The Effects of Childhood Sexual Abuse on Pregnancy, Labour, Birth, and Postpartum Experiences of Adult Female Survivors

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Abstract

Child sexual abuse (CSA) is a widespread problem that has long-lasting effects into adulthood. The purpose of this review was to perform a systematic review of the literature to find if a history of CSA has a significant impact on adult female survivors during the childbearing year and to determine what practices are effective in caring for survivors during this experience in order to guide midwifery care. Medline, CINAHL, and PsycInfo were systematically searched and 18 quantitative and 11 qualitative research studies were included. Survivors were found to have higher rates of psychological and social problems during pregnancy, negative experiences during labour and birth, higher rates of assisted and operative deliveries, and difficulties with breastfeeding. Some suggestions from survivors for maternity care providers were also included. Based on these suggestions, midwives may be the best practitioners to provide maternity care for survivors of CSA. More good quality research is needed on the experiences and outcomes of survivors during the childbearing year and on how to best care for these women, both in general and specifically within the midwifery model of care.

Introduction

Child sexual abuse (CSA) is an international problem with long-lasting effects (Pereda et al., 2009). It is classically defined as "contact and non-contact sexual experiences between a person under 18 years of age and an adult or other person at least 5 years older" (Pereda et al., 2009). CSA involves an age-related power imbalance in a sexual act that the victim is developmentally unable to consent to and from which the perpetrator gets sexual gratification (ACOG, 2001; Briere & Jordan, 2009).

Reports of the prevalence of CSA vary. In a recent international review, Pereda et al. (2009) reported rates for women ranging from 0-53%, but most are between 10-20%. In Canada, it was reported as 13% (Pereda et al., 2009). The incidents of police-reported sexual assaults on girls are 315/100,000 (Statistics Canada, 2008), implying that most cases are not reported.

Much research has been done on the effects of CSA on adult life (Neumann et al., 1996). Psychosocial problems include psychological dysfunction, depression, self-mutilation, suicidal ideations and attempts, anxiety, substance abuse, anger, aggressiveness, sexual maladjustment (early and inappropriate sexual behaviour, sexual promiscuity, and prostitution), relationship problems, obsessions and compulsions, eating disorders, somatisation, impaired self concept and self-esteem, shame, conduct disorders, dissociation, delinquent criminal behaviour, engagement in the perpetrator-victim cycle, academic difficulties, and noncompliance with health treatment (Havig, 2008; Martsolf & Draucker, 2005; Neumann et al., 1996; Paolucci, Genuis, & Violato, 2001). Physical effects include sexual and reproductive problems, chronic pelvic pain, urinary problems, gastrointestinal distress, compromised immune system, cancer, obesity, heart and liver disease, headaches, musculoskeletal complaints, generalized pain, and medically unexplained conditions (Briere & Jordan, 2009; Havig, 2008). Jacobs (1992) found that survivors are more

likely to become pregnant at an early age and to terminate a pregnancy. Effects that have been shown to be particularly associated with CSA are re-victimization (including all types of abuse), sexualized behaviour, and posttraumatic stress disorder (PTSD) symptoms (Briere & Jordan, 2009; Neumann et al., 1996; Paolucci, Genuis, & Violato, 2001). It is widely thought that CSA involving a father figure, genital contact, and force is most damaging; however, a meta-analysis by Paolucci, Genuis, and Violato (2001) found effects did not vary significantly based on type of abuse, relationship to perpetrator, age during abuse, and number of incidents of abuse.

There is little research on indicators that may suggest a history of CSA. Holz (1994) recommends the following characteristics may alert providers: sexual dysfunction, low self-esteem, addictions, phobias, self-destructive tendencies, multiple medically unexplained somatic complaints, and inappropriate affect.

The purpose of this study is two-fold: to perform a systematic review of the literature to find if a history of CSA has a significant impact on adult female survivors during the childbearing year and to determine what practices are effective in caring for survivors during this experience in order to guide midwifery care.

Methods

Articles specifically relating to adult females with a history of CSA and their experiences with pregnancy, childbirth, and the immediate postpartum period were compiled for this review. The databases Medline and CINAHL were searched using the terms: “child abuse, sexual” and each of “pregnancy”, “prenatal care”, “pregnancy complications”, “pregnancy outcome”, “perinatal care”, “labour, obstetric”, “delivery, obstetric”, “parturition”, “postpartum period”, “breast feeding”, “midwifery”, “nurse midwives”, and “obstetrics”. PsycInfo was searched using the terms: “child abuse”, “sexual abuse”, and each of “birth”, “obstetrics”, “pregnancy”,

"pregnancy outcomes", "perinatal period", and "breast feeding". Articles published before October, 2009 were included. Several other studies were found using the reference list of the review by Leeners et al. (2006b). The results were reviewed and all research studies written in English were compiled. To be included in this review, studies had to specifically look at CSA as a unique variable. Studies were excluded if their sample included pregnant teenagers, as the issues faced by this group were thought to be unique.

Results

The review yielded18 quantitative and 11 qualitative studies (see Table 1 and 2 in the Appendix). Sample sizes ranged from 28 to 61,865 in quantitative studies and 1 to 75 in qualitative studies. Response rates ranged from 44% to 99%. All of the quantitative and none of the qualitative studies had a control group. Reported CSA prevalence ranged from 6.9 to 51%.

Pregnancy

Psychological Effects.

When compared to other pregnant women, CSA survivors have higher rates of depression and anxiety (Benedict et al., 1999; Lang Rodgers, & Lebeck, 2006). Farber, Herbert, and Reviere (1996) also found CSA to be correlated with suicidal ideation. Eating disorder are higher, with a large quantitative study reporting higher rates of laxative use, purposeful vomiting, and concerns regarding weight and body shape during pregnancy (Senior et al., 2005). Two large quantitative studies found that survivors have an increased fear of labour and childbirth (Heimstad et al., 2006; Lukasse et al., 2009).

A qualitative study by Seng et al. (2004) reported survivors considering self harm and taking part in high risk behaviour during their childbearing year. They also reported post-traumatic sequelae, including intrusive re-experiencing and increased state of arousal, and that

many of these women had high-risk pregnancies. Study participants also reported dissociating during prenatal appointments and experiencing somatisation, including hyperemesis, fibromyalgia, and repetitive preterm contractions.

Social Effects.

Dietz et al. (1999) and Prentice et al. (2002) reported higher rates of unintended and unwanted first pregnancies in survivors. Benedict et al. (1999) found that they are more likely to be abused during pregnancy. Additionally, survivors are more likely to use alcohol prenatally (Noll et al., 2007), but did not have higher rates of prentatal cocaine use (Jantzen et al., 1998). A very small quantitative study found they were also likely to experience more stress during pregnancy (Jacobs, 1992).

Maternity Care.

Prentice et al. (2002) found that survivors are more likely to present for antenatal care later in pregnancy. Other smaller studies have found that they accessed health care more often during pregnancy, presenting at hospital with threatened preterm labour and having more ultrasounds (Grimstad & Schei, 1999; Jacobs, 1992). A qualitative study by Coles and Jones (2009) reported survivors having difficulty being physically examined during pregnancy.

Leeners et al. (2006a) found that very few (11.5%) women disclosed their abuse history to their care providers during pregnancy. However, 75% of those who did stated they would again in future pregnancies. A qualitative study reported participants were more likely to disclose after the initial visit, as trust in the practitioner grew (Seng et al., 2002).

Grimstad & Schei (1999) and Lukasse et al. (2009) found that survivors have higher rates of health complaints during pregnancy. A smaller study also found that survivors have more prenatal medical problems (Jacobs, 1992).

Labour and Delivery

Experience of Labour and Childbirth.

Only qualitative studies have been done researching survivors' experiences of labour and childbirth. Survivors report feelings of powerlessness (Smith, 1998), vulnerability (Parratt, 1994), betrayal by their body (Rhodes & Hutchison, 1994), and being threatened (Seng et al., 2004). They may have difficulty trusting their care provider (Seng et al., 2004) and express a need for privacy and control during labour (Parratt, 1994). Survivors also reported experiencing dissociation and flashbacks during labour and delivery (Parratt, 1994; Rhodes & Hutchison, 1994; Seng et al., 2002; Seng et al., 2004; Smith, 1998). Childbirth is a common time to remember abuse for the first time (Parratt, 1994; Rhodes & Hutchinson, 1994).

Rhodes and Hutchison (1994) did a small qualitative study interviewing 15 participants and theorized that there are four labouring styles typical for survivors. Fighting against the sensations of labour was the classic reaction. Others tried to control their body and environment. Surrendering and retreating were associated with dissociations and flashbacks.

Pain medication was typically reported negatively. Parratt (1994) found that survivors she interviewed felt that Demerol® interfered with their feelings of control. Also, those with histories of substance abuse wanted to avoid use of sedatives and narcotics (Seng et al., 2004).

Coles & Jones (2009) reported that vaginal exams can feel like a violation and may bring up negative feelings, causing survivors to dissociate or have intrusive flashbacks. Parratt (1994) also reported women tensing their vaginas, making exams and suturing difficult.

Outcomes of Childbirth.

There were several quantitative studies of varying sizes that looked at outcomes of childbirth for survivors. A large study found an increased likelihood of assisted or operative

delivery (Heimstad et al., 2006), also finding that this relationship was even more significant for those who had a previous complicated delivery. Two smaller studies found no significant difference in mode of delivery (Benedict et al., 1999; Gramistad & Schei, 1999), though Benedict et al. (1999) found a non-significant trend of more assisted and caesarean deliveries, which were often attributed to failure to progress or descend.

Different findings have been reported about prematurity, with Noll et al. (2007) finding that survivors were three times as likely to have premature babies and Benedict et al. (1999) finding no increase. Grimstad et al. (1998) and Benedict et al. (1999) also reported the infants are no more likely to have low birth-weight. Studies reporting length of labour had conflicting results, with Van der Leden and Raskin (1993) reporting shorter labours and Benedict et al. (1999) reporting no difference. Jacobs (1992) contradicted these studies by finding survivors in their very small study had long pregnancies and labours and infants with high birth weights.

Benedict et al. (1999) found no difference in use of anaesthesia, labour dystocia, fetal distress, low Apgar scores, and NICU admissions. Grimstad and Schei (1999) did not find higher rates of complications or interventions during childbirth for survivors.

Postpartum

Infant Exams.

A qualitative study found that survivors had difficulty with infant examinations (Coles & Jones, 2009). Survivors expressed concerns that the caregiver would sexually abuse their baby and feelings of being unable to protect their baby, especially when their genitals were touched.

Breastfeeding.

Prentice et al. (2002) did a quantitative study finding that survivors were 2.6 times more likely to initiate breastfeeding. They did not find a difference in breastfeeding duration. All

other studies on breastfeeding were qualitative. Intrusive flashbacks, dissociation, and panic attacks were common, causing discontinuation of breastfeeding and interference with mother-infant bonding (Beck, 2009; Seng et al., 2004). Klingelhafer (2007) reported an internal conflict in which the external message received from care providers ("breastfeeding is best") conflicted with the internal message stemming from abuse. One mother in their study reported being uncomfortable with breastfeeding because her baby could not consent to a part of her body being put into his mouth. Coles (2009) also found that breastfeeding was challenging, but could positively contribute to the mother-infant bond. Many did not trust their bodies to be able to breastfeed and felt validated if they could. Another common problem was the image of their breasts as a sexual object (Coles, 2009). Coles (2009) also found that survivors were unlikely to mention the sexuality of breastfeeding that is commonly felt by mothers.

Postpartum Depression.

Several small quantitative studies have been done looking for an association between CSA and postpartum depression (PPD). Cohen et al. (2002) found no association, while others found survivors have longer and more severe PPD (Buist, 1998a; Buist & Barnett, 1995). Buist (1998a) studied women admitted to hospital with PPD and found many were survivors and that they were more likely to have impaired mother-infant relationships. These participants were followed up after 3 years by Buist and Janson (2001), who found they continued to have higher depression, anxiety, and stress, and that there was more long-term impact on the mother-child relationship, the mother's mental health, and the child's emotional development.

Maternity Care

Seng et al. (2002) qualitatively interviewed 15 survivors retrospectively about their desires for maternity care and found individual variation in their needs for maternity care based

on several factors. They identified three distinct groups. The first were those far along in recovery who wanted providers who were knowledgeable about the effects of abuse and would work with them to create a flexible, individual care plan. Survivors who were aware of their abuse, but could not process it because they were still experiencing ongoing trauma made up the second group. They desired an empathetic provider knowledgeable about other problems, such as current abuse or substance use, who would help them access relevant resources. The third group were not aware of or able to disclose their abuse and desired a provider who would respond to their distress and subtly prepare them for disclosure, but not pressure them to do so.

Several other qualitative studies interviewed survivors asking for recommendations for maternity care providers. Survivors recommended that practitioners should become well informed about the effects of CSA (Coles & Jones, 2009; Parratt, 1994; Wescott, 1993), but did not expect their maternity provider to act as a therapist, wanting referrals to be offered (Seng et al., 2002). They suggested that questions should be asked in pregnancy about CSA and time should be allowed for discussion that may result, including discussing the effects on pregnancy (Seng et al., 2002). Survivors felt that for women with symptoms, CSA should be assumed and disclosure should not be forced (Seng et al., 2002; Wescott, 1993). Confidentiality was important if disclosure occurred (Seng et al., 2002). They felt that practitioners should discuss individual needs, avoid triggers, and flexibly changing their practices (Parratt, 1994; Seng et al., 2002; Wescott, 1993). Survivors also wanted practitioners to provide education on violence against women, symptoms of posttraumatic stress, and therapy options in their routine care (Seng et al., 2002). Coles and Jones (2009) also found they desired continuity of care to develop a trusting relationship with their provider, as well as additional support in the postpartum period.

Specific to examinations and procedures, Coles and Jones (2009) found that survivors felt it was important to ask permission and explain the procedure, including indications and alternatives, prior to starting. They also wanted practitioners to keep checking in during it, modifying or stopping it if the woman experienced distress.

Discussion

This review has shown that survivors of CSA are more likely to face certain challenges in pregnancy, labour, and postpartum. During pregnancy, they are more likely to have psychological sequelae, including depression, anxiety, and eating disorders, and social sequelae, including stress, abuse, and unhealthy behaviour. Because of this, survivors may need more support from their provider and others to have a healthy and rewarding experience. Screening for depression during pregnancy may also be prudent. The findings that survivors both avoid care during pregnancy and access care more often may be because of individual variation. Some may access more care because of a need for reassurance due to a lack of faith in their body, whereas others may avoid care to avoid exams and touch (Kitzinger, 1990). Additionally, if current abuse is occurring, accessing care may be either a way to increase their safety or a result of the abuse. The increase in health complaints may also be psychosomatic, a result of physical sequelae from the abuse, or a justification to have increased access to maternity care.

Many of the labour and birth experiences of survivors reported in the qualitative literature are negative. Though this literature lacked a control group, survivors seemed to have novel experiences that would not occur in women who do not have histories of CSA, such as dissociations and flashbacks to the abuse. Rhodes and Hutchison (1994) provide a framework for survivors' reactions with their four styles of labour, but this theory is based on only 15 survivors with no comparison group and may not have external or internal validity. They did

acknowledge that any labouring woman may have similar behaviours, but felt that survivors may exhibit them to an extreme degree.

Parrat (1994) and Rhodes and Hutchinson (1994) reported that childbirth is a common time to remember abuse for the first time. They hypothesized that this may be because it involves similar musculature, that IVs or EFM monitors may recall being tied down, that labour and birth positions may be similar to those in which the abuse took place, and that much focus is given to the genital area. As well, childbirth is a time of change that involves sexuality and a parent/child relationship.

Though somewhat contradicting, the research also showed that outcomes of childbirth may be affected by a history of CSA. A large study gave a strong indication that survivors are more likely to have assisted or operative deliveries. Other conflicting results are probably due in part to the small sample sizes, as well as variability in the definition of CSA and in research methodology. Additionally, individual variation in abuse and responses to the abuse may affect the outcome of childbirth. For example, Simkin (1992) theorized that survivors may experience a shorter labour if they dissociate or a longer labour if their body stops progressing at a pain level where they feels in control.

The only qualitative study on breastfeeding after CSA found a higher rate of initiation in survivors. Prentice et al. (2002) proposed that their finding may be due to the increased concern for being a good parent, since the community message is that breastfeeding is best. However, there needs to be a balance between the benefits of breastfeeding and the importance of maternal mental health and a positive connection between mother and child. The qualitative research reported various challenges that survivors have while breastfeeding. Survivors may benefit from

extra support and anticipatory guidance, or may need permission to stop breastfeeding and help to find an optimal individualized solution, such as pumping and cup feeding.

The studies that were found on PPD in survivors are small quantitative studies and the only study done on a non-clinical population did not report an association between CSA and PPD (Cohen et al., 2002). Because the risk of depression is higher during adult life (Neumann et al., 1996; Paolucci, Genuis, & Violato, 2001), a higher rate of PPD would be expected. More research needs to be done on whether this is the case or, if there is actually no increased risk of PPD in survivors, why this is the case.

Quality of Current Research

The research that has been done on CSA has provided some conflicting results. This may be due to the lack of a standard definition of CSA, the wide variety of populations in which it has been studied, the retrospective nature of much of the research, and the wide variety of confounding variables that are often not controlled.

Many of the studies that were found in my search had unique definitions of CSA. Definitions vary based on the maximal age of the victim, the nature of the sexual act, and the age difference between the victim and perpetrator. Some studies did not define CSA. Due to the variety of definitions, the samples for each study also varied widely; women who were included in the abused group in some studies would not have been if another definition of CSA was used.

The population from which the samples were drawn also varied. Many drew participants from a non-clinical population, either from a geographic region or from a maternity clinic. Other studies drew participants from clinical populations. The impact of CSA is typically found to be greater in clinical studies (Neumann et al., 1996). Thus, the external validity for applying the conclusions from these studies to midwifery clients or the general public should be questioned.

The majority of the research is also based on retrospective studies which rely on recall. Blocking memories of CSA or keeping them secret is common among adult survivors (Briere & Jordan, 2009; Leeners, 2006b). Thus, control groups in these studies may be contaminated. Those women who do not recall a history of abuse or hide it may also experience childbearing differently than those who acknowledge their abuse. It is also possible that sample groups can be contaminated by women who have false or fabricated memories of CSA.

There are also a wide range of confounding variables in the relationship between CSA and adult childbearing, such as other forms of abuse, family function, current support systems, and substance abuse (Briere & Jordan, 2009; Leeners et al., 2006b; Neumann et al., 1996). Very few studies have commented on these confounding variables or attempted to control them. Thus, it is difficult to interpret results of correlational studies and causal statements cannot be made. Additionally, the significant length of time between the abuse and pregnancy also increases the likelihood that the effects of CSA may be positively or negatively mediated by other factors.

Contributions from Non-Maternity Research

Findings from research that has been done on survivors of CSA using medical care give more information that may apply to maternity care. Though I did not include these results in my literature review, some of them add information to subjects that briefly came up in the maternity research. Their applicability to maternity patients and their caregivers should be studied.

The results of this literature review showed very low rates of disclosure of CSA, but did not explain them. Other non-pregnancy-related research found low disclosure rates are due to providers not routinely screening for CSA, even though the research states that routine screening can positively affect survivors' healthcare experiences, behaviours, and outcomes (Havig, 2008; Seng & Petersen, 1995). Havig (2008) found that providers are just as, or more, likely to be a

survivor and that this is a further barrier to discussing CSA. The time typically allotted for prenatal appointments is also too short to allow for appropriate handling of disclosure (Havig, 2008). Misdiagnosis of health problems and misunderstandings are common when providers are unaware of a history of CSA (Havig, 2008). The literature also reports that the vast majority of survivors want to be asked, providing confidentiality and that the provider is sensitive and informed about the effects of CSA (Seng & Petersen, 1995). Lack of trust may also be an issue.

There is no consensus in the literature regarding how this screening should be carried out (Havig, 2008). Different researchers have found support for written or face-to-face disclosure, being asked once or on an ongoing basis, and open-ended versus closed ended questioning. Maternity care patients who are survivors suggested providers should ask "How do you feel this abuse has affected you life?" and "Is there anything I need to know or anything I can do as your care provider to help make this birth a positive experience?" (Wescott, 1993). Even if CSA is not disclosed, asking about past experiences with gynaecological and other medical exams may provide information that can be used to improve the maternity care experience.

Havig (2008) reported that genital examinations are the most likely exam to cause traumatic reactions, dissociation, and intrusive flashbacks in survivors. Disclosure, appropriate responses, and flexibility can reduce the chances of causing re-traumatisation with these exams (ACOG, 2001). Because survivors may dissociate during appointments, Havig (2008) suggests providing written information, to increase the chance that the survivor will get this information.

Therapies

There has been no research done on counselling and interventions during pregnancy for survivors. However, ACOG (2001) suggest referral to a counsellor experienced with working with survivors. Anticipatory guidance may also be positively used by care providers to improve

the childbearing and breastfeeding experiences of survivors (Beck, 2009; Coles, 2009; Roussillon, 1998).

There is no standard way to assess or treat the effects of CSA in adult life (Havig, 2008). Martsolf and Draucker (2005) did a systematic review of the literature looking at the use of psychotherapy with survivors. They concluded that psychotherapy is beneficial, reducing distress, depression, anxiety, and trauma. They also compared different types of psychotherapy, but found that each approach had similar effectiveness. Individual and group therapy were found to be equally effective. It is also unknown how long therapy should last.

Implications for Midwifery

To date, there have been quite a few opinions and reviews published about CSA in midwifery journals, but no research looking specifically at midwifery care of survivors. Thus there was not enough information in the literature to address my second hypothesis, to determine what practices are effective in caring for survivors of CSA during this experience with midwifery care. However, the suggestions for practitioners that were obtained from participants in qualitative studies can be incorporated into midwifery care to improve the quality of care and experiences of survivors.

Many of the suggestions about what survivors want in their maternity care reflect the midwifery style of care, including continuity of care, longer appointments for disclosure and relationship development, ability to have more control and input in decisions, and being able to have more support in the postpartum period. Additionally, having a female provider may be important for many survivors (Havig, 2008). Other suggestions from survivors may be incorporated by midwives, including being knowledgeable about the effects of CSA on pregnancy and birth, being flexible about care and generating an individualized care plan, and

referring to therapists experienced in working with survivors of CSA. Midwives should also be aware of support groups and programs that may be useful for survivors during pregnancy and early parenting. Parratt (1994) also mentioned that some survivors may choose homebirth to enhance their feelings of control, safety, and privacy. Midwives also have schedules which allow more time to be spent with each client and can provide more flexibility and support. They also typically develop a relationship with clients before labour and are able to be present for much of labour and delivery, providing clients with familiar care. As women do not disclose or remember their abuse, all women should be cared for as if they are survivors.

Several barriers to care were suggested by authors. Parrat (1994) commented that practitioners are either highly aware of signs of CSA or misinterpret them. Kitzinger (1990) also thinks that many practitioners feel as if they cannot talk to colleagues about CSA and are unprepared to support survivors during birth. The maternity care system, as well as midwifery specifically, needs to become more aware of the effects of CSA on childbearing and train their providers accordingly. Even when midwives become familiar with these effects, an egalitarian relationship is important because the survivor is the expert about her own personal experience with CSA and its effect (Havig, 2008; Seng & Hassinger, 1998). It is also important for midwives to be aware of the language they use during vaginal exams and birth, as similar language may have been used by the perpetrator during abuse.

Rhodes and Hutchison (1994) suggest that a positive childbirth experience can help reframe a survivor's trust in her body and self concept, helping her recover from abuse. Because of this, midwives should spend considerable time during pregnancy discussing with survivors how their experiences of abuse may impact their labour and birth and make contingency plans for different reactions. Though not researched, Simkin and Klaus (2004) include a section that

may be helpful for midwives in their book on providing maternity care for survivors of CSA. Midwives should be aware that CSA may cause unexpected reactions during childbirth, even if it is not disclosed prior to labour. Breastfeeding is also a sensitive activity and midwives are in the position to vastly improve survivors' experiences of breastfeeding with much support and anticipatory guidance. Additionally, because survivors often come from a dysfunctional family, many do not have an example of good parenting (Buist, 1998b; DiLillo & Damashek, 2003). Though this subject was too large to include in this paper, midwives also have a role in providing guidance for early parenting and suggesting resources that may guide parenting in the future.

Collaborative care programs may also be important in providing good maternity care to survivors (Cole, Scoville, & Flynn, 1996). In Salt Lake City, Utah, Birth Care Health Care Associates involves shared maternity care between nurse midwives and psychiatric advance practice nurses for survivors of abuse. The goals of this program include making it easier for survivors to access counselling for abuse issues and to allow holistic obstetrical care that accounts for psychiatric effects of abuse. Holistic care and interdisciplinary treatment planning are also factors that Havig (2008) supports in offering optimal health care to survivors.

Future Research

Research into the effects of CSA on adult childbearing is still in its early stages. Quantitative studies need to be designed and preformed to further investigate some of the conclusions that have only been found in qualitative studies, as well as to clarify why some of the results from different studies have been conflicting. Additionally, having studies with larger sample sizes and that control for many of the confounding variables would increase confidence in findings. Conversely, Briere and Jordan (2009) lobby for looking at CSA within the complex and interactive framework in which it is often found: within a poorly functioning family, co-

occurring with other forms of child and adult abuse, and so on. They state that studying CSA in this way may be more helpful for application in clinical situations. Prospective studies should also be done involving CSA and adult childbearing.

A universal definition of CSA would also be helpful in order to start comparing and analyzing different studies in this area. This definition should focus on differentiating women at varying degrees of recovery from the effects of CSA.

There is a huge need for research into interventions and therapies that may be helpful during the childbearing year. Simkin and Klaus (2004) state that counselling during the childbearing year may need to be different than at other times in a survivors' life because of the many physical, emotional, and social changes that are occurring. They state that this may not be the time to try to work through the abuse. Roussillon (1998) suggests that anticipatory guidance may be a helpful for survivors during pregnancy, so research should be done to see if this can improve childbearing experiences and outcomes.

Additionally, there are no studies looking at how midwifery care affects childbearing experiences and outcomes for survivors. Considering midwifery care has many components survivors have found important for maternity care, research should be done in this area.

In conclusion, we still have much to discover about the effects of CSA on childbearing for adult survivors. Many of the results of past research have been conflicting and do not provide a clear understanding of the effects and concerns in providing maternity care for this group of women. Research needs to continue and be improved in order to determine if there are care components that can universally help this group of women during childbearing.

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Appendix

Table 1

Quantitative Studies Included

Reference	Topic	Sample Number	Response Rate (%)	Rate of CSA (%)
Benedict et al. (1999)	PPD	357	82	37
Buist (1998a)	PPD	56	NR	50
Buist & Janson (2001)	PPD	45	80	51
Cohen et al. (2002)	PPD	200	76	14
Dietz et al. (1999)	Pregnancy	1193	63.4	29.2
Farber, Herbert, & Reviere (1996)	Pregnancy	309	NR	14
Grimstad & Schei (1999)	Childbearing	173	78	19
Grimstad et al. (1998)	Pregnancy	175	78	14
Heimstad et al. (2006)	Labour & Delivery	2680	54	8.2
Jacobs (1992)	Childbearing	28	NR	NR
Jantzen et al. (1998)	Drug Use	1189	99	10
Lang, Rodgers, & Lebeck (2006)	Childbearing	44	NR	31.8
Leeners et al. (2006a)	Pregnancy	226	69.1	11.5
Lukasse et al., (2009)	Pregnancy	61,865	44	6.9
Noll et al. (2007)	Labour & Delivery	186	NR	NR
Prentice et al. (2002)	Breastfeeding	1220	55	7
Senior et al. (2005)	Pregnancy	10,641	76	18.2
Van der Leden & Raskin (1993)	Labour & Delivery	144	NR	10

Note: PPD = Postpartum Depression; NR = Not Reported.

Table 2

Qualitative Studies Included

Reference	Topic	Sample Number
Beck (2009)	Breastfeeding	1
Buist & Barnett (1995)	PPD	4
Coles (2009)	Breastfeeding	11
Coles & Jones (2009)	Postpartum	18
Klingelhafer (2007)	Breastfeeding	3
Parratt (1994)	Labour & Delivery	6
Rhodes & Hutchinson (1994)	Labour & Delivery	15
Seng et al. (2002)	Maternity Care	15
Seng et al. (2004)	Pregnancy	15
Smith (1998)	Childbearing	1
Wescott (1993)	Maternity Care	75

Note: PPD = Postpartum Depression.