would opt for a vaginal delivery in the future. Relevant to the rising cesarean

section rate is the importance of discussions initiated by healthcare providers about birth preferences, fears, and assumptions. This is especially important for CSA survivors, as the above research explicates the relationship between anxiety, history of CSA, and the preference for elective cesarean sections.

### **Intrapartum experience.**

*Pain.* Childhood sexual abuse survivors report heightened levels of pain during labour (Clarke, 1998; Leeners et al., 2006; Parratt, 1994; Rhodes & Hutchison, 1994). Existing literature suggests that many women with a history of CSA experience higher levels of pain during delivery, which may be caused by increased anticipation of pain during delivery and/or pre-existing perineal scars. Among incest survivors, the suturing of episiotomies or lacerations was also consistently more painful and fear provoking (Parratt, 1994). Interestingly, Rhodes and Hutchison (1994) found that CSA survivors either demonstrated an extremely high pain tolerance, or a very low pain tolerance. These authors suggested that participants' expressing either a 'fighting' or 'retreating' response to childbirth could explain this dichotomy. Those who demonstrated a 'fighting' response to childbirth were fearful, mistrusting, outwardly expressed pain, and often demonstrated an exaggerated response to it. Participants who demonstrated a 'retreating' response to labour often laboured quietly, with little outward demonstration of pain (Rhodes & Hutchison, 1994).

Some survivors of CSA present with physical ailments or complaints that are medically unexplained, and this is particularly true for women during pregnancy where seemingly 'normal' pregnancy events or bodily changes are experienced as painful or uncomfortable (Seng et al., 2003). Some survivors present with complaints of pain or other physical manifestations in the body areas where abuse occurred. For example, a woman forced to perform oral sex had

frequent complaints of mouth and throat pain, fear of the dentist, and procedures involving the mouth (Burian, 1995). Somatic experiences such as these can be more common among survivors of CSA, and may be explained as a post-traumatic stress response to their past abuse experiences (Courtois & Courtois Riley, 1992; Seng et al., 2003).

Parratt (1994) reinforced the importance of healthcare providers' awareness of what birth may be like for abuse survivors. She reinforces that birth may look vastly different for different women survivors, where some may retreat and surrender to the experience, while others may present with extreme resistance, pain and anxiety.

Using a hermeneutic approach, Clark and Smythe (2011), had registered Midwives in New Zealand summarize their extensive experience with cues and behaviours in labour, and provide a close examination and articulation of the lived-experiences of women CSA survivors. The authors give a fictional story of a woman named Jenny, a story that was composed based on the midwives' experiences with survivors of CSA. The story captures a dominant, seemingly well-adjusted woman in her struggle with childbirth. Vaginal exams are very difficult for her, and labour eventually slows. Although the article aims not to create facts or certainties about childbirth for survivors, it does illustrate a story based on the authors' experiences. As such, it does not adopt the claim of research, rather anecdotal reflections on this experience. "On one end of the continuum is the abuse survivor who experiences the birth as the ultimate healing experience, and on the other is the woman who feels that her birthing experience is tantamount to a recurrence of the sexual abuse" (p.205) (Kendall-Tackett, 2004 as cited in Clark & Smythe, 2011).

***Dissociation.*** Dissociation, or psychologically ‘leaving the body’, is adopted by some survivors of CSA as method to cope with their intense feelings. As child victims of abuse, many survivors dissociate as a way to cope with the pain and reality of what is happening (Hobbins, 2004; Leeners et al., 2006) when neither “fight nor flight is possible” (Seng et al., 2003, p. 609). When a woman dissociates during labour, she may experience altered levels of consciousness, limiting her ability to feel fetal movement, or participate in labour events such as pushing (Hobbins, 2004).

Dissociation occurs along a continuum from normal, adaptive splitting off of awareness or affect to more comprehensive and problematic forms where the person responds to stressors as though from within an earlier developmental stage, or in the case of dissociative identity disorder, from within a part of themselves that has different personality attributes. (Seng et al., 2003, p.609)

Rose (1992) articulates how a seemingly routine procedure of obtaining swabs during pregnancy caused her to dissociate. Factors contributing to this event included a perceived lack of care from the healthcare practitioner, fear of infection and contamination, and pain associated with the speculum insertion. During her second delivery, she describes losing her awareness of reality:

My panic was so intense that I had a hard time being present, and was retreating so much that my eyes kept rolling up toward the ceiling. I couldn’t maintain eye contact. In fact, I felt as if I were viewing the whole scene from outside my body, up near the ceiling and to my left, about 10 feet away from where I lay (Rose, 1992, p. 217).

Another survivor, Terry, describes her birth experience:

I can only remember [labour up to] a point, and then it just all goes away...And I picked that up from, you know, when my brother used to molest me...You know what I would do is I would just close my eyes real tight and just imagine my spirit being lifted up out of my body and sitting on my bed until he was done. Then I would come back into myself. [And in labour] what happened was [the doctor] left and while I was going through labour I just blocked myself out. I blocked myself out through the pain and just took it. (Seng et al., 2003, p. 2010)

“The memory of the violations during my childhood was locked in my birthing muscles for all these years, only recently coming to the surface of my conscious awareness.” (Rose, 1992, p. 216). Dissociation can serve to further challenge labour patterns, such as pushing, when patients ‘escape’ from the labour experience. (Hertiage, 1998; Hobbins, 2004; Leeners et al., 2006); Nerum, et al., 2012; Rhodes & Hutchison, 1994).

***Flashbacks, Triggers, and Suppression of Memories.*** Sexual abuse experienced as a child has lasting effects and despite therapy or counseling, may resurface through many of life’s significant events. New intimate partner relationships, pregnancy, and childbirth are frequently reported periods of life when abuse triggers are present or suppressed memories surface (Courtois & Riley, 1992). Research indicates that 57-64% of women have some amnesia regarding their childhood abuse experiences (Hobbins, 2004). Repression of traumatic memories often occurs as a method to cope with the challenge and pain associated with reconciling the abuse. As such, for many women these abuse experiences remain repressed and triggers may cause survivors to remember their abuse experiences for the first time (Hobbins, 2004). Burian (1995) says that sounds, smells, physical sensations, or certain phrases can be traumatizing and may cause flashbacks to the abuse experience. Hobbins (2004) provides the example of a child named Olivia who provided detailed accounts of her abuse experience. However, years later when Olivia was an adult, she was unable to recount ever being abused. Olivia says, “it’s my mind's gift to me” (Hobbins, 2004, p. 488).

Several women in one qualitative study presented with no memory of abuse until the perinatal period. One participant, Emily, describes remembering the abuse when her infant first breastfed (Seng et al., 2003). Another woman describes the emotional numbing she went through to cope with her past: “It was kind of like a piece of clothing, you know... You put on

your shoes, you put on your socks, you've been abused, you put on your shirt, you put on your pants...I don't know how to describe it...there was no emotion to it" (Seng et al., 2003, p. 608).

Leeners, Richter-Appelt, Imthurn and Rath (2006) completed a systematic review to evaluate the effects of CSA on pregnancy, labour, and postpartum. Drawing definite conclusions from this work is problematic as the studies were largely heterogeneous, adopted different definitions of CSA, and measuring different variables and outcomes. Despite this, the authors articulated that one significant difference among survivors of CSA is the triggering or 'remembering' of past experiences and memories during pregnancy, labour, and the postpartum period. The authors explained that these memories may resurface during this perinatal period because of similar sensations and/or pain as they have associated with the abuse, anxieties around parenting and keeping their baby safe, feelings of inadequacy with parenting, and diminished self-efficacy.

***Trust and mistrust.*** As trust was broken at an early age for many CSA survivors, they may be unwilling to trust those around them in positions of perceived power. Survivors are often very aware of any power differences that exist in relationships and often struggle in personal relationships (Muzik et al., 2013; Simkin, 1992). The survivor may erroneously perceive others to have ill intent and to not have her best interests at heart. She may be led to choose a healthcare provider that is the opposite gender as the abuser, or if she feels she is responsible for the abuse where she blames herself rather than the perpetrator, she may consider a healthcare provider that functions under a largely paternalistic approach (Simkin, 1992). Relevant to this study, it has been reported that survivors of CSA choose female midwives more often as their choice of obstetrical care provider (Hobbins, 2004).

Survivors' mistrust of their own body was another theme identified in the literature. According to Simkin (1992), survivors may experience labours that abruptly halt, despite interventions to assist with the progression of labour. Simkin acknowledges this may be an unconscious or conscious mistrust of the healthcare team, perceiving them as "re-enactors of the abuse" (p. 225). An ethnographic study evaluating labour patterns of CSA survivors identified that some women had the belief their body was their enemy. They explain that their body betrayed them long ago, and because of that they have an ongoing mistrust and disconnect with it (Rhodes & Hutchison, 1994). It has been reported that mistrusting the body may contribute to longer labours with increased rates of interventions. Due to the experience of abuse as a child, some survivors are more attuned to the feelings and experiences of others than they are to their own bodies. Heritage (1998) describes a survivor's inability to feel the intense pain of her contraction, rather choosing to believe the monitor instead of her own bodily sensations (Rhodes & Hutchison, 1994; Simkin, 1992).

**Control.** Survivors of childhood sexual abuse have often experienced loss-of-control in its most significant form. Survivors learn from an early age that to lose control is unsafe and likely means impending pain and victimization (Burian, 1995).

She may try to maintain as much control as possible—over the care she receives, her care during labour, and her responses to the pain and stress of labor. The prospect of losing control over her care or behavior, and the thought of being vulnerable and dependent are frightening. (Simkin, 1992, p. 224)

As such, control is an identified theme among survivors during their childbirth experience. Montgomery (2013) describes control as external or internal. External control relates to the control or perceived lack-of-control based on how others make us feel, whereas internal control refers to the control we feel within ourselves, or 'self-control'. Montgomery identified the parallel between experiencing this loss of self-determination as children and patients' behaviours

during childbirth. As childbirth is an experience where the body involuntarily labours, it can serve to be an unsettling and frightening experience for survivors (Burian, 1995; Montgomery, 2013). Burian (1995) found ‘control’ was the most pressing and recurring theme identified through participant interviews. Four ways CSA survivors expressed regaining control were: “through aggression, submission, ritual, and living in a state of crisis” (p. 255).

Through the care and supervision of labour, healthcare practitioners may unknowingly contribute to patients’ re-experiencing of past abuse experiences. Coles and Jones (2009) gives the example of asking the patient to undress or requesting they lie down as part of a routine examination. This qualitative research study examined women’s feelings about perinatal professional touch and examination. Interviews were audio-recorded and thematically analyzed and coded. Eighteen participants were interviewed in total. Two main domains emerged from this work: *Safety Issues Identified by Childhood Sexual Abuse Survivors in the Clinical Encounter*, and *Making the Encounter Safe*. Themes such as pain, guilt, and shame emerged in response to having physical examinations. Participants also had some difficulty with their infants being examined. One participant named Alice describes not being able to stand up to healthcare practitioners similarly to her inability to object to her abuser. “It’s just the way you are used to dealing with people. Like the doctors and the health nurse, I felt like I couldn’t really say too much about it because I couldn’t just stand up and say no” (p. 233). Penny discussed her discomfort with having a male physician examine her baby “...it would be extra hard...to hand over another innocent child and trust...I trust you not to hurt her...especially if it was a male in that category of men I distrust...it is just difficult” (p. 233).

**Birth Outcomes.** Nerum, Halvorsen, Straume, Sorlie, and Oian (2012) evaluated if the length and outcome of labour was different for nulliparous women who had experienced CSA or rape in adulthood (RA), compared to a group of women with no reported abuse. The results indicated that the RA group had increased operative deliveries, including forceps, vacuum, and cesarean sections. Caesarean section rates were 18% (CSA), 36% (RA), compared to 12% in the control group. Importantly, there were no statistically significant differences among the groups in their perceived risk for requiring assistance with vacuum, forceps, or need for a caesarean delivery. There was also no statistically significant difference between the CSA and control group in requiring augmentation with oxygen (50% versus 54%), and vacuum or forceps deliveries (11% compared to 14%). There was a slight increase in need for episiotomies among women in the CSA group (35% compared to 33%). Overall, the RA group demonstrated significant labour patterns (longer labours), and labour outcomes that were not evident in the CSA group. As evidenced in other publications, all stages of labour were shorter among the CSA group when compared to the cohorts (Leeners et al., 2006); Nerum, et al., 2012). The authors suggested that one reason for this is could be the perceived withdrawal from the labour experience that was observed among some CSA survivors. As mentioned above, some survivors during childbirth disassociate or detach from the birth experience, thus succumbing to the process of labour (Rhodes & Hutchison, 1994). The authors' contrasted the experience of CSA with RA, whereby the child's experience often involves perpetration from an adult where an existing relationship is present, often using subtle tactics, such as bribery and manipulation. They compared this to rape as an adult which often involves force and is "often unexpected, and has a more violent character" (p. 492). They described these differences as potentially impacting the experiences in labour, where the CSA group may resist and withdraw, allowing labour to

continue, the RA group was more consistently fighting the experience of the fetus descending and labour progressing.

Anxiety and discomfort with childbirth experienced by survivors of CSA may even extend beyond the childbirth event. An understudied area of research is the impact of CSA on postpartum posttraumatic stress reactions. Although childbirth is not a widely recognized 'traumatic event', some women experience postpartum posttraumatic stress reactions to their childbirth, while others can go on to develop full-blown posttraumatic stress disorder (PTSD) after childbirth (Ayers & Pickering, 2001; Lev-Wiesel, Daphna-Tekoah & Hallak, 2009; Soet, Brack, & Dilorio, 2003).

## **Summary**

The perinatal period is a time of significant physical and emotional change. Generally viewed as a happy experience, childbirth may greatly affect a woman's self-efficacy, realization of expectations, and esteem. Available research suggests childhood sexual abuse survivors have increased fear of birth, demonstrate increase pain during childbirth, and present with postpartum posttraumatic stress reactions more frequently (Grimstad et al., 1999; Lev-Wiesel et al., 2009; Melender, 2002; Nerum et al., 2002). Palmer (2004) acknowledges the impact healthcare providers can make to the healing and recovery of survivors of CSA through the perinatal period. She emphasizes the important responsibility of nurses and allied staff to understand the childbirth experiences for this group of women in order to improve the experience for others. The literature search highlighted the impact and sequelae of child sexual abuse. For many women survivors the abuse experience does not end in childhood but permeates through other significant life events (Alexander, 1992; Burian, 1995; Clark & Smythe, 2011; Clarke, 1998; Coles & Jones, 2009; Courtois & Riley, 1992; Duncan, 2009; Fergusson & Mullen, 1999;

Heritage, 1998; Hobbins, 2004; Leeners et al., 2006; Palmer, 2004; Simkin, 1992). The individual experiences of survivors giving birth is understudied in the literature and within the Canadian context. The majority of literature on childbirth among CSA survivors includes anecdotal accounts from healthcare professionals on their observations of labouring women (Clarke & Symthe, 2011; Rhodes & Hutchison, 1994; Simkin, 1992) or is a quantitative research design, examining fear of childbirth, birth patterns, and outcomes (Heimstad et al., 2006; Leeners et al., 2006; Lev Weisel et al., 2009; Nerum et al., 2006; Nerum et al., 2012; Ryding et al., 1999). These quantitative accounts represent the movement toward understanding what childbirth is like for survivors of CSA, however fails to hear the individual voices, examining the “why” behind the statistics. Qualitative research on this topic is considerably lacking (Coles & Jones, 2009; Montgomery 2013; Muzik, 2013; Palmer, 2004; Rhodes & Hutchison, 1994). As an aim of qualitative research is to illuminate the voices of individuals, so it is my aim through this phenomenological study to bring awareness to an understudied topic, in seeking to understand how CSA survivors experience childbirth.

### **Chapter 3: Methodological Approach**

This chapter will provide an overview of the methodology and philosophy of phenomenology used to address the research question that guided this thesis study, as well as discuss the specific approach applied to data analysis, Interpretative Phenomenological Analysis (IPA). Also outlined in this chapter is a discussion of the sample, the recruitment process and the process of consent.

#### **Research Question**

Although a growing body of quantitative research has been conducted on the sequelae of CSA, relatively little is known about its effects on significant life events such as childbirth. Moreover, links between childhood sexual abuse and childbirth have only recently been examined using qualitative methods.

Understanding the uniqueness, complexity, and universality of experience was the basis for exploring childbirth and childhood sexual abuse using an interpretative phenomenological approach. Guided by the philosophies of a Heideggerian interpretative phenomenological perspective as proposed by Smith and colleagues (2007), this research study began with the research question: *How do childhood sexual abuse survivors experience childbirth?*

#### **Overview of Methodology**

**Phenomenology.** Phenomenology is both a philosophy and research method aimed at exploring the lived-experiences of individuals experiencing a similar phenomenon. Founded by the philosopher Edmund Husserl, phenomenology has roots in philosophy, psychology, and sociology (Creswell, 2013). “Phenomenology is as much a way of thinking or perceiving as it is a method. The goal of phenomenology is to describe lived experience” (Streubert & Carpenter, 2001, p. 74). Phenomenological research cannot be viewed as one homogenous philosophy and

research approach, as embedded within phenomenology exists different philosophies, world-views, and methodological interpretations (Walters, 1995). As branches of phenomenology adopt different views, phenomenology extends from the positivist paradigm with works from Husserl, to the interpretivist paradigm (Heidegger), to the constructivist paradigm, with works from philosophers such as Gadamer (Dowling, 2007).

**The phenomenology of Edmund Husserl.** Husserl began the modern philosophical movement just prior to World War I, where his quest for philosophically rooted science was inspired by Franz Brentano (1838-1917), who first coined the term “psychology phenomenology” (Moran, 2000, as cited in Dowling, 2007). Intentionality, or the conscious awareness of internal meaning, is central to Husserl’s phenomenology. Individuals become conscious of their feelings, emotions, and memories, and the aim of phenomenology is to uncover the person’s intentionality (Dowling, 2007; Owen, 1994). Husserl also placed emphasis on un-interpreted, unreflective accounts from participants.

**Phenomenological reduction.** Husserl aimed to have phenomenology be a rigorous, scientific encounter, eliminating bias by holding “subjective perspectives and theoretical constructs in abeyance and facilitate the essence of the phenomena to emerge” (Dowling, 2007, p. 133). He terms this process phenomenological reduction. Explanations or interpretations are to be withheld until the phenomena is clearly understood. Understanding comes from the participant’s pre-reflective lived experiences. That is, before the participant reflects and makes sense of the situation as it pertains to their worldview (Dowling, 2007). Researchers ensure phenomenological reduction through the process of bracketing, whereby presuppositions and experiences are clearly acknowledged and set aside (Walters, 1995). Husserl refers to this using the Greek word, *epoche*, which means “a suspension of judgment” (Walters, 1995, p. 792).

**The phenomenology of Martin Heidegger.** Martin Heidegger (1889-1976), a student of Edmund Husserl, challenged some of his concepts and ideologies as it pertained to a person's autonomy and the positions they hold in the world. Heidegger argues that from the existential perspective, individuals are inseparable from their world and are products of the social and political constructs in which they live; he calls this 'Being-in-the-World' (Heidegger, 1962 as cited in Maggs-Rapport, 2001). Heidegger acknowledges that individuals cannot be separated from the world in which they live, including the cultural and societal influences that are present (Walters, 1995). He "considered understanding rather than description, believing not only in phenomena but also in their interpretation" (Maggs-Rapport, 2001, p. 377). Heideggerian phenomenology is ontological in nature, whereby the primary focus is "the meaning of Being" (presence in the world) (Dowing, 2007, p. 133). Heidegger also challenged some of Husserl's beliefs on consciousness and intentionality, believing he ignored other important influences such as anxiety, fear, and death (Walters, 1995). Heidegger also argued against the researcher's involvement and level of neutrality in Husserl's interpretation of phenomenology, believing that the experiences researchers have cannot be set-aside and forgotten (Walters, 1995).

**Hermeneutics and interpretative phenomenology.** Interpretative or hermeneutic phenomenology involves making sense of people and how they are situated within their world from their own personal accounts. The researcher and the participant enter into a relationship of co-creating research together, "the participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world" (Smith & Osborn, 2007, p. 53). Research questions addressed using an interpretative phenomenological perspective are broadly phrased with an emphasis on the participant to elucidate further themes and generating areas for further questioning. As such, the research question proposed above is

broadly phrased to capture the unique and specific experiences of childbirth without leading the participants to an eventual outcome or intended goal.

### **Interpretative Phenomenological Analysis**

Interpretative Phenomenological Analysis (IPA) involves making sense of people and how they are situated in their world from their own personal accounts. Scholars purport that IPA is a blend of phenomenology, hermeneutics, and idiography (Smith, Flowers, & Larkin, 2013). Where phenomenology and hermeneutics are defined above, idiography refers to the in-depth analysis leading to the development of interpretations of a small, specific group of individuals, as opposed to a nomothetic approach which focuses on making assertions or claims of larger groups of people and populations (Smith & Osborn, 2007). Also closely linked to IPA is psychology, as both share a focus on the cognitive paradigm where the central point of exploration is cognition. How IPA and psychology study cognition is different, more specifically, psychology is foundationally linked to empirics and quantitative methods of research, while IPA is concerned with an in-depth interpretative analysis (Smith et al., 2013; Smith & Osborn, 2007). Unlike descriptive phenomenological approaches, the researcher is valued for their experience and knowledge with which they approach the research. As such, this is an appropriate method and philosophy for this research study, as my experience as a Registered Nurse in a Maternal-Child Unit has contributed to my existing knowledge on CSA survivors.

In IPA the researcher and the participant enter into a relationship of co-creating research together, Smith and Osborn (2007) call this reciprocal analysis a two-step hermeneutic process. In order to *understand*, Smith and Osborn (2007) say that there are two actions required, 1) To understand through “identifying or empathizing” (p. 54) and 2) To understand as “trying to make sense of” (p. 54).

**Design appropriateness.** Heideggerian phenomenology involves an ontological quest aimed at not only describing, but also understanding lived-experiences (Dowling, 2005). This research project was aimed at understanding the experiences of sexual abuse survivors during childbirth. Interpretative phenomenology was chosen as the research method due to its emphasis on understanding the phenomenon, its iterative nature, and its emphasis on researcher and participant co-creating the research together. The hermeneutic circle, described by Gadamer, refers to the iterative process of fusing horizons (Maggs-Rapport, 2001). Fusing horizons refers to the process of acknowledging personal prejudices and personal histories, as we cannot begin to understand a phenomenon until we have understood the impact historical events have on our understanding of them (Maggs-Rapport, 2001). Where other phenomenological methods such as descriptive phenomenology focus on bracketing one's biases, interpretative phenomenology acknowledges the importance of conscious awareness of life experiences, as true interpretation cannot occur when one tries to separate from their consciousness (van Manen, 1990). As a researcher with clinical experience in the area of Maternal-Child nursing, I felt it important not to dismiss or set-aside my experiences, but rather acknowledge them as important and valuable to the research process. Further, data analysis was completed in part by the whole thesis committee, all healthcare professionals with different experiences with this phenomenon. As such, it was not possible to set aside the years and depth of experience that the committee brought with them to the data analysis meetings. Rather, aligned with interpretative phenomenology, it is important to acknowledge the importance and value of one's own history.

The majority of the published literature on childbirth among CSA survivors is limited by the description and interpretation being solely under the power of the researcher, wherein researchers both describe and interpret participants' experiences during labour. In such work,

the voices of the participants are not clearly heard, with the exception of a few sporadic qualitative accounts. In an attempt to illuminate more richly and clearly their stories and to hear the voices of CSA survivors, an in-depth, cooperative approach was necessary to help fill the gap existing in the current literature. Interpretative phenomenology was therefore deemed the most appropriate method to explore this understudied phenomenon.

### **Sampling**

Purposive sampling, a common qualitative sampling method, sample individuals who have experienced a similar phenomenon (Speziale & Carpenter, 2007). This was deemed the most appropriate sampling method to employ for this qualitative study, as the purpose of this research study was to understand childbirth experiences of childhood sexual abuse survivors.

### **Sample Size**

A distinctive feature of interpretative phenomenology studies is a commitment to an in-depth, detailed analysis. Thus studies utilizing this method are commonly completed with a very small sample size (Smith & Osborn, 2007). Smith (2004) has argued for the consideration of one, single participant, while Smith and Osborn (2007) suggest that a suitable sample size for a student completing IPA for the first time is three participants. As such, it was our aim to have a sample size of approximately three participants, recognizing the importance of depth over breadth. Present in other qualitative approaches is the aim for data saturation. That is, the repeated data generation and analysis until no new findings emerge. While data saturation is present in qualitative approaches such as grounded theory, data saturation is not evidenced in interpretative phenomenological studies, as the aim of IP is the analysis of unique experiences (Hale, Treharne, & Kitas, 2007). Smith and Osborn (2007) suggest that deciding on an appropriate sample size includes “the degree of commitment to the case study level of analysis

and reporting, the richness of the individual cases, and the constraints one is operating under” (p. 56).

Our final sample included four female adults in their late twenties to early forties, who spoke and understood English.

### **Inclusion Criteria**

All potential participants were 18 years or older and were required to have given birth to their baby within the last five years. The rationale for this was to reduce recall bias as much as possible in discussing their childbirth experiences. Another requirement for participation was that participants speak English and that they had experienced childhood sexual abuse. As mentioned earlier, our definition was the following: *Involvement of a child before the age of 16 or exposure to sexual contact, activity or behavior by another youth or adult*. In assessing eligibility for the research study, the researcher asked participants to self-identify with our definition of childhood sexual abuse by stating, “yes” if it happened to them or “no” if it had not happened to them. As a research team, we recognized the potential for harm in discussing abuse experiences, and considered assessing for this criteria in a way that may encourage the least amount of harm or emotional distress (see Appendix A: Telephone Script).

### **Recruitment**

Recruitment was completed through eight midwifery clinics in Southern Ontario. Midwifery services provide obstetrical care to healthy women throughout pregnancy and up to six-weeks postpartum. Midwives in Ontario have the guided philosophy of informed consent, believing women who are informed should have the right to make choices as it relates to their obstetrical care (Association of Ontario Midwives, 2015). Clinics were emailed a request to participate (Appendix B), included in the E-mail was a brief outline of the proposed thesis study

(Appendix C). Interested practices scheduled meetings with me, as the primary researcher, to discuss feasible recruitment through individual practices and were emailed a participation letter confirming cooperation with recruitment (Appendix D). All practices decided on the same recruitment method, as outlined below.

Recruitment was completed in the postpartum period, as participants were required to have gone through the process of childbirth in order to consent to this study. Participants were provided a study pamphlet in their final visits with their clinic (Appendix E). Their midwife informed them that the study was being completed through Ryerson University and was not affiliated with the practice in any way. They were also informed of their anonymity to the practice itself if they chose to participate or not. All clients leaving midwifery services were given a pamphlet regardless of their perceived or confirmed history of sexual abuse. Interested potential participants contacted the primary researcher through telephone or E-mail. Once contact was made, a telephone call was arranged to discuss the research study in more detail and to assess eligibility. Three participants were recruited through this method.

As recruitment proceeded slowly, we augmented our recruitment strategy. With approval from the Ryerson University Research Ethics Board, we added another form of recruitment to our existing strategy. Two of the Midwifery practices had active Facebook pages for their clients to keep updated to clinic events and patient education. Our study pamphlet was added to a Facebook post, inviting past and present clients to participate in our research initiative. This strategy ultimately led to the recruitment of one participant.

## **Consent**

Consent (Appendix F) was gained throughout the research process, beginning with the telephone script (Appendix A), and before and throughout the interview process. Participants

were reminded of their ability to withdraw from the research study or to choose not to answer a question at any time without giving a reason in doing so. Participants were reassured of their anonymity to the midwifery practice and that their choice to not continue with the research study would not impact their continued or future care with the midwifery practice to which they belonged. Participants were given time to review the consent prior to the interview, and given an opportunity to reflect and ask questions. All participants chose to continue with the research study. The consent form was signed, witnessed by the primary researcher. Participants were offered a copy of the consent form for personal reference. All participants also consented and signed in agreement to have their interview audio-recorded.

## **Ethics**

The Ryerson University Research Ethics Board approved this study. Since the affiliated midwifery clinics did not have their own ethics boards, Ryerson University Research Ethics Board approval was the only requirement.

As part of the recruitment strategy, the pamphlet outlining study details clearly identified the interest in the specific sample of women; survivors of CSA. Potential participants were not contacted by the research team until they, based on their interest, made initial contact. This method of recruitment was chosen to minimize participants from feeling coerced into participating.

The nature of the research study is based on the premise that the participants have a history of CSA. Although the aim and methods of the research study did not include asking participants to explicitly recall abuse experiences, we recognize that in discussing childbirth experiences, some participants might experience distress. As such, participants were reminded they may choose not to answer any question they wished not to answer. As well, they could

choose to terminate the interview at any time. No participant distress was noted at any point during the interview, however if distress was noted, the interview was to be stopped and emotional support provided.

As the consent outlined, participants' personal information would be released only in the event that they expressed intention to harm themselves or their infant, or if the interviewer suspected any form of child neglect or endangerment. No participants expressed any suicidal ideations, nor did the interviewer have any concern about child neglect or endangerment. All participants were provided with resources at the beginning of the interview including: Healthy Babies Healthy Children, Sexual Assault Centre of Hamilton (SACHA), Crisis Outreach and Support Team (COAST), and Women's Health Concerns Clinic (WHCC). Although the participants are considered vulnerable, being both women and CSA survivors, this protocol was considered minimal risk due to the nature of the interview discussion.

### **Data storage**

To ensure participant confidentiality, the consent forms and audio-recordings were kept in a locked storage cabinet. All participants were assigned a unique code, which was used to identify the participants and no names or other identifiers were used. The consent forms and audio-recordings will be destroyed once the primary researcher has graduated and the anonymized data will be kept for a period of five years in the event that the primary researcher intends on completing further research. The transcriptions are being kept on an encrypted external hard drive and will be destroyed once the primary researcher has graduated. All of these arrangements were discussed with participants and were consented to.

## **Data Collection**

Interviews were scheduled to last 45 minutes to 1 hour. Most participant interviews required the full hour to complete. I transcribed the interviews and this was completed within two weeks of each interview. Participants had a choice of the interview occurring at their home, or at a nearby public library, but all chose to have them conducted privately and in person in their homes. As with other qualitative methods, interviews completed in the participant's home foster a greater sense of participant ease and comfort, and this study allowed participants to be with and care for their babies in their home environments (Smith & Osborn, 2007). Two participants had their babies present for the interview, the other two arranged childcare for the duration of the interview. No other family members were home or present.

The primary researcher asked few, open-ended questions, adhering to the interpretative phenomenological approach. This allowed the participants to guide the flow of the interview, focusing discussion on areas and themes that were most important for them. This also assisted in mitigating distress or harm, as they largely directed the interview content and commented on aspects of their childbirth they were comfortable discussing.

Creating transparency in the research process is important in establishing rigour (Ortlipp, 2008). Reflective journaling was adopted throughout the research process and was an important aspect of data collection, whereby pre-interview feelings were captured, preconceptions, attitudes, assumptions, and structural information were recorded through the interview process, and detailed post-interview reflections.

## **Data Analysis**

The aim of IPA is to understand the respondent's psychological view of the world (Smith & Osborn, 2007). "Meaning is central and the aim is to try to understand the content and

complexity of those meanings rather than measure their frequency” (Smith & Osborn, 2007, p. 66). This process is considered phenomenological in nature as it attempts to illuminate the participant’s perception of the phenomenon instead of making objective statements about the experience (Smith, Jarman, & Osborn, 1999). The process of data analysis requires the full immersion in the respondent’s worldview by following a cohesive process.

The process of data analysis was employed using the steps in Heideggerian, interpretative phenomenological analysis presented by Smith and colleagues (Smith & Osborn, 2007; Smith, Jarman, & Osborn, 1999). This approach was chosen for its applicability for use in health psychological research as well as its clearly articulated method and philosophy in which to apply to phenomenological analyses. This study’s application of the four-step process of IPA presented by Smith and Osborn (2007) is outlined below.

1. *Looking for themes in the first case.* This important first-step of IPA involves the researcher immersing herself/himself in the respondent’s worldview by reading and re-reading the transcript. Smith and Osborn (2007) outline the importance of numerous readings of each transcript as each reading may illuminate new details and nuances. Also recommended in this step is the free capturing of notes and annotations in the margin. These annotations may be a condensed summary of the respondent’s words, “or associations or connections that come to mind” (Smith et al., 1999, p. 220). Smith et al. (1999) reinforce the fluidity of this process, with no confined guidelines for what should be captured in this initial phase. Once preliminary readings are completed and notes/annotations captured, subsequent reading(s) are recommended with the intention of identifying themes for each line of the transcript. We followed the recommendation of Smith and colleagues by using the left-handed margin for initial notes and annotations,

followed by the right margin for capturing our line-by-line themes. Identified themes can be one single word, a cluster of words, or a direct quote from the participant's own language. Some themes may come up consistently throughout the transcript and no attempt should be made to remove or omit themes at this stage.

2. *Looking for connections.* The next step in IPA involves writing down all of the identified themes on a separate sheet of paper and beginning the process of looking for connections between the themes. Superordinate themes may be identified and may assist in explaining other themes. The researcher begins to cluster the themes into groups with alike or similar themes. This process began by each committee member individually capturing themes on post-it notes and placing them on a large wall used as a work-surface. We also identified the page and line the theme was generated from on the post-it to use as a reference. Then, collectively we began to cluster the themes by moving the notes around to migrate toward other like-themes. We did not encounter any discrepancies or disagreements during this period, but as a group decided a few themes were outliers and could not be grouped. Once we had themes clustered we assigned each cluster of themes a cluster title. These were later changed to better reflect the theme content. We captured this process through photographs.
3. *A table of themes.* Smith and Osborn (2007) articulate the next step in this process as the development of a table to organize themes and their identifiers. The list of themes are outlined, titled with their superordinate theme. The primary researcher, using the themes generated from the collective data analysis meeting, completed the creation of the table. Smith and Osborn (2007) recommend doing this for one participant by which all further analysis may be applied to the framework.

4. *Continuing analysis with other cases.* Smith and Osborn (2007) gives the researcher the option of repeating these four-steps with every transcript or using the table as a framework to which to apply to the other transcripts. Smith and Osborn caution that the researcher should ensure that they are acknowledging all potential themes, including new themes that have not been identified in earlier transcripts. For this research study, I adopted the approach of repeating the steps for each transcript I reviewed. This was chosen because I am a novice researcher in IPA and wanted to ensure that I captured all of the themes accurately. When all four interviews were analyzed, a final table was constructed using superordinate and subthemes, and identifiers from the transcripts.

### **Rigour**

Maggs-Rapport (2001) acknowledges that inherent to demonstrating rigour in a qualitative research study, is the firm grounding of the work in the chosen methodological approach. It has been suggested that the criterion that is utilized to determine rigour in other qualitative studies does not adequately apply or measure rigour in interpretative phenomenological research (de Witt & Ploeg, 2006). The framework proposed by de Witt and Ploeg (2006) was utilized from the start of this research project to represent the expression of rigour in this interpretative phenomenological study. The following section will outline the important expressions of rigour as described in de Witt and Ploeg (2006).

**Balanced integration.** I was conscious to embed Smith and colleagues' IPA in all aspects of the research process, from the formulation of the research question through to the data analysis and writing up of the thesis. A careful balance of expressing the participants' words and the philosophies of IPA was taken. Furthermore, a clear and intentional explication of the philosophical importance to the research study and researcher were explained.

**Openness.** All decisions and discrepancies were reconciled through the lens of the study's philosophical underpinnings. An example of this includes the decision to return-to-findings in the form of returning to the participants' words. Although present in some interpretative phenomenological work is the returning to subjects to confirm findings or interpretations, we continually returned to the participants' words to ensure we were capturing their essence. Smith and Osborn (2007) stress the importance of returning-to-findings in the form of returning to the transcripts to ensure the participants' words and meaning is captured.

**Concreteness.** I presented concreteness through the thesis write-up, situating the participants' experiences, or 'lived thoroughness' by articulating CSA itself and its social and historical contexts. Concreteness was also demonstrated through use of reflective journaling on the implications of child sexual abuse and the author's reflections.

**Resonance.** Resonance refers to the "experiential or *felt effect* of reading the study findings upon the reader" (de Witt & Ploeg, 2006, p. 226). Resonance is further described as the moment when the true meaning of text melds with the reader's self-understanding. As work in this project has been a significantly experiential process for me, it is the aim for this research to resonate with its readers on an experiential level. That is, in reading the text the reader comes to a "sudden perception" (de Witt & Ploeg, p. 226) where the experience and their self-understanding meet. As such, thesis committee and I feel an obligation and commitment to writing in a way that conveys the essence and story behind the words.

**Actualization.** Actualization is an extension of resonance, where the process of interpretation is not stagnant or ever fully complete. Interpretative phenomenological research, once resonated with the reader, continues to accomplish merit through further interpretation. "A phenomenological interpretation does not end when a study is finished" (de Witt & Ploeg, p.

226). It is my sincere hope that this research resonates with its reader and research on this topic is further explored and interpreted.

**Member Checking.** Often an integral step in the demonstration of rigour in qualitative research studies is the process of member checking. Member-checking has been cited as an opportunity to discuss findings with participants in order to validate researcher interpretations and allow participants the option of confirming or augmenting initial statements (Bradbury-Jones, Irvine, & Sambrook, 2010). Member-checking in interpretative phenomenology has been problematized based on its assumption that one truth may be produced by the researcher which can be confirmed by the participant, and the potential for distress to be felt by the participant (Ashworth, 1993; Lillibridge, Cox, & Cross, 2002). Smith and Osborn (2007) instead support the process of returning to interview findings and participants' language to validate interpretations.

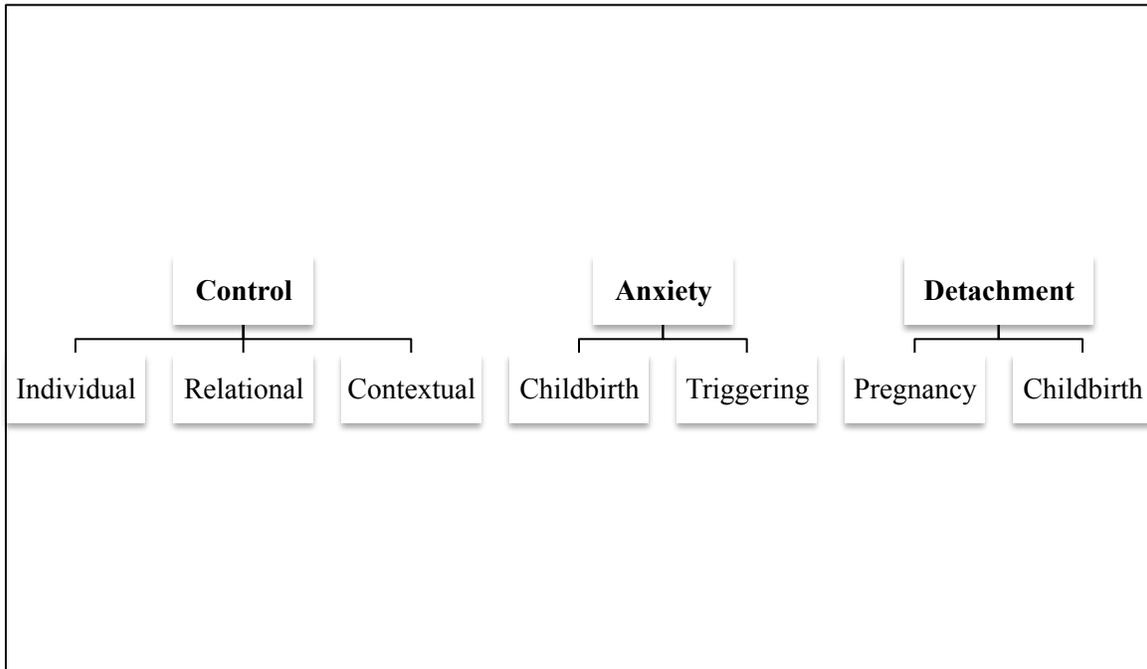
## **Summary**

This chapter outlines the steps and processes employed in applying Smith and colleagues' philosophy of IPA to this project. Inherent in our sampling, sample size, design appropriateness, recruitment, inclusion criteria, consent, ethics, data storage, data collection, data analysis, and rigour were the philosophies of Smith and colleagues, whose imperatives guided our decision-making processes.

## Chapter 4: Results

Themes and codes are used in the IPA process to capture language and important topics that surface during the data collection process. In the qualitative literature, it is important to note that a number of definitions exist for the terms ‘codes’ and ‘themes’ (Saldana, 2009). For the purpose of this qualitative study, I utilize Saldana’s (2009) approach and definition. The data analysis process of this study began with the careful line-by-line reading coding, which Smith (2007) calls ‘annotating’. Codes can be named using the participants’ direct language and use of phrasing. These codes are called in vivo codes (King, 2008). In vivo codes were used intentionally throughout the data analysis process to effectively capture the essence of the participants’ language. In vivo coding was used to express the three main superordinate subthemes that emerged in the work, those of *control, anxiety, and detachment*. After line-by-line annotating was complete, themes began to emerge from the data and were clustered into like-groups. Themes were clustered and for similarities and were further organized into superordinate themes and subthemes. Superordinate themes express higher-order, pervasive themes consistent among the transcripts. These themes were then expressed in a coding tree to aid in organization and meaning (Figure 1).

**Figure 1. Coding Tree**



## **Participants**

The women varied in age from their late twenties to early forties. Three of four women were recruited after the birth of their second child, and one participant was recruited after the birth of her first baby. Multigravida participants did discuss details from their first and second birth experiences during the interview.

All four women sought out midwifery services for their obstetrical care in pregnancy. Two participants (P2 and P3) required either a full transfer to an obstetrician or an obstetrical consultation during their pregnancy (P3) or labour (P2). The other two participants (P1 and P4) remained in midwifery care and did not access any other obstetrical service provider during pregnancy or childbirth. The birth location varied among the women. P1 had a homebirth, P2 had a hospital birth with both babies, P3 had two cesarean sections, and P4 a hospital birth for her first baby and a homebirth for her second. All participants were married and educated at a

College (P2) or University level (P1, P3, and P4). In order to protect the privacy of the participants, their professions will not be stated explicitly, however all participants were employed in various designations under the umbrella of *health and social care*.

Relevant to this study, all participants had experienced CSA. Abuse details were not shared during the interview, nor were questions asked about these experiences. All participants did spontaneously mention that they had previously disclosed their history of abuse with their partners, and two participants disclosed this to their care provider(s) (P3 and P4). Those who did not disclose to their care providers were not explicitly asked during routine antenatal visits. Two participants discussed receiving professional counseling related to their abuse during adulthood. None of the participants discussed receiving counseling or professional help during childhood. One participant discussed seeking professional psychiatric help during pregnancy in an attempt to become connected with a care provider in the event her pregnancy or labour events required her to need further support.

## **Synthesis**

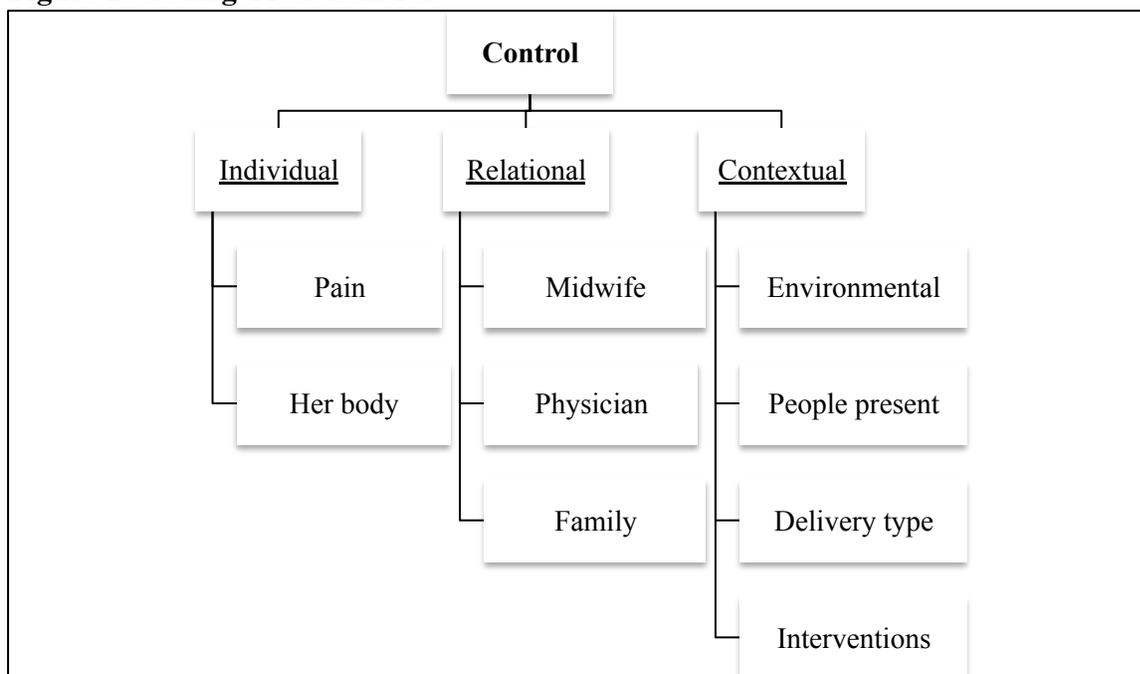
The following is a synthesis of the results, arising from the described data analysis process. Quotes are used to express the participants' language, as this is an integral component of IPA and represents the careful delineation between the participants' words and the researcher's interpretation of them. Smith (2007) states that this is particularly important, "...when one see's the extracts again within the unfolding narrative, often one is prompted to extend the analytic commentary on them. This is consonant with the processual, creative feature of qualitative psychology" (p. 76). The four participants will be identified as P1, P2, P3, and P4, representing the order in which the interviews took place. Lastly, the names that are included in the quotations have been changed to safeguard confidentiality.

The three main superordinate subthemes emerged in the work, those of *control*, *anxiety*, and *detachment*. The presentation of the results will begin with control, as it was the most predominant superordinate theme.

## Control

Throughout the interviews, the term *control* was repeatedly used by participants in describing their pursuit of autonomy and avoidance of powerlessness. Participants also used this term to describe the lack of control they felt during pregnancy and labour and to express their desire to control certain aspects of labour and birth, such as the environment and the people present. Control was expressed through individual, relational, and contextual factors (Figure 2).

**Figure 2. Coding Tree: Control**



**Individual factors.** Individual factors include pain and her body. These were expressed as factors that participants have attempted to control during pregnancy and childbirth. Again, we notice the difference in experience of participants either wanting to feel the pain of childbirth or

adopting strategies to avoid the pain entirely. In bodily functions we notice that one participant expressed concern with some of her body's functions becoming involuntary.

**Pain.** Evidenced throughout this study is the paradoxical presentation of views on various aspects of pregnancy, labour, and birth. While some participants described the need to avoid pain, others welcomed the painful experience of birth "I wanted to feel it all" (P3). One participant who underwent a cesarean section for both births, expressed grief over the loss of experiencing birth and all that she felt encompassed it. For others, control was expressed in the participants' strong desire to choose pain relief "I thought I wanted drugs"(P4), and in their loss of control when pain was experienced.

*It was unbearable. It was sooooo, sooooo intense...umm...I felt very tense, like my whole body, even though I knew some of the coping strategies and breathing techniques, I could not use them. I was just so...immersed by this pain, I was just frozen...(P2)*

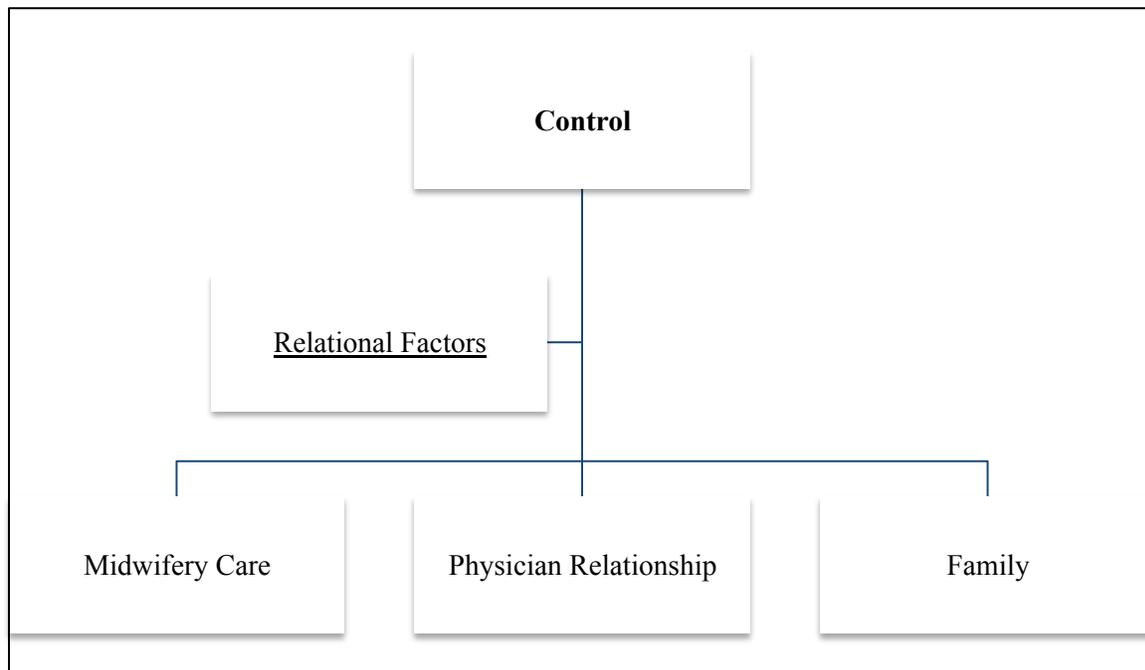
**Her body.** Participants described feeling a loss of control of their body's involuntary responses during pregnancy and childbirth, and in one case, in the loss of control of body movements. This was captured in the experience of vomiting during pregnancy and childbirth, and in the inability to prevent defecation. "The pooing...that was when I realized that I'm truly losing control" (P4). "I'm a little phobic of the whole vomiting phase...I will do everything to try and keep it down" (P4).

Another participant described the anxiety that accompanied the loss of movement after receiving the epidural anesthetic prior to her cesarean section:

*...From the moment I had the epidural, the pain...like I screamed, and the feeling of loss of move...like you can't move...and the feeling of loss of control really spiraled me to anxiety actually. I felt like having a panic attack on the table, but I didn't tell anybody, I just kept it to myself thinking, "you should be able to handle this"...I was kind of freaking out. (P3)*

**Relational factors.** Relational factors have been defined in this study as the therapeutic and personal relationships that exist between the participant and others, including: midwifery relationship, relationships with physicians, and family relationships (Figure 3).

**Figure 3. Coding Tree: Control, Relational**



**Midwifery care.** *“I felt empowered through the coaching of the midwives.”* One participant described the relationship she had with her midwives as *“beautifully supportive”* (P4), which was echoed through the other participants' interviews as well. The midwifery model of care focuses on informed choice, facilitating women in making decisions on their obstetrical and newborn care after being provided information on their choices (Association of Ontario Midwives, 2015). Midwifery practices across Ontario all choose their own model of care with respect to the organization of midwifery teams and on-call schedules. All participants experienced the model in which two midwives are assigned to each pregnant client, where midwives alternated visits. This allows the client to develop a relationship with both midwives

throughout pregnancy, and at the time of birth one of the two midwives is always on-call. One participant described the appreciation of their on-call service:

*If you think it's great before, you just wait until you get the aftercare...like it's amazing, right? I've got a 24-hour pager, I can call whenever I need to...I can ask any old dumb question that I think is stupid that I think I need to...(P4)*

Another participant described appreciating the personal relationship that is formed between midwife and client: *"Part of the reason I had chosen midwives was because I wanted that relationship, I didn't want just a stranger delivering my kids" (P1).*

Midwives, as expressed through the interviews, were described as taking an unhurried listening approach, allowing time to discuss the participants' feelings, fears, life situations, and stressors. One participant underwent a very difficult personal situation during her pregnancy and described her midwife's attention and focus on her emotional wellbeing. She accommodated more frequent visits and allowed more time for her to discuss her emotional well-being. She further explains the relationship:

*So I cannot say enough great things about midwifery care...I don't think it would have gone as well if I was feeling like...like a doctor was sort of coming in and out, like they never left the room, they only left the room when they had to do paperwork...not leaving your side, using physical touch: 'I'm going to push on your arm here, is that ok?' ... 'You're going to feel some pressure, are you ok with that?'(P4)*

Midwifery care, the participants felt, allowed the control to be placed back with the client. Decisions surrounding pregnancy and birth were discussed and the participants felt like they were included in the decision-making process *"You get to make your own decisions"(P1).* One participant describes the need for an episiotomy and the discussion that took place prior to the intervention: *"It was definitely not 'we're doing this, let's go'...it was 'this is what we're thinking...why we're thinking...if would benefit you, and get this baby out'..." (P1).* The interaction between client and healthcare provider in making decisions appeared to be of great

importance to these women. They wanted and needed to feel a sense of self-efficacy during pregnancy and birth. One participant describes the frustration with feeling no control over the events and interventions associated with birth:

*I had so little control at that point. I had asked for the natural delivery...no. The natural c-section, everything was no, no, no. I was trying to get my lactation consultant in the room, they wouldn't go for that, so she was in recovery just to help with latching and stuff, so having my midwife there to me was a victory like 'ok, I got something that I wanted'. (P3)*

**Physician relationship.** The participants all had very different experiences with members of the healthcare team. These members included an obstetrician, psychiatrist, and an anesthesiologist. One participant was connected with a psychiatrist in pregnancy to discuss her concerns about how labour and birth may be affected by her history of CSA. In her previous pregnancy she was connected to a psychiatrist with whom she described a difficult and uncomfortable relationship. However in this pregnancy she was referred to a different psychiatrist with whom she developed a therapeutic and trusting relationship. She describes the second psychiatrist as fostering a sense of control and confidence in her ability to manage pregnancy and childbirth. She contrasts these relationships:

*I felt very different...he was much nicer, much kinder, and again, very reassuring in saying 'you got your shit together really well', like 'I'm not worried about you'...they were really confident and reassuring which was really quite great...but I think it was so in contrast and also because I'm in the helping profession I have sort of standards in what I expect...things like sitting behind the desk, and standing when there was a chair beside me, 'I am the expert, you are not the expert on yourself', you know...and that's just not the values I have for people or the way I interact with people myself. (P4)*

Another participant described her positive relationship with the anesthesiologist involved in her second cesarean delivery. Due to her uncomfortable first experience with the spinal, she disclosed to her anesthesiologist about her history of sexual abuse. She further describes her experience with her second anesthesiologist below.

*The anesthesiologist there was amazing...his calm voice...[he] came and talked to me about options, I explained what had happened last time, and he goes 'we would want to know that, we want to help you, we don't want people to go through that...like if you're feeling uncomfortable there are things that we can do'...so he ended up prescribing Ativan...and that was all I ended up needing...it really ended up improving the experience, it was a lot better than with Lindsay, because I was calmer and it was a very jovial environment in the delivery room, like my anesthesiologist was a total jokester but like really good and just was a different energy...I really enjoyed, I really could just focus on my baby coming to me and not any fear, and that meant a lot. (P3)*

She contrasts this positive experience with her anesthesiologist with the way she felt during her cesarean delivery. This illustrates the nature of how seemingly casual conversations can serve to foster feelings of a loss of control.

*I did find it strange, and I know this is normal, but the OBs are just talking about their day, or like...to me that was just sort of odd...like...I think it makes you feel like you could just be a car they were working on, like you're not a person, you know? (P3)*

In other experiences, comments by members of the healthcare team served to perpetuate feelings of inadequacy and the belief that their body was broken: “...If you can't take an examination...I don't know how you're going to...[give birth]” (P3). The same healthcare provider said once the baby was delivered via caesarean section: “[because she was 9 pounds]...he was like ‘there is no way you could have been able to deliver her vaginally’”(P3).

**Family.** Expressed in the subtheme of family were tensions surrounding what family would be present at the birth, and whether their presence would decrease or add to her anxieties. One participant was worried about her lack of perceived control if her mother was present, expressing concern about her mother making decisions in labour “I didn't want her making decisions for me or talking for me” (P1). While she ultimately allowed her mother to be present, she later recounted her presence as helpful and supportive.

The other three participants labored and/or had cesarean delivery with only their husband present. The husband's role in delivery varied, but was overall described as supportive, yet not

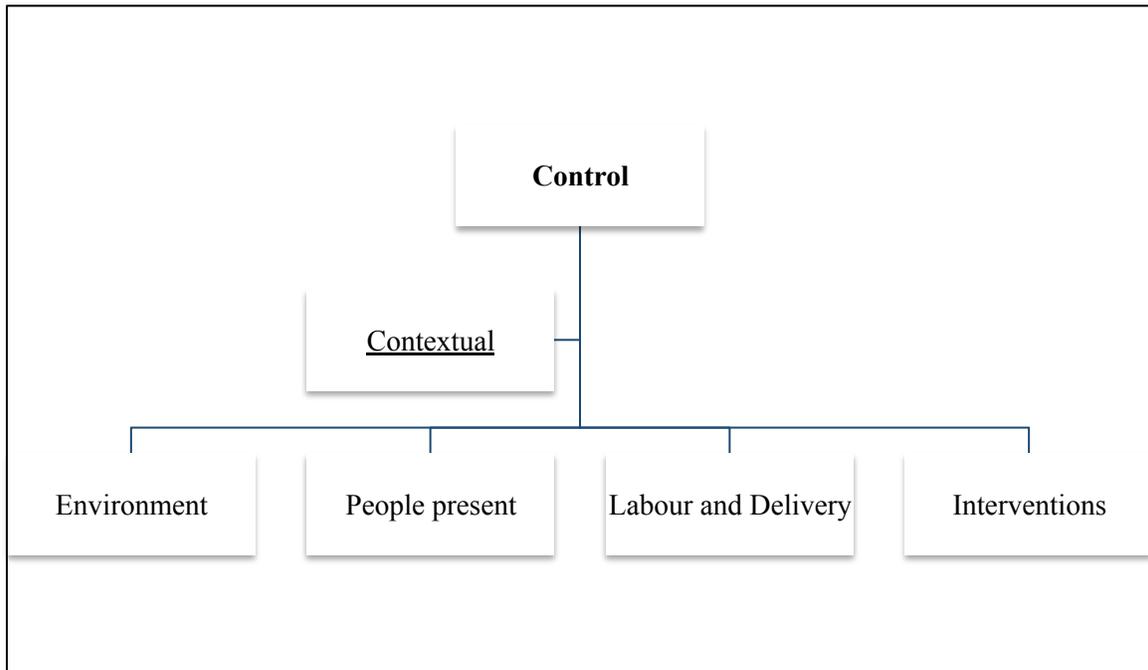
overly helpful. In the three cases, participants described healthcare professionals present for the birth as being the major source of support. *“I only wanted my husband there...and I just wanted him there, I didn’t want him like touching me, didn’t want him doing much, I just wanted to know he was there and if I needed something...”* (P2). Another participant describes her husband’s support during labour:

*What I liked was [midwife] directing Mike on how to be supportive...and she really looked to him because she was like ‘it’s your experience’ and that was really important. So she would try something and it would work, like pushing down...down on my back and then she would show Mike how to do it. He didn’t do it as well...what I needed was the support and the knowledge and the understanding...I wanted to be present, I wanted to know what was going on but I also needed Mike to be able to support me. (P4)*

Another participant elected to not tell her immediate family she was in labour as she didn’t want to feel the pressure of them waiting on her to give birth. *“Didn’t feel pressure for me, like people are waiting...”* (P3).

**Contextual factors.** Contextual factors (Figure 3) include factors about the labour and birth experience that either supported or impacted the participants’ experience of childbirth as it relates to the superordinate theme of control. Contextual factors are organized into subthemes of: environment, people present at the birth, the labour and delivery, and medical interventions.

**Figure 4. Coding Tree: Control, Contextual**



***Environment.*** Relevant to midwifery care is the choice that is provided to women on their preference of birth location. Healthy, low-risk women are provided the option of homebirth. Homebirth in Ontario continues to be a controversial subject. Organizations such as the Association of Ontario Midwives (2015) acknowledge the safety of homebirth for low-risk women within the presence of skilled birth attendants present, along with medically necessary equipment and medications. Other organizations such as The Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN) and the Society of Obstetricians and Gynecologists of Canada (SOGC), acknowledge the importance of an intervention-free birth (where possible), but in the setting of a hospital specifically (Journal of Obstetrics and Gynecology of Canada, 2008). Again, present within this subtheme is the paradoxical nature of the participant’s responses. Two participants desired a homebirth “...Being in the hospital feels impersonal and just uncomfortable” (P1), one was ultimately unable to deliver at home due to complications that

arose during pregnancy. P3 also described her desire to have a homebirth: “It just feels so organic and so natural so-to-speak right? So that would have been really appealing, just to have a little bit more control” (P3).

Another participant wished to be in the hospital for both of her deliveries and to her, the hospital environment provided more comfort and control “*I felt so calm, in control...the entire time at the hospital*” (P1). The last participant (P4) wanted her first birth to be in the hospital because of her perceived desire for pain relief during labour (which she ultimately did not require), and chose for her second delivery to be at home. She contrasts her experiences of hospital and home births:

*Looking back I remember in hospital, like moaning and groaning and crying out, then at one point shouting out. I better be pretty quiet because the women down the hall who are labouring are going to say get me an epidural because I don't want to go through what that girl is. So I remember feeling inhibited...I remember feeling...aware of my surroundings, where here [at home], I was much louder. I think because it was my own home. (P3)*

Of the participants that chose home births, it was evident that the nature of the midwife-client relationship was one built upon trust and understanding. One participant expresses how she is comfortable in the way her midwife would make decisions based on her behalf: “...*When it is outside of their expertise they are so clear, like this is outside of my realm, I'm moving on, right?*” (P3) and when asked what drew her to a home birth she answered: “*My trust of [midwife], knowing that...I think if I had paged and it was someone else I may not have necessarily. I felt really comfortable with [midwife] and very...caring...I think the trust around that*” (P3).

This participant later discussed how she felt stigmatized on her choice to deliver at home when during her postpartum period she had to present to the Emergency Department with heavy postpartum bleeding:

*I felt very judged for having a home birth...in that moment “Oh you had a home birth”...I said, “I’m not hemorrhaging because I had a homebirth, I’m hemorrhaging because I’m hemorrhaging!” There is a big difference and I felt like I was having to educate. (P3)*

This example may evidence the choice for midwifery care, in that decisions that are made by the clients themselves are supported. Although discussions about choice and promoting autonomy are not limited to midwifery relationships, the experience of this participant demonstrated the felt judgment by other healthcare providers on her choice of birthplace.

**People present.** Expressed in this subtheme was the participants’ desire to have certain people present at their labour and birth and their desire to exclude others from being present. All the participants expressed a desire to have the birth experience be private, free from family or healthcare providers who were not required to be there. One participant describes an unsettling experience while watching a delivery where many people were present:

*...There was people running in and out of the room...all the time...they made everybody that was in the room delivering the baby wear these full personal protective, full gown, full mask, full glove...and this was sort of like...it was really weird...so there was all these inspector people...and...health and safety...like the people that worked in the hospital and they kept coming in and out...and you know...this women is up in the stirrups...I was like “Oh my God!”...But it seemed to me that that wasn’t a very good enough reason to have people running in and out of the room while you’re delivering your baby...so...that kind of stuck in my mind. (P1)*

Another participant described her homebirth experience as comfortable, whereby she could control the number of people present for her birth. *“I feel I would just be a little bit more relaxed, a little more comfortable at home...without people running in and out”(P1).*

Another participant describes the loss of control she felt when several different healthcare professionals came into the room in response to a deceleration in fetal heart rate:

*...Then I guess there was a sense of decreased control when...I knew when everyone was coming into the room and at the beginning his heart rate was dropping and he was in stress, and the midwives were kind of pushing to the side and I could definitely feel the sense of divide between the obstetrician and the midwife...and it was kinda like 'ok, we're taking over here'... (P2)*

**Labour and Delivery.** Expressed within this subtheme are the participants' responses to childbirth as it relates to the superordinate theme of control. Participants responded to labour in different ways, some seeking control from the careful watching of the monitor, others surrendering to the loss of control which will be later discussed under 'detachment'.

*"I felt like I could not stop watching the monitor and watching the baby's heart rate...and...I was just making sure that he wasn't stressed out" (P2). "You have to be so open-minded and easy-going and just let what's going to happen, happen, because you can't control everything" (P2).*

One participant describes the difficult pushing phase:

*...The pushing phase, uh...it was hard...like I felt initially, you're doing all this work and they'd be like 'Ok, he's coming down, he's coming down' and you're like 'ok, almost there', and the next thing you know he's gone back up. So like you're pushing, and he goes back up a little bit...it was kind of 'Oh my God...how much longer?' and it was a long pushing stage. (P2)*

This participant later described her need to receive an episiotomy as the baby's heart rate was dropping and baby needed to be delivered more urgently. Another participant describes her reaction when she saw her newborn's head was round, instead of moulded, after a difficult pushing phase: *"...Her head was like perfectly round...and I was like...I got really upset...that little thing couldn't have even moulded her head a little bit for me?"(P1)*

**Interventions.** Expressed by three participants was the loss of control felt with interventions associated with pregnancy and childbirth, such as stretch and sweeps (also known as sweeping the membrane), epidural, and episiotomy. “I definitely wanted the option of an epidural, I wanted to go as long as I could without it but I wanted the option of having it” (P2).

*[On receiving the epidural] ...The feeling of loss of move...like you can't move...and the feeling of loss of control really spiraled me to anxiety actually. I felt like I was having a panic attack on the table, but I didn't tell anybody, I just kept it to myself... (P3)*

*[The episiotomy]* “...Was the hardest part of the entire birthing process” (P1). One participant did not speak of requiring any of the above interventions. Two participants required an episiotomy in labour, and two required an epidural. Again I notice reactions on opposite ends of the spectrum to interventions occurring during childbirth, having in common the strength of conviction with which they state. Two participants readily expected to want pain relief during labour, and the other two wanted to have a natural birth. One participant describes the difficult experience of having a stretch and sweep:

*I really struggled with the idea of [the obstetrician] doing a stretch and sweep. Because, I think pain...around that...even though birth is painful too right? I still struggled with...like I didn't know her; it was just my first visit. Like I had only seen her once by the time she wanted to do a stretch and sweep and I just...I really struggled, I hated that I struggled...like I hated that I was having those feelings...so I was aware that I was feeling sensitive and vulnerable and not comfortable...and knew it was related to being abused as a child...(P3)*

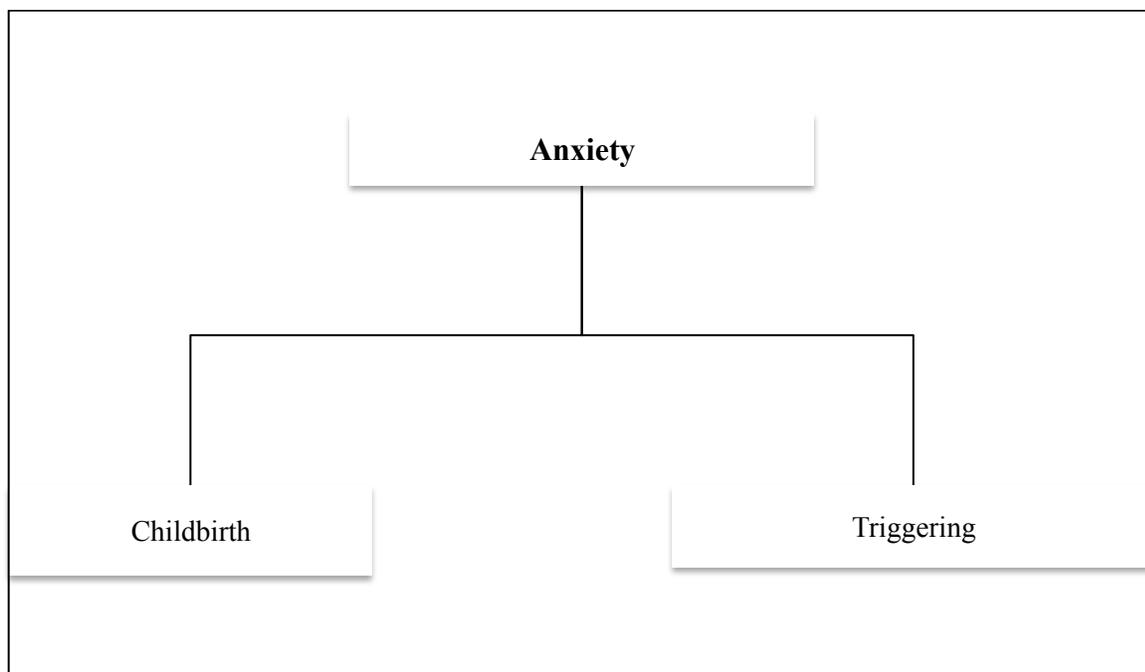
She later shared that in disclosing her past history of abuse her female obstetrician was understanding and “gentle”. She also describes an experience with a male obstetrician doing a pelvic exam: “...He couldn't even really examine me, I was so tense...so he said to me, ‘if you can't take an examination...I don't know how you're going to...you know...” This participant felt a strong sense that her body was ‘broken’, unable to do or tolerate the things that labouring women manage. Present with all interventions was intimate therapeutic touch, pain, and/or a

loss of movement. Some participants made an explicit connection between how their abuse experiences affected their desire or discomfort with these interventions, while others did not explicitly express this association.

## **Anxiety**

Anxiety is the title of this superordinate theme as it was consistently described by all participants during pregnancy. This theme describes the anxiety and worry participants felt about their upcoming childbirth and the anxiety they felt about how their past abuse experiences would affect their labour (Figure 4).

**Figure 5. Coding Tree: Anxiety**



**Childbirth.** Expressed in the subtheme of childbirth was the anxiety participants felt about their upcoming childbirth experience, or during their labours. One participant describes her anxieties about what labour would be like:

*I did a bit of catastrophic thinking, like it's going to be awful. I'm going to be traumatized, I'm going to be immobilized; I'm going to be a wrecking...a bawling mess. I'm not going to feel bonded with this baby... (P4)*

*Like I had visions of me breaking down in the middle of labour, like being upset, you know?(P4)*

The same participant describes her anxiety about birth, perpetuated in part by the media's influence:

*What was it going to feel like? Cause again, you don't know how you're going to deliver, so...was it going to be this rush-chaotic place? And you know, the media makes it to be this different experience of birth than it really is. (P4)*

One participant sought out the advice of a nurse on coping through her epidural; one intervention that carried some anxiety with this participant: *"Do you have any suggestions with how to be okay with the epidural?" Cause I found myself having anxiety around it" (P3).*

Participants consistently expressed what helped to alleviate some of these anxieties was the disclosure of these feelings with a trusting healthcare provider and the resources and support that was offered.

**Triggering.** Triggering, as expressed by the participants in this study, was the remembering or re-experiencing past abuse experiences as a response to their situation. In the interviews participants' discussed their anxiety about being 'triggered' in childbirth. One participant expresses how she had been triggered in a past sexual relationship:

*What is this sort of triggering going to be? But...for me, the other piece was...so for me the trauma was abused as a child, repressed it, and then had a...sort of rape experience when I was in my early twenties, and that's what triggered the earlier...so...hadn't been vaginally raped but there were other pieces that would constitute rape, so...for me, I was sort of working though all those pieces, and I didn't have intercourse, until I was...we were married. Umm...and so, for me there was also more lead up, to even around intercourse and what that was going to be like. So because that was sort of my experience of working through the emotions around that, and what that was going to be like, and you know, having to overcome some pretty big triggers and things...(P4)*

The same participant expresses her anxiety about how her abuse will affect her labour experiences:

*Kind of worried about this kind of connection to my sexual abuse trauma, so was I going to be retriggered? Was I going to be overwhelmed? What was it going to be like? So not necessarily about the physical...I wasn't worried about the physical piece of it, it was more around the... emotional trauma. Like what was it going to feel like? (P4)*

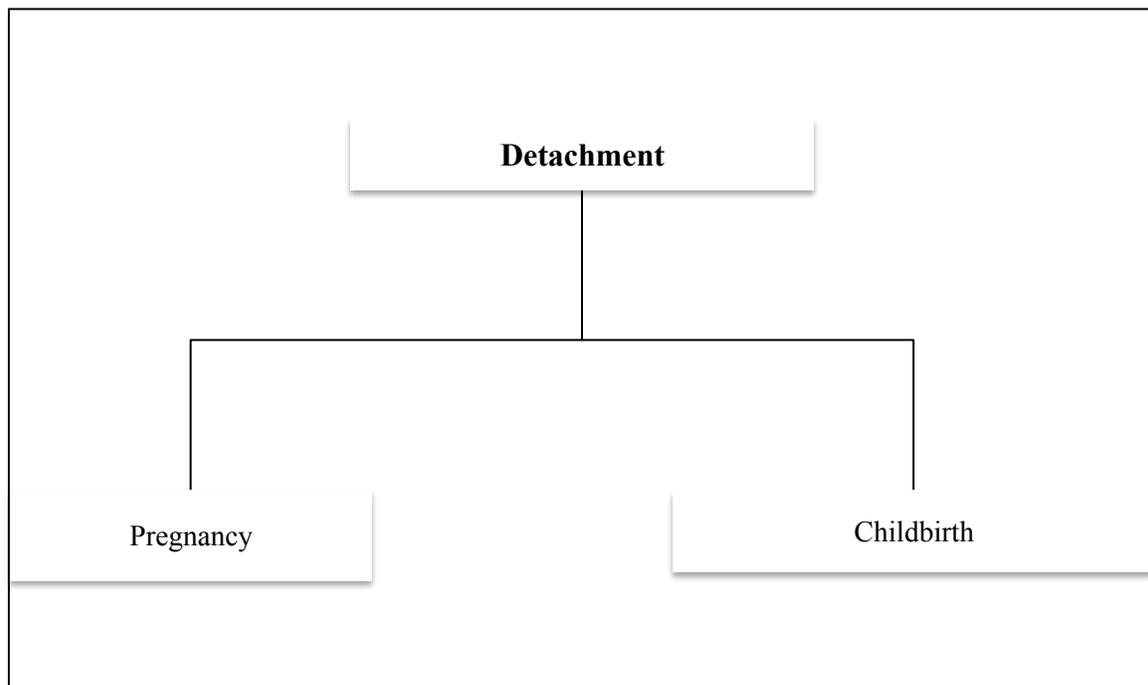
Another participant describes some anxiety she felt with the potential of being triggered through her childbirth experiences:

*With Lindsay I think I just wasn't sure how that was going to impact [her abuse experiences on childbirth], so when my midwives asked me about it I told them about it and they just kind of let me know that it's not unusual to have those feelings, or for those experiences to come up, and in the end they didn't really come up for me...at least with Lindsay that much. (P3)*

## **Detachment**

The last superordinate theme that was expressed through this study was 'detachment' (Figure 5). Detachment was expressed by the participants in their psychological avoidance or blocking-out of experiences as a response to the stressful stimuli they were experiencing. This for some was manifested through a gap in memory for certain experiences in pregnancy and childbirth as a method of coping.

**Figure 6. Coding Tree: Detachment**



**Pregnancy.** During pregnancy, one participant described their level of detachment with her pregnancy and bond with her unborn baby.

*I think emotionally I don't think I was bonded to her in the same way...like this 'ok I'm growing a human being in me', but not sort of knowing the relationship that I would be able to have with her down the road. (P3)*

The same participant describes her demeanor during pregnancy as a form of detachment: “*I don't know if that was anything around depression or anxiety, I think it was just sort of a detachment*”. Although the pregnancy was not examined as the primary focus of this qualitative study, participants did express some feelings of detachment with their pregnancies and unborn babies.

**Childbirth.** Detachment in childbirth was consistently expressed among most participants. They expressed their detachment or evidence of detachment in different ways. One participant intentionally ‘blocked-out’ thoughts of her birth because she was not comfortable

thinking about it “*If I didn’t think about it, I didn’t have to deal with it*” (P2). Rather, she thought she would avoid thinking about the birth until it was approaching. “*I almost blocked it out, the entire pregnancy...up until the end...it was just nerve-wracking...*” (P2).

Another participant described the detachment she experienced during childbirth in her inability to hear or focus on external stimuli:

*And then the piece around...so I was pushing and didn’t hear. So I was definitely in a zone because was pushing with gritted teeth, the whole bit. [Midwife] I guess told me to stop because the cord was wrapped around the baby’s neck and I didn’t hear her say that, and then they all screamed at me ‘you need to stop!’ (P4)*

Another participant describes not remembering a medical intervention that was frequently done throughout her labour: “*I don’t really remember cervical checks*”(P1).

The above accounts are expressed ways that the participants' identified with detaching from their thoughts and experiences. However, these women may have detached in other ways, ways that could only have been observed by those present at the time and that may not have been fully realized by the participants themselves.

## **Conclusion**

This chapter reviewed the results from an Interpretative Phenomenological Analysis of four female CSA survivors' accounts of their childbirth experiences. Through their descriptions we understand the experiences these women endured in their pregnancies and during childbirth. Smith’s (2007) methodological framework was utilized in the data analysis and presentation of the results. Emerging from this analysis were the superordinate themes of *control*, *anxiety*, and *detachment*. These themes are integral to the four survivors' birth experiences. Expressed in their experiences are *victories over something feared*, *the challenge and struggle with something difficult*, and *the relationships that facilitated these processes*.

In the next chapter (Chapter 5: Discussion), an interpretation of the results will be presented from the exploration of related theoretical literature. Included in this final chapter is an overview of the study's implications for practice, education, and further research.

## Chapter 5: Discussion

Few qualitative studies exist that seek to understand the childbirth experiences of childhood sexual abuse (CSA) survivors (Coles & Jones, 2009; Montgomery, 2013; Palmer, 2004; Rhodes & Hutchison, 1994). This is particularly unfortunate given the high prevalence of CSA and the profound influence that it can have in all spheres of women's lives. The body of literature that exists on this topic is largely quantitative, examining specific types of abuse such as incest (Parratt, 1994), rape in adulthood (Nerum et al., 2012; Nerum et al., 2009), past physical abuse (Grimstad et al., 1999; Heimstad et al., 2006; Schroll, 2011), and child neglect (Muzik, et al., 2013). The present phenomenological study is uniquely situated having captured the childbirth experiences of CSA survivors, as described by the participants themselves.

The paper by Rhodes and Hutchison (1994), a highly cited manuscript on this topic, uses an ethnographic approach to rely on the observed behaviors of survivors from the perspective of healthcare providers. While informative, it fails to capture the rich and unique perspectives as described from the survivors themselves. Additional qualitative works have focused on the maternity care experiences of survivors (Palmer, 2004), but not those occurring during the period of childbirth itself. As a result, the current phenomenological study extends knowledge on the feelings, experiences, and life worlds relevant to childbirth of the survivors *themselves*.

The superordinate themes that emerged in this work, those of control, anxiety, and detachment will be discussed in the context of the existing empirical and theoretical literature, as well as through my own reflections. The factors involved in disclosure will be examined, and the implications of this work for practice, education, and further research will be explicated.

## **Theme One: Control**

Control has been cited as an observed or reported factor in the childbirth experiences of survivors of CSA (Burian, 1995; Coles & Jones, 2009; Montgomery, 2013; Palmer, 2004; Rhodes & Hutchison, 1994). Rhodes and Hutchison (1994) reported that the most prominent observed labour style for survivors of childhood sexual abuse was ‘fighting’. They term the fighting style as the ‘quintessential’ labour style in which women are described as in conflict with authority; resisting interventions, and examinations. They further state that women who exhibit this ‘fighting’ strategy have longer labours, increased operative interventions and report higher pain. The combative nature Rhodes and Hutchison (1994) describe was not expressed by participants in this study. The women highlighted the assertion of control (or wishes to avoid loss of control) by way of their detailed birth plans, requests around specificity of birthplace, individuals present, and interventions. Unfortunately, these women are sometimes described as demanding, egotistical, and ‘difficult patients’ (Palmer, 2004), when they are trying to navigate a difficult battle within themselves of control vs. loss of control.

In this study, the issue of control was evident when participants described their hopelessness during pain and during interventions involving touch (stretch and sweeps, episiotomies, and epidural).

In a metasynthesis of the maternity care needs of women who were sexually abused as children, Montgomery (2013) cited the theme of ‘control’ as significant to all eight eligible studies. Control manifested itself in the participant’s feeling a loss of control, and a subsequent need for control, particularly in vulnerable situations. She likened the loss of control these women experienced to the loss of control that was experienced as part of their abuse. Consistent with the findings in my study, participants sought to control with a need for self-determination,

need for privacy, and the desire for a controlled environment for birth. One study suggested that the interventions and invasive procedures were not as distressing as the loss of control that accompanied them (Garratt, 2011, as cited in Montgomery, 2013).

In her doctoral thesis, Palmer (2004), examined the maternity care needs of survivors of CSA. Using a grounded theory approach, Palmer (2004) identified the theme of ‘Protecting the Inner Child’ (p.128). This theme explicates the iterative process that survivors endure to protect themselves and their children. Control, power, and choice were significant findings that were evidenced throughout the childbearing cycle. Consistent with these findings, we found that control permeated through many other themes and subthemes, including pain, interventions, and individuals present for their birth.

### **Theme Two: Anxiety**

As experienced throughout the study process, themes are interpretative, and many directly relate to other themes and subthemes. IPA is an iterative, dynamic process whereby themes are named and categorized based on the interpretation of the researchers. As present in this study, subthemes may directly relate to other superordinate themes for example the relationship between anxiety and control. Anxiety was experienced by the survivors in response to their perceived inability to control their situations, bodily functions, and sensations. Consistent with other research, participants reported feelings of anxiety repeatedly (Grimstad et al., 1999; Heimstad et al., 2006). These feelings were manifested in worry about the birth, as well as anxiety on how their labour might impact or “trigger” re-experiencing of their abuse experiences. Hobbins (2004) terms this type of anxiety, *hypervigilance*. She suggests that survivors of CSA more consistently present with many questions, concerns, and complaints about bodily ailments. Other literature explicates the link between anxiety and increased elective

cesarean section rates (Lukasse et al., 2011). While the desire to have a cesarean section was not expressed in this study, the anxiety surrounding childbirth and the interventions that accompanied it was.

Triggering can occur over the course of a lifetime, and particularly in vulnerable or stressful situations (Rhodes & Hutchison, 1994). Triggering may cause anxiety as it reminds survivors of their past abuse experiences, and the prospect of being reminded of their trauma may precipitate feelings of worry and anxiety. Two participants expressed concern over how their childbirth experiences might cause them to ‘remember’ or be ‘triggered’ to their past abuse. Germane to this point, Rhodes and Hutchison (1994) outline the notion of “forced remembering” (p. 215):

Memories can occur in small fragments or in full. Fragments may be triggered by labor that evokes sensory information present at the time of the original abuse. Sometimes sensory memories are tripped, causing the woman to “remember” the sexual abuse with bodily sensations but not necessarily on a conscious level. (p. 215)

Although women in this study experienced both internal and external triggers, related to feelings of worry and anxiety, and in response to exposures occurring around them, most of the anxieties emerged from their worries about how they might be triggered as a part of their birth experience.

### **Theme Three: Detachment**

The three superordinate themes of control, anxiety, and detachment may be interpreted as closely linked. Where anxiety may be a manifestation of a loss of control and detachment may be interpreted as the avoidance of thoughts and stressful stimuli as a method of control.

Detachment or avoidance can be described as the psychological process of blocking out ideas, feelings, or upcoming events/situations as a method to cope. Detachment or avoidance can be a conscious decision, like the avoidance of places and/or people, or can occur

subconsciously as a response to uncomfortable or distressing stimuli (Seng et al., 2002).

Waymire (1997) states that birth can be very similar to childhood sexual abuse experiences:

“Birth can recall or re-enact previous violations of their body because the anatomy involved in childbirth is typically the same anatomy involved in sexual abuse” (p. 47).

Evidenced in this phenomenological study was the paradoxical nature of response expressed by the participants. While some participants experienced anxiety about pain, others readily sought out a natural-birth. While P1 and P3 wished to experience an unmedicated birth, P2 and P4 (with her first labour) wanted to have hospital births because of their perceived need to access pain relief measures. These differences in characteristics are consistently seen among individuals with posttraumatic stress disorder (PTSD), and among those who have been continuously exposed to neglect or abuse particularly at a young age (Frewen & Lanius, 2006). Frewen and Lanius (2006) further explain that these differences in reactions can occur at different times within the same individual:

The individual with PTSD is characteristically unable to manage or down regulate his or her level of psychophysiological aversive arousal and distress. Comparatively, at other times individuals with PTSD appear to be unable to up regulate their level of arousal, for example, during periods of hypoarousal, such as anhedonia and felt “emotional numbness.” (p. 111)

This juxtaposition of opposite appearing behaviours is noted by Rhodes and Hutchison’s (1994) in their work, and is manifested in the labour styles of women as either “fighting” (p. 216) or “surrendering” (p. 216). The participants either exhibited signs of struggle, intense pain, and panic responses (fighting) or labours characterized by uninhibited and retreating behaviors (surrendering). “Retreating is an attempt by the survivor to remove herself emotionally or mentally from sensations that replay the abuse” (Rhodes & Hutchison, 1994, p. 218). While experts describe these dissociative behaviors using a variety of terms, we use the term

detachment (also an in vivo code) to describe the verbalized avoidance of feelings and experiences. It is important to acknowledge that not all women who ‘detach’, ‘avoid’, or ‘disassociate’ realize that this is happening or consciously do so 'on purpose'. Rather, it is sometimes the healthcare providers or family members that notice these behaviours (Rhodes & Hutchison, 1994).

Detachment was expressed throughout the participants’ pregnancies both toward their baby or upcoming birth, as well as in their coping strategies during labour. One participant (P3) speaks to the level of detachment she has to her unborn baby, unable to imagine the relationship that she may have with her. Another participant, describes her ‘blocking out’ of the labour until the very end of her pregnancy:

I almost blocked it out, the entire pregnancy...up until the end...just because, it was nerve-wracking...thinking about the pain...and you know, you don’t know what to expect...how I would cope with it...so I didn’t really think about it much, with both of my pregnancies, up until the end...and then I did start getting a little anxious. I am the type that can block things out pretty well...so I felt that was my coping strategy. (P2).

Another participant (P1) recounts that she doesn’t really remember her cervical checks. During the course of the interview, she reacts as surprised that she cannot clearly recall having her cervix checked during labour. Another participant (P3) discusses her experience of coping during childbirth. She explains that she was in a “zone”, unable to hear those around her calling her name to stop pushing.

Cited as a time of significant physical and emotional change (Courtois & Riley, 1992; Heritage, 1998; Hobbins, 2004; Seng et al., 2002; Simkin, 1992), pregnancy events and interventions can serve to remind survivors of their past abuse experiences, causing some to retreat emotionally as a protective measure. Also important to the theme of triggering are those women who remember their abuse for the first time during stressful or vulnerable situations,

such as childbirth. Whilst there is debate in the psychological literature about the possibility of forgetting particularly traumatic memories as children (Shobe & Kihlstrom, 1997), researchers such as van der Kolk (1994) state the traumatic memories may be “coded differently” than other memories, whereby victims cannot explicitly recount their abuse experiences, rather they surface in subconscious manifestations such as feelings or sensations. This may have explained why in one participant’s (P3) account she remembered her childhood abuse for the first time during an adult rape experience.

As the degree to which the survivor begins to rebuild and heal from their experience depends largely on individual and contextual factors, there is no typical and reliable presentation of the CSA survivor, healthcare providers should “be aware that any childbearing woman may be a survivor of childhood sexual abuse” (Waymire, 1997, p. 47). “Part of that restoration comes through sensitive nursing care that helps create a positive birth experience” (Waymire, 1997, p. 47). Coles and Jones (2009) outline how to make the healthcare encounter safer by having a relationship with the healthcare provider, having access to services, and for healthcare providers to have knowledge on trauma and its implications later in life.

## Chapter 6: Recommendations

### Strategies for Sensitive Care

I engaged in reflective practices, such as reflective journaling throughout the study process. Through this, I recognized that my prior knowledge on sensitive care for survivors of CSA was limited. I acknowledged in my own practice, the importance of asking for consent prior to any intervention, and in providing an unhurried listening approach to patients and families. I adopted the belief that cervical checks, labour, and other intimate interventions could be distressing for survivors of CSA, but was not aware of a number of the other considerations important to providing sensitive care to this group of women. As healthcare providers' knowledge and experience working with CSA survivors likely varies, this chapter is intended to bring awareness to the important considerations developed from this research.

The following section provides recommendations informed from this research and the recommendations of others (Burian, 1995; Hobbins, 2004). The strategies provided for healthcare practitioners can be used to better support survivors of CSA during the perinatal period. The recommendations includes: 'know thyself', importance of a therapeutic relationship, allow time for disclosure and discussion, offer individualized support, and have a plan.

**'Know Thyself'**. Burian (1995) begins her recommendations for sensitive care by prompting the healthcare provider to consider their own response to a woman who discloses her history of abuse. Hobbins (2004) furthers this by stating, first and foremost, healthcare providers must "know thyself" (p. 493). As evidenced throughout this study, the responses of healthcare professionals can both foster feelings of trust and further a therapeutic relationship, or can unintentionally precipitate shame and feelings of judgment.

While some experts suggest that practicing our own responses as healthcare providers can be helpful to prepare for clinical encounters with CSA survivors (Wilson, 2011), practicing these responses may be difficult, as survivors' contexts and responses can vary widely. Practicing through simulation can help professionals work through the difficult conversations and their responses to patient disclosures. Simulation experiences are more widely utilized in healthcare education and may assist in the modeling and practicing of effective communication with CSA survivors specifically. As well, simulation may provide an opportunity to engage with standardized patients simulating the responses of women who have experienced CSA through the difficulties of childbirth and its associated interventions.

**Therapeutic Relationship.** *Empathy, genuineness and positive regard* are important tenants to establishing therapeutic relationships between providers and clients/patients. *Empathy*, defined as the ability to relate to another by sharing the feelings of another person functions as a core element in therapeutic relationships. Healthcare providers can demonstrate this by taking time to hear the life stories of women, allowing for a greater understanding of their experiences, their lives, and their strengths and challenges (Rogers, 1951).

*Genuineness*, or the ability to relate to others through sincerity is another component of a therapeutic relationship. Patients need to feel their healthcare providers are 'real' and relatable. Being genuine does not refer to the healthcare provider disclosing all personal thoughts and feelings, but rather refers to being sincere and genuine in communication with clients/patients. Lastly, displaying *positive regard* refers to the acceptance and acknowledgement of a patient's feelings and experiences. Patients feeling acknowledged and accepted can further facilitate the development of rapport between healthcare professional and patient (Rogers, 1951).

Establishing empathy, genuineness, and positive regard can create a safe, trusting environment where patients feel a sense of “openness and un-hurried listening” (Burian, 1995, p. 254).

Coles and Jones (2009) also outline the importance of emotionally sensitive health care, whereby healthcare practitioners are attuned to the emotional responses of their patients and are able to explore concerns and adapt care accordingly. They suggest recommended “universal precautions” (p. 230) be applied *to all women*, though such steps may be particularly important in the obstetrical care of CSA survivors. In consideration of empathy, genuineness, and positive regard, strategies could include informed consent before any treatment; frequent ‘check-ins’ to assess comfort, an explanation of the need for all procedures, and allowing time to stop or slow pace can help optimize obstetrical care for CSA survivors.

Burian (1995) suggested that safe encounters for patients involve three important elements: having a trusting relationship with their healthcare provider, having appropriate access to services, and for the healthcare professional to have knowledge of trauma and abuse and its long-term effects. While the former can be fostered by attending to the core elements of the therapeutic relationship, healthcare professionals should also be aware of the latter two. One participant discusses the importance of abuse awareness and knowledge:

Understanding that somebody who’s been traumatized 10 years ago, 20 years ago, 50 years ago may have no relevance to how far they’ve progressed. Asking their patients when they are comfortable...asking questions early is more useful than when we are in crisis. (Burian, 1995, p. 234)

As explicated in the literature review chapter, survivors of CSA frequently present with difficulties in intimate relationships and in relationships with perceived power imbalances. Furthermore, survivors of CSA have higher rates of diagnoses such as posttraumatic stress disorder, depression, and increased levels of stress and fear. Their behaviors during labour may

be stoic or detached, or may demonstrate an exaggerated response to pain and intervention. It is important that healthcare providers be knowledgeable to trauma-informed care, applying principles of a therapeutic relationship and adapting care according to the individual needs of the client/patient. Two relevant resources healthcare providers may find useful are: “*Universal Precautions*”: *Perinatal Touch and Examination after Childhood Sexual Abuse* (Coles & Jones, 2009), and *Survivors of Childhood Sexual Abuse: Implications for Perinatal Nursing Care* (Hobbins, 2004). Hobbins (2004) provides an overview of CSA and its sequelae with a focus on the perinatal period. She outlines clear recommendations for healthcare providers working with CSA survivors during the perinatal period. She also includes information on disclosure and triggers during the perinatal period that may cause emotional or psychological harm for survivors of CSA. Furthermore, she explains how the antepartum, intrapartum, and postpartum experiences of CSA survivors may be impacted by their history.

Coles and Jones (2009) focus their recommendations based upon interventions involving touch, providing a list of 7 measures that can be used by healthcare providers. Some of their recommendations include: the importance of never assuming consent and allowing time for discussions about interventions involving touch, and providing frequent ‘check-ins’ to assess comfort.

**Allow time for disclosure and discussion.** While there remains some debate on whether universal screening for CSA should be undertaken in all women in the perinatal period, Coles and Jones (2009) found that participants wanted their healthcare providers to “open the door” (p. 234) to discussions on women's history of abuse and other difficult topics. Other researchers support the routine screening of all women for history of sexual abuse (Waymire, 1997).

Nurses need to overcome their own discomfort in discussing abuse issues with women. Not talking about abuse doesn't mean that abuse issues won't surface. Instead, nurses

need to be taught how to sensitively open the lines of communication so that the woman feels comfortable talking about past sexual abuse experiences...the nurse's willingness to be candid and open about the issue also will signal the woman that her secret is not too awful or unique to talk about. (p. 48)

Many women will not disclose their history of abuse without prompting from a trusted professional, and even then, many still do not share their history. Others do not think their abuse was significant or harmful enough to discuss because it did not include more violent forms of sexual abuse (Heritage, 1998).

Before recommendations can be made to promote how and when screening for CSA should occur, more research needs to be done to study how women feel about screening antenatally (see Areas for Further Research). Currently, healthcare providers could focus on developing principles of a therapeutic relationship and allowing time for discussion of sensitive topics. This approach could be made at every appointment as client/patients may choose to disclose at anytime.

In addition to discussions throughout pregnancy, special attention needs to be given to the postpartum period. Leeners et al. (2006) recommends that women be offered an opportunity to discuss their labour experiences after the birth of their baby. This discussion may be facilitated by a medical and/or mental health professional, and may serve to improve future birth experiences and diminish post-traumatic stress and other negative sequelae.

**Offer individualized support.** As each pregnant woman has a unique history, women also have unique needs and preferences during the perinatal period. Healthcare providers should be prepared to divert from their usual plan of care and offer support based on the perceived or known needs of the patient.

The words healthcare providers choose may also inadvertently serve to remind survivors of their past abuse. “Triggers are actions, situations, or words that cause a survivor to remember or re-experience the abuse” (Heritage, 1998). Seemingly supportive or benign language may mirror phrases their abuser has used. Heritage (1998) gives the example of a survivor being abused as a result of a family member telling her he was going to teach her about her body. Years later, an obstetrician used similar language about teaching her about her body and it brought her back to her abuse experience. Simkin (1992) advises healthcare providers to carefully choose their language. Phrases such as “surrender” (p. 225) to the experience, or “trust your body” (p. 225) may serve as triggers to past abuse experiences. Simkin (1992) also reinforces keeping aware of the positioning of women during labour. Laying on her back with legs supported by stirrups, referred to as the lithotomy position, may trigger memories and serve to slow or halt the progression of labour. Indeed, survivors may be more comfortable labouring in the standing, squatting, or side-lying positions.

Being prepared for detached or dissociative behaviors, outbursts, or unusual responses to pain, is important during the perinatal period. Experts suggest the most effective response from healthcare providers is one that exhibits acceptance, empathy, genuineness, positive regard, gentle reassurance, emotional support, and reminders about what is occurring. Reminding the labouring woman that the source of her discomfort is labour or an important intervention, may prevent her from disassociating and experiencing other traumatic effects (Burian, 1995; Coles & Jones, 2009; Simkin, 1992; Waymire, 1997). Simkin (1992) recommends asking the distressed woman if she can explain what she is feeling, which will aid the healthcare provider in addressing her concern.

Hobbins (2004) explains that a large part of offering sensitive care to survivors of CSA is allowing them to feel in control; she titles this “relinquish the control” (p. 495). Although this may be difficult for some healthcare providers that perhaps view themselves as experts, one can still be helpful if not in control. In other words, allowing the CSA survivor to be ‘the lead in the dance’. Hobbins (2004) encourages healthcare providers to consider the merits of a patient-centered, feminist, or a humanistic approach to care, where the woman is viewed as valuable, knowledgeable, and participates in healthcare decisions along with the team.

**Have a plan.** Present in the debate on whether to universally screen for history of CSA is the capacity of the healthcare provider to meet the needs of their patients after disclosure. One can liken discussions as these to ‘opening a can of worms’, where healthcare providers may feel an obligation to offer education and support that may exceed their knowledge and skill. Healthcare providers should be aware of the resources in their community and be prepared to make necessary referrals when required. They should not feel they have to independently counsel or fully provide all of the psychological treatment needs of the CSA survivor through pregnancy and birth. As pregnancy and childbirth may trigger unexpected experiences and feelings, this time period may best be supported through an intradisciplinary approach with a trained psychologist or psychiatrist. In addition to being aware of available resources attention to the elements of the therapeutic relationship (empathy, non-judgmental stance, genuineness, positive regard) can be helpful in acute situations that exceed professionals' expertise.

## Chapter 7: Implications and Conclusion

### Areas for Further Research

This study highlighted the childbirth experiences of four women who chose midwifery care antenatally. Although appropriate to our methodological approach, this study captured only four women's experiences of childbirth. As mentioned above, the aim of this study and other qualitative works is not to produce findings that are generalizable to all women, but to glean rich insights about the unique experiences of the participants themselves, and to translate information to practice where appropriate. Other research methodologies and study questions may aid in confirming, extending or adding to the themes generated by this study.

**Qualitative and mixed method approaches.** Other qualitative approaches that may be considered for further research on this area of study are: ethnography and mixed methods approaches. Ethnography focuses on the immersion of the researcher into the participant's life or setting. Data collection is completed through methods, which include: observations, field notes, interviews, and the use of other documents/materials (such as patient charts/medical records) (Pope, 2005). Ethnography may be an appropriate method to collect not only the participant's experiences of a situation or event, but to combine data collection measures to include observations, discussions with care providers, and hospital records.

*Interpretative phenomenology* may be a useful method in continuing research on related topics to childbirth and CSA survivors. For example, how survivors of CSA experience caesarean sections. As the rate of cesarean sections is on the rise, this has particular relevance to the current context of obstetrics.

*Mixed-methods research* may be employed when both quantitative and qualitative research approaches can be seen as valuable in satisfying a research aim. A mixed-methods

approach might be valuable in understanding the best way to screen for history of CSA among antenatal women. For example, interviews and questionnaires can both be utilized in seeking to understand the most appropriate way to screen for CSA and how survivors want to be asked. Where an interview approach to data analysis may yield a particular set of data, some women might find it more comfortable to respond via questionnaire. These two approaches may facilitate broader results that may inform practice and policy.

*Participatory Action Research (PAR)* is a qualitative research methodology aimed at working with participants for intended practice change. Empowerment underpins this research methodology in engaging participants to construct his or her own knowledge (Glasson, Chang, & Bidewell, 2008). PAR may be considered with survivors of CSA or members of the allied health team to facilitate practice change in the system of obstetrical care in Canada.

The *Antenatal Record 1* form is initiated in Ontario when women attend their first antenatal visit with their healthcare provider (e.g. obstetrician, midwife, nurse practitioner, etc.) and in some cases is started by the family physician. Contained on this form are questions pertaining to current and past health and current social information and demographics. The Antenatal Record 1 form contains no questions on history of sexual abuse or any other type of abuse. The only relevancy to abuse is found in the criterion of *Family Violence*. It is left to the discretion of the healthcare provider to screen for CSA.

**Obstetrical models of care.** Explored in this study was the midwifery model of care, where participants developed relationships overtime with their midwives and autonomy and informed-decision making was encouraged throughout the pregnancy and childbirth period. As recommendations from research indicate continuity of care is especially important for CSA

survivors. Thus, further research may be indicated to explore patient's experience of childbirth with other models of care, such as the traditional obstetrical model of care.

As the focus of this study was the childbirth experience specifically, pre-conception, pregnancy, and postpartum were not explicitly explored. Some research points to the difficulty CSA survivors encounter through these processes (Coles & Jones, 2009; Palmer, 2004). As evidenced in work from Clotire et al. (2006), childhood abuse impairs models of attachment, which has an impact on relationships later in life. Relevant to this is the further exploration of maternal attachment during pregnancy and the postpartum period.

### **Scope and Limitations**

This section will briefly capture the intended scope of this study and discuss some limitations that were present, as well as outline how these were mitigated throughout the research process. This study captures the childbirth experiences of four participants who chose midwifery services for their antenatal care. These four women are not representative of women of childbearing age in the general population, nor all female CSA survivors. However, the aim of this, and other qualitative works is not to provide generalizable results that should be applied to all women. By its nature, the purpose of this study was to hear and attempt to understand the rich experiences and stories of a particular sample, gleaning insight from the messages that this research has illuminated.

Phenomenology is a project of sober reflection on the lived experience of human existence – sober, in the sense that reflecting on experience must be thoughtful, and as much as possible, free from theoretical, prejudicial and suppositional intoxications. But, phenomenology is also a project that is driven by fascination: being swept up in the spell of wonder, a fascination with meaning. (van Manen, 2006, p. 12)

Discovering 'meaning' is most central to interpretative phenomenology. Jasper (1993) outlines two important aspects of generating meaning: hearing the participants' prereflective experiences

and being mindful of the interpretations by the researcher. While other methods within phenomenology require the research to clearly acknowledge assumptions, through a process called bracketing, interpretative phenomenology rests on the interpretation by the researchers and places value on the researcher's past experiences and knowledge.

**Prereflective experiences.** Hearing participants' prereflective experiences, that is, before they process and make sense of their life worlds, can be difficult. Hearing pre-reflective experiences is important to avoid participants selecting what is important to share, or avoiding topics and experiences that are troubling (Jasper, 1993). Creating an open, trusting environment to share is important in allowing the participant to readily discuss aspects of the experience that were difficult (Jasper, 1993). As the primary researcher, I made attempts to develop a therapeutic relationship in the short time before the interview in order to create a comfortable environment for sharing. This process became easier as my interview skills deepened throughout the research process. I allowed for more conversation and discussion about neutral topics before the interview to develop mutual comfort and found that participants began to share difficult or negative experiences more readily as the interview progressed.

Due to participants' knowledge of the study, it was unavoidable that they come with no acknowledgement and/or reflection of the content that would be discussed in the interview. Whilst this was unavoidable, other strategies were adopted to mitigate this. Participants were not given the questions that were asked during the interview, and the interviews largely took an individual course as the participants' stories began to unfold. Further, I did prompt participants to return to content that was briefly mentioned or required clarification. This prompted 'spontaneity', which Munhall and Oiler (1986) promote to avoid pre-reflection (as cited in Jasper, 1993).

**Interpretations.** While inherent to Interpretative Phenomenological Analysis (IPA) is the interpretation of meaning based on what is heard and seen, misinterpretations are problematic and affect the rigour and usefulness of the study moving forward. As the primary researcher, I was readily attuned to the participant's language, hearing and making sense of what was said (and not said) in order to generate meaning. Careful attention to the power-imbalances that occur through research, interviews took place in an environment that was chosen by the participants themselves. As well, the participant chose how and where the researcher and participant were situated throughout the interview.

The data analysis process began with the thesis committee. Themes were discussed and thematically clustered based on mutual interpretations. We returned to the interview transcripts to ensure the language of the participant was not lost through the discussions. While Smith (2007) does not clearly place emphasis on the process of member checking with IPA, he does promote the return-to-findings through the re-listening to the audio-recordings and re-reading the interview transcripts. Careful and frequent journaling captured this process that I completed in order to acknowledge pre and post interview reflections, and reflections throughout the data analysis process. After the superordinate themes and subthemes were presented to the committee, further discussions were made to explore meaning and consider other interpretations.

## **Reflections**

Embedded in this chapter are the acknowledged assumptions I had prior to completing research on this topic. After completing this work, what has been impressed most strongly upon me has been the importance of treating all women as if they are potential survivors of CSA and applying 'universal precautions'. All women come to pregnancy and childbirth with their own history and personal story. Some may clearly acknowledge their story, while some may keep it

hidden. Others may not remember their difficult past at all. Importantly, women's voices should be acknowledged and listened-to. Their choices, desires, and feelings should be valued. They should not be made to feel trapped or pressured into disclosing a difficult past (or an unnecessarily challenging present). Rather, an environment of openness should be encouraged. Healthcare providers must allow flexibility for change and place a greater value on autonomy. Whether managing a critical, high-risk obstetrical plan, or supporting a low-risk labouring woman, humanizing the experience of birth necessitates all else.

Humanization of childbirth is a unique approach which has been implemented whose target is to make childbirth a positive and satisfying experience for both the women, and their family as a whole. This strategy is used to empower women and their care providers by taking into consideration humanized values such as the women's emotional state, their values, beliefs, and sense of dignity and autonomy during childbirth. (Behruzi et al., 2010, p. 1)

## **Conclusion**

This study adds to the current body of work on the childbirth experiences of childhood sexual abuse survivors. This phenomenological study extends current knowledge by seeking to understand meaning from the perspective of the woman herself. Interpretative phenomenology provided both a philosophy and a methodology that was adopted throughout the research process. Through in-depth, semi-structured interviews, data was obtained and analyzed using Interpretative Phenomenological Analysis (IPA) informed by Smith (2007). The study began with the question: *How do childhood sexual abuse survivors experience childbirth?* Through thematic analysis and reflexive practices, the themes of *control*, *anxiety*, and *detachment*, were generated to represent the participants' account of their births. Implications for practice include the importance of a trusting relationship between practitioner and patient and allowing space and time for disclosure of abuse. Additionally, interventions involving touch were found to be

especially difficult for participants. Healthcare providers should take time to explain necessary interventions and procedures, allowing time to obtain informed consent. Areas of further research may include exploring the facilitators and barriers in disclosing of abuse, and experiences of birth with alternate care providers.

## Appendix A

### Telephone Script for Assessment of Eligibility

#### **Telephone Script:**

Initial script over the phone (assessing eligibility):

Thank you for calling and expressing interest in this research study. I have a few questions to ask you to see if you are eligible for this research study. Some of these questions will be personal in nature. This will take approximately 10 minutes. Do you have time to complete this now?

If yes: Proceed to questions 1-5

If no: That is ok. Is there a day or time I may call you back to discuss the questions?

1. Do you read and speak English?
2. What is your age?
3. Did you have a baby in the last year?
4. Did you have a midwife as your care provider?
5. One of the requirements of this study is that women have themselves experienced childhood sexual abuse. One common definition of CSA is: “Involvement of a child before the age of 16 or exposure to sexual contact, activity or behavior by another youth or adult”

If meets inclusion criteria: Thank you for answering my questions. Based on your answers you are eligible to participate in this study. This study involves meeting for an interview with myself after you consent to take part. The interview will last between 1-2 hours and will be audio recorded with your permission. Questions will be asked about your childbirth experiences and will be similar to: “can you describe your early labour?” No details or questions will be asked about your abuse. After the interview a package of community resources will be provided to you. As a thank you for participating, a \$25 Superstore gift card will be given to you. You may also choose not to answer a question if you choose not to.

Your choice to participate in this research study is voluntary and will not affect your current or future care with your midwives. Any information that you will share in your interview will be kept confidential. Your involvement in this study will remain confidential.

Do you have any questions? Are you interested in finding out more about being a part of this research study?

*If yes: set up a time to meet for the interview/consent.*

*If no: That is ok. Thank you for taking the time to express interest. If you change your mind, you can certainly call and inquire at a later time.*

If does not meet inclusion criteria: “Based on the answers you’ve provided you are not eligible in participating in this study. We appreciate your interest and thank you for your time”

## Appendix B

### Letter of Collaboration

The logo for Ryerson University, featuring the text "RYERSON UNIVERSITY" in white, uppercase letters on a blue rectangular background with a yellow vertical bar on the right side.

To Whom It May Concern:

We are requesting your collaboration in an upcoming qualitative research study. My name is Caitlin Mathewson and I am currently completing my Masters of Nursing at Ryerson University. I am completing a thesis on what childbirth is like for survivors of childhood sexual abuse using a descriptive phenomenological approach.

We will be recruiting participants from participating Midwifery practices in Southwestern Ontario and would be interested in discussing collaboration with your practice on this research initiative. We hope to begin recruitment early 2015.

I have attached a research outline to this email.

Thank you for your time.

Sincerely,

Caitlin Mathewson RN BScN MN(s)

## Appendix C

### Research Outline



RYERSON  
UNIVERSITY

### **MN – Thesis Research Outline** Caitlin Mathewson RN BScN MN(s) Ryerson University

#### Research Team:

Dr. Sherry Espin

Dr. Patricia McNiven

Dr. Sharon Dore

Dr. Ryan Van Lieshout

#### ***Study Title***

Childbirth. Understanding what labour is like for survivors of childhood sexual abuse.

#### ***Study Abstract***

Childhood sexual abuse (CSA) can have lasting psychological effects, including post-traumatic stress disorder, depression, anxiety, and difficulty in social situations. Research suggests that labouring women who have a history of CSA have more obstetrical interventions, poorer neonatal and maternal outcomes, and increased fear of childbirth. This descriptive phenomenological study will seek to understand the phenomenon of childbirth for women who have a history of childhood sexual abuse. Participants will be recruited from Midwifery practices in Southwestern Ontario, Canada. They will be recruited in the six weeks following delivery while still under Midwifery care. Individual midwives will provide each client in their practice with a pamphlet outlining the study's aims and processes. Interested participants will contact the researcher if they wish to become involved in the study. In-depth, semi-structured interviews will take place as the method for data collection. Interviews will be audio-recorded with consent from the participants and field notes will be taken throughout. The aim of this study is to better understand what childbirth is like for survivors of childhood sexual abuse. Findings of this study will be disseminated to healthcare professionals to assist in improving the care of survivors of sexual abuse within the obstetrical setting.

#### ***Design & Data Collection***

Descriptive phenomenological approach  
Semi-structured interviews

#### ***Population***

##### *Inclusion*

- Adult women (>18 years of age)
- English-speaking

- History of childhood sexual abuse
- Had a baby within the last 5 years under Midwifery care

### ***Recruitment***

Recruitment will occur in the six weeks after delivery (still while under Midwifery care). For participating midwifery practices, the midwife will provide each client a pamphlet outlining study details and contact information. Interested clients will contact the research team for further information.

## Appendix D

### Letter of Participation

The logo for Ryerson University, featuring the text "RYERSON UNIVERSITY" in white capital letters on a blue rectangular background with a yellow vertical bar on the right side.

### Childbirth Experience Study

Primary Researcher:

Caitlin Mathewson RN MN(s)

Thesis Supervisor:

Sherry Espin RN PhD

Thesis Committee

Dr. Patrician McNiven

Dr. Sharon Dore

Dr. Ryan Van Lieshout

Thank you for your participation with this research study. We are excited to collaborate with your practice in seeking to understand what childbirth experiences are like for survivors of sexual abuse.

Participation will involve providing each client a pamphlet at a postpartum visit or clinic appointment. We ask that you inform clients of the following:

- The research study is being conducted through Ryerson University and is not affiliated with the collaborating midwifery practice in any way
- Midwifery practices and individual midwives will not be aware of those who choose to participate in this research study.

We kindly ask that you provide all clients the research pamphlet regardless of the perceived suitability to participate.

Thank you again for your participation. Please contact me with any questions or concerns.

Best,

Caitlin Mathewson  
caitlin.mathewson@ryerson.ca

# Appendix E

## Study Pamphlet

<p><b>Please note: this is a research study and not intended to be a therapeutic experience</b></p> <p><b><u>How can I find out more?</u></b></p> <p>If you would like to find out more about this research study please contact the primary research below, or Dr. Sherry Espin for more information.</p> <p><b>Primary Researcher:</b> Caitlin Mathewson RN <a href="mailto:caitlin.mathewson@ryerson.ca">caitlin.mathewson@ryerson.ca</a> 416-979-5000 ext. 2565</p> <p><b>Thesis Supervisor:</b> Sherry Espin PhD RN <a href="mailto:sespin@ryerson.ca">sespin@ryerson.ca</a> 416-979-5000 ext. 7993</p> <p>Thank you for your interest</p>	<p><b><u>Community Resources</u></b></p> <p><b>Hamilton Public Health</b> Healthy Babies Healthy Children 905-546-3550 M-F 830a-430p</p> <p><b>SACHA</b> Sexual Assault Centre of Hamilton 905-525-4162 (24 hour Crisis Line)</p> <p><b>COAST</b> 24-hour support 905-972-8338</p> <p><b>Women's Health Concerns Clinic (WHCC)</b> Hamilton, ON 905-522-1155 ext. 33979</p>	<p><b>Childbirth.</b></p> <p>Understanding what <b>labour is like</b> for survivors of childhood sexual abuse</p> <p></p> <p>A Research study affiliated with Ryerson University</p>
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<p><b><u>What we are doing:</u></b></p> <p>We are interested in talking to women who are survivors of childhood sexual abuse (CSA) about their labour experiences.</p> <p><b>It is important to us to hear your story.</b></p> <p><b><u>We would like to speak to women who:</u></b></p> <ul style="list-style-type: none"><li>- Are 18 years of age or older</li><li>- Had a baby in the last 5 years with a midwife</li><li>- English speaking and can read and write in English</li><li>- Have experienced childhood sexual abuse</li></ul> <p><b><u>Why are we doing this?</u></b></p> <p>Some research shows the survivors of CSA have different outcomes when compared to women with no abuse history.</p>	<p>We are interested in talking to women about how they feel their birth experience was in order to gain more understanding for healthcare professionals who care for pregnant and labouring women.</p> <p><b><u>What does being involved mean?</u></b></p> <ol style="list-style-type: none"><li>1. Participating in a 45 minute- 1 hour interview with the primary researcher at your home or a room booked in a nearby Public Library</li><li>2. Questions will be asked about your childbirth experiences.</li></ol> <p><b>You will receive a \$25 Superstore gift card as a thank you for your participation</b></p> <p><b>No questions will be asked about details of your abuse</b></p>	<p><b><u>How will the information be kept private?</u></b></p> <p>We are taking important steps to ensure your privacy. Your midwife and care team will not be aware of your participation or what you've discussed in your interview.</p> <p>Your name will be assigned a number at the beginning of the study. Your name or personal identifiers will not be used at any point.</p> <p><b><u>What if I change my mind about participating?</u></b></p> <p>At anytime you can decide to withdraw from the study or choose not to answer any question. You may withdraw without giving a reason.</p> <p>No one will contact you further.</p>
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## Appendix F

### Study Consent

Research Ethics Board, Ryerson University

Revised November 2014



### **Ryerson University Consent Agreement**

You are being invited to participate in a research study. Before you consent to participate, please read this consent form and ask any questions so that you understand what your participation will involve.

#### **Childbirth. Understanding what labour is like for survivors of childhood sexual abuse**

#### **INVESTIGATORS:**

The investigator of this study is Caitlin Mathewson who is completing this study as part of a Masters Degree under the direct supervision of Dr. Sherry Espin from the Yeates School of Graduate Studies at Ryerson University.

#### **PURPOSE OF THE STUDY:**

The purpose of this study is to better understand what childbirth is like for women who have experienced sexual abuse as a child. We are interested in talking with English speaking women who have given birth with a midwife in the last year, and who were sexually abused before the age of 16. This study is being completed as part of a Master of Nursing Graduate Degree thesis through Ryerson University. This is a research study and is not intended to be a therapeutic experience. Your participation in this study is voluntary.

#### **WHAT PARTICIPATION MEANS:**

If you volunteer to participate in this study, it will mean the following:

- You will have an interview with the primary investigator about your childbirth experiences. Interviews will last between 45 minutes to an hour and may occur at your home or a room booked in a public library. The library will not know why the room will be used.

- Questions in the interview will be about your childbirth experiences. No questions will be asked about your abuse experiences. Questions will be similar to: *Can you tell me about the events of your early labour?*
- You may stop the interview at any time. If you require the interview to stop before it is scheduled to end you may reschedule the remainder of the interview for another date.
- All participants will be provided information at the beginning of the interview for the following community resources for new mothers:
  - o Health Babies Healthy Children
  - o SACHA – Sexual Assault Centre of Hamilton
  - o Women’s Health Concerns Clinic, Hamilton
  - o COAST – Crisis Outreach and Support Team Hotline, Halton
  - o Brant Community Health Centre Hotline, Brantford

**POTENTIAL BENEFITS:**

There is limited information available on what childbirth is like for survivors of childhood sexual abuse. We are interested in learning about the experiences of childbirth for survivors of CSA and bringing this information to journals and conferences to help educate healthcare providers.

I cannot guarantee, however, that you will receive any benefits from participating in this study.

**WHAT ARE THE POTENTIAL RISKS TO YOU AS A PARTICIPANT:**

It is possible that some questions that are asked during your interview could make you feel uncomfortable and may remind you of negative experiences or memories. If, during your interview, you feel uncomfortable or experience negative memories, you may choose to end the interview. You may choose not to answer any question that is asked or choose to stop the interview altogether. You do not need to provide a reason for ending the interview or for withdrawing from the study.

**CONFIDENTIALITY:**

The personal information provided will be assigned a unique identification number. No names or other personal identifiers will be used. Your personal information and the consent will be kept in a secured, locked cabinet and will be destroyed at the end of the research study. The anonymized study data will be kept on an encrypted, password protected external hard drive and will be kept in a secured location for a maximum of 5 years. The anonymized data will be kept for a maximum of 5 years for the purposes of completing further research and/or secondary analyses.

As the interviews will be audio-recorded the audio-recordings will be kept in a locked cabinet until transcribed to a secure external hard drive. The audio recordings will be destroyed after the

research study has ended. As this is small study, some unique details may be changed to ensure you are not identified as a participant.

When the study information is shared at conferences or published in journals no personal identifiers will be used.

Although we will protect the privacy of your information, if the law requires it, we will have to reveal some person information. This would only occur if you expressed thoughts of self-harm or if we suspected there is risk of harm or neglect to your infant.

**INCENTIVES FOR PARTICIPATION:**

Women who participate will receive a \$25 Superstore gift certificate.

**COSTS TO PARTICIPATION:**

You do not need to arrange childcare during the interviews for your baby or other children. It is ok to have your children present for the interview. If you do wish to arrange childcare during the interview this may involve an extra cost to you. If you choose to have your interview at a public library, instead of your home environment, there may be added transportation and parking costs.

**VOLUNTARY PARTICIPATION AND WITHDRAWAL:**

Participation in this study is completely voluntary. You can choose whether to be in this study or not. If any question makes you uncomfortable, you can skip that question. You may stop participating at any time and you will still be given the incentives and reimbursements described above. If you choose to stop participating, you may also choose to not have your data included in the study. Your choice of whether or not to participate will not influence your future relations with Ryerson University or the investigators Caitlin Mathewson and Sherry Espin involved in the research.

**QUESTIONS ABOUT THE STUDY:** If you have any questions about the research now, please ask. If you have questions later about the research, you may contact:

Caitlin Mathewson RN  
[Caitlin.mathewson@ryerson.ca](mailto:Caitlin.mathewson@ryerson.ca)

Sherry Espin RN, BScN, Med, PhD  
[sespin@ryerson.ca](mailto:sespin@ryerson.ca)  
416-979-5000 ext. 7993  
Ryerson University  
350 Victoria Street  
Toronto, ON  
M5B 2K3

This study has been reviewed by the Ryerson University Research Ethics Board. If you have questions regarding your rights as a participant in this study please contact:

Research Ethics Board  
c/o Office of the Vice President, Research and Innovation  
Ryerson University  
350 Victoria Street  
Toronto, ON M5B 2K3  
416-979-5042  
[rebchair@ryerson.ca](mailto:rebchair@ryerson.ca)

**Childbirth. Understanding what labour is like for survivors of childhood sexual abuse**

**CONFIRMATION OF AGREEMENT:**

Your signature below indicates that you have read the information in this agreement and have had a chance to ask any questions you have about the study. Your signature also indicates that you agree to participate in the study and have been told that you can change your mind and withdraw your consent to participate at any time. You have been given a copy of this agreement. You have been told that by signing this consent agreement you are not giving up any of your legal rights.

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

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

I agree to be audio-recorded for the purposes of this study. I understand how these recordings will be stored and destroyed. I understand that I can request that audio recording be halted permanently or temporarily at any time during the interview

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

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