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The Effects of Sexual Abuse on Birth: Obstetric Outcomes, Maternal Experience, and Professional Intervention

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THE EFFECTS OF SEXUAL ABUSE ON BIRTH: OBSTETRIC OUTCOMES, MATERNAL EXPERIENCE, AND PROFESSIONAL INTERVENTION

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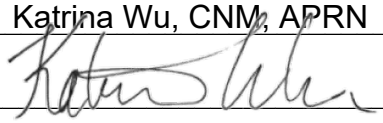
Project Advisor Signature: 

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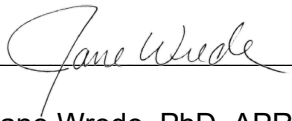
Second Reader Signature: 

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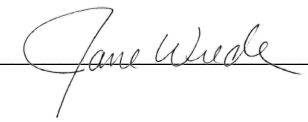
Director of Nurse-Midwifery Program Signature: 

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Abstract

Background/Purpose:

The purpose of this literature review is to determine how a past history of sexual abuse impacts labor and birth and what strategies can be used to help mitigate retraumatization. The desire is that this review will encourage further studies and the creation of guidelines and interventions to be used in maternal care settings.

Theoretical Framework:

The Neuman Systems Model is a theoretical framework utilized in this paper. It provides a framework for identifying stressors, assessing a patient's response, developing strategies/treatments to move women back toward stability, and adapting practices to reduce triggers from occurring in the first place (Neuman, 1996). It can be used in both patient care settings as well as research to evaluate how an individual responds to stressors in their environment and the impact of primary, secondary, and tertiary prevention strategies on their overall wellbeing (Alyward, 2005).

Methods:

An initial search was conducted using Bethel University's Online Library with the PubMed MEDLINE, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and Google Scholar databases. 20 articles were selected that met the inclusion criteria of sexual abuse and the intrapartum period. Each of the articles identified effects of sexual abuse on the intrapartum period and posed questions and suggestions regarding what types of interventions may help to address adverse birth outcomes and women's perceptions of their experience.

Results/Findings:

Two themes identified: Outcomes and interventions. Outcomes were further broken down into physical obstetric outcomes and psychological outcomes. Physical obstetric outcomes include an increase in prolonged labor, risk for low birth weight, risk for preterm birth, antepartum bleeding, labor inductions, operative vaginal deliveries, and medically necessary and elective cesarean births. Psychosocial outcomes include symptoms of post-traumatic stress disorder (PTSD), increased maternal stress during labor, and an increase in intense fear of birth. Interventions were broken down into two groups: personal coping skills and professional interventions. Personal coping skills include a need for control over who the provider is and physical exams, ability and freedom to "take charge," engagement in counseling, and forgiving perpetrators or forgetting abuse through suppression of memories or substance use. Professional interventions include routinely screening patients for abuse history, developing a therapeutic patient-provider relationship, discussing triggers and avoiding them when possible, giving patients control, practicing shared decision making, and antenatal counseling.

Implications for Research and Practice:

Implications for practice include ensuring that all maternity care providers are screening patients for a history of sexual abuse, universal precautions for all patients regardless of stated history, empowering women through shared decision making, discussing triggers and avoiding them, and encouraging antenatal counseling for those who disclose a sexual abuse history.

More research, including larger studies with diverse patient populations is needed to establish a causal relationship between sexual abuse and poor birth outcomes.

Keywords: Sexual abuse, sexual assault, rape, birth, labor, intrapartum, trauma informed care

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Chapter One: Introduction

Evidence Demonstrating Need

The Adverse Childhood Experiences (ACE) Study, completed between 1995 and 1997, looked at the effects of childhood abuse and neglect on the health of individuals when they became adults (Centers for Disease Control and Prevention [CDC], 2019). The study found that an increase in childhood abuses, neglect, or traumatic experiences correlated to poor mental health, poorer maternal health outcomes, chronic diseases, substance abuse, and risky behaviors, among others. A majority of the individuals in the study experienced at least one ACE with 1 in 5 having experienced three or more. The more ACEs an individual experienced, the greater the adverse impacts in adulthood. This study was groundbreaking because it showed that childhood experiences impact future health in many different realms. This study is important to maternal health because there is a great number of women who have experienced sexual abuse, and likely other abuses as well, who will become pregnant and seek out maternal care services. In the ACEs study, 24.7% of the women were survivors of childhood sexual abuse (CDC, 2019). In the total population, it is estimated that 1 in 9 girls less than 18 years old experience sexual abuse from an adult and 1 in 5 women will be raped or experience an attempted rape at some point during their life (Rape, Abuse & Incest National Network [RAINN], n.d.a; American College of Obstetricians and Gynecologists [ACOG], 2019a). The ACE study demonstrated that the women who experienced abuse in their childhood have an increased risk of complications during labor and are more likely to have complex emotional and mental health problems that have the potential to impact their labor experiences (CDC, 2019).

Sexual assault has many physical, emotional, and psychological impacts on women. Women who have experienced sexual abuse have higher rates of pelvic pain, sexual dysfunction,

and painful periods (ACOG, 2019a). In addition, these individuals have higher rates of mental health disorders, including high rates of posttraumatic stress disorder, and substance use disorders (ACOG, 2019a). According to ACOG (2019b), women who are survivors of sexual abuse report that exams that are routinely done in women's health visits and labor, such as pelvic exams and cervical checks, often bring up memories of abuse, including fear and feeling a lack of power (ACOG, 2019b). A meta-synthesis that evaluated women who are survivors of sexual abuse's experiences in labor found that feelings of control, how their health providers interacted with them, and the trust they were able to build allowed the women to feel safe and empowered in their birthing experience (Montgomery, 2013). When these were not there, many women stated that they felt as though they were being re-victimized during labor and birth (Montgomery, 2013).

Caring for women in antepartum, intrapartum, and postpartum has many complexities and is influenced by clients' past life experiences as well as current situations they face at the time of care. Women who are survivors of sexual abuse are coming are coming in with the added complexity of living through trauma, something many of them continue to carry with them throughout their lives. Pregnancy and birth have the potential to bring back memories of their abuse, especially as the process of growing, delivering, and then caring for a baby contains many elements that are often out of an individual's control and may elicit pain (Montgomery, 2013). It is important that health care providers be aware of the many ways that labor and birth can be impacted by women's histories. Guidelines of care that promote healing and empowerment through the birthing experience instead of retraumatization should be adapted and applied. To date, the American College of Nurse-Midwives (ACNM) does not have a position statement regarding sexual abuse history and the care of women during and outside of pregnancy (ACNM,

n.d). For guidance on how to best care for women with these histories, providers must turn to ACOG, which has a committee opinion that recommends screening for sexual abuse history for all women and utilization of a trauma-informed care framework when serving women with sexual abuse histories (ACOG, 2019a). However, even this recommendation is lacking, as ACOG only gives a brief overview of the trauma-informed care framework, but does not address what trauma-informed care practices actually are and how to apply them to women during pregnancy, birth, or general gynecological care (ACOG, 2019a).

The purpose of this literature review is to determine how a past history of sexual abuse impacts labor and birth and what strategies can be used to help mitigate retraumatization. The desire is that this review will encourage further studies and the creation of guidelines and interventions to be used in maternal care settings.

Significance to Midwifery

Midwives and other maternal care providers enter into the sacred and personal spaces of childbearing individuals. They journey with them through pregnancy and during labor and birth. Many situations in labor and birth can create a sense of loss of control. They can cause pain, remind them of their abuse, and cause dissociation and other symptoms of posttraumatic stress disorder (PTSD) (Carroll & Banks, 2019). Control has been cited as a common need for birthing individuals who have a history of sexual abuse/assault (Montgomery, 2013). Midwives and maternal care providers have the ability to add to trauma or help to create an empowering experience. In order to do this, all women's health-focused professional organizations need to create and provide position statements and practice guidelines for practitioners. ACNM is not the only professional organization that is lacking such a statement. Official statements were not found for the Royal College of Obstetricians and Gynaecologists (RCOG), the Society of

Obstetricians and Gynaecologists of Canada (SOGC), or the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).

Theoretical Framework

Neuman Systems Model

While seeking to gain a greater understanding of the impacts of sexual trauma on maternity care and how to care more effectively for these patients, the Neuman Systems Model will be applied. This model provides a lens for the evaluation of a woman's experiences, triggers, and outcomes.

The Neuman Systems Model is a theoretical framework that can be used in both patient care settings as well as research to evaluate how an individual responds to stressors in their environment and the impact of primary, secondary, and tertiary prevention strategies on the overall wellbeing, or the balance of energy forces, of the individual (Alyward, 2005). The idea is that individuals are constantly impacted in positive and negative ways by their past and present experiences, the environment, cultural and/or spiritual ideologies, and people around them. Every interaction involves an exchange of energy that moves the individual toward or away from stability. Evaluating and caring for individuals involves identification of stressors (disruptive energy forces), awareness of personal factors, identification of possible stressors (primary prevention), immediate treatment of an individual's response to stressors (secondary), and long-term treatment and adaptation to help prevent similar responses when stressors occur in the future (tertiary). This requires providers to constantly evaluate and adapt their practice to guide individuals/patients toward balance and wellness (Alyward, 2005).

Adaptation of the Neuman Systems Model to Research on Sexual Trauma and Maternity Care

The Neuman Systems Model is appropriate for conducting and evaluating nursing research as it provides a holistic evaluation of an individual's interaction with health systems, environment, and people and thier impacts on wellness (Neuman, 1996). It encourages researchers, nurses, and providers to look at all the factors that can influence a client or patient's responses when in stress-inducing environments, such is the case during hospitalization or possibly even in a clinic setting (Neuman, 1996). In the case of individuals who have experienced sexual trauma, it is important to recognize how their trauma impacts their interaction with health care providers and health systems.

According to the American College of Obstetricians and Gynecologists (ACOG) the effects of sexual trauma, whether in childhood or adulthood, are often carried throughout the individual's life (2019a). It has psychological, emotional, and physical impacts, which can be triggered during labor and birth (ACOG, 2019a). According to the Neuman Systems Model, personal experiences influence responses to stressors. In the case of an individual with a history of sexual abuse, a vaginal exam may be a major stressor that causes the individual to move toward instability by triggering memories of her past abuse. Neuman's model looks at more than just one type of stressor, therefore, it is important for midwives and other maternity care providers to be conscious of the myriad of triggers a woman may have during labor and delivery and respond accordingly.

The purpose of this research is to evaluate what common triggers exist for women with histories of sexual abuse, their impacts, and how providers can apply primary, secondary, and tertiary prevention strategies to better serve them and reduce feelings of traumatization that they may have through the whole experience. Neuman's model provides a lens for identification,

prevention, and response to these triggers. Neuman (1996) states that there are six rules for applying the Neuman systems model to research. The rules include:

- Evaluation of all potential influencers that can impact an individual's response to stressors
- Assessment of clinical practices that can trigger stressors
- They may be applied to individuals or larger groups
- Qualitative and quantitative research strategies are appropriate
- Research must further understanding and provide strategies for prevention.

Research on sexual abuse survivors and strategies to be applied at the clinical level to reduce triggers fits within the identified rules.

Maternity care for survivors of sexual abuse is complex. It requires the identification of stressors that move the individual from stability toward instability. The Neuman Systems Model provides a framework for identifying these stressors, assessing a patient's response, developing strategies/treatments to move women back toward stability, and adapting practices to reduce triggers from occurring in the first place.

Chapter II: Methods

The purpose of this chapter is to describe the methods used to identify and critically appraise scholarly literature addressing the impact of sexual abuse on the intrapartum birth experience and outcomes. Search strategies, criteria for inclusion and exclusion, and evaluation criteria will be included. After using multiple databases, 39 scholarly articles initially met the search criteria. A final 20 articles were selected after applying the inclusion and exclusion criteria. The mechanisms for evaluating the level and quality of evidence will also be reviewed.

Search Strategies

An initial search was conducted using Bethel University's Online Library with the PubMed MEDLINE, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and Google Scholar databases. The initial search resulted in 230 studies; these abstracts were reviewed to determine their relevance to the topic. After careful review, 39 scholarly articles were selected. Full-texts were then reviewed and the inclusion and exclusion criteria were applied, yielding a final 20 articles to be relevant to the impact of sexual trauma on childbirth experience and outcome. Key search terms used in the databases included: sexual abuse, birth, midwifery, sexual trauma, trauma-informed care, women's health, childbirth, labor, and intrapartum.

Criteria for Inclusion and Exclusion

The studies selected to be included in the literature review included sexual abuse and the intrapartum period. Chosen articles included maternal and neonatal outcomes and maternal experiences. Research from multiple countries was included due to the universal nature and experience of sexual abuse. Due to the personal maternal experience aspect of this review, all study designs were included from any publication year. .

The exclusion criteria included articles that addressed the impact of sexual abuse on the antepartum or postpartum periods without addressing the intrapartum period. Research around breastfeeding outcomes was also excluded. All systematic reviews were excluded. Studies were also excluded if the full-text articles were not available in English.

Summary of Selected Studies

After careful research and review, 20 scholarly articles were chosen. The scholarly writings that were included in the final review included 9 quasi-experimental trials, 4 non-experimental trials, and 7 qualitative studies. These studies were published between 1998 and 2019. The literature included research from the United States, Canada, Belgium, Iceland, Denmark, Estonia, Norway, Sweden, India, England, Israel, Germany, Iran, and Australia.

Evaluation Criteria

The Johns Hopkins Research Appraisal Tool was utilized to evaluate the strengths and quality of the 20 articles selected for review (Dearholt & Dang, 2012). The selected articles were graded by strength on a scale of I-III. Qualitative and non-experimental studies made up level III which included the majority of the research articles selected due to the nature of the chosen topic. Level II studies are made up of quasi-experimental studies and reviews of quasi-experimental and randomized controlled trials. Of the articles selected, 17 articles were level III and 3 articles are level II.

After the articles were examined for the level of evidence, the articles were then examined to determine quality. Research quality is divided into three categories as A, B, C from high to low. Quality was classified by the following factors: sample size, generalizability, consistency of results, consistency of recommendations, and clear conclusions. Of the articles selected one is level A, 12 are level B, and 7 are level C.

Summary

The literature review search utilized Bethel University's Online Library to access PubMed, CINHAL, and Google Scholar to identify relevant scholarly articles. Inclusion and exclusion criteria were used to determine which articles remain in the review. The articles selected were then evaluated for both strength and quality. 20 scholarly articles were ultimately selected to be included in the review matrix.

Chapter III: Literature Review and Analysis

Synthesis of Matrix

20 scholarly articles are included in this review. They include five cohort studies, three phenomenological studies, two cross-sectional studies, two longitudinal studies, two case studies, two qualitative semi-structured interviews, two narrative studies, one qualitative, grounded theory study, and one retrospective study. While one study is identified as a retrospective study, all of the studies have retrospective elements. All the studies were evaluated for the level of evidence and quality using the John Hopkins Research Evidence Appraisal Tool (Dearholt & Dang, 2012). Each matrix includes the purpose of the study, sample and setting, John Hopkin's appraisal, research design (methods/instruments/measurements), findings, strengths and limitations, recommendations, and implications for clinical practice. The matrix is organized alphabetically. The matrix synthesis review includes purpose, design, and important findings relevant to caring for patients, who are survivors of sexual abuse, in pregnancy, labor, and birth.

Synthesis of Major Findings

All 20 articles address the effects of sexual abuse history on pregnancy and birthing experiences of women who are survivors of sexual abuse. Each of the articles posed questions and suggestions regarding what types of interventions may help to address adverse birth outcomes and women's perceptions of their experience, with 10 containing information regarding interventions that are effective or that women desired in order to improve their perceptions and experience of pregnancy, labor, and birth. The synthesis of major findings reviews sexual abuse risk factors on labor and birth, including physical birth outcomes and women's perceptions of their birthing experience; how women cope with labor and birth when they have a sexual abuse history, and effective interventions for addressing birth outcomes and

women's perceptions of their experience.

Effects of Sexual Abuse History on Labor and Birth

Physical Birth Outcomes. Eight of the studies included in the matrix researched physical birth outcomes for individuals with a history of sexual abuse. Between the studies, some findings were inconsistent. For example, one study that included 1,068 women with a history of sexual abuse found that they had a 40% higher risk of a prolonged first stage of labor when compared to women without a sexual abuse history (95% CI = 1.03-1.88), but that the second stage was not different between women who had a history compared to those who did not (Gisladottir et al., 2016). In contrast, two other studies, one by Nerum et al. (2013) that included 47 women with a history of rape as adult and 185 who experienced childhood sexual abuse and one by Nerum et al.(2010) that included 50 women who were raped as an adult, found that the second stage of labor was prolonged for those with a history of rape as an adult, with an average length of 120 mins compared to 55 minutes in controls ($p < 0.01$) (Nerum et al., 2013; Nerum et al., 2010). No difference in labor length was seen for women who experienced sexual abuse as a child compared to controls (Nerum et al., 2013). Gidsladottir et al. (2016) and Nerum et al. (2013) both examined exposure of sexual abuse in childhood versus adulthood with a control group of unexposed women. The 2010 study by Nerum et al. likely drew from the same adult survivor group as the 2013 study as many, but not all, of the authors are the same between the two studies and the participants were from the same hospital system in the same timeframe (Nerum et al., 2010; Nerum et al., 2013). One other study demonstrated an increase in the length of labor and birth from start to finish, but did not make a delineation between the first and second stages of labor ($p < 0.01$) (Leeners et al., 2016).

Studies in this review identified several other adverse physical birth outcomes for women

with a sexual abuse history. These include an increased risk for antepartum bleeding (RR 1.95, CI 1.22-3.07) (Gisladottir et al., 2016), labor inductions (81% of women raped as an adult [RA] versus 55% of controls [CG], $p = 0.01$) (Nerum et al., 2013); a need for emergent instrumental delivery as seen in three studies with Nerum et al. (2010) showing a rate as high as 67% in women raped as an adult compared to 13% of the control group ($p < 0.01$) (Gisladottir et al., 2016; Nerum et al., 2013; Nerum et al., 2010); an increased risk of cesarean delivery ($p < 0.01$) (Nerum et al., 2013; Nerum et al., 2010; Schei et al., 2014), and non-medically indicated or elective cesarean delivery (OR 3.74, CI 1.24-11.24) (Schei et al., 2014). Two studies looked at the potential for increased risk of preterm birth and low birth weight among women who had experienced sexual abuse. Bohn (2002) studied Native American women with a history or current experience of sexual and physical abuse as well as factors that can impact their pregnancy such as sexually transmitted infections and substance use. Among the 30 women studied, 40% experienced sexual abuse in childhood, 60% experienced sexual abuse in either childhood or adulthood, and 20% experienced sexual abuse in both childhood and adulthood, with three of the women experiencing sexual assault during the pregnancy studied. The more abuse events, sexual and physical, the women experienced in adulthood or over their lifetime was related to increased etiological factors for preterm labor and/or low birth weight (greater than three total abuse $p = 0.014$ and greater than three abuse events in adulthood $p = 0.002$) (Bohn, 2002). Ashby et al. (2019), found no statistical difference between preterm delivery (7% vs 9%; $p = 0.28$) in adolescents enrolled in the Colorado Adolescent Maternity Program (CAMP) who had trauma-informed care applied to their maternity care versus those who did not. In those who received trauma-informed care, they had a significantly decreased rate of low birth weight infants (6.6% versus 11.4%; $p = 0.02$) (Ashby et al., 2019).

Psychological Outcomes. Women with histories of sexual abuse, whether in adulthood or childhood, identified several psychosocial outcomes that impacted their care either during the prenatal period or during labor and delivery. 13 studies in the matrix found increased adverse psychosocial outcomes for women with a history of sexual abuse. These were either determined through screening tools or based on narrative stories from women regarding their childbirth experiences. Symptoms of post-traumatic stress disorder (PTSD), particularly flashbacks and disassociation, are the most common psychosocial outcome that is identified during pregnancy, labor, and delivery for women with a history of sexual abuse in the research. The matrix included 11 studies where PTSD symptoms are specifically identified (Coles & Jones, 2009; Leeners et al., 2016; LoGuidice, 2017; Sobel et al., 2019; Lev-Wiesel et al., 2009; LoGuidice & Beck, 2016; Montgomery et al., 2014; Berman et al., 2014; Roller, 2011; Seng et al., 2010; Burian, 1995). One other study found a 60% (CI = 1.01-2.79) increased risk of maternal distress during labor for women with a history of sexual abuse, but it did not specify the triggers were or what type of distress the mothers experienced (Gisladottir et al., 2016). Gottfried et al. (2015) found an increase in antenatal and postpartum sexual dysfunction and depression in women with a history of sexual abuse. Leeners et al. (2016) and Lukasse et al. (2010) found that women with a history of sexual abuse, in either adulthood or childhood, had a significantly higher rate of an intense fear of delivery compared to women without a history of sexual abuse ($p < 0.01$ and $p = 0.001$). Seven studies that identified psychosocial outcomes compared women with a history of sexual abuse to women without and found that feelings of fear and PTSD symptoms were most prevalent among the women who had a sexual abuse history compared to those without (Lukasse et al., 2010; Gisladottir et al., 2016; Gottfried et al., 2015; Leeners et al., 2016; Sobel et al., 2019; Lev-Wiesel et al., 2009). A longitudinal study found that, while childhood sexual abuse can have

negative long-term effects on pregnant women, there was no clear evidence to conlude that childbirth causes retraumatization of their childhood sexual abuse (Lev-Wiesel et al., 2009). Despite this conclusion, the researchers did find that women with a history of childhood sexual abuse did more frequently experience PTSD symptoms than individuals without sexual trauma ($p < 0.001$) (Lev-Wiesel et al., 2009).

Personal Coping Techniques

The experience of trauma can bring lifelong trials that individuals need to either live with or overcome. Women with a history of trauma related to sexual abuse are no different. Pregnancy and birth is a time when these women can re-experience their trauma through direct experiences with the pregnancy itself or through routine procedures and exams, such as vaginal exams (LoGuidice & Beck, 2016; Roller, 2011). In four of the studies included in the matrix, women mentioned strategies they have used in order to cope with these triggers (Sobel et al., 2019; Roller, 2011; Seng et al., 2010; Berman et al., 2014). Each of these four studies were qualitative with a combined total of 79 women who have a history of sexual abuse. All the women in the studies were interviewed and asked to share their birth experience and how it was impacted by their past history of abuse. Two of the studies used a semi-structured interview (Sobel et al., 2019; Berman et al., 2014), one asked open-ended questions (Roller et al., 2011), and one just asked women to recount their childbirth story (Seng et al., 2010). All but one study used grounded theory methodology for data collection and analysis (Sobel et al., 2019; Roller, 2011; Berman et al., 2014).

Women cope in different ways. A common theme among the women in the four studies that include coping strategies is the need for control or taking charge (Sobel et al., 2019; Roller, 2011; Seng et al., 2010; Berman et al., 2014). Some women stated they did this by requesting

specific providers, most often women, or by changing providers when they felt that the provider was insensitive to their needs as a sexual trauma survivor (Sobel et al., 2019; Roller, 2011; Seng et al., 2010). Other women did this by learning to forget or forgive the perpetrators of their abuse (Berman et al., 2014). Deciding who was present in the room with them during vaginal exams or other times when their body may be exposed was empowering for them and helped them cope with this specific type of trigger (Sobel et al., 2019). In addition, women were further able to take charge by asking their providers to explain what was occurring during procedures and asking them to slow down or stop when they felt they were not coping effectively (Sobel et al., 2019; Roller, 2011; Seng et al., 2010). Ultimately, some women felt they were able to take charge by seeking out treatment and engaging in counseling (Roller, 2011; Seng et al., 2010).

Berman et al. (2014) found that women who have a history of sexual abuse cope in many different ways: forgiving and forgetting, containing their trauma by not disclosing it to their providers or others, and having hopes and dreams for their families that includes protecting them and living in a way that is opposite to the trauma they themselves experienced. One way that some women "forget" about their trauma is by engaging in risky behaviors (Berman et al., 2014). Roller (2011) found that women admitted to using illicit substances to help them forget and cope with their past traumas. When they found out they were pregnant, many of them attempted to stop behaviors they felt were more harmful to their babies and would then choose ones they thought were not as bad, such as choosing to smoke cigarettes instead of using illicit drugs or alcohol (Roller, 2011). These women also found that they engaged in more sexually risky behaviors, but many attempted to discontinue and change behaviors when they found out they were pregnant. According to Roller (2011), it wasn't uncommon for these women to enter care later in the pregnancy, especially first pregnancies, in order to avoid contact with providers and

situations that may trigger memories of their abuse.

Effective Professional Interventions

10 of the 20 research articles in the matrix include interventions that women with histories of sexual trauma have either stated they desire from their providers or that have been researched and been shown to improve birth outcomes and perceptions of birth. Three of these research articles contained control groups (Sobel et al., 2019; LoGuidice, 2017; Ashby et al., 2019).

Relationship with providers and providers' knowledge of how to support women with sexual trauma histories was greatly desired by these patients. Retraumatization occurred when providers did not respond well to their emotional needs during labor or when the women felt that their voice and power were being removed from them (LoGuidice & Beck, 2016). Providers that asked about trauma, responded well to the disclosure of sexual abuse trauma, addressed women's emotional responses to exams and procedures, and allowed the women to have a voice in their care helped to decrease women's discomforts and flashbacks to their past abuse (Coles & Jones, 2009; Seng et al., 2010; Montegomery et al., 2014).

One study evaluated providers' responses to a case study of a sexual abuse survivor during her labor and birth (Seng & Hassinger, 1998). The care providers, which included labor and delivery nurses, midwives, and OBGYNs, stated that they felt unprepared to care for patients who disclosed a history of sexual assault, particularly the emotional aspects of their care. The case study that they responded to helped them explore and identify the emotional needs of patients with sexual abuse. Three processes for empowering patients and improving the patient-provider relationship that were identified included egalitarian work, exploring meaning, and framing boundaries (Seng & Hessinger, 1998).

Seng et al. (2010) conducted a qualitative, retrospective narrative study that included 15 women who self-identified as as survivors of sexual abuse who experienced PTSD symptoms during childbirth. Seng et al. (2010) utilized a storytelling format for women to recount their childbirth stories. A narrative analysis was completed and the authors determined that women in different stages of recovery from their sexual trauma histories required different provider-patient relationships. Those who were still involved in dangerous situations desired for their providers to be aware of red flags, to help connect them with resources, and to follow-up to see if the patient was getting the help and support they needed to be safe. Those who were not yet in a place where they felt they could disclose their abuse or even acknowledge it for themselves, desired for their providers to be aware of warning signs that point toward a history of sexual trauma and to then have the knowledge to provide care that does not cause further trauma. For patients that are further along in their recovery, they desired a provider that could be a collaborative ally. A collaborative ally is someone who they felt comfortable disclosing their history to and who responded well to this disclosure. A collaborative ally asks about triggers and avoids them as much as possible; they always ask for permission prior to performing exams, and they give the woman control by making sure she knows she can ask the provider to slow down or stop at any point in time (Seng et al., 2010).

Similar needs to those identified by Seng et al. (2010) were brought up in several other studies. Coles & Jones (2009) found that women desired universal precautions. The idea behind universal precautions is that sexual abuse history may not be known to providers, so they must always be on guard for red flags that point toward trauma and respond accordingly. In addition, they should treat all patients as if they carry these types of histories. This means always obtaining consent for exams, not just treating them as routine, explaining why and how exams

are performed, letting them know they can stop or slow down at any time, and then extending these same practices to the patients' babies (Coles & Jones, 2009). These same principles of care were found to be important in other studies as well, and are part of providing trauma-informed care (Ashby et al., 2019). In addition to walking women through procedures and giving them power over what and when exams are completed, other studies found that having the power to say who can be present during exams and minimizing exposure of their bodies were beneficial to their labor and birth experiences (Sobel et al., 2019; Burian, 1995; Coles & Jones, 2009; Seng et al., 2010). When all these elements were included in care, with the addition of providing patients with time and not turning them away when they showed up late to appointments, there was an improvement in attendance to prenatal appointments (increased median number of visits from 6 to 9 between controls and intervention groups) as well as a decrease in the percentage of women who had low birthweight babies (11.4% versus 6.6% between controls and intervention groups) (Ashby et al., 2019). All of the elements discussed lead to shared decision making between the patients and their providers, which has been found to improve labor satisfaction (Leeners et al., 2016).

The last intervention that was found to be beneficial for women was antenatal counseling. In a case study by LoGuidice (2017), a patient who had not received antenatal counseling and whose providers had not discussed the effects of childhood sexual abuse on labor and birth withdrew from the birthing experience and appeared traumatized through this process. Another patient who was screened properly, something that is cited as being important for patients in a study by LoGuidice & Beck (2016), and then given antepartum counseling went on to have a very empowering birthing experience that she stated as being "restorative" (LoGuidice, 2017). This finding was consistent with a study by Roller (2011) that found that women move through

three different stages toward recovery after sexual trauma. The final stage of "moving beyond the pain" of their trauma was receiving counseling. This was most profound for women who received this counseling prior to or during pregnancy and helped to reduce the trauma associated with the child birthing process (Roller, 2011).

Critique of Strengths and Weaknesses

Strengths

One of the greatest strengths of each of these studies is that most of them provided suggestions on what can be done to address adverse birth outcomes and perceptions for women who have a history of sexual trauma. Each of the authors recognizes the impacts that sexual trauma has on pregnancy and birth and the need to research and develop effective interventions to address them. It is also important that research studies look at physical and psychosocial outcomes. Eight of the studies included in the matrix addressed physical outcomes and 13 addressed psychosocial outcomes, meaning one study looked at both. The studies that addressed psychosocial outcomes were qualitative studies or had qualitative components. Qualitative studies are important in this type of research because it provides a greater understanding of how a sexual abuse history impacts labor and birth and how providers and birth workers can help empower and create a healing experience or add to retraumatization. Increasing understanding and learning strategies women feel are helpful for creating a healing and empowering experience are important for developing guidelines for how to care well for this population. Another strength seen in the research is the number of women involved in the different studies. Two studies had more than 1000 women who had experienced sexual violence, and one as many as 2323 (Schei et al., 2014; Gisladottir et al., 2016) and five had greater than 100 (Ashby, Ehmer, & Scott, 2019; Nerum et al., 2013; Lukasse et al., 2010; Lev-Wiesel et al., 2009; Gottfried et al.,

2015)

Weaknesses

There were several weaknesses with these studies, including low levels of evidence and quality of studies, with only three studies being a level two (Gisladottir et al., 2016; Leeners et al., 2016; Schei et al., 2014). All the remaining studies are level three. Additionally, many of the studies were completed on homologous groups, with the majority of participants being white. Only two studies had some ethnic diversity amongst their study participants (Ashby et al., 2019; Berman et al., 2014). All of the studies included in this matrix were either completely retrospective or had retrospective elements due to sexual abuse most often occurring prior to the studies. Lastly, many of the studies had very small sample sizes. 12 studies had sample sizes of less than 100 women who had experienced sexual violence.

Summary

This Matrix review included 20 research articles made up of cohort studies, phenomenological studies, cross-sectional studies, longitudinal studies, case studies, qualitative semi-structured interviews, narrative studies, qualitative, grounded theory studies, and retrospective studies. Each article was evaluated using the Johns Hopkin's appraisal tool for level and quality. The research articles ranged from evidence level II, with B quality to evidence level III, with C quality. All of the articles included a retrospective aspect due to the studies looking at a prior history of sexual abuse and its effects on pregnancy, labor, and birth outcomes.

Findings from the studies ranged from reporting on physical birth outcomes, such as low birth weight babies and increased incidence of non medically indicated cesarean births (Bohn, 2002; Ashby et al., 2019; Schei et al., 2014) to psychological outcomes, such as PTSD symptoms

during the childbearing and birthing process (Coles & Jones, 2009; Leeners et al., 2016; LoGuidice, 2017; Sobel et al., 2019; Lev-Wiesel et al., 2009; LoGuidice & Beck, 2016; Montgomery et al., 2014; Berman et al., 2014; Roller, 2011; Seng et al., 2010; Burian, 1995).

10 of the 20 research articles included interventions that women felt were helpful or that improved physical and psychological birthing outcomes. These interventions included trusting relationships with knowledgeable providers (LoGuidice & Beck, 2016; Seng et al., 2010; Coles & Jones, 2009; Montegomery et al., 2014), giving women control, asking permission, explaining physical exams and procedures (Sobel et al., 2019; Burian, 1995; Coles & Jones, 2009; Seng et al., 2010; Leeners et al., 2016), and providing pregnant women who are sexual abuse survivors counseling on the impacts of their past trauma on the birthing process (Roller, 2011; LoGuidice, 2017)

Strengths of the studies included in the matrix were that they addressed both physical and psychological outcomes associated with histories of sexual trauma and the childbearing/birthing process as well as interventions to help mitigate some of these adverse outcomes. Weaknesses of the studies were that very few included diverse populations, their level of evidence was low, and the sample sizes of most of the studies included less than 100 women with sexual abuse histories.

Knowledge and data exist that show the impacts of sexual abuse histories and the childbearing process. Many of the research studies included in this matrix address what women state they desire to help improve their psychological outcomes during birth, but there is still a lot of research that needs to be completed to help develop and implement effective interventions in practice settings. Providers need to be aware that they will come in contact with women who have this type of history and should be prepared to effectively care for these women in a way that

helps them have as empowering of an experience as is possible.

Chapter IV: Discussion, Implications, and Conclusions

The purpose of this literature review is to summarize the impact of sexual abuse on childbirth outcomes and maternal experience. Twenty scholarly articles were selected and evaluated using the Johns Hopkins Research Evidence Appraisal Tool. The examination of these scholarly writings revealed current trends and gaps in the literature. Recommendations for further research and the implications for nurse-midwifery are explored in this final chapter. The evidence found in this review is integrated and applied through Betty Neuman's Systems Model.

Synthesis of the Literature

The research questions that formed the foundation for this critical review were to examine the impact of sexual abuse on childbirth. The literature reviewed focused specifically on birth outcomes and maternal experiences. Sexual abuse was found to significantly impact both the maternal experience of childbirth and the birth outcomes.

Several studies identified increased length of the 1st and 2nd stage of labor in women who had experienced sexual abuse (Nerum, 2010; Gisladottir et. al., 2016). Several other birth outcomes were associated with women who have experienced sexual abuse including low birth weight babies, preterm birth, antepartum bleeding, induced labor, shoulder dystocia, and operative deliveries (Nerum, 2010; Gisladottir et. al., 2016). Maternal experiences during childbirth included flashbacks, extreme fear of childbirth, dissociation, and post-traumatic stress disorder (Coles & Jones, 2009; Leeners et al., 2016; LoGuidice, 2017; Sobel et al., 2019; Lev-Wiesel et al., 2009; LoGuidice & Beck, 2016; Montgomery et al., 2014; Berman et al., 2014; Roller, 2011; Seng et al., 2010; Burian, 1995)

In order to avoid retraumatization during childbirth, women coped with birth by requesting a certain provider, controlling who was present for vaginal exams, and avoiding bodily exposure

when possible (LoGuidice & Beck, 2016; Roller, 2011). Interventions that were found to be helpful for women with a history of sexual abuse included having a consistent relationship with an obstetric provider who addressed their trauma and response to discomforts (Sobel et al., 2019; Roller, 2011; Seng et al., 2010). Antenatal counseling was found to be helpful to address fear around the birthing process (LoGuidice, 2017). All women should have access to antenatal counseling and be given control over who their obstetric provider is and who is present for times of bodily exposure during labor and delivery.

Current Trends

Current literature has explored how sexual trauma affects childbirth physically as well as the psychological impacts on women. Phenomenological methodology, where women with a history of sexual trauma are prompted to recount their childbirth stories and identify how their history impacted their experience, was utilized often by studies included in this review. This is a current trend in the research that permits the authors to identify common experiences of women with histories of sexual trauma and determine effective interventions based on what the women feel would have been beneficial.

With an increased awareness of the effects of sexual abuse on birth and birthing women, trauma-informed care has become more popular with labor and delivery nurses, midwives, and OBGYN's seeking further training in order to learn to provide care that is tailored to avoiding retraumatizing women who have a history of sexual abuse. The current trend is to address not only the physical outcomes associated with childbirth for women with a history of sexual abuse, but also the psychological outcomes on the birthing person. Important factors to reduce retraumatization that were identified in the research are centered around giving women with histories of sexual trauma power: the power to disclose her history by asking if she has ever

experienced sexual abuse,the power to choose her provider and to decline any procedures or exams she is uncomfortable with, the power to choose who is present at her delivery, and the power to make decisions about the care provided to her child, to name a few (Coles & Jones, 2009).

Gaps in the Literature

There is a tremendous need for further research on effective interventions for women with a history of sexual abuse in their childbearing process, specifically with the psychological effects on women and their experience of birth. Many of the studies used in the literature review were unable to draw definitive relationships between sexual trauma, birth outcomes, and maternal experience. Several of the studies used had small sample sizes and homogeneous samples, which makes the generalizability of both outcomes and interventions difficult.

Recommendations for Further Research

Further research on the effect of sexual abuse on birth outcomes is needed to establish a causation relationship between sexual abuse and poor birth outcomes. Studies are needed with control of other variables in order to draw more clear conclusions on the effects of sexual abuse on birth outcomes. In order to establish a causation between sexual abuse and poor birth outcomes, control of variables including education, socioeconomic status, and geographic location are needed. Larger studies would also be beneficial in establishing this relationship between sexual abuse and poor obstetric outcomes.

Studies addressing the type of abuse, timing of abuse, and frequency of abuse are needed in order to further understand the impact of different forms of sexual abuse on birth. This includes differentiating between childhood sexual abuse, rape, and intimate partner violence. Broader studies with additional populations would assist in addressing the effects of culture,

social norms, and religion on the birthing experience of women who have experienced sexual abuse. Further research is also needed to identify a screening tool that can be used prenatally to identify women who have experienced sexual abuse and connect them with resources to minimize poor outcomes and retraumatization during their birth experience. The impact of the application of universal precautions needs to be identified in diverse populations and geographic areas in order to identify if this is a generalizable intervention that is effective in reducing the retraumatization of women. Overall, interventions to reduce retraumatization need to be further researched in order to provide clear recommendations for obstetric providers.

Implication for Nurse-Midwifery

The critical appraisal of the literature has many implications for the practice of nurse-midwives. Due to the number of women who experience sexual abuse, it is imperative that nurse-midwives have a comprehensive understanding of the effects of sexual abuse on birth outcomes and maternal experience. Awareness of these effects helps nurse-midwives to implement screening tools and interventions to decrease poor birth outcomes and reduce retraumatization during the birthing process. Nurse-midwives can reduce retraumatization by allowing women to choose their obstetric provider, giving women the option of who they would like present in the room during vaginal exams, reducing bodily exposure when able, and explaining the purpose of routine procedures. Nurse-midwives should slow down or stop exams or procedures when women are not coping effectively. One of the main requests of women with a history of sexual abuse was to have a relationship with their provider where they felt their voice was heard. Nurse-midwives can prevent retraumatization by empowering women as partners in their health care and using shared decision making to help decrease maternal discomfort and flashbacks. Nurse-midwives should ask about triggers and always ask permission

before performing examinations. Since many women do not disclose their sexual abuse history, universal precautions should be implemented by nurse-midwives for all women (Cole & Jones, 2009). This includes obtaining consent for all exams, explaining the rationale for exams, and reminding women that they can ask for the exam to be slowed or stopped at any point. Nurse-midwives should be aware of the effect of antenatal counseling on survivors of sexual abuse and help to connect women to local resources to empower their birthing experience (LoGuidice, 2017).

Theoretical Framework: Integration and Application

The Betty Neuman Systems Model was applied as a theoretical framework to gain a greater undersanding of the impact of sexaul trauma on birth outcomes and maternal experience. The Neuman Systems Model is a theoretical framework used to evaluate how a patient responds to stressors in their environment and the impact of primary, secondary, and tertiary prevention strategies on the overall wellbeing, or the balance of energy forces, of the individual (Alyward, 2005). The Neuman systems model is applied through three levels of prevention strategies including primary prevention by identifying possible stressors, secondary intervention by addressing an individual's response to the stressors, and tertiary intervention by assisting the woman to work towards preventing stress responses to future triggers. This framework recognizes how the sexual abuse women have experiencd impacts their experience and outcomes with childbirth. According to the American College of Obstetricians and Gynecologists (ACOG,) sexual trauma has lifelong impacts (2014). Routine visits, pregnancy, and birth can be triggers for the trauma caused by sexual abuse (ACOG, 2014). The application of the Neuman Systems Model, reveals how stress from sexual abuse may lead an individual to move towards instability by being triggered. This may result from a vaginal exam or the bodily exposure often

experienced during birth. It is imperative for midwives and other maternity care providers to be aware of the myriad of triggers a woman may have throughout her pregnancy, labor, and delivery and implement measures to reduce retraumatization.

Caring for women who have experienced sexaul abuse requires the identification of stressors (triggers) that move the individual from stability toward instability. The Neuman Systems Model provides a framework for identifying the stressors or triggers women have during childbirth, assessing patient's responses, identifying strategies to move birthing persons back toward stability, and changing practices to reduce retraumatizing women during childbirth.

Conclusion

The purpose of this litetature review was to critically examine the current research and literature available on the effects of sexual abuse on birth outcomes and maternal experiences. The findings of this critical review reveal the massive impact sexual abuse has on birth outcomes and maternal experience of childbirth. After a thorough search, twenty articles were examined and applied through Neuman's Systems Model. This review identified physical obstetric outcomes impacted by sexual abuse including prolonged length of the 1st and 2nd stage of labor, increased low birth weight babies, preterm birth, antepartum bleeding, induced labor, operative vaginal deliveries, and medically indicated and elective cesarean births. Maternal experience of childbirth included intense fear of birth, stress during labor, and post-traumatic stress disorder. Women with a history of sexual abuse coped with the experience of birth by having control of who their care provider is, by understanding examinations, and utilizing antenatal cousneling. The research suggests that providers should screen all patients for sexual abuse history, address warning signs, and ask patients about triggers during the prenatal period. Providers should use universal precautions for all women by informing women of the rationale for examinations, ask

consent, minimize bodily exposure, and give patient's control to slow or stop any examination or procedure at any point. Numerous women have experienced trauma through sexaul abuse and it is the provider's responsibility to practice trauma informed care to reduce retraumatization through the birthing experience.

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Appendix 1 – Literature Review Matrix

Source: Ashby, B. D., Ehmer, A. C., & Scott, S. M. (2019). Trauma-informed care in a patient-centered medical home for adolescent mothers and their children. *Psychological Services, 16*(1), 67–74. https://doi.org/10.1037/ser0000315

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: Explore whether or not trauma-informed care in a patient-centered medical home with adolescents with history of sexual abuse, physical abuse, and domestic violence positively impacts pregnancy care and outcomes. **Sample/Setting:** 844 pregnant adolescents enrolled in The Colorado Adolescent Maternity Program (CAMP) 415 intervention group enrolled in CAMP between 1/2012 and 12/2013 429 in pre intervention group enrolled in CAMP between 1/2007 and 12/2008 **Johns Hopkins Evidence Appraisal** Level of Evidence: III Quality:B	**Design:** Program evaluation, cohort study **Methods:** Implementation of Six Key principles of trauma informed care: Safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice, and cultural, historical, and gender issues. **Instruments:** - 1 hr psychosocial interview - CES-D - Chi-square tests - IBM SPSS Version 21 **Measurements:** Demographics, depression, abuse, domestic violence, antenatal data, and birth outcomes.	**Results:** - Increased median # of prenatal visits: 6 in preintervention and 9 in intervention ($p<0.001$) - No statistical difference between gestational age(39.7 vs. 39.6; $p = .534$) and weight (3,090 vs. 3,142; $p = .260$) at birth between groups - Rate of preterm not significantly different between intervention (7%) and preintervention (9%) (p=0.28). - Significant difference between groups for low birth weight infants (11.4% in preintervention versus 6.6% in intervention group [p=0.02] **Conclusion:** - Implementation of trauma informed care improved attendance of prenatal care visits, rate of low birth weight infants, and rate of preterm birth (not statistically significant).	**Strengths:** - All staff trained in trauma informed care by behavioral health staff - Staff retreats required for further discussion and training - Providers, care coordinators, and patient educators trained in motivational interviewing - Ethnically diverse patients **Limitations:** - Potential for bias due to self-reported data. - Retrospective evaluation of pregnancy & birth charts. - Difficult to implement this intervention due to amount of training required.
Author Recommendations: - Further studies to evaluate other trauma forms based on ACE study. - Studies to evaluate this program's impact on long term outcomes for the children of these mothers.			
Implications: - Implementation of trauma informed practices to help address poor attendance of prenatal visits and birth outcomes.			

<table>
<tr><td colspan="4">Source: Berman, H., Mason R., Hall, J. Rodger, S., Classen, C. C., Evans, M. K., … Al-Zoubi, F. (2014). Laboring to mother in the context of past trauma: The transition to motherhood. Qualitative Health Research, 24(9), 1253-1264. doi: 10.1177/1049732314521902</td></tr>
<tr><td>Purpose/Sample</td><td>Design
(Method/Instruments)</td><td>Results</td><td>Strengths/Limitations</td></tr>
<tr><td>Purpose:
Evaluate how women with trauma history are shaped through process of becoming mothers
Sample/Setting:
32 women older than 18 with interpersonal trauma histories - n=18 with hx of CSA, n=8 refugees, 3 of which had hx of CSA, n=3 aboriginal, n=1 interpersonal trauma as young adult all recruited from 2 Canadian Communities in urban Ontario

Johns Hopkins Evidence Appraisal
Level of Evidence: III
Quality: C</td><td>Design: Qualitative, cross-sectional
Method:
- Grounded theory methodology
- Purposive sampling then theoretical sampling for recruitment of research participants
- Semistructed, dialogic interviews in 2nd trimester of pregnancy
- Data collected until saturation
Instruments:
- Semi structured interview guide
- Field & theoretical notes for research team records
- NVivo 8 qualitative software
Measurement:
Thematic content analytic methods:
- Substantive & theoretical coding</td><td>Results:
Themes:
- Forgive & Forget
- Containing Trauma
- Navigating Chaos of Everyday Life (coping)
- Pregnant with Possibilities (hopes & dreams)
Conclusion:
- Hx of trauma requires emotional & cognitive laboring during transition to motherhood including forgetting or forgiving those responsible for trauma.
- Many felt need to contain trauma hx
- Women with trauma hx are resilient and resourceful
- Women desire to protect family & live an ideal normative life</td><td>Strengths:
- Ethics approval from IRBs
- All team members specifically trained for interviewing
- Support provided for interviewers
- Interviews done in preferred language of participants with interpreters and culturally appropriate translation procedures
- Culturally and ethnically diverse group
- Written consent obtained prior to interviews
Limitations:
- $25 given to all participants (small potential for coercion)
- Retrospective, risk for recall bias</td></tr>
<tr><td colspan="4">Author Recommendations:
- Changes to culture and clinical practice settings to empower women with histories of interpersonal trauma.</td></tr>
<tr><td colspan="4">Implications:
-Providers need to actively engage in creating spaces for survivors of trauma to be empowered to share their experiences & challenge dominant views of motherhood to change view of women with trauma hx as resilient and good, capable mothers.
- Women should be connected with pregnancy and postpartum resources such as emergency shelters, safe, accessible housing, and trauma-informed counseling.
- Providers and counselors should increase their knowledge of trauma-informed practices.
- Focus should be placed on empowerment and strength versus pathology and weakness.</td></tr>
</table>

<table>
<tr><td colspan="4">Source: Bohn, D.K. (2002). Lifetime and current abuse, pregnancy risks, and outcomes among Native American women. Journal of Health Care for the Poor and Underserved, 13(2), 184-198. http://doi.org/10.1353/hpu.2010.0624</td></tr>
<tr><td>Purpose/Sample</td><td>Design
(Method/Instruments)</td><td>Results</td><td>Strengths/Limitations</td></tr>
<tr><td>Purpose: To examine the effects of physical & sexual abuse on pregnancy risks & outcomes
Sample/Setting: Native American women (N=30) 28-36 wks gestation from an urban Indian clinic where they received prenatal care

Johns Hopkins Evidence Appraisal
Level of Evidence: III
Quality: B</td><td>Design: Mixed methods; Quantitative, non-experimental cohort study; Qualitative phenomenological study
Methods:
- Women offered $10 compensation for participation
- Postpartum review of hospital records, Scale for Adequacy of Prenatal Care & etiological factors list reviewed
Instruments:
- Interview protocol for demographic information & abuse info
- 39-item preterm birth/low birth weight etiologic factors list (PTB/LBW)
Measurement:
- Age, parity, obstetric history, substance use, sexually transmitted diseases (STDs), abuse history</td><td>Results:
- Women currently involved w/ a partner who had been abusive before or during pregnancy (n=21) had babies w/ LBW (70%)
- Cumulative lifetime abuse, rather than current intimate partner abuse was significantly related to higher PTB/LBW scores (40%)
Conclusion:
- There is an association between abuse & adverse pregnancy outcomes, but not a cause & effect relationship established</td><td>Strengths:
- All participants approached joined the study
- Written consent obtained
- Women given referral numbers for further help
- Homogenous sample
- Adequate sample size
Limitations:
- The sample is Native American women only who have distinct demographics
- No mention of protecting participant’s privacy
- No mention of ethics board approval</td></tr>
<tr><td colspan="4">Author Recommendations:
- Further research focused on abuse & PTB/ LBW is needed.
- Further funds for prevention of PTB/LBW is needed in at-risk women.</td></tr>
<tr><td colspan="4">Implications:
-Abuse effects pregnancy outcomes including unintentional pregnancy, substance use, inadequate prenatal care, reduced or low birth weight, preterm labor, & fetal & maternal death.</td></tr>
</table>

<table>
<tr><td colspan="4">Source: Burian., J. (1995). Helping survivors of sexual abuse through labor. Journal of Maternal Child Nursing. Retrieved from https://journals.lww.com/mcnjournal/pages/articleviewer.aspx?year=1995&issue=09000&article=00009&type=Abstract</td></tr>
<tr><td>Purpose/Sample</td><td>Design
(Method/Instruments)</td><td>Results</td><td>Strengths/Limitations</td></tr>
<tr><td>Purpose:
To understand the experience of sexual abuse survivors during labor and to takes steps towards creating a safe environment for birth for sexual abuse survivors
Sample/Setting:
-Seven women who came voluntarily agreed to be interviewed about their birth experience

Johns Hopkins Evidence Appraisal
Level of Evidence:
III
Quality:
B</td><td>Design:
Qualitative study of semi structured interviews
Methods:
Seven private interviews were conducted by two CNMs, tape recorded
Instruments:
-Interviews on the intrapartum experience of a survivor of childhood sexual abuse</td><td>Results:
-Most survivors of sexual abuse do not disclose this history to their health care providers
-Strategies for sensitive care include:
● Being prepared to respond to women who disclose a history of sexual abuse
● Providing an emotionally and physically safe environment
● Establishing an atmosphere of unhurried listening and openness
● Being aware of body exposure
● Letting women choose who/when she receives vaginal exams
● Providing reassurance during birth of safety
● Honoring the emotions that she is experiencing
-Somatic discomfort, dissociation, and flashbacks are common
Conclusion:
Care should be taken to address the specific effects of sexual abuse on the birth experience of women.</td><td>Strengths:
-First-hand experiences shared through interviews
-Themes identified through all interviews conducted

Limitations:
-Small sample size with seven participants
-Homogenous sample</td></tr>
<tr><td colspan="4">Author Recommendations:
-Health care providers should be prepared to respond to women who disclose a history of sexual abuse.</td></tr>
<tr><td colspan="4">Implications:
-Strategies of sensitive care should be implemented for all women who show signs of sexual abuse since most women do not disclose this history.</td></tr>
</table>

Source: Coles, J. & Jones, K. (2009). Universal precautions: Perinatal touch and examination after childhood sexual abuse. *Birth, 36*(3), 230-6. http://dx.doi.org/10.1111/j.1523-536X.2009.00327.x

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To explore women's responses to perinatal professional touch & examination of themselves & their babies **Sample/Setting:** Phase 1: Women (N=11) who self-identified as sexually abused by a family member in Melbourne, Australia Phase 2: Women (N=7) who self-identified as sexually abused by a family member from Melbourne & Gippsland, Australia **Johns Hopkins Evidence Appraisal** Level of Evidence: III Quality: C	**Design:** Qualitative, phenomenological study **Methods:** - In person, in-depth interviews were conducted exploring the impact of abused women's experiences prenatally and in early parenting **Instruments:** - In-depth, semi-structured interviews were recorded & transcribed **Measurement:** - Impact of CSA on mothering & experiences during prenatal care - How support/care could have been improved	**Results:** - CSA survivors identified several ways in which the clinical encounter could be made safer & less traumatic, 3 themes were identified: 1. Relationship w/ their provider 2. Access to services 3. The providers knowledge of past trauma & effects **Conclusion:** - Survivors experienced pain, dissociation, fear, blame, helplessness, & guilt in their encounters w/ healthcare providers - Healthcare providers can adopt & implement the "Recommended Universal Precautions in Postnatal Care" in order to relieve some distress for women who have survived CSA	**Strengths:** - To ensure more rigorous analysis, 1 in 3 interviews were randomly selected & coded by an independent, experienced qualitative researcher - 1st hand accounts from women who survived CSA & how it affected their experience during routine prenatal care **Limitations:** - Small sample size - Data provided was mostly retrospective, memories could have been distorted
Author Recommendations: - Implementation of "Universal Precautions" during prenatal and intrapartum examinations.			
Implications: - Exams during pregnancy, childbirth, and postpartum can trigger feelings associated w/ the abuse, such as powerlessness, pain, shame, etc..			

Source: Gisladottir, A., Fernandez, M.A., Harlow, B., Gudmundsdottir, B., Jonsdottir, E., Bjarnadottir, R.,… Valdimarsdottir, U. (2016). Obstetric outcomes of mothers previously exposed to sexual violence. *PLoS ONE, 11*(3), 1-12. https://doi.org/10.1371/journal.pone.0150726

Purpose/Sample	Design (Method/Instruments)	Results	Strengths/Limitations
Purpose: To investigate whether women exposed to sexual violence present w/ different obstetric outcomes than women w/o record of sexual violence. **Sample/Setting:** Study population of deliveries (n=1,068) of women exposed to sexual violence compared to deliveries (n=9,126) of women not exposed to sexual violence from the Icelandic Medical Birth Registry (IBR) & Rape Trauma Service (RTS) in Iceland from 1993-2011 **Johns Hopkins Evidence Appraisal** Level of Evidence: II Quality: C	**Design:** Quantitative, experimental, prospective cohort study **Methods:** - A data administrator performed a record linkage of the unique ID numbers of women attending RTS from 1993-2011 to the IBR) to obtain info on obstetric outcomes **Instruments:** - ICD-10 codes were used to define outcomes - NCSP codes used to define obstetric interventions **Measurement:** - Differences in risk of labor characteristics & delivery interventions between exposed & non-exposed cohorts	**Results:** - Exposed women were: -40% increased risk of prolonged 1st stage labor compared to non-exposed, no difference in 2nd stage labor - 60% increased risk of being diagnosed w/ maternal distress during L&D -2 fold risk of antepartum bleeding - 28% increased risk for induced labor - 29% increased risk for shoulder dystocia - 60% increased risk of having prolonged 1st stage labor - increased risk of emergency instrumental deliveries **Conclusion:** - Women who were sexually assaulted are at an increased risk of pregnancy & delivery complications.	**Strengths:** - No participants were contacted, data was analyzed anonymously - Data was retrieved from a registry so there was no selection bias or recall bias **Limitations:** - Some women in the non-exposed cohort may still have been exposed to severe sexual violence, yet not attended RTS for help - Smoking & BMI were not electronically registered in IBR
Author Recommendations: **-** Further studies are needed to assess which obstetric interventions are most beneficial for women w/ a history of sexual trauma.			
Implications: - The findings indicate women who have been exposed to sexual violence have an increased risk of pregnancy & delivery complications.			

Source: Gottfried, R., Lev-Wiesel, R., Hallak, M., & Lang-Franco, N. (2. *Midwifery, 31*, 1087-1095. http://doi.org/10.1016/j.midw.2015.07.011			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**

Purpose: To look at inter-relationships between sexual abuse on mode of delivery and maternal birth experience. **Sample/Setting:** Jewish pregnant women (N=293) from 2 large medical centers in Israel recruited by trained female research assistants. **Johns Hopkins Evidence Appraisal** Level of Evidence: III Quality: A	**Design:** Quantitative, non-experimental, comparative, descriptive, longitudinal **Methods:** Data collected across 3 time periods - during 3rd trimester, 1 mos postpartum (PP) & 6 mos PP - Collection 1: Antenatal information via questionnaires - Collection 2: Subjective birth experience obtained via phone, mode of delivery collected via medical record - Collection 3: Online questionnaires **Instruments:** - Beck Depression Inventory - Modified Traumatic Events Questionnaire - Subjective Birth Experience Questionnaire	**Results:** - Sexual abuse (SA) survivors were 2.66x more likely to report antenatal female sexual dysfunction (FSD) as compared to no SA history - Antenatal depression shown to increase the risk for antenatal FSD (OR=4.32) - Antenatal FSD shown to increase risk for cesarean (OR=3.34) - Women w/ antenatal depression reported more negative experience w/ birth, as did women w/ distressed antenatal FSD **Conclusion:** - There is a strong relationship between sexual abuse, distressed sexual function, & childbirth	**Strengths:** - Authors have strong literature review & clearly demonstrate importance of further research - Ethical principles followed - All instruments written in Hebrew - Strong measurements - Well controlled variables - Adequate sample size **Limitations:** - Study length limited, omitting PTSD & anxiety
Author Recommendations: - Due to these findings, prevention & intervention efforts must be implemented and more research on anxiety & PTSD.			
Implications: - Women must be screened & assessed for sexual abuse, depression, & sexual concerns both pre-delivery & post-delivery. - Women should be provided w/ trauma sensitive maternity care as well as support through pregnancy & labor, regardless of disclosure.			

Source: Leeners, B., Görres, G., Block, E., & Pascal Hengartner, M. (2016). Birth experiences in adult women with a history of childhood sexual abuse. *Journal of Psychosomatic Research, 83*, 27-32. http://doi.org/10.1016/j.psychores.2016.02.006			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**

Purpose: To provide information on associations, mediating influences, risk & protective factors childhood sexual abuse (CSA) has on childbirth experiences. **Sample/Setting:** - CSA group (n=85) and control group (n=170) recruited from German Frauennotruf society. **Johns Hopkins Evidence Appraisal** Level of Evidence: II Quality: B	**Design:** Retrospective, descriptive study *Follows Leeners, Görres, Block, & Hengartner (2010) study **Methods:** - 2 matched controls obtained for every woman in CSA group - Questionnaires taken at home & mailed back anonymously **Instruments:** - Wyatt questionnaire on CSA - 3 hr interviews used to diagnose CSA - Researcher developed questionnaire in conjunction w/ German Frauennot-ruf **Measurement**: - Self-reports of CSA experiences	**Results:** - Women w/ CSA reported intense fear of delivery more frequently than the control group (24.7 vs. 5.3%; $p<0.01$) - Women w/ CSA reported a significantly longer duration of delivery (14.5 vs. 7.2 h; $p<0.01$) - Extreme duration of labor was 3x as likely in women w/ CSA compared to control (31.8 vs. 11.2%) - Participation in decision making was related to an increase in satisfaction - Reduced satisfaction was related to obstetrical complications, the need for pain relief, & long duration of delivery - Memories of abuse arose & disturbed delivery in 41.2% of women w/ CSA **Conclusion:** - Shared decision making is a key intervention to reduce retraumatization in childbirth for women who have experienced CSA	**Strengths:** - Informed consent - Ethics committee approval - Thorough questionnaire - Large sample size - Control group matched for age, number & age of children **Limitations:** - Room for subjectivity - Retrospective design - Emotional experience of childbirth may have been difficult to accurately remember
Author Recommendations: - Due to demographic differences as well as minimal control on variables, more studies could compare variables to be able to establish cause & effect relationships.			
Implications: -Shared decision making should be a key aspect of childbirth for all women in order to empower women and reduce retraumatization for survivors of CSA.			

Source: Lev-Wiesel, R., Daphna-Tekoah, S., & Hallak, M. (2009). Childhood sexual abuse as a predictor of birth-related posttraumatic stress and postpartum posttraumatic stress. *Child Abuse & Neglect, 33*(12), 877-887. http://doi.org.10.1016/j.chiabu.2009.05.004			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**

Purpose: Examine to what extent re-traumatization of childhood sexual abuse (CSA) and postpartum posttraumatic stress (PTS) reactions are caused by childbirth **Sample/Setting:** Convenience sampling of 1,586 (837 by end of study) Jewish, Israeli women 6+ months pregnant 3 Groups studied: 1. Women with history of CSA (n = 323) 2. Women with history of non-CSA trauma (n=868) 3. Women without trauma history (152) **Johns Hopkins Evidence Appraisal** Level of Evidence: III Quality: B	**Design:** Longitudinal study **Methods:** - 1hr face-to-face or phone interviews at 3 intervals **Instruments:** -Symptom Scale (PSS-SR) -Traumatic Events Questionnaire (TEQ) -Childhood Sexual Experiences Scale (CSA) - Hebrew Dissociative Experiences Scale (H -DES) - PTS Scale (PSS-I) **Measurement:** - PSS-I: 17 item interview assessment of severity of DSM-IV PTSD symptoms in past 2 wks. - TEQ: 9 types of traumas and severity measured by 7-point likert scale - CSA: 14 sexual relational items occurring prior to age 14 - H-DES: Frequency of 28 dissociative experiences	**Results:** - CSA group scored higher than other groups on total PTSD score [$F(2,703) = 11.7$, $p < .001$], avoidance level [$F(2,833) = 5.76$, $p < .01$], and dissociation score [$F(2,719) = 11.4$, $p < .001$] and higher on intrusion levels than no-trauma group [$F(2,833) = 4.48$, $p < .01$]. -Intrusion increased over time for CSA group compared to other trauma group [$F(2,833) = 3.27$, $p < .05$]. **Conclusion:** - CSA is a traumatic event with negative long-term effects in pregnant women - No clear support that childbirth increases retraumatization of CSA, but may function as a retraumatization of CSA over time	**Strengths:** - Approved by Ethics Boards - Consent obtained - Large sample size - All instruments in questionnaire with established reliability & validity in Israel - All instruments explained in detail in article - Hypothesis and findings supported by cited sources **Limitations:** - Homogenous population: Jewish pregnant women - High attrition rate (47%), particularly for younger women, those with higher levels of intrusion, and lower education - Retrospective self reporting of CSA (time and self-report bias)
Author Recommendations: - Further research to determine if childbirth functions as retraumatization of CSA over time.			
Implications: - Important to identify in early pregnancy, establish a risk assessment, and increase monitoring to decrease L&D complications and postpartum PTS symptoms.			

<table>
<tr><td colspan="4">Source: LoGuidice, J. (2017). “Birth as restorative.” Journal of the American Psychiatric Nurses Association. Doi:10.1177/1078390317734632</td></tr>
<tr><td>Purpose/Sample</td><td>Design
(Method/Instruments)</td><td>Results</td><td>Strengths/Limitations</td></tr>
<tr><td>Purpose: To explore the impact of sexual abuse on the maternal experience of childbirth.

Sample/Setting:
Two case studies of maternal experience of vaginal birth after CSA in the United States

Johns Hopkins Evidence Appraisal
Level of Evidence: III
Quality: B</td><td>Design:
Case study

Method:
Evaluation of two case studies with a CNM</td><td>Results:
-One survivor of CSA did not receive prenatal counseling on the effects of CSA on the intrapartum period and was traumatized by her birth experience
-On survivor of CSA received counseling and antenatal psychiatric support during her pregnancy and found birth to be a restorative experience

Conclusion:
-Prenatal screening and counseling for survivors of CSA can be therapeutic intervention to prevent retraumatization during the intrapartum period</td><td>Strengths:
-First hand experience of CNM with two survivors of CSA
-Privacy protected through use of pseudonyms

Limitations:
-Small sample size
-Retrospective case study</td></tr>
<tr><td colspan="4">Author Recommendations:
-Prenatal screening and counseling to prepare survivors of CSA for the intrapartum experience.</td></tr>
<tr><td colspan="4">Implications:
-Screening for CSA should be standard of care for all women prenatally.
-Counseling should be encouraged for survivors of CSA to prepare for birth and prevent retraumatization.</td></tr>
</table>

<table>
<tr><td colspan="4">Source: LoGuidice, J. A. & Beck, C. T. (2016). The lived experience of childbearing from survivors of sexual abuse: “It was the best of times, it was the worst of times.” Journal of Midwifery & Women’s Health, 61(4), 474-481. http://doi.org/10.1111/jmwh.12421</td></tr>
<tr><td>Purpose/Sample</td><td>Design
(Method/Instruments)</td><td>Results</td><td>Strengths/Limitations</td></tr>
<tr><td>Purpose: To understand the lived experience of pregnancy, labor, & birth from survivors of sexual abuse
Sample/Setting: 8 U.S. female, self-identified survivors of sexual abuse aged 38-58 years old with at least one childbearing experience and English speaking

Johns Hopkins Evidence Appraisal
Level of Evidence: III
Quality: C</td><td>Design: Qualitative, phenomenological study
Methods:
- Recruitment from support, counseling & advocacy organizations for survivors of domestic & sexual abuse (snowball sampling)
- Interviews conducted through one-on-one interviewing (n=6), email interview (n=1), and a phone interview (n=1)
Instruments:
- Dialogue transcribed from verbal conversation (n=7) & email conversation (n=1)
Measurement:
- Colaizzi’s method of descriptive phenomenology</td><td>Results:
- 302 significant statements that formed 7 overarching themes
1. “No one asked me, just ask me” (n=6)
2. “An emotional roller coaster: From excitement to grief for what could have been a better experience” (n=8)
3. “All of a sudden I was that little girl again (n=5)&/or I compartmentalized it: The all-or-nothing experience” (n=3)
4. “Am I even here?: Nothing was explained & I had no voice” (n=5)
5. “All too familiar: No support, nowhere to turn” (n=5)
6. “Holding on to the choices I can make: Who my doctor is and how I feed my baby” (n=8)
7. “Overprotection: Keeping my child safe” (n=7)
Conclusion:
- Women felt they lacked a voice in the intrapartum period, leading to feelings of revictimization
- Vaginal exams were greatest triggers for flashbacks</td><td>Strengths:
- Approved by IRB
- Informed consent obtained
- Themes validated by both authors
- Researchers state they reached saturation
- Participants had immediate access to counselors if need be

Limitations:
- All births located in hospitals
- Homogeneous group of participants
- Small sample size
- Birth recollections were retrospective</td></tr>
<tr><td colspan="4">Author Recommendations:
- Further research the experiences of survivors who have a home or birthing center birth.</td></tr>
<tr><td colspan="4">Implications:
-Providers need to be aware of situations that can cause flashbacks such as vaginal exams, skin to skin contact, verbally reporting cervical dilation to patient, and not maintaining privacy during exams. Patients should be asked preferences around these situations.</td></tr>
</table>

Source: Lukasse, M., Vangen, S., Øian, P., Kumle, M., Ryding, E.L., & Schei, B. (2010). Childhood abuse and fear of childbirth - a population-based study. *Birth, 37*(4), 267-274. http://dx.doi.org/10.1111/j.1523-536X.2010.00420.x

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To examine the association between a self-reported history of sexual, physical, & emotional childhood abuse & fear of childbirth **Sample/Setting:** 2,365 Pregnant women at 5 obstetric departments in Norway between 1/2008 and 3/2009 who did not have any ultrasound identified pathologies **Johns Hopkins Evidence Appraisal** Level of Evidence: III Quality: B	**Design:** Quantitative, population-based, cross-sectional study **Methods:** - Questionnaires **Instruments:** - Norvold Abuse Questionnaire:measures childhood abuse (sexual, emotion, & physical) - Wijma Delivery Expectancy Questionnaire version A: measures fear of childbirth - Score ≥85 = severe fear of childbirth - Edinburgh Depression Scale (EDS-5) **Measurement:** - Type of childhood abuse - Fear of childbirth - Depression	**Results:** - 23.9% (n=566) of women experienced any childhood abuse - 35% exposed to 2 or more types of abuse - 18% of women with history of childhood abuse reported severe fear of childbirth more often than those without abuse history (10%) (p=0.001) when adjusted for primiparas (adjusted OR: 2.00; 95% CI: 1.30–3.08) - Association of childhood abuse and fear of childbirth remained for primiapars after adjusting for confounders (adjusted OR: 2.00; 95% CI: 1.30–3.08), but did not for multiparas (adjusted OR: 1.17; 95% CI: 0.76–1.80) **Conclusion:** - History of childhood abuse significantly increases the risk of fear of childbirth	**Strengths:** - Ethics approval - Norvold Abuse Questionnaire is a validated instrument **Limitations:** - Low response rate (50%) - Retrospective reporting of abuse subject to recall bias - Cannot determine causal relationships, only associations due to cross-sectional design

Author Recommendations:
- Further research needed to determine if causal relationship between childhood abuse, type of abuse, fear of childbirth, and depression.

Implications:
- This study shows a significant association between childhood emotional abuse & severe fear of childbirth in primiparous women. There is a need for interventions to reduce fear and empower survivors of sexual abuse in childbirth.

<table>
<tr><td colspan="4">Source: Montgomery, E., Pope, C., & Rogers, J. (2014). A feminist narrative study of the maternity care experiences of women who were sexually abused in childhood. Midwifery, 31(1), 54-60. http://doi.org/10/1016/j.midw.2014.05.010</td></tr>
<tr><td>Purpose/Sample</td><td>Design
(Method/Instruments)</td><td>Results</td><td>Strengths/Limitations</td></tr>
<tr><td>Purpose: Explore impact of childhood sexual abuse (CSA) on women’s experiences of maternity care

Sample/Setting: Purposive sampling of 9 women from a single maternity service in South of England who were greater than 18 y.o, had experienced sexual abuse prior to age 16, and spoke English fluently

Johns Hopkins Evidence Appraisal
Level of Evidence: III
Quality: C</td><td>Design: Qualitative, narrative study

Methods:
- In-depth narrative interviews. - Interviews began with a prompt question: ‘I’d like to find out what being pregnant and having a baby was like for you. Starting however you want, please could you tell me?’
- Voice-Centered Relational Method

Instruments:
- Voice-centred relational method of analysis
- Thematic analysis

Measurement:
- Coded data arranged into themes for translational analysis</td><td>Results:
Themes:
- Women’s narrative of self: denial, fitting in, guilt/shame, impact of history, & self-image
- Women’s narrative of relationship: abandonment, control, dissociation, alone, scared, flashbacks, power/powerlessness, re-enactment of abuse, safety, strangers, triggers, trust, & vulnerability
- Women’s narrative of context: maternity care environment, hidden issue, disclosure, & imprisonment
- Childbirth journey: experience of care and experience of labor
Conclusion:
- Participants felt silenced during their birthing experience and experienced flashbacks to their abuse</td><td>Strengths:
- Ethical approval from Research Ethics Committee
- Women able to provide their narrative without interruption
- Women provided with resources for support and a thank you letter
- Privacy well maintained

Limitations:
- Length of time between interviews and birthing experiences, recall bias & maternity care changes over time
- Small sample size
- All white, heterosexual women, limiting generalizability
- Conflict of interest: one author now a Trustee of CISters (organization recruited from)</td></tr>
<tr><td colspan="4">Author Recommendations:
- Further research on the impact of childhood sexual abuse on women’s experience of childbirth.</td></tr>
<tr><td colspan="4">Implications:
- Women’s experiences and feelings need to be validated and preferences respected. Maternity care providers should not shy away from addressing and acknowledging the patient’s experience. Maternity care providers need to be perceptive to unexpected reactions and recognize this may be due to sexual abuse history.</td></tr>
</table>

Source: Nerum, H., Halvorsen, L., Øian, P., Sørlie, T., Straume, B., & Blix, E. (2010). Birth outcomes in primiparous women who were raped as adults: A matched controlled study. *British Journal of Obstetrics and Gynaecoogists, 117*(3), 288-294. http://dx.doi.org/10.1111/j.1471-0528.2009.02454.x

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: Compare duration of labor & birthing outcomes in primips with history of rape in adulthood (>16yrs) and controls **Sample/Setting:** 50 women with history of rape as adults (RA) (≥ 16 y.o) and 150 controls (3 controls per RA) from the University Hospital in North Norway between 2000-2007 **Johns Hopkins Evidence Appraisal** Level of Evidence: III Quality: B	**Design:** Quantitative, matched controlled cohort study **Methods:** -Women with RA hx recruited following mental health referral in subsequent pregnancy - Counseling completed to obtain assault information - Birth outcomes from birth records obtained - Controls & RA matched for age, yr of 1st childbirth, & fetal presentation **Instruments:** - PARTUS (electronic journal system) - Chi-square or Mann-Whitney U test - Labor records - Multivariable logistic regression model - SPSS 16.0 & STATA 10.1 **Measurement:** - Obstetric risk factors - Labor/birth outcomes: Spontaneous labor vs augmentation, labor duration, epidural use, operative vaginal delivery, caesarean, episiotomy, & blood loss	**Results:** - Average age at time of rape: 18.5 y.o - RA group: longer 2nd stage of labor than controls (120 vs 55 minutes, P<0.01) - Oxytocin Augmentation: RA: 80%; Control: 55% (P=0.01) - Epidural: RA: 57%; Controls: 31% (P=0.01) - Ventouse/forceps: RA: 67%; Controls: 13%. (P<0.01) - 13-fold increased risk of caesarean for RA group compared to controls **Conclusion:** - Women with history of sexual abuse in adulthood have longer duration of 2nd stage, higher rates of oxytocin augmentation, and significant increased risk of caesarean and operative vaginal delivery.	**Strengths:** - Ethical approval - 1st study that shows an association between rape in adulthood & different birth outcomes **Limitations:** - Findings not generalizable due to homogenous sample - Relatively small sample size

Author Recommendations:
- Further studies needed to see if findings are replicated in other settings.
- Studies should be done that evaluate management strategies in second stage to see which ones have positive impacts on birth.
- Qualitative studies needed to evaluate women's experiences and care needs.

Implications: - Rape in adulthood can impact labor course and outcomes. Obstetric providers should be aware of this. - Obstetric providers need to be prepared to identify, address, and support women with histories of sexual abuse/assault so as not to retraumatize them.

Source: Nerum, H., Halvorsen, L., Straume, B., Sørlie, T., & Øian, P. (2013). Different labour outcomes in primiparous women that have been subjected to childhood sexual abuse or rape in adulthood: a case-control study in a clinical cohort. *British Journal of Obstetrics and Gynaecoogists, 120*(4), 487-495. http://dx.doi.org/10.1111/1471-0528.12053

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To compare duration & outcome of the first labor in women with history of childhood sexual abuse (CSA) & those raped in adulthood (RA) **Sample/Setting:** 373 Primiparous women, 185 with CSA, 47 RA, & 141 without abuse history - control group (CG), from the University Hospital of North Norway between 2000 and 2007 **Johns Hopkins Evidence Appraisal** Level of Evidence: III Quality: B	**Design:** Quantitative, case-control study in clinical cohort **Methods:** - Obstetric risks: chronic somatic illness, diabetes, pre-eclampsia, polyhydramnios, oligohydramnios, intrauterine growth restriction (IUGR), 42 + weeks gestation, prelabor rupture of membranes (PROM) with no labor for greater than 24 hours, & meconium in amniotic fluid **Instruments:** - Multinominal regression analysis - Chi-square test or Kurskal-Wallis test to compare groups **Measurement:** - Obstetric risk -Induction/augmentation -Epidural analgesia -NICU transfers - Mode of delivery -Duration of 2nd stage of labor	**Results:** - Obstetric risk: CSA: 34%; RA: 17%; CG: 22% (P<0.01) - Oxytocin Induction/augmentation: CSA: 57%; RA 81%, CG: 55% (P=0.01) - Epidural: CSA 42%; RA: 58%; CG: 31% (P,<0.01) - NICU transfer: CSA: 13%; RA: 19%; CG: 4% - Mode of birth: (P<0.01): + Non-operative Vaginal: CSA: 73%; RA: 21%; CG: 77% + Forceps: CSA: 9%; RA: 43%; CG: 12% + Cesarean: CSA 18%; RA: 36%; CG: 11% - Labor duration of 2nd stage (P<0.01): CSA: 46 mins; RA: 120 mins; CG: 50 mins **Conclusion:** - RA group had 13-fold increased risk for operative vaginal delivery and 12-fold increased risk of cesarean compared to CSA and CG.	**Strengths:** - 1st study comparing labor outcomes between CSA, RA, & control - Ethical approval obtained - Clear inclusion/ exclusion criteria **Limitations:** - Mental health of participants not discussed - CSA group unable to be matched by age with controls - Sexual abuse/assault is subjective experience

Author Recommendations:
- Future research to determine effective interventions during pregnancy and birth for women with a history of sexual abuse.

Implications:

- This research suggests that there are differences between women who experience sexual abuse in childhood versus adulthood. This should be taken into account when caring for women with any history of sexual abuse.

Source: Roller, S. G. (2011). Moving beyond the pain: Women's responses to the perinatal period after childhood sexual abuse. *Journal of Midwifery & Women's Health, 56*(5), 488 - 493. doi: 10.1111/j.1542-2011.2011.00051.x.

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: Create a theoretical framework to describe how CSA survivors manage intrusive memories of their abuse during perinatal period. **Sample/Setting:** 12 women with history of CSA who gave birth within past 12 months in midwestern urban setting **Johns Hopkins Evidence Appraisal** Level of Evidence: III Quality: C	**Design:** Qualitative, grounded theory study **Method:** Grounded theory, open ended questions regarding CSA experience and how this impacted perinatal period **Instruments:** - NVivo 8: qualitative computer software program	**Results:** - Invasive procedures & pregnancy triggered flashbacks of CSA in most participants - Coping with flashbacks through Identified framework: "Moving beyond the pain" with 3 phases 1) "Reliving it" 2) "Taking charge of it": through substance use, late entry to care, female providers, & full explanation of procedures. 3) "Getting over it": counseling **Conclusion:** - Many women with a history of CSA have intrusive reexperiencing of trauma during pregnancy, labor and birth - 3 phases of coping & moving beyond the pain of their abuse during perinatal period	**Strengths:** - IRB approval - Findings consistent with past research studies **Limitations:** - Recounting of perinatal experience was retrospective - Homogeneity of participants - No formal screening for PTSD completed - smaller sample for grounded theory methodology
Author Recommendations: - Further studies looking at demographically different participants to establish generalizability of framework.			
Implications: **-** Framework can be used to guide providers when caring for patients with CSA history.			

Source: Schei, B., Lukasse, M., Ryding, E.L. Campbell, J., Karro, H., Kristjandottir, H., ... Steingrimsdotti, T. (2014). A history of abuse and operative delivery: Results from a European multi-country cohort study. *Plos One, 9*(1), e87579. https://doi.org/10.1371/journal.pone.0087579			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To assess if history of sexual (SA), emotional, or physical abuse, reported during pregnancy, was associated with an operative delivery & if the association varied by type and timing of abuse (adulthood vs childhood) **Sample/Setting:** 6724 pregnant women receiving routine antenatal care in Belgium, Iceland, Denmark, Estonia, Norway, & Sweden 2323 with abuse history: 1567 as a child, 1309 as an adult, 553 in adulthood and childhood **Johns Hopkins Evidence Appraisal** Level of Evidence: II Quality: B	**Design:** Quantitative, prospective cohort study **Methods:** - 6,724 Pregnant women receiving routine antenatal care given questionnaires asking about abuse exposure and type, post-traumatic stress symptoms, fear of childbirth, and depression **Instruments:** - Hospital records - 68 item questionnaire based on Norvold Abuse Questionnaire (NorAQ), Wijma Delivery Expectancy Questionnaire (W-DEQ), & Edinburgh Postpartum Depression Scale (short version, EPDS-5) - Binary logistic regression analysis - Multinomial regression analyses **Measurement:** - Outcomes: Vaginal delivery, elective caesarean, forceps or vacuum delivery, Emergency caesarean	**Results:** - No association between hx of any type of abuse and operative delivery for primips (AOR 1.16 [0.99–1.36]) or multips (AOR 1.04 [0.86–1.25]) - Primips:CS rate 18%, 7% no medical indication. SA in adulthood (>18 yo) increased r/o elective CS (OR 2.12 [1.28-3.49]) & non-obstetrically indicated CS (OR 3.74 [1.24-11.24]). Highest risk for current SA (AOR 4.07 [1.46-11.3]). - Primips: no increased rate of operative delivery for hx of physical abuse at any time or SA in childhood. - Multips: hx of physical abuse significant increase in emergency CS (AOR 1.51 [1.05-2.19]). Sexual & emotional abuse not associated with operative delivery **Conclusion:** - SA in adulthood increases risk of non-medically indicated & elective CS among primips - Multips with hx of physical abuse at greatest risk for emergency CS	**Strengths:** - Large sample size - Performed in multiple European countries - Well defined instruments - Followed ethical guidelines of each country and WHO - Appropriate statistical analyses - Study based on pregnant women receiving routine antenatal care - Used instruments with proven high validity **Limitations:** - Recruitment varied across sites and countries - Antenatal care practices and guidelines differ between countries - Lacking concrete inclusion & exclusion criteria across geographical locations - Individuals with PTSD may be triggered by questionnaire and not participate - Lacks generalizability for countries outside of Europe

Author Recommendations: - Further research to determine best mode of delivery for women with abuse history. - Research to determine long-term psychological impacts of labor and birth.
Implications: - Identifying sexual abuse history before or during pregnancy may influence decision-making about mode of delivery, particularly non-medically indicated CS. - Providers should be aware and working to reduce suffering during labor and birth of women with hx of abuse.

<table>
<tr><td colspan="4">Source: Seng, J., Hassinger., J. (1998). Relationship strategies and interdisciplinary collaboration: improving maternity care with survivors of childhood sexual abuse. Journal of Nurse Midwifery. doi: 10.1016/s0091-2182(98)00018-4</td></tr>
<tr><td>Purpose/Sample</td><td>Design
(Method/Instruments)</td><td>Results</td><td>Strengths/Limitations</td></tr>
<tr><td>Purpose:
To illustrate strategies to improve the maternity care of survivors of sexual abuse
Sample/Setting:
-A nurse-midwife, clinical psychologist, childbirth educator, consultant obstetrician, labor and delivery nurse, and postpartum abuse survivor all provide input into a case study in the United States
Johns Hopkins Evidence Appraisal
Level of Evidence:
III
Quality:
B</td><td>Design:
A qualitative collaborative case study
Methods:
Six individuals from six different specialties were interviewed and asked how they would respond to one case study
Instruments:
-case study on the intrapartum experience of a survivor of childhood sexual abuse</td><td>Results:
-Many providers feel poorly equipped to screen for sexual trauma and to meet the needs of patients who have experienced sexual trauma
-All providers placed the empowerment and safety of their patients at the top of their priority list for caring for patients who have experienced sexual trauma
Conclusion:
The three processes that helped to create an empowering and safe client-provider relationship were egalitarian work, exploring meaning, and framing and boundaries.</td><td>Strengths:
-Collaboration between six different specialties
-Interdisciplinary approach

Limitations:
-Small sample size with one case study and only six providers</td></tr>
<tr><td colspan="4">Author Recommendations:
-A more multidisciplinary approach to women’s health care than takes into account the context of a woman's life including her past and current abuse.</td></tr>
<tr><td colspan="4">Implications:
-Women’s health practitioners must collaborate with other providers to benefit the care of their patients.
-Sexaul trauma impacts the perceptions of pregnancy and birth for survivors.</td></tr>
</table>

<table>
<tr><td colspan="4">Source: Seng, J. S., Sparbel, K. J. H., Low, L. K., & Killion, C. (2010). Abuse-related posttraumatic stress and desired maternity care practices: Women's perspectives. Journal of Midwifery & Women's Health, 47(5),360-370 .doi: 10.1016/s1526-9523(02)00284-2</td></tr>
<tr><td>Purpose/Sample</td><td>Design
(Method/Instruments)</td><td>Results</td><td>Strengths/Limitations</td></tr>
<tr>
<td>Purpose:
Determine what maternity care practices are optimal to women with history of PTSD related to abuse

Sample/Setting:
Targeted convenience sample of 15 women with self-identified abuse-related (child sex abuse only, adult rape, adult battery) PTSD that affected childbirth occurring 1 week to 26 years prior.

Johns Hopkins Evidence Appraisal
Level of Evidence: III
Quality: C</td>
<td>Design: Qualitative, retrospective narrative study

Methods: Narrative analysis of childbirth in storytelling format:
- "2 minute version" of childbearing story
- In-depth narrative of childbearing story including effects of abuse and PTSD
- What the women desired from providers (bullet points)

Instruments:
- Descriptive analysis: chronology of abuse, pregnancy, and abuse recovery
- PTSD symptoms, features, and comorbid conditions
- Bullet points abstracted
- Rated high or low on 4 assessment factors.</td>
<td>Results:
- 4 assessment factors emerged:
1) awareness of trauma and PTSD as relates to her life
2) awareness of how chlidbearing affected by abuse and PTSD
3) Ability to advocate for self
4) Extent of current safety and well-being
- Women placed in 3 groups:
1) Far along in trauma recovery
2) Not currently safe
3) Not ready to "know" their own abuse
Conclusion:
- Women far in recovery desired a provider who was a collaborative ally
- Women not currently safe desired a provider that was a compassionate authority figure
- Women who are not ready to know desire a provider who is a therapeutic mentor</td>
<td>Strengths:
- IRB approval from University of Michigan and University of Iowa
- Federal confidentiality certificate obtained

Limitations:
- Not all participants had received therapy prior to pregnancy, but had received therapy prior to study
- Retrospective study
- No formal diagnosis of PTSD</td>
</tr>
<tr><td colspan="4">Author Recommendations:
- Continued research, including comparison studies, to look at impacts of PTSD on childbearing process.</td></tr>
<tr><td colspan="4">Implications:
- Provides information from women about what they desire from providers during the childbearing process and what impacts their care have on PTSD symptoms.
- Women discuss ways in which PTSD symptoms were aggravated during pregnancy and birth.</td></tr>
</table>

<table>
<tr><td colspan="4">Source: Sobel, L., O'Rourke-Suchoff, D, Holland, E., Remis, K., Resnick, K., Perkins, M., Bell, S. (2019). Pregnancy and childbirth after sexual trauma: Patient perspectives and care preferences. Journal of Obstetrics and Gynecology. doi 0.1097/AOG.0000000000002956</td></tr>
<tr><td>Purpose/Sample</td><td>Design
(Method/Instruments)</td><td>Results</td><td>Strengths/Limitations</td></tr>
<tr><td>Purpose: To explore pregnancy and childbirth experiences and preferences of women with a history of sexual trauma (ST) in order to identify trauma-informed care practices.
Sample/Setting:
ST: Women (n=20) who self-identified as having a history of sexual trauma who were voluntarily recruited had at least one birth experience in the last 3 years.
Control: Women (n=10) who had a birth within the last 3 years and did not disclose a history of sexual trauma.
Johns Hopkins Evidence Appraisal
Level of Evidence: III
Quality: B</td><td>Design:
Qualitative study of semi structured interviews
Methods:
-Interviews were audio-recorded and transcribed verbatim
-Grounded theory was used to derive themes from the participants' own words
Instruments:
-Individual interviews
Measurement:
-self reports of having a history of sexual trauma</td><td>Results:
-Women desired control over who was present in the labor room at the time of cervical examinations
-Women desired health care providers to avoid language that served as a reminder of prior sexual trauma
-Women desired to be asked about their preference for a female health care provider
Conclusion:
-Women with a history of ST have preferences for their care during the intrapartum period
-Women who have experienced ST have needs for control over body exposure, cervical examinations, and male health care providers</td><td>Strengths:
-1st hand accounts of birth experiences of women with a history of ST
Limitations:
-Small sample size
-All births took place in a hospital setting
-Accounts are retrospective
-Long time between experience and interview (up to 3 years)</td></tr>
<tr><td colspan="4">Author Recommendations:
-Give women control over who they have in the labor room at the time of cervical examinations and avoid unnecessary body exposure.
-Health care providers should avoid language that reminds survivors of ST of their prior sexual trauma.</td></tr>
<tr><td colspan="4">Implications:
-Women need to be asked about their preferences for the intrapartum period.
-This study provides important information on the preferences of women who have experienced sexual trauma during the intrapartum period.</td></tr>
</table>