

**THE CHILDBEARING EXPERIENCE OF WOMEN  
WHO ARE CHILDHOOD SEXUAL ABUSE SURVIVORS**

by

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## ABSTRACT

### **The Childbearing Experience of Women who are Childhood Sexual Abuse Survivors**

**A...perspective which draws our attention to the lives of girls and women, to the secret, private, hidden experiences of everyday pain, reminds us that traumatic events do lie within the range of normal human experience. When we begin to acknowledge that reality, we make our professions revolutionary; we challenge the status quo, and participate in the process of social change.**

**L. S. Brown (1991)**

Our society deems the birth of a child to be a joyous occasion. For women survivors of childhood sexual abuse, this is often not so. Over the past decade, some survivors of childhood sexual abuse have begun to reveal what the experiences of pregnancy, birth, and mothering mean for them. They have provided rich information about their violations and have shown us the legacies of their assaults with their actions and with their bodies. The purpose of this qualitative research study was to explore the experience of childbearing for survivors of childhood sexual abuse through listening to and embracing survivors' life stories. Using grounded theory method, the primary objective of this study was to generate a substantive theory explaining the consequences of this abuse in women's lives. A total of 85 audiotaped interviews were completed with 46 survivors of childhood sexual abuse and 22 health care professionals.

"Protecting the Inner Child" was identified as the core process used by survivors to navigate the challenges of childbearing. This process consisted of two seemingly competing elements: '(over) protecting self' and '(over) protecting their child'. Vulnerability and resiliency were the two core concepts influencing this process. Other influential factors included trigger points (events or emotions) and coping strategies (internal and external forces). A woman's sense of moving beyond survival was

ultimately achieved through seeking and finding her own centerpoint—a sense of inner peace and balance. This grounded theory study addresses the complexity of the childbearing experience for survivors of childhood sexual abuse and provides a platform for survivors' voices to be heard. The findings of this study suggest that survivors actively strive to be the best mothers they can be amidst their history of sexual abuse. If survivors' strategies to achieve balance are supported by health care professionals, this process is facilitated. Conversely, if these strategies are not supported, aspects of survivors' abuse experiences may inadvertently be reproduced in their health care experiences. Theory emerging from this study can be used to inform practice so that health care professionals are able to provide care that supports women and facilitates their achievement of balance.

## TABLE OF CONTENTS

	<u>Page</u>
<b>ABSTRACT . . . . .</b>	ii
<b>TABLE OF CONTENTS . . . . .</b>	iv
<b>LIST OF FIGURES . . . . .</b>	xi
<b>LIST OF CONVENTIONS . . . . .</b>	xii
<b>DEDICATION . . . . .</b>	xiii
<b>ACKNOWLEDGEMENTS . . . . .</b>	xiv
<b>CHAPTER ONE: INTRODUCTION . . . . .</b>	<b>1</b>
 <b>THE CHILDBEARING EXPERIENCE OF CHILDHOOD SEXUAL ABUSE SURVIVORS</b> 	
Background of the Research Study . . . . .	1
Purpose of the Study: Missing Voices . . . . .	4
The Research Question . . . . .	5
Background of the Researcher . . . . .	6
Establishing a Common Language . . . . .	7
Childhood Sexual Abuse . . . . .	8
Survivor . . . . .	9
Organization of the Thesis . . . . .	9
<b>CHAPTER TWO: REVIEW OF EXISTING KNOWLEDGE . . . . .</b>	<b>10</b>
Childhood Sexual Abuse . . . . .	10
Historical Perspective of Childhood Sexual Abuse . . . . .	11

Characteristics of Child Victims . . . . .	13
Theoretical Perspectives of Childhood Sexual Abuse and Childbirth . . . . .	14
Attachment Theory . . . . .	16
Intergenerational Transmission . . . . .	17
Post Traumatic Stress Disorder . . . . .	19
The Effects of Childhood Sexual Abuse on Adult Women . . . . .	22
The Effects of Childhood Sexual Abuse during the Childbearing Year . . . . .	24
Summary of the Current State of Knowledge . . . . .	32
<b>CHAPTER THREE: RESEARCH DESIGN AND IMPLEMENTATION</b>	<b>33</b>
Theoretical Perspective: Grounded Theory Method . . . . .	34
The Researcher's Perspective . . . . .	37
Researcher's Personal Assumptions . . . . .	38
Study Participants . . . . .	38
Criteria for inclusion in the research study . . . . .	38
Criteria for exclusion in the research study . . . . .	39
Ethical Considerations . . . . .	40
Purposive Sampling . . . . .	43
Recruitment . . . . .	44
Description of Study Sample . . . . .	46
Childhood Sexual Abuse Survivors . . . . .	46
Health Care Professionals . . . . .	49
Data Collection . . . . .	50

Interviewing Procedure . . . . .	50
Participant Profiles and Field Notes . . . . .	54
Personal Journal . . . . .	55
Focus Groups . . . . .	56
Anecdotal Materials . . . . .	58
Data Analysis . . . . .	58
Rigor . . . . .	64
Credibility . . . . .	64
Auditability . . . . .	65
Fittingness . . . . .	66
Confirmability . . . . .	67
Reflexivity . . . . .	68
Summary . . . . .	72
 <b>CHAPTER FOUR: THE CONTEXT OF WOMEN'S LIVES</b> . . . . .	 74
<b>MEANINGS UNVEILED AND CONNECTIONS     MADE: THE SIGNIFICANCE OF CHILDHOOD     SEXUAL ABUSE ON WOMEN'S AND MOTHER'S     LIVES</b>	
Setting the Landscape: The Context of Women's Lives . . . . .	75
The Defining Moment of Self: The Beginning of the Abuse . . . . .	77
Family Atmosphere . . . . .	81
Relationships within the Family . . . . .	82
Parents . . . . .	83
Mother-Daughter Relationships . . . . .	93

Siblings . . . . .	95
Relationships outside the Family . . . . .	98
Socioeconomic Status . . . . .	100
Aftermath: The Consequences of Abuse . . . . .	105
Influencing Factors and Coping Strategies . . . . .	107
Positive Influencing Factors . . . . .	108
Negative Influencing Factors . . . . .	112
Coping Strategies (Survival Skills) . . . . .	115
Living a Dual Life: The Blurring of Child and Woman . . . . .	121
<b>CHAPTER FIVE: THE CONTEXT OF SURVIVORS' CHILDBIRTH</b>	<b>125</b>
<b>PROTECTING THE INNER CHILD: A PROCESS REFLECTING THE EXPERIENCES OF MOTHERS WHO ARE CHILDHOOD SEXUAL ABUSE SURVIVORS</b>	
The Process of Protecting the Inner Child . . . . .	128
Imbalances: (Over) Protecting Self and (Over) Protecting Child . . . . .	134
Pre-Conception . . . . .	138
(Un) Worthiness . . . . .	139
Intimacy and Fertility Issues . . . . .	142
Pregnancy . . . . .	145
Triggers experienced in Pregnancy . . . . .	147
Coping Strategies employed in Pregnancy . . . . .	155
Labor and Birth . . . . .	167
Triggers experienced in Labor and Birth . . . . .	169

Body Memories . . . . .	169
Touch . . . . .	170
Sound . . . . .	171
Sight . . . . .	174
Taste and Smell . . . . .	175
Gender of the Caregiver and Institutional Disempowerment	177
Coping Strategies employed in Labor and Birth . . . . .	181
Postpartum . . . . .	192
Triggers experienced in Postpartum . . . . .	193
Gender of the Baby . . . . .	193
Girls . . . . .	194
Boys . . . . .	196
Breastfeeding . . . . .	199
Coping Strategies employed in Postpartum . . . . .	204
Mothering . . . . .	211
Triggers experienced in Mothering . . . . .	212
Coping Strategies employed to Protect Self . . . . .	215
Coping Strategies employed to Protect Child . . . . .	221
A Summary of Protecting Imbalance . . . . .	225
Finding Balance: Healthy Connections, Healthy Boundaries . . . . .	231
Resiliency . . . . .	234
Support Systems . . . . .	238
Making Connections: Moving Beyond Survival . . . . .	243

<b>CHAPTER SIX: BEYOND SURVIVAL: MAKING SENSE OF EXPERIENCE: IMPLICATIONS, AND CONCLUSIONS</b>	246
Study Limitations	246
Implications	249
Health and Social Policy	250
Research	254
Education	258
Clinical Practice	261
Nursing Care for Women Survivors	261
Pre-Conception	262
Pregnancy	263
Labor and Birth	269
Postpartum	272
Motherhood	275
Care for Nurses	276
Concluding Comments	279
<b>REFERENCES</b>	282
 <b>APPENDICES</b>	
<b>Appendix A: Recruitment Brochures and Advertisements</b>	324
<b>Appendix B: Information Letters</b>	329
<b>Appendix C: Consent Forms</b>	334

<b>Appendix D:</b>	<b>Interview Guides</b>	.	.	.	.	.	.	342
<b>Appendix E:</b>	<b>Participant Profiles</b>	.	.	.	.	.	.	350
<b>Appendix F:</b>	<b>Characteristics of Sample</b>	.	.	.	.	.	.	356

**LIST OF FIGURES**

	<b><u>Page</u></b>
Figure 4.1: The Context of Women's Lives . . . .	77
Figure 5.1: The Process of Protecting the Inner Child . . . .	128
Figure 5.2: The Process of Protecting: Imbalance: (Over) Protecting Self	134
Figure 5.3: The Process of Protecting: Imbalance: (Over) Protecting Child	135
Figure 5.4: The Process of Protecting: In Balance: Finding Centerpoint	232

## LIST OF CONVENTIONS USED IN THE INTERVIEW QUOTATIONS

In the quotations provided in the thesis, for the sake of clarity, the author inserted a word in the quotation, or, for the sake of brevity, a few words or some sentences may have been omitted. The conventions used in the quotations are outlined below:

- ... A word or a few words omitted from the quotation
- .... A sentence or a few sentences omitted from the quotation
- [ ] Insertion of a word by the author to clarify the dialogue

## DEDICATION

To my husband and children for loving me,  
believing in me and supporting me in countless ways.

To my family and dearest friends who never ceased  
to provide love, encouragement and support.

To all of the women who participated in this  
study and who are continuing to face the  
challenges ahead on their road to self love,  
acceptance and healing.

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Some special people deserve special mention and my heartfelt thanks...

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In gratitude,

Becky

**CHAPTER ONE: INTRODUCTION**  
**THE CHILDBEARING EXPERIENCE OF**  
**CHILDHOOD SEXUAL ABUSE SURVIVORS**

Violence against women is a global epidemic with far-reaching consequences (Heise, 1994a, 1994b; Rogers, 1994; Statistics Canada, 2003). Over the last decade, numerous publications and presentations have drawn attention to the impact of violence and abuse on women's health. Abuse of women, in particular sexual abuse, is a significant health problem with immediate and long-term physical and psychosocial sequelae (J.C. Campbell, 1993; J. C. Campbell & Sheridan, 1989; J. L. Herman, 1992; Stark & Flitcraft, 1991). For women with a history of childhood sexual abuse, these sequelae often present during the childbearing years. In this research study I examine the childbearing experience of women who are survivors of childhood sexual abuse, in the hope of better understanding this experience.

**Background of the Research Study**

The childbirth experience is an extremely significant life event for women, one that brings profound changes into their lives. For women survivors, this experience may be adversely affected by their history of childhood sexual abuse. The physical experience of pregnancy and birth itself may trigger "body memories," that is, extreme pain and tension, or psychological reactions of fear, panic, dissociation, withdrawal, or flashbacks (Simkin, 1994). Routine clinical care at various stages of the childbearing cycle may also include numerous potential triggers. Potential triggers include vaginal exams, breast exams, injections, blood samples, bladder catheters, intravenous fluids, administration of epidurals, episiotomies, forceps or vacuum extractions, and restrictions to bed (Seng &

Hassinger, 1998). For survivors of childhood sexual abuse, any or all of these can become metaphors for abuse since they involve the invasion of body boundaries, exposure of sexual body parts, physical restraint in the "victim" position, and a sense of powerlessness (Rhodes & Hutchinson, 1994).

Possible indicators of past sexual abuse specific to pregnancy include multiple unplanned pregnancies, many ending in abortion; avoidance of or little prenatal care; threatened premature labor; fertility problems; recurrent pregnancy loss; fear of being a poor mother; worry the child might be molested; gender preferences for baby and caregiver; exaggerated symptoms of pregnancy; difficulty taking part in childbirth classes; and flashbacks (Clarke, 1998). In addition, there is a reported association between childhood sexual abuse and a variety of medical problems and health risk behaviors that also affect women's health during their childbearing years, including chronic pelvic pain; gastrointestinal illness; eating disorders (bulimia nervosa in particular); substance abuse; and other health risk behaviors such as cigarette smoking, age of first intercourse, number of sexual partners before the age of 18, total number of sexual partners, and adolescent pregnancy (Winslow & Jacobson, 1998). In short, a woman's health may be profoundly affected by her experiences of childhood sexual abuse, and the effects of such a history are significant not only for the woman and her child, and her family, but also for her health care providers.

There are no recent, accurate prevalence data regarding the number of women who are of childbearing age and who are survivors of childhood sexual abuse. This is largely due to the problematic nature of obtaining accurate prevalence rates, particularly in abuse populations where the number of abuse survivors who disclose and report their

history is low. The problem of determining the prevalence of childhood sexual abuse has been a source of ongoing debate and controversy (Bagley, 1990; Finkelhor, 1994a).

Although in this study I will not enter this debate in any depth, it is important to note the overall criticisms regarding prevalence estimates. According to Fergusson and Mullen (1999), the reasons why estimates have varied from study to study include (1) variations in the definition of childhood sexual abuse, (2) variations in the methods by which abuse has been assessed, (3) variations in the characteristics of the samples being studied, and (4) variations reflecting sampling errors. In addition, it is important to note that many women do not disclose their histories of abuse, and some may not be consciously aware of their history. All of these reasons illuminate the challenges faced by researchers and epidemiologists in reporting accurate prevalence rates. Despite these challenges, research studies report prevalence rates ranging anywhere from one in five women to over half of all women, depending on the definitions and methods used (Bohn & Holz, 1996; Finkelhor, 1994a; Finkelhor, Hotaling, Lewis, & Smith, 1990; Geffner, 1992; Gibbons, 1996; Gorey & Leslie, 1997; Grimstad & Schei, 1999; Heise, 1994a, Holz, 1994; Horan, Hill, & Schulkin, 2000; Kendall-Tackett, 1998; Morrow & Smith, 1995; Russell, 1983; Seng & Hassinger, 1998; Wyatt, 1985; Wyatt & Newcombe, 1990).

Health Canada and Statistics Canada report that 53% of women experience some form of sexual abuse as children (Health Canada, 2001; Statistics Canada, 1993) and many of the experts in the area of childhood sexual abuse agree that these figures are underestimates. Given the possibility that the majority of these women survivors of childhood sexual abuse will eventually become pregnant, it is critical that health care providers gain an enhanced understanding of the childbearing experience for women with

a history of childhood sexual abuse.

Childbearing women who are survivors of childhood sexual abuse may present themselves to health care providers in many different ways. Many of these women will not disclose their history of sexual abuse. This may be because they have repressed traumatic memories that only surface during relatively traumatic moments in the pregnancy, labor, birth, or postpartum period, or because they are too afraid or ashamed to disclose the abuse to health care providers. Some women may have had prior negative experiences with disclosure and are consequently unwilling to risk further exposure. In addition, some women may not consciously recognize the connections between their experience, behaviors, or reactions and their history of abuse.

Women's health care providers are being challenged to screen for and respond to the effects of abuse and violence in their clinical practices (Bohn & Holz, 1996; Burian, 1995; B. V. Cole, Scoville, & Flynn, 1996; Courtois & Riley, 1992; Finkelhor et al., 1990; Fleisher, 1994; Grant, 1992; Heritage, 1998; Holz, 1994; King & Ryan, 1989; Parsons, Zaccaro, Wells, & Stovall, 1995; Seng & Hassinger, 1998; Seng & Petersen, 1995; Seng, Sparbel, Low, & Killion, 2002; Waymire, 1997). Many health care providers, including nurses, feel poorly equipped to do so. Addressing the impact of a history of childhood sexual abuse on the survivor's experience of pregnancy, labor, and childbirth is a particularly challenging task, which is currently compounded by the paucity of relevant literature available on this topic.

### **Purpose of the Study: Missing Voices**

The purpose of this research study is to enhance our understanding of the experiences of childbearing women who are childhood sexual abuse survivors, and to

generate a theoretical model explicating the ways in which they manage, negotiate, or realize their childbirth experience. Given the estimated prevalence of women who have experienced some form of childhood sexual abuse, the presumed number of women for whom the abuse has long-term sequelae and the possibility that many of these women eventually become pregnant, the childbearing cycle presents as an opportune time for professionals to make a significant contribution to the health and social welfare of these women. However, in order to make these contributions, nurses and other allied professionals must be able to understand the childbearing experiences of women who are childhood sexual abuse survivors.

### **The Research Question**

The research question guiding this study was “*What is the experience of the childbearing cycle for women who are survivors of childhood sexual abuse?*” I chose to use grounded theory method to approach this study. With this method, as with other qualitative methods, the researcher is an integral part of the research process (Carpenter, 1995; P. N. Stern, 1980). During in-depth interviews and focus groups, the researcher interacts on a personal level with study participants. The researcher listens carefully, creates a relaxed, trusting atmosphere that facilitates honest and comprehensive responses, and observes non-verbal behaviors. During data analyses, the researcher interacts with the data by constantly comparing themes and exploring possible linkages between themes to create a higher level of abstraction. Intuition, creativity, and rigorous attention to method are used to gain insights from the data (May, 1994). Since I, the researcher, bring a unique perspective to the research process, a brief background, including both my relevant professional and personal experiences, is provided below.

## **Background of the Researcher**

The idea for this research study arose from both my professional and personal experiences. As a health care professional working in the specialized fields of perinatal nursing and midwifery, I have had the opportunity and privilege to work with numerous women during their childbearing cycle, some of whom were childhood sexual abuse survivors. Although limited, my experiences inspired me to gain an enhanced understanding of this experience for women so that I might personally be able to provide more appropriate and sensitized care. After exploring the rather limited literature available on the topic, I made a decision to undertake this study. This study also built on my master's thesis, which was a qualitative study exploring women's experiences of eating disorders (anorexia nervosa and bulimia nervosa) during their pregnancy. A central theme that emerged from this research was the impact and influence of childhood sexual abuse on the development of the women's eating disorders.

In addition to my professional experience, my personal experience is also a factor. When I began working on this project six years ago, I was not a woman who had experienced a history of childhood sexual abuse. Since beginning the project, however, it has become clear to me that although sexual abuse was not a part of my childhood, other forms of abuse were. Although a detailed account of my own personal healing process has no place here, it is important to note that I have tried to faithfully analyze and present the research without letting my own perspective unduly influence the discussion. Thus, although pure objectivity is not the goal, an acknowledgment of my role as a researcher and the reflexive process within my work is critical. In addition to my own personal experiences, I discovered that a close female relative (a child) was sexually abused

around the time of conception of this research study, so that a significant part of my motivation in undertaking this research study was also to gain insights and strategies into how best to support her as she deals with her own traumatic experience. In summary, I bring to this research study relevant experiences both professional and personal in nature.

### **Establishing a Common Language**

In order to establish the parameters of this dissertation, it is necessary to provide a definition of childhood sexual abuse as it was understood and used within this research study. In addition, a definition of “survivor” is provided in order to gain clarity regarding the researcher's understanding of and perspective on childhood sexual abuse. Although definitions of childhood sexual abuse vary throughout the literature on the subject, I have chosen to define the concept broadly to include a variety of experiences. This strategy is supported by current research which promotes the movement away from strict definitions that aggregate a diverse set of childhood experiences into a general category (Fergusson & Mullen, 1999), and instead advocates accounts that describe the nature, extent, and intrusiveness of unwanted sexual experiences in childhood, rather than providing strict definitions. This research also promotes the exploration of how these experiences may affect children as adults (J.C. Anderson, Martin, Mullen, Romans & Herbison, 1993; Fergusson, Horwood & Lynskey, 1996, 1997; Haugaard & Emery, 1989; Mullen, Martin, Anderson, Romans & Herbison, 1993).

It is also important to acknowledge that there has been considerable recent debate around the truthfulness of claims of childhood sexual abuse, particularly when alleged victims have forgotten or repressed all or part of their abuse experiences (Morrow & Smith, 1995). Much of the controversy has centered on the phenomenon of “recovered”

memories, situations in which individuals report recalling traumatic events that they previously did not remember (Alpert et al., 1996; Enns, McNeilly, Corkery, & Gilbert, 1995; Lindsay & Read, 1994; Loftus, 1994). Beyond the specific issues associated with recovered memories, the general validity of memories for traumatic events in children and adults has also been the subject of discussion. Despite the recent focus on reports of lost and recovered memories, it is clear that traumatic events are usually remembered and that the memories are often remarkably accurate (Berliner & Briere, 1999; Widom & Morris, 1997; Widom & Shepard, 1996; Williams, 1994, 1995). I do not intend this dissertation to resolve the many extant questions about trauma and memory; rather, despite these concerns, my intention within this research study was to acknowledge and respect each participant's self-identification as a survivor, and therefore to accept their report of abuse at face value.

### ***Childhood Sexual Abuse***

Childhood sexual abuse is defined as any sexual activity between a child (less than 18 years of age) and an older child, adolescent, or adult in a position of authority or power over the child. In some cases, the abuser may be the same age as the victim, but have more power and authority than the victim. The sexual activity may be a one-time, regular, or random occurrence, and may vary in its intensity. Although childhood sexual abuse may involve physical touching, it may also include other forms of sexual abuse such as pornography, exhibitionism, or masturbation (Bass & Davis, 1994; Holz, 1994). The abuse may be extra-familial (occurring outside the family system) or intra-familial (perpetrated by a family member). In this research, the concept of family is self-defined by each participant.

### ***Survivor***

In adulthood, many victims of childhood sexual abuse have preferred to refer to themselves as “survivors” rather than “victims” (Kelly, 1988). While “victim” is defined by Webster (1989) as “a person who suffers from a destructive or injurious action” (p. 1591), the notion of “survival” implies that these women are no longer in their abusive situation. The emphasis on growth beyond victimhood to survivorhood acknowledges explicitly one’s victimization while simultaneously conveying the abused person’s potential for growth, development, and empowerment, and her ability to move beyond the dependency implied by “victim” (Mawby & Walklate, 1994). In order to recognize this transition, I refer to abuse victims as abuse survivors throughout this study.

### **Organization of the Thesis**

This dissertation is divided into six chapters. Chapter One introduces background information about the research topic and the researcher. Chapter Two reviews pertinent literature related to childhood sexual abuse and its intersection with childbearing. Chapter Three describes the study design and discusses the way in which the grounded theory method was applied in this study. Chapter Four introduces the context of the women’s lives and provides a framework for understanding the unique challenges faced by survivors as they enter their childbearing years. Chapter Five introduces the central themes developed from the accounts of mothers who are survivors and highlights the social psychological process of “Protecting the Inner Child.” Chapter Six locates the contribution of this research study in relation to other knowledge about the impact of childhood trauma on childbearing and presents implications and directions for health and social policy, research, education, and clinical practice.

## **CHAPTER TWO: REVIEW OF EXISTING KNOWLEDGE**

In this chapter, I review the existing literature to provide a historical and current context in which to examine the experiences of childbirth for survivors of childhood sexual abuse. As is common in grounded theory method, I initially familiarized myself with pertinent literature to ensure that I was knowledgeable and theoretically sensitized to the field. I then tried to avoid an excessive reliance on existing literature so that I could remain open to discovery while avoiding premature closure of the analysis and contamination of the process of concept generation and development. This chapter includes work reviewed prior to and in the early phases of data collection and analysis. The literature reviewed subsequently has been incorporated into chapters four through six, as work which supports or contrasts with the presented findings. Current developments in the field are presented in relation to the theoretical and clinical implications of this project.

It is beyond the focus and scope of this dissertation to critically examine sexual abuse and childbearing as independent conditions in any depth. For this reason, I have limited this review to literature that deals with (1) childhood sexual abuse in general, (2) theoretical perspectives of childhood sexual abuse and childbirth, (3) the effects of childhood sexual abuse on adult women, and (4) the effects of childhood sexual abuse specific to the childbearing year. I conclude this review with a summary of the current state of knowledge on the subject.

### **Childhood Sexual Abuse**

In the last 20 years, public awareness of childhood sexual abuse as an increasingly prevalent event in the lives of children has become widespread, as has the belief that such

experiences not only produce immediate consequences, but also generate long-term devastating effects (Banyard, Williams, & Siegel, 2003; Benedict, Paine, Paine, Brandt, & Stallings, 1999; Bohn & Holz, 1996; DiLillo & Damashek, 2003; Fergusson & Mullen, 1999; Fleisher, 1994; Moeller, Bachmann, & Moeller, 1993; Noll, Trickett, & Putnum, 2003; Roberts, O'Connor, Dunn, & Golding, 2004). In order to understand the genesis of these devastating effects, a brief review of childhood sexual abuse is provided below.

### *Historical Perspective of Childhood Sexual Abuse*

The phenomenon of childhood sexual abuse has been discovered and rediscovered throughout history (Olafson, Corwin, & Summit, 1993). Although Freud's work in the late 1800s is perhaps the best known of the earlier research, there was relatively little interest in the topic before the early 1970's (Fergusson & Mullen, 1999). It is no coincidence that a resurgence of interest occurred at the same time as the women's movement was gaining strength and momentum. During this time, adult women began reporting on their personal experiences of childhood sexual abuse; their accounts were often directly linked to themes emerging from the women's movement (Russell, 1986). This "rediscovery" of childhood sexual abuse, as described by Scott (1995), can be represented by four stages: discovery, diffusion, consolidation, and reification. These four stages will be briefly explored as they relate to the historical perspective of childhood sexual abuse.

The "discovery," or rather "rediscovery," of childhood sexual abuse is said to have taken place from 1970 to 1980 (Fergusson & Mullen, 1999), when it first began to be identified as a social problem. For the first time, the experience of childhood sexual abuse was reported from the perspective of adult women, rather than the perspective of

health care professionals who medicalized the abuse. According to Fergusson and Mullen, concerns about childhood abuse were largely founded on clinical concerns about the identification, treatment, and management of abuse. In contrast, feminist models of childhood sexual abuse have remained closely aligned with issues of the politics of gender and victimization, because women were able to speak autobiographically about their abuse and therefore contribute to the emerging narrative. In this way, women were able to compete with professionals in shaping the discourse on childhood sexual abuse.

During the diffusion phase (1980-1990), it was principally women survivors who disseminated knowledge about childhood sexual abuse to the general population. In essence, they let the public, policymakers, and professionals know that childhood sexual abuse was prevalent, damaging, and constituted a major social issue (McDevitt, 1996). This growing awareness of childhood sexual abuse began to spread through the mental health field, and health care professionals began to see a role for themselves in sexual abuse treatments and therapies. The research community also became interested as it began to see a role for itself in verifying and examining claims about the prevalence and consequences of childhood sexual abuse, as well as the social context within which the childhood sexual abuse occurred (A. H. Green, 1993). It was during this time period, and into the early 1990's, that much of the research on childhood sexual abuse took place. To date, however, there has been minimal research focusing on the effects of childhood sexual abuse in relation to the childbearing year.

Scott (1995) identifies consolidation and reification as the final phases in the historical perspective on childhood sexual abuse. Consolidation refers to the three general conclusions about childhood sexual abuse which emerged from previous

research: (1) exposure to unwanted sexual experience during childhood was not uncommon, (2) children reared in certain social or family circumstances were at increased risk of childhood sexual abuse, and (3) exposure to childhood sexual abuse was associated with increased risks of mental health and adjustment problems later in life. These conclusions led to the development of various services and systems specifically designed to support victims of childhood sexual abuse. Reification refers to a fluid social process which becomes solidified into a rigid construct and whose general properties and features remain beyond doubt or question (Scott). In other words, childhood sexual abuse is now recognized by our society as a significant issue in the lives of many children.

### ***Characteristics of Child Victims***

It is no coincidence that the rediscovery of childhood sexual abuse is largely credited to the adult women who disclosed their histories of abuse, and there is little doubt that there is a gender component to such abuse. In a review of the literature up to 1986, Finkelhor and Baron (1986) estimated that rates of childhood sexual abuse were 2.5 times higher in females than in males. Similarly, current research findings suggest that females are at significantly greater risk for childhood sexual abuse (Bass & Davis, 1994; Desai & Jann, 2000; Finkelhor, 1993, 1994b; Gibbons, 1996; Matsakis, 1992; Roberts et al., 2004; Roussillon, 1998; Russell, 1986).

It is also important to note the age of onset of abuse given that, for some survivors, abuse has consumed the majority of their childhood memories. It has been reported that the median age of onset is between ten and eleven years of age, usually prior to the onset of menstruation (J.C. Anderson et al., 1993). J.C. Anderson et al. also

report a sharp rise in the frequency of the first incident of abuse between four and eight years of age. In addition to gender and age of onset of abuse, it is necessary to consider the social and family environments of children. A growing body of evidence links childhood sexual abuse to a social and family history of dysfunction and difficulty, including marital conflict and disharmony, family change, step parenthood, parental adjustment problems, and impaired parent-child attachments (Dietz et al., 1999; Fergusson, Lynskey, & Horwood, 1996; Mullen, Martin, Anderson, Romans, & Herbison, 1996). Interestingly, although some research studies have focused on the social class of families of sexually abused children, socioeconomic status was not found to be related to a history of childhood sexual abuse (Bergner, Delgado, & Graybill, 1994; Connelly & Straus, 1992; Dubowitz, Hampton, Bithoney, & Newberger, 1987; Fergusson, Lynskey, & Horwood, 1996; Finkelhor, 1993; Fleming, Mullen, & Bammer, 1997; Martin & Walters, 1982; Mullen et al., 1996; Whipple & Webster-Stratton, 1991). In order to further understand the nature of childhood sexual abuse and the characteristics of its survivors, theoretical perspectives of childhood sexual abuse are presented below.

### **Theoretical Perspectives of Childhood Sexual Abuse and Childbirth**

There have been a number of attempts to explain the linkages between childhood sexual abuse and later social and psychological problems in adulthood. Earlier theories focused on attachment as an explanation, while more recent theories include the intergenerational transmission framework and post-traumatic stress disorder theories (Banyard et al., 2003; DiLillo & Damashek, 2003; Fergusson & Mullen, 1999). Recent studies (relevant to childbirth) have shown that early life trauma, including childhood sexual abuse, can result in various psychological consequences such as attachment

disturbances (Bowlby, 1984, 1988; Brody, 1993; B. V. Cole et al., 1996) and posttraumatic stress disorders (Bohn & Holz, 1996; M. M. Cohen, Ansara, Schei, Stuckless, & Stewart, 2004; Famularo, Fenton, Kinscherff, Ayoub, & Barnum, 1994; Kendall-Tackett, 1998; Loveland Cook, Flick, Homan, Campbell, McSweeney, & Gallagher, 2004; Seng, 2002; Seng, Low, Sparbel, & Killion, 2004; Terr, 1985).

Intuitively one might expect that women with traumatic histories might manifest more problems at the time of pregnancy, labor, and birth than women without a history of childhood sexual abuse, and clinical literature supports this assumption (B. V. Cole et al., 1996; Courtois & Riley, 1992; Seng & Hassinger, 1998; Tidy, 1996).

Theoretical explanations of childhood sexual abuse have appeared in the literature for more than a century, beginning with Freud's "seduction theory" in the late 1800's, which attributed the development of hysteria to childhood exposure to sexual trauma (Fergusson & Mullen, 1999). I now direct attention towards those theoretical perspectives of childhood sexual abuse which are in current usage within the professional disciplines and which are relevant to the phenomenon of interest. Three theoretical perspectives on childhood sexual abuse are presented here: (1) attachment, (2) intergenerational transmission, and (3) post-traumatic stress disorder. The assumptions of these theoretical frameworks are reviewed and discussed as they relate to the context of childbirth for women survivors. It is important to note that these frameworks do not take into consideration women's experiences of childbirth specifically; rather, they focus on women's experiences of parenting. Additional research focusing on survivors' birth experiences is needed, and this study takes a first step towards this.

### *Attachment Theory*

Bowlby's (1951) theory of attachment has been used by various attachment theorists to explain linkages between childhood sexual abuse and subsequent parenting difficulties (Beck, 1998; Petterson & Albers, 2001; Rutter, 1995; Seifer & Dickstein, 1993). In essence, attachment theory highlights the role of parents' early experiences in the development of their own caregiving responses to their children. It has been theorized that mothers' own attachment experiences in childhood influence their internal model of attachment as adults, which in turn influences whether their infant develops a secure or insecure attachment relationship with them (Bowlby, 1988). Alexander (1992) has argued that there may be a reciprocal relationship between parent-child attachment and sexual abuse such that, while poor parental attachment may increase children's risks of childhood sexual abuse, conversely, childhood sexual abuse may lead to poor parent-child attachment. Alexander further asserts that children who have been abused may experience problematic attachment relationships that have long-term consequences in terms of both mental health symptoms and interpersonal relationships.

From a social learning perspective, high levels of dysfunction found in sexually abusive families suggest that survivors of intra-familial abuse may have had inadequate opportunities to observe and learn from healthy, effective parenting models (DiLillo & Damashek, 2003). This is supported by reports from mothers with a history of childhood sexual abuse who cite a lack of exposure to successful parenting models as an impediment to their own effective mothering (Armsworth & Stronck, 1999). Attachment theorists support this explanation for linkages between sexual abuse and subsequent mothering problems (Alexander, 1992).

Researchers addressing the relevance of the mother's own experience of attachment have found that women's childhood experiences may be an indicator of subsequent impaired attachment behavior with their children (Fonagy, Steele, & Steele, 1991; Fonagy & Target, 1997; Steele, Steele, & Fonagy, 1996). However, Fonagy et al. assert that individuals can overcome adversity from their childhood and break the intergenerational transmission of insecurity. The applicability of the attachment theory to childhood sexual abuse has been questioned by researchers in the field of child abuse. The strongest critique concerns the limited application of attachment theory to the analysis of inter-familial abuse and the weak support for Bowlby's position on the role of attachment in the development of a psychiatric disorder (Fergusson & Mullen, 1999).

### ***Intergenerational Transmission***

Researchers in the field of childhood abuse often discuss notions of an intergenerational cycle of abuse. It is estimated that approximately 30 % of parents who were abused as children go on to perpetrate abusive behaviors against their own children (Kaufman & Zigler, 1987). This statistic is representative of child abuse in general and is not specific to childhood sexual abuse. The intergenerational transmission framework suggests that when children who have been abused become parents themselves, they model their parenting behaviors on what they observed and learned as children (Muller, Hunter, & Stollack, 1995). Attachment theory similarly highlights the role of mothers' early childhood experiences in the development of their own mothering responses. Kaufman and Zigler critique the intergenerational transmission theory as too limited and encourage researchers to move beyond addressing intergenerational theories and instead direct attention to the conditions under which parents abuse their own children.

Literature addressing the intergenerational nature of childhood sexual abuse is sparse, as the issue has only recently received attention. Maker and Bittenheim (2000) assert that identification with the woman's abuser could lead mothers who are sexual abuse survivors to reenact the trauma of their own abuse through sexual victimization of their own children. I have been unable to locate any additional literature that directly supports or refutes this assertion; however, given that the perpetrators of childhood sexual abuse are rarely females, it seems likely that intergenerational transmission from survivors to their own children would be minimal. Nevertheless, this raises the question of whether mothers with a history of childhood sexual abuse may unknowingly subject their children to potentially abusive situations. Two retrospective studies found that children of sexual abuse survivors experienced an increased likelihood of being sexually abused than children of non-abused mothers, although it remains unclear whether abuse in the second generation is more likely to be intra-familial or extra-familial (McCloskey & Bailey, 2000; Oates, Tebbutt, Swanston, Lynch, & O'Toole, 1998).

Researchers have only recently begun to explore the impact of witnessing family violence in childhood and its relationship to psychological distress, focusing mainly on child witnesses and the variety of mental health and behavioral consequences that may follow from witnessing violence (Grych, Jouriles, Swank, McDonald, & Norwood, 2000; Jouriles, Norwood, McDonald, Vincent, & Mahoney, 1996; Levendosky & Graham-Bermann, 1998). A study by Ericksen and Henderson (1992) focused on children's experiences of witnessing family violence, and found that these children accepted violence as a way of coping with interpersonal conflict, perceiving violence as normal and acceptable and remaining unaware of alternative means of expression or resolution.

These findings lend support to the intergenerational transmission framework in that a cycle of abuse and violence is an increased risk for children witnessing family violence.

Without direct intervention, intergenerational abuse may be difficult to arrest.

### ***Post Traumatic Stress Disorder***

Researchers in the field of child sexual abuse have used Post Traumatic Stress Disorder (PTSD) as a model to account for the symptoms that develop as sequelae of abuse and violence, suggesting that PTSD may be the best-fitting diagnosis for the “syndrome” commonly seen in child sexual abuse survivors (M. M. Cohen et al., 2004; Greenwald & Leitenberg, 1990; Kendall-Tackett, Williams & Finkelhor, 1993; Koverola, Foy, Heger, & Lytle, 1990; V. V. Wolfe, Gentile, & Wolfe, 1989). Within the maternal child nursing and midwifery literature, some researchers have suggested that PTSD is useful for understanding the abuse-related symptoms of childbearing women, and for developing appropriate care provision (Bohn & Holz, 1996; Seng & Hassinger, 1998; Seng, 2002). PTSD in general has been studied in both breadth and depth, having applications to a multitude of situations in which trauma has occurred. Given the vast range of literature on PTSD, I have narrowed my focus to literature that specifically examines childhood abuse, childbirth, mothering, and parenting.

Post Traumatic Stress Disorder affects an estimated 12.3% of women in the general population of the United States (Seng et al., 2002). This percentage increases to 25-50% among women exposed to abuse or assault trauma (Seng, Oakley, Sampelle, Killion, Graham-Bermann, & Lizeron, 2001). In essence, PTSD theory asserts that exposure to traumatic stress, including childhood sexual abuse, results in a broadly similar pattern of responses. These responses are characterized by initial intense fear,

helplessness, or horror, followed by a persistent re-experience of the traumatic event, avoidance of stimuli associated with the trauma and, psychologically, by a numbing of general responsiveness and persistent symptoms of increased arousal (American Psychiatric Association, 1994). Seng and Hassinger (1998) assert that for survivors of childhood sexual abuse, triggers eliciting a post-traumatic stress response involve three clusters of symptoms: 1) intrusive reliving (flashbacks or body memories); 2) autonomic arousal (flight or fight response, hypervigilance); and 3) numbing or avoidance efforts (dissociation, substance use, phobia). In addition, there is some evidence that when children are sexually abused at a young age, they are more vulnerable to the development of posttraumatic stress symptoms and depression (Cicchetti & Lynch, 1993; D. A. Wolfe, Sas, & Wekerle, 1994).

The three theoretical frameworks of childhood sexual abuse presented here provide a foundation from which to begin to understand survivors' childbearing experiences. However, in isolation, these frameworks cannot explain the variations in children's experiences to their abuse. A review of the relevant literature discovered two factors which may help to account for a large portion of the variations in children's responses to stress and trauma: the quality of children's attachments, and their ego resilience (Cicchetti & Lynch, 1993). The strength and importance of attachments plays a crucial role in children's vulnerability to extreme stress. According to Cicchetti and Lynch, approximately two thirds of abused children show insecure attachments to their mothers. Pregnancy evokes for women their identification with and relationship with their own mothers. Notman and Nadelson (2002) emphasized that if a woman's relationship with her mother is positive, pregnancy provides a less conflicted shift

between daughterhood and motherhood, and becomes a step toward a concept of adulthood. However, if the woman has a strained relationship with her mother, her pregnancy may be a distressing experience. It marks her transition from daughter to mother, and she may feel anxious that she will repeat her mother's perceived "poor mothering." Within the parenting literature, research is predominantly directed towards children's attachments to their mothers.

Within the past decade, a considerable amount of research has been directed towards individuals' internal coping mechanisms such as resiliency (Beeghly & Cicchetti, 1994; Cicchetti & Rogosch, 1997; Luther, Cicchetti, & Becker, 2000; Masten, 2001; Masten, Hubbard, Gest, Tellegen, Garmezy, Ramirez, et al., 1999; J. L. Robinson, 2000; Werner, 1994, 1995). Cicchetti, Rogosch, Lynch, and Holt (1993) note that some abused children are more resilient than others and, as a result, these children show less severe consequences of their abuse.

Resilience refers to "a dynamic process encompassing positive adaptation within the context of significant adversity" (Luther et al., 2000, p. 543). It consists of an interaction between protective processes and vulnerability processes (Drummond, Kysela, McDonald, & Query, 2002). Implicit within this notion are two critical conditions: (1) exposure to a significant threat or severe adversity, and (2) the achievement of positive adaptation despite major assaults on the developmental process (Garmezy, 1990, 1991; Rutter, 1990, 1993). Polk (1997) describes the significance of resilience in terms of nursing as follows:

The primary domain of nursing research and practice becomes that separate reality of suffering in which persons struggle to go on despite illness, despite

losses, despite handicaps and despite pain that temporarily or permanently presents obstacles to wholeness (p. 2).

Polk adds “nursing is concerned with the individual who is in the process of overcoming or moving through adversity and with its own contribution to that process” (p. 2). The concept of resiliency has received minimal attention within the nursing literature and has not been applied to the childbearing experiences of women. It is, however, well documented within the disciplines of developmental psychology, psychiatry, and child development. Despite its absence in the nursing literature, it clearly has implications within this research study.

The three theoretical perspectives of childhood sexual abuse presented here provide a beginning framework for understanding the experiences of adult survivors. To further understand survivors’ experiences, it is necessary to explicate the effects of childhood sexual abuse on adult and childbearing women.

### **The Effects of Childhood Sexual Abuse on Adult Women**

In recent years, increasing clinical attention has been paid to the impact of childhood abuse on women’s health across the lifespan. The effects of childhood sexual abuse are varied and complex, ranging from no apparent effects to severe and debilitating effects (J. Herman, Russell, & Trocki, 1986). It can be difficult to see the link between these effects and the history of sexual abuse, largely due to the lack of knowledge available on the effects of childhood sexual abuse in later adulthood (Fleisher, 1994). However, past and current sexual abuse literature points to a number of psychosocial, interpersonal, social, and physical problems that appear to be more common among adults who were sexually abused as children than among those without such childhood

experiences.

Numerous studies have found that sexual and physical abuse histories are common among women and girls who have been diagnosed with mental illnesses (Alexander & Muenzenmaier, 1998; Fisher, 1998; Muenzenmaier, Meyer, Struening, & Ferber, 1993; Swett & Halpert, 1993). A study of trauma histories at British Columbia's provincial psychiatric hospital, Riverview, revealed that 58 % of women had been sexually abused before the age of 17 (Fisher, 1998). Firsten's (1991) study of women psychiatric inpatients found that 83 % of women had experienced severe physical or sexual abuse as children. These studies suggest that symptoms of trauma may be diagnosed as mental illnesses without acknowledgement of the sexual abuse context of women's lives. They also show that more investigation is needed to understand the role of violence and trauma in the etiology of mental illness.

Some of the more common effects of childhood sexual abuse in women's lives include increased rates of depression (Bagley, 1995; Bagley, Wood, & Young, 1994; Briere & Runtz, 1988; Courtois, 1988; Fergusson, Horwood, & Lynskey, 1996; Finkelhor, 1994a, 1994b; Kendall-Tackett, 1998; Moeller et al., 1993; Silverman, Reinherz, & Giaconia, 1996); post traumatic stress symptomatology including flashbacks, intrusive memories, sleep disturbances, nightmares, poor concentration, dissociation, and hypervigilance (Briere & Runtz, 1990, 1993; Courtois, 1988); anxiety and sleep disorders (Briere & Runtz, 1988; Courtois, 1988; Mullen et al., 1993, 1994); antisocial behaviors (Briere & Runtz, 1988; Courtois, 1988; Fergusson, Lynskey, & Horwood, 1996); substance abuse (Briere & Runtz, 1988; Mullen et al., 1993; Scott, 1992); eating disorders (Moyer, DiPietro, Berkowitz, & Stunkard, 1997; Root & Fallon, 1988; Waller,

1992); suicidal and self-damaging behaviors (Browne & Finkelhor, 1986; Mullen et al., 1993) sexual adjustment, inability to trust and form intimate relationships (Fergusson, Horwood, & Lynskey, 1997; Kinzl, Traweger, & Biefl, 1995; Mullen et al., 1994); physical symptoms including gastrointestinal and respiratory effects, nausea, rectal discomfort, muscular tension, pelvic inflammatory disease, bladder infections, chronic pain, hemorrhoids, headaches, and chronic sore throats (Bass & Davis, 1994; Browne & Finkelhor, 1986; Chew, 1999; Courtois, 1988). Although it is difficult to establish a causal relationship between a history of childhood sexual abuse and the above-listed symptoms, there is considerable evidence that such a relationship exists. Although the impact of the abuse on each survivor is individual, it has been noted that the severity of the effects of childhood sexual abuse are related to the duration of the abuse, the number of perpetrators, the relationship of the perpetrator to the victim, the cumulative effect of additional abuses, and the absence of intervention to arrest the abuse (Browne & Finkelhor, 1986; Dietz et al., 1999; Fergusson, Lynskey, & Horwood, 1996; Fergusson & Mullen, 1999; Finkelhor et al., 1990; Mullen et al., 1996).

### **The Effects of Childhood Sexual Abuse during the Childbearing Year**

The experience of childbirth is undeniably life-altering for most women. The psychosocial, interpersonal, and physical issues of adulthood are not invisible during the childbearing cycle. In actuality, these issues simply unite, and often conflict and compete with the various tasks and issues of pregnancy and motherhood. For those women with a history of childhood sexual abuse, the experience is potentially traumatic and additionally complex. Perhaps surprisingly, Cassin (1996) has noted that some women survivors view having a child as part of their healing process. If this is true, it is imperative that health

care providers be able to supply the care required in order to facilitate this healing process for women.

Motherhood is usually constructed as a normal, natural, even essential role for women. The birth of a child and the nurturing of that child are understood to be joyous occasions, but for women with a history of sexual abuse, this may not be so – indeed, the transition to motherhood is rarely so ideal or romantic. Bergum (1989) discusses women's transitioning into their mothering experience and offers an alternative view of the context of motherhood which captures more of the complexity of forces that shape women's experiences, but although she offers new insights into the various factors that may affect mothering, such as poverty, she does not provide a more in-depth analysis into other personal factors, such as a history of sexual abuse. This dissertation provides evidence of the need to examine the social context of birth for women, with particular attention directed towards childhood experiences.

Rubin (1976, 1984), one of the key theoreticians of the psychosocial aspects of pregnancy and mothering, developed a framework within which she identified four main maternal tasks: (1) seeking safe passage for herself and her child, whereby the mother passes through pregnancy without threat to her well-being or that of the unborn child; (2) acceptance by others of both the pregnancy and the baby, meaning the woman's pregnancy is affirmed by significant others and society; (3) binding-in to the baby; and (4) giving of oneself, whereby the woman lets go of former identities (memories of attachments and associated events of the former self) that may be incompatible with her new role as mother. Her work has contributed significantly to the understanding of the process of maternal-fetal adaptations and the establishment of relationships. The

adaptation to pregnancy and motherhood is understood to be a complex social and cognitive process that is not intuitive but learned.

Although Rubin describes the tasks of pregnancy and motherhood, like Bergum (1989), she does so without considering influencing factors such as a history of childhood sexual abuse. Given that women bring to childbirth a lifetime of experiences that have shaped them (Simkin, 1994), it is not difficult to see how each of these tasks of pregnancy might be significantly impaired by a history of childhood sexual abuse. For example, in the "giving of oneself" phase, sexual abuse survivors are challenged to remember their former selves. This may be exceptionally traumatic for a survivor of sexual abuse and may trigger memories of the abuse experience, inhibiting the successful achievement of "giving of oneself" and concurrently inhibiting the healing process as well. A woman may also feel emotionally drained by having to meet her own needs as a sexual abuse survivor and may find it difficult to provide the care required by a new baby, thus inhibiting her ability to achieve "binding in" to the baby. These are just two examples of ways in which a history of childhood sexual abuse may inhibit the ability of a mother to successfully meet the tasks of pregnancy and motherhood.

The majority of the meagre literature to date presents autobiographical or anecdotal accounts of the experience of childbirth for survivors of childhood sexual abuse. Additional literature discusses the care that should be provided to women with this kind of history (B. V. Cole et al., 1996; Courtois & Riley, 1992; Grimstad & Schei, 1999; Hedin, 2000; Heritage, 1998; Holz, 1994; Rickert, Edwards, Harrykissoon, & Weimann, 2001; Roussillon, 1998; Seng & Hassinger, 1998; Seng & Petersen, 1995; Simkin, 1992). Some of the personal accounts of abuse survivors are addressed below.

One of the first reports of the effects of childhood sexual abuse on childbirth came from Anna Rose (1992), a childhood sexual abuse survivor and mother of two. In her personal account, using a narrative storytelling approach, Rose discloses her own childhood sexual abuse history and links this childhood experience to her two experiences of childbirth. Within the narrative, Rose describes the sensations and emotional manifestations of her experience and identifies the aspects of her health care which were either helpful or unhelpful. This autobiographical account opened the door for dialogue and renewed interest amongst health care professionals. Rose's experience has been reinforced by numerous clinicians including Clarke (1998), who contends that maternal pregnancy and childbirth outcomes are adversely affected by a history of childhood sexual abuse.

Rose's (1992) personal account spearheaded a flood of articles by numerous authors within the same publishing year, each offering similar contributions to the dialogue on both the effects of childhood sexual abuse on the mother during her childbearing year, and on the improvement of maternity care for women survivors (Bergstrom, Roberts, Skillman, & Seidel, 1992; Courtois & Riley, 1992; Grant, 1992; Kitzinger, 1992; Lowe, 1992; Simkin, 1992). Similar articles then emerged addressing the topic of helping survivors of sexual abuse during childbirth (Burian, 1995; Holz, 1994; Peterson, 1993; Simkin, 1992). All of these contributions were based on the authors' own experiences of caring for childbearing women who were childhood sexual abuse survivors.

Two research studies addressed the experience of labor and childbirth for survivors of childhood sexual abuse. Rhodes and Hutchinson (1994) conducted an

ethnographic study designed to describe and analyze the labor experiences of childhood sexual abuse survivors. In this sample of seven women (with additional anecdotal reports from five nurse-midwives and three perinatal nurses), women reported both forgetting and remembering their abuse experiences while in labor. Additionally, the participants reported that their labor sensations were reminiscent of past sexual abuse. In a similar study, Parratt (1994) used a phenomenological approach to discover what experiences, including feelings, women incest survivors had during childbirth. In this sample of six women, the childbirth experience provoked memories of the abuse experience, although responses were individual. Despite differences in qualitative approaches, the findings of both studies support the need for additional research to be undertaken with the aim of enhancing understanding and knowledge of the relationship between childhood sexual abuse and the childbearing cycle. Both Rhodes and Hutchinson (1994) and Parratt (1994) were limited by their scope and lack of conceptual clarity regarding childhood sexual abuse. In addition, they focused on only one aspect of the childbearing experience, namely labor and birth. It is my contention that the childbearing experience must be explored in its entirety. To compartmentalize and break the continuum of the childbearing cycle may negate important and relevant experiences that exist along this continuum.

I found no articles that addressed the continuum of childbearing in relation to childhood sexual abuse, or the postpartum adjustment of childbearing women survivors. The majority of the literature focuses on the labor and birth experiences of sexual abuse survivors. One article by Kendall-Tackett (1998) examines the possible effects of childhood sexual abuse on a mother's breastfeeding experience. These effects include

such issues as difficulty establishing an effective latch due to reminders of the abuse, impaired lactation, and the inability to breastfeed at night. Kendall-Tackett identifies some of the long-term effects of childhood sexual abuse on women and comments on various intervention strategies designed for lactation consultants to promote a healthy breastfeeding experience for survivors of childhood sexual abuse. However, although this article is relevant and interesting, it provides only anecdotal evidence, which is problematic for the creation, enactment, and support of policies designed to improve the care provided to breastfeeding women survivors.

Although some of the literature reviewed addresses survivors' experiences of childbirth, much of it focuses on health care professionals' screening and treatment practices for abuse histories. There is considerable scholarly and clinical debate surrounding screening women for abuse during the childbearing cycle. Van Der Leden and Raskin (1993) contend that screening pregnant women is a critical component of the medical response to the epidemic of violence and victimization of women. This notion is reinforced by Seng and Petersen (1995) and King and Ryan (1989), who advocate for the incorporation of routine screening for history of childhood sexual abuse into maternity care. These authors assert that without knowledge of the abuse, health care providers may observe problems but overlook their cause. Thus, the childbearing cycle presents as an opportune time to assist in survivors' healing processes through the provision of appropriate care.

While there is increasing evidence to support the idea that screening for abuse during pregnancy is beneficial for women, the adoption of screening as best practice for many nurses and physicians has yet to occur. According to Parsons et al. (1995), the lack

of education or training in dealing with psychosocial issues is the most common reported barrier to screening. Other barriers include concerns about the lack of time to screen and deal with abuse, feelings of frustration and inadequacy at not being able to solve or cure the "problem," fears of offending women by asking, concerns regarding verification of abuse, beliefs that abuse is not a medical problem, and a personal history of abuse in the physician or health care provider. Additional barriers include inadequate support services and lack of readily available and accessible resources. With these barriers in mind, it appears that objections to screening for abuse are not rooted in philosophical beliefs; rather, they are the result of inadequate education in how to effectively and sensitively screen, inadequate service delivery to screen appropriately, and inadequate support and referral resources to follow through on the abuse disclosure.

While philosophical objections to screening are not paramount in the reported literature, some researchers have expressed concerns regarding the ethical issues involved. There is some apprehension that questioning people about their histories may have harmful or distressing effects on those questioned (Fergusson, Lynskey, & Horwood, 1996; Lyons, 1998; Merry & Andrews, 1989). This anxiety is based on the knowledge that many people cope with abusive experiences through mechanisms involving denial (choosing not to talk or think about the abuse), and that asking them to disclose may disrupt this coping strategy (Himelein & McElrath, 1996; McNulty & Wardle, 1994). Lyons asserts that asking questions may unnecessarily disturb distressing memories which might otherwise have lain dormant during childbirth. Her reasons for recommending non-screening (unless a mother asks for help) include the following factors: women are more vulnerable during pregnancy and consequently their reactions

may be intensified; women survivors have higher rates of depression, self harm, and suicide attempts; and if a woman discloses her memories of abuse, there is a possibility that the mother will associate the memory of the disclosure with the midwife, thereby damaging the client-caregiver relationship. However, by not adequately assessing women's health concerns, health care providers may also unintentionally do harm by misdiagnosing women's health care issues.

In addressing the issues about disclosure in relation to screening practices, Finkelhor et al. (1990) found that many women did not disclose their history of childhood sexual abuse unless asked. Additionally, some women repressed their memories of abuse until they were triggered by an event such as childbirth (Courtois & Riley, 1992; Rose, 1992). The goal of screening is to not reintroduce trauma to the woman's experience, but rather to provide a safe and trusting environment in which she can embrace the experience of childbirth. This can only be accomplished through an awareness and understanding of the needs of childhood sexual abuse survivors and through the adoption of a perspective that focuses on women's health rather than women's illnesses. In adopting a women's health perspective, the underlying tenet is that women are the best judges of their situation and that the role of the health care provider is to help empower them. To this end, health care providers must enhance their current state of knowledge of women's experiences of childbirth situated against a backdrop of childhood sexual abuse. This can only be accomplished through collaboration between researchers, practitioners, and women survivors who are committed to increasing our understanding of the phenomenon at hand. Even more importantly, the advancement of knowledge can only be achieved by ensuring that women's voices remain at the centre of research about their

lives.

### **Summary of the Current State of Knowledge**

In summary, childhood sexual abuse is a significant health problem for childbearing women, having both immediate and long-term physical and psychosocial sequelae (J. C. Campbell, 1993; J. C. Campbell & Sheridan, 1989; J. L. Herman, 1992; Stark & Flitcraft, 1991). The existing literature comprises predominantly personal accounts, anecdotal evidence, and some research suggesting that women with a history of sexual abuse may experience trauma related to their history of abuse during their childbearing cycle. Overall, the current literature specific to this phenomenon is limited at best, and there are significant gaps which need to be addressed. Although the autobiographical and anecdotal accounts of this experience communicate valuable information and should not be discounted, it is also important to provide research on which to base and from which to support clinical practice. The literature review suggests the need for additional research in order to increase awareness and understanding of the experience of childbearing for women who are childhood sexual abuse survivors. This enhanced understanding has significant implications for clinical practice, not only for hands-on care, but also for the screening and management of the disclosure of sexual abuse.

In this chapter, I have presented a review of the literature supporting the importance and significance of this research study. In the next chapter, I outline the theoretical perspectives employed within this study and discuss my application of the grounded theory method. Research ethics and scientific rigor are also addressed.

### **CHAPTER THREE: RESEARCH DESIGN AND IMPLEMENTATION**

The focus of this dissertation was to generate a detailed, contextually grounded description and theoretical explanation of the experience of childbearing for women who are childhood sexual abuse survivors. In Chapter Three I provide an overview and discussion of the methods used, including the rationale for the study approach, relevant ethical considerations, the specific research procedures followed, and issues of rigor. The utilization of grounded theory allowed me as a researcher to gain an understanding of the childbearing experiences of women survivors. The result is a theory that describes the key components of women's experiences of childbirth and mothering and the impact of those experiences on women's lives.

The specific research design was chosen on the premise that it must be suitable for the state of existing knowledge about the questions being asked (Field & Morse, 1985; Siegel, 1983). Qualitative methods are indicated when there is limited knowledge about a phenomenon. Qualitative methods are also indicated when the researcher wishes to explore and describe a phenomenon from an emic perspective, that is, the perspective of the person experiencing it, because the phenomenon deals with subjective experience and situational meaning. To date, little is known about childhood sexual abuse survivors' experiences of the childbearing cycle, and women who are themselves childhood sexual abuse survivors are clearly the most pertinent source of information about their experiences. Thus, a qualitative design was deemed suitable. Specifically, grounded theory method, a qualitative research method particularly suited to a focus on social psychological processes, was selected (Daly, 1992). In the following section, I outline descriptions and details of the research design and method.

### **Theoretical Perspective: Grounded Theory Method**

Qualitative approaches are designed to uncover the nature of persons' experiences, to explore concepts and relationships that are complex and not yet clearly understood, and to generative substantive and formal theory (Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1990). This study focused on developing a description and theoretical explanation of the social psychological experience of childbearing for women who are survivors of childhood sexual abuse, using grounded theory method (Glaser, 1992; Strauss & Corbin, 1998). This method was selected because it allows for the analysis of processes rather than static situations, and contributes to developing theory in a field that has been subjected to little inquiry.

The widespread adoption of grounded theory method in health research has resulted in considerable debate regarding its proper application. Despite divergent views on the principles and practices of grounded theory, however, the main tenets are generally agreed upon (Creswell, 1998; Dey, 1999; Glaser, 1992; Strauss & Corbin, 1990), and include: (1) The aim of grounded theory is to generate or discover a theory; (2) theory focuses on how individuals interact in relation to the phenomenon under study; (3) theory asserts plausible relationships between concepts and sets of concepts; (4) theory is derived from data acquired through fieldwork interviews, observations, and documents; (5) data analysis is systematic and begins as soon as data become available; (6) data analysis proceeds through identifying categories and connecting them; (7) Further data collection (or sampling) is based on emerging concepts; (8) these concepts are developed through constant comparison with additional data; (9) data collection can stop when no new conceptualizations emerge; (10) data analysis proceeds from "open"

coding (identifying categories, properties, and dimensions) through axial coding (examining conditions, strategies, and consequences) to selective coding around an emerging story line; and (11) the resulting theory can be reported in a narrative framework or as a set of propositions. This study was conducted in adherence to the above tenets of grounded theory method. In navigating the method, I did not choose one protocol over another; rather, I made deliberate, informed decisions throughout the research process which are explicated in my description of the application of the grounded theory method used in this study.

Grounded theory method is used to generate theory rooted in observational and interview data provided by those most informed about the phenomena of interest, in this case, childbearing women who are childhood sexual abuse survivors. The research process followed in this study was consistent with naturalistic research principles, as outlined by Blumer (1969). Blumer stressed the importance of staying open to new lines of inquiry, points of observation, and recognition of relevant data during the exploratory phase of research. Furthermore, he recommended data collection strategies such as observation, interviewing, and reviewing life histories and documents. He also proposed introspection, which involves the intensive examination of the empirical content of concepts and of relations among concepts so that sensitizing concepts can be developed and then refined.

Grounded theory methodology is informed by the sociological perspective of symbolic interactionism (Strauss & Corbin, 1990), within which individuals are seen as creative social actors whose actions are always performed in a social context that includes other people and social structures such as family, friends, culture, and society

(Blumer, 1969). Meanings, identity, and experiences are created, sustained, and modified through interactions over time within a social context. Symbolic interactionists believe that individuals define their world by processing knowledge in the following ways: (1) Human beings act toward things on the basis of the meanings that the things have for them; (2) the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows; and (3) meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he/she encounters (Blumer).

To summarize, symbolic interactionism as described by Mead (1934) and Blumer (1969) is considered the basis for the grounded theory method, a qualitative research method that requires the researcher to interpret human behaviour in light of the symbolic meaning conveyed through social interaction and its context. Given that the childbearing experience of women is located within a particular social context and involves extensive social interaction, grounded theory method appears particularly suited to the study of women survivors' experience of pregnancy, labor, birth, postpartum adjustment, and mothering. Using grounded theory to examine and explore the process by which childhood sexual abuse survivors experience their childbearing cycle allowed me, as the researcher, to "discover what is going on, rather than assuming what should be going on" (Glaser, 1978, p. 159).

Grounded theory researchers' a priori knowledge, experience, and practice can provide sensitivity to and awareness of the subtleties of meaning in data and help to formulate theory faithful to the reality of the phenomenon being investigated (Strauss & Corbin, 1998). Thus, the researcher's perspective must be considered.

### **The Researcher's Perspective**

I subscribe to the nurse pragmatist position that the only defensible reason for the development of the discipline of nursing is to provide knowledge that supports service to clients and the health of society (Donaldson, 1995). In other words, the knowledge derived from scholarly inquiry must be employable and have utility in clinical practice. Thus, my epistemological position is that of a critical realist, who views reality as not fully apprehended, and requiring that I take into account the sociocultural context in which individuals live their lives.

The notion of objectivity has been extensively criticized by scholars working within the social sciences. Subscribing to this notion requires one to believe that it is possible, indeed necessary, to separate the researcher from the research process to ensure unbiased results. Since I do not subscribe to this notion, I wish to be clear about how my beliefs have shaped my practice and my views of the research subject at hand. Therefore, one of my first tasks as a researcher was to declare to myself (and to the members of my committee) the assumptions that I brought to the research design and research topic.

The assumptions underlying this work were an integral part of the interactive research process. L. Thompson (1992) suggests that rather than trying to separate ourselves from the data, we should use our personal experience and prejudgments as a way of generating knowledge. To this end, I made the following assumptions:

### ***Researcher's Personal Assumptions***

1. Sexual abuse of children is wrong.
2. Sexual abuse of children crosses racial and class lines.
3. There is no classic family profile in child sexual abuse.
4. Sexual abuse distorts one's own experience of one's sexuality.
5. The childbearing cycle and motherhood are important aspects of the life of any woman.
6. Childhood sexual abuse has an impact on women's lives and the childbearing cycle.
7. While there is considerable diversity in women's experiences, there may also be commonalities that provide useful insights for nursing practice.

### **Study Participants**

Given the focus of this study, it was necessary to locate and recruit study participants who were the most informed about the phenomenon of interest, in this case, childhood sexual abuse survivors who were mothers. The criteria for inclusion and exclusion in the research study are detailed below.

#### ***Criteria for inclusion in the research study:***

- a) Women, over the age of 18, who are self-reported childhood sexual abuse survivors and who are currently pregnant, postpartum, or mothers able to recall their childbirth experiences.
- b) Women who are cognitively able to reflect on and verbalize experiences related to the topic and who have the ability to speak and understand English.
- c) Women who live within Vancouver or outlying communities that can be reached by vehicle or women who are able to participate through telephone contact.

***Criteria for exclusion in the research study:***

- a) Women who do not meet the above listed inclusion criteria.
- b) Women currently experiencing violence in their lives.
- c) Women who feel unable to practice self-care while exploring their abuse histories.

In addition to the survivors themselves, health care professionals who work with women survivors who are mothers were also included in the study because their perspective might provide valuable insights and reveal factors affecting the childbearing experience of which the survivors themselves might be unaware. It was thought that this data source would enrich conceptual development and theory construction. Inclusion criteria for health care professionals were that they were able to participate in interviews and that they had worked with childbearing women who were childhood sexual abuse survivors.

During the conception of the research proposal, I also considered including the partners of women survivors as a source of data. The rationale was the same as for health care professionals in that partners might be able to provide insights which would contribute to the understanding of the experience and therefore to the development of the generating theory. Upon entering the field, however, I realized that I had made two unwarranted assumptions: (1) Partners were the biological fathers of the children, and (2) most survivors would be partnered or in relationships. In fact, only 21 of the 46 participants interviewed defined themselves as being in a “relationship” (self-defined), and only four of these remained in partnership with the biological fathers of their children. Consequently, I decided to ask participants about the possibility of including their partners in the research study, regardless of biological connections to the children.

Participants with partners did not feel comfortable with their partners contributing to the study because many had not disclosed their histories or did not want to share some of their private experiences for fear of future rejection. With this in mind, I chose not to include partners in the research study. However, it is an interesting finding in and of itself that so few of the participants were in partnerships, and even fewer with the biological fathers of their children. It would be valuable to explore the experiences of partners of survivors' during the childbearing phases with the aim of discovering strategies to support both partners of survivors and the women themselves in an appropriate and effective way. Furthermore, the issue of these women's relationships with their partners warrants further investigation in future research studies, not just within the context of childbearing.

### **Ethical Considerations**

The research study was first approved by the University of British Columbia Behavioral Research Ethics Board and by the Executive Board of the Center used for recruitment of participants. To protect the anonymity of the recruitment setting, it is referred to as the "Recruitment Center" throughout this document. Research brochures and recruitment advertisements (Appendix A) and information letters (Appendix B) were made available to various community centers and through the Recruitment Center. To enhance recruitment in this study, several special efforts were made. On four occasions I met with various members of the Recruitment Center team to present the research study and to discuss any issues or concerns that they might have. I made available to the Executive Board at the Recruitment Center my research proposal and my literature review. I also attended and presented at research conferences related to women's health

in order to further profile my research. I presented my research proposal to public health nurses and perinatal nurses and made telephone calls to the social workers and lactation consultants at hospitals providing obstetrical services in the Greater Vancouver region.

During the process of data collection, potential participants contacted me by phone, letter, or email. A private telephone line and email address was provided to ensure that I alone had access to participants' messages, and any documents on the researcher's computer hard drive were accessible by a password known only to myself. When I contacted individuals to discuss the study, any questions and concerns were dealt with. Participants were informed their participation in the study was voluntary, and that they could withdraw from the study, refuse to answer any questions, or terminate interviews or observations at any time without jeopardizing health care or access to services. The study participants chose the date, time, and location of the interviews and had full control over the length of the interview. The participants were also offered the opportunity to have a support person with them during the interview; however, none of the participants elected to make use of this option.

Prior to meeting with participants, a "check-in" phone call was made to ensure that the planned interview was still convenient. During this time, I addressed personal details such as how busy their day might be, and whether they had a support person available to them following the interview. These steps were taken knowing that the interview process might be physically and emotionally exhausting, and might bring up difficult issues. I wanted to ensure that participants had support systems available to them, and that they had time reserved in their day for self-care. If needed, I brought along resource cards listing referral sources and resources for women in the Greater

Vancouver Area.

An informed consent was obtained from all participants before starting interviews (Appendix C). At this time, issues of anonymity and confidentiality were addressed and reiterated. Because the interviews might raise disturbing issues, might lead to the disclosure of many intimate details, or might evoke vulnerability for some study participants, I emphasized that the participant could ask to end the interview, refuse to respond to question(s), redirect the interview, ask for audio-taped information to be erased in their presence, or ask for sensitive information to remain private at any time. Furthermore, I explained that when a sensitive topic arose, the way in which the participant wanted to proceed would be respected. At frequent intervals during the interview process, participants were asked how they were doing and whether they wished to proceed with the interview. Participants were also told that I would be taking some notes while we were talking, and that they would have access to these notations should they wish to view them. On the day following any interview, with prior permission from the participant, I re-connected by phone with the participant to check in with them and ensure that they were coping in the aftermath of the interview. Participants were offered a copy of their transcripts, opportunities to respond to the transcripts, opportunities to respond to the problems and processes I had identified, and an executive summary of the results. The research study transcribers were also asked to sign a consent form indicating their commitment to ethical processes (Appendix C) and provided an executive summary of the results.

In addition to following ethical guidelines as outlined above, the research procedures employed in this study also followed a guideline. The generation of grounded

theory involves several research processes operating simultaneously. Sampling, data collection, and analysis occur as part of an iterative process (Strauss & Corbin, 1998). I describe each of these processes in more detail below.

### **Purposive Sampling**

Purposive or theoretical sampling is used in grounded theory method (1) to ensure the appropriateness of the sample and (2) to ensure reliability (Morse, 1991). This form of non-probability sampling is driven by the need to collect data in order to investigate theoretical linkages or categories, and to ensure that the generated theory is representative of the phenomenon of interest. Therefore, the sample is intended to be representative of the investigated phenomenon rather than the general population.

Purposive sampling entails deliberately selecting participants according to the direction and theoretical needs of the study. Initially, women who are knowledgeable about the phenomenon under study are interviewed. Data collection continues as linkages and provisional categories are identified. Sampling continues until the emerging analysis begins to provide a credible explanation about the social psychological phenomenon of interest. Then, as concurrent data collection and analysis proceed, other individuals may be sought out to provide information to refine the emerging theory. In this way, sampling moves from purposive to theoretical. The number of participants needed is based on the goal of achieving theoretical completeness (Sandelowski, Davis, & Harris, 1989).

Data collection continued until no new information was gained, and the phenomenon was richly described, (i.e., theoretical saturation). Accuracy and completeness of the theory were determined through regular dialogue with study

participants who provided critical feedback regarding the emerging theory until they felt it fully represented their experiences. Thus, saturation of categories for descriptive or theoretical purposes also helped determine appropriate sample size.

### **Recruitment**

With sensitivity to participants' privacy and their willingness to share experiences, the participants were recruited using a variety of techniques. The first source for obtaining potential participants was the Recruitment Center. This Center was selected as the primary potential source for recruiting participants due to the nature of the population utilizing these services--those women with a history of childhood sexual abuse. As mentioned in the previous section, potential participants had access to research brochures (Appendix A) and an information letter (Appendix B) which were made available in the waiting room and in therapists' private offices. These brochures and letters explained the research study and provided a contact number to obtain more information about the study. Permission to leave the brochures and information letters for potential participants was obtained from the Executive Board and from the independent therapists.

To enhance recruitment of study participants, I requested the opportunity to speak to the Recruitment Center team directly in order to present the research study and address and issues or concerns. I also felt that direct contact might be beneficial in that I would be able to demonstrate my interest in the subject, as well as establish credibility with the group. An added bonus of this strategy was that these key individuals working within the sexual abuse field were able to communicate with both colleagues and potential participants, and therefore spread the word about the study. This proved to be the most

successful recruitment strategy and was ultimately responsible for the recruitment of 16 of 22 health care professionals and 28 of 46 survivors of childhood sexual abuse. In dialogue with the participants, I learned that some of the brochures made available at the Recruitment Center had ultimately been distributed in a larger geographical area. In these situations, participants connected with me via long distance phone calls.

Another fruitful recruitment strategy was a letter to women survivors placed in the Pen Pals section of Today's Parent Magazine. This letter provided information regarding the study and the researcher's contact information. This strategy was responsible for the recruitment of an additional 12 participants in the research study. Word of mouth was responsible for recruiting the remaining six participants in the research study and the remaining six members of the health care professionals sample group. Other recruitment strategies included placing an advertisement at local community centers and making information letters and brochures regarding the research study available to three Midwifery Practices in Vancouver. However, these proved unsuccessful.

No potential participants refused to take part in the study following initial contact by telephone. Eight potential participants left messages requesting more information about the study, but three attempts to reach them failed. I understood this to mean that the potential participants no longer wished to be contacted about the research study.

### **Description of Study Sample**

In total, 46 women survivors of childhood sexual abuse (42 mothers and four “childless by choice” survivors) and 22 health care professionals volunteered to be interviewed. Over the course of this study, a total of 85 interviews were conducted. Twenty seven women survivors were interviewed a second time and five women were interviewed for a third time. One focus group was conducted with 16 health care professionals (at a work venue) and the remaining six health care professionals were interviewed independently. No health care professionals were interviewed a second time. Two different groups of participants were interviewed: (1) childhood sexual abuse survivors and (2) health care professionals. Details regarding these sub-samples follow. Characteristics of the study sample are also presented in Appendix F.

#### ***Childhood Sexual Abuse Survivors***

Most of the women interviewed learned of the study through their association with the Recruitment Center or through Today’s Parent magazine. A few women had simply heard about the research and independently indicated their willingness to be interviewed. Forty six of the women were interviewed once, 27 were interviewed twice and five women were interviewed a third time. First interviews lasted approximately four hours each, with subsequent interviews lasting approximately one hour. Most women were interviewed during the first year of becoming a mother or several years following their pregnancies. Two women were interviewed pre-conceptually and followed through postpartum. Four of the women were not mothers (childless by choice) and provided valuable insights into why some survivors choose not to become parents. Most women were multiparous, while eight were first time mothers. Some pregnancies were planned,

others unexpected. Some pregnancies ended early (miscarriages and terminations) and some children born were placed for adoption. None of the women in this study experienced stillbirths.

As study participants, these women were asked to share their stories and allow their narratives to serve as the foundations of my analysis. Using the Recruitment Center as the dominant recruitment source restricted participation primarily to women who had the financial means and/or knowledge of such resources and services. However, this restriction was offset somewhat by the participants recruited through Today's Parent and by the self-referrals. Most women interviewed had received some kind of treatment or therapy for their abuse, ranging from independent therapy sessions to self-help groups, and dependent largely on access and financial resources. Many of the women described the study interviews as liberating and a part of their healing process, or as illuminating in that the interviews helped them make sense of their experience, even though they involved recalling difficult and/or long-forgotten memories. For most, this was the first disclosure of their abuse, apart from their disclosures to therapists. All of the women in this study were aware of, or could recall their experiences of, childhood abuse throughout their lives. Five women reported that some of their subsequent memories were triggered by their childbearing experiences.

The average age among the women survivors in the study was 37 years, ranging from 19 to 56 years old. Some had university degrees but most did not, although the majority had completed high school and had attended some college. The women worked in a range of occupations, including nurse (n=9), sex trade (n=4), university student (n=4), counselor/therapist (n=3), artist (n=3), and social worker (n=1) and day care

employee (n=1). Approximately half of the women described themselves as unemployed or homemakers (n=21), whereas the other half were employed outside the home in part time (n=13) or full time positions (n=12). The majority of the survivors were single parents (n=25) and eight participants did not have custody of their children. Twenty-one participants were married (legal or common-law) and seven of these women shared with me that they were in same-sex relationships. Most women in this study were of Western-European heritage; other ethnic groups represented included Aboriginal and East Indian populations.

The women stated they had grown up in various types of communities ranging from rural parts of Canada to large urban environments such as Toronto and Vancouver. Eight participants were from Eastern Canada and six were from Central Canada. Most participants grew up in Greater Vancouver or Northern British Columbia. Several participants stated that their families had moved from place to place when they were growing up. Most of the women described having more than one brother or sister; two of the women interviewed were only children. Approximately half of the women were the only girls in their families. Most participants referred to growing up in situations of economic hardship but identified themselves as lower middle class. For many of the women, financial hardship continued to be a reality. In contrast, a few of the women in this study reported living in "above average" socioeconomic brackets.

The average age of onset of abuse was six years of age, and the average length of abuse was seven years. All participants described abuse as ongoing, that is, no women reported only a single episode. The majority of participants had disclosed their abuse as children, but this disclosure rarely put an end to the abuse. Some participants were

placed in foster care, but most remained in living situations which allowed perpetrators access to them. Many of the participants were abused by more than one perpetrator (n=18). One participant, a woman with multiple personalities, was ritually abused over prolonged periods of time. Most participants described using self-destructive behaviors to cope with their life experiences, such as alcohol and drug use, over-the-counter drugs use, eating disorders, suicide attempts, cutting or marking themselves, smoking cigarettes and other inhalation drugs, and risky sexual practices. Many also experienced paralyzing depression.

The abusers were predominantly male. Two participants—Archimedes and Beesh—reported female abusers. Archimedes had been ritually abused and her female abuser was her day care worker. Beesh's female abusers included her mother, two of her sisters, and an aunt. In all these situations, the abuse was "shared" by male abusers as well. Most abusers were close family acquaintances or family members. Other abusers were individuals in positions of trust such as day care workers, clergy, and neighbors.

### ***Health Care Professionals***

A total of 22 health care professionals were interviewed. Sixteen members of the Recruitment Center team participated in a focus group early in the process of data collection. The range of occupations included social workers, child abuse counselors, psychologists, transition workers, victim service workers, and psychiatrists. The remaining six participants were nurses who volunteered for the research study after hearing about it. All were perinatal nurses and reported having worked with (or suspected they had worked with) survivors of childhood sexual abuse. The nurses were interviewed individually. It should be noted that four nurses disclosed childhood abuse

histories themselves. Three of these four nurses did not have any children, and the one who had children elected not to participate as a “survivor,” stating that she would rather focus on her professional experiences. Although none of the participants in the focus group disclosed childhood abuse histories, they acknowledged feelings of vicarious traumatization in relation to their professional roles. This does not suggest that members of the focus group were not survivors themselves, but rather that disclosure was not the context or the purpose of the group.

### **Data Collection**

Data collection began in May 2000 and concluded in December 2003. In accordance with grounded theory method, the main mode of data collection was semi-structured, in-depth interviews with women survivors of childhood sexual abuse and with health care professionals who were informed about the phenomenon of interest. Additional data were collected through participant observation, participant profiles, fieldnotes, personal journals, focus groups, and additional anecdotal information. These will be further detailed in the following section.

### ***Interviewing Procedure***

Once a woman verbally agreed to participate in the study, I reviewed with her both the information letter (Appendix B) and the informed consent (Appendix C). At this time, the participant’s rights in the research study were reiterated. To ensure that each participant fully understood her role in the study, I reviewed the consent form orally before obtaining permission to audiotape the interview for subsequent transcription. All interviews were audio-taped.

Study participants were encouraged to choose a code name to maintain

confidentiality and privacy for interviews, records, and any documentation pertaining to them. A participant profile (Appendix E) was also completed which supplied additional information about each participant, namely biographical and socio-demographic characteristics. The use of biographical questions at the beginning of the interview helped support the participants to gain self-confidence about their answers and to reflect on their lives in terms of their childhood and childbearing histories. The participant profiles and the interview guides developed were informed by the literature, consultation with practitioners in the field, and the developing theory.

All interviews were informal and relaxed (although focused), and participants were apparently able to develop a trust relationship with the researcher as evidenced by their ability to freely elaborate on their personal experiences of childhood sexual abuse and childbearing. To establish trust with the participant, I enacted my skills as a nurse and researcher and communicated both therapeutically and empathetically. The length of first interview was approximately four hours, and subsequent interviews averaged approximately one hour. Despite my best efforts to keep the interview length within the parameters detailed in the consent form, most of the women in the study welcomed the opportunity to talk about their issues and to explore them in some depth. As a result, longer interviews were often required and I was particularly careful about "checking in" with the participants regarding time limits at regular intervals. Thirty-six interviews were conducted in the participants' homes by their choice, and the remaining interviews were conducted via telephone. Interviews were conducted by telephone because the participant lived outside of Greater Vancouver, or preferred to be interviewed by telephone. This was often the case for second and third interviews. All interviews with

the health care professionals were conducted in person. I transcribed approximately 25% of the interviews; the remainder were transcribed by skilled personnel. The transcripts that were completed by paid personnel were checked against the audio-tape recordings by me and any corrections required were made at this time.

At the beginning of the interviews, participants were encouraged to share their experiences of childhood trauma or their experiences of childbearing of pregnancy, starting wherever they felt most comfortable. The interviews began with open-ended prompts such as, "Tell me what your pregnancy/labor/birth was like for you?" An interview guide was utilized as a tool to assist the researcher in facilitating the interview although it was rare that conversation did not flow freely (Appendix D). The purpose of this open approach was to elicit the participants' perspective with as few prompts as possible. Additionally, the depth and breadth of the interview depended on the level of comfort each participant had in sharing information about intimate aspects of their lives.

Throughout the interviews, participants' actions and interactions were noted. These observations were complementary to the interview collection process in that I was able to observe and understand the participants' reactions to particular subject matters. These (re)actions assisted me in recognizing particularly painful aspects of women's experiences, especially with those participants who were in the "early" stages of processing their life experience or had difficulties articulating their feelings.

As the data collection and concurrent analysis progressed, the nature of the interviews changed, and questions often became more specific. This specificity assisted in gaining further information, exploring identified concepts, and looking for commonality and differences in the participants' stories, as outlined by grounded theory

(May, 1991). The questions asked in subsequent interviews were guided by the theoretical requirements of the study and were used to test the relationships among the emerging concepts. Follow-up interviews served as opportunities to clarify information shared by the participants and to focus on any change in perceptions or different thoughts participants may have had about their experiences since the first interview.

After several interviews were completed, I was able to reassure participants that they were not alone when voicing their fears, concerns, and struggles with their experiences. This reassurance was important for them because, for the majority of participants, I was the first person to whom they had spoken openly about their histories. Due to the sensitive nature of this research and the issues surrounding disclosure, follow-up contact became an integral aspect of data collection. After making prior arrangements with the participant, I agreed to phone them the day following the interview to check in with them and to remind them about additional resources, such as resource cards for services in the community as well as emergency service numbers. Thereafter, every two to three months, I would either arrange follow-up interviews or provide updates about the study. All the interviewees communicated that they felt they truly were "participants in the study" and appreciated the opportunity to share their insights in order to make a difference for other women with similar experiences.

Although the research participants were mothers, no problems arose surrounding childcare during the interviews. In only one case, where the baby was one week old, was a child present for the interview. For all other interviews, prior childcare arrangements had been made, the children were old enough not to require supervision, or they were not in the custody of the participant. On one occasion an interview was suddenly interrupted

by the arrival of the participant's child who was being cared for by a neighbor. The interview ended promptly and was rescheduled for a later date. The challenge of this abrupt ending was that the participant was in the midst of sharing a very emotional insight and was noticeably shaken when her child arrived home. Prior to my departure, I asked permission to phone her in a couple of hours to check on her and she agreed. I also contacted her the next day to ensure that she felt supported and was self managing appropriately.

### ***Participant Profiles & Fieldnotes***

In addition to the interviews, demographic information in the form of participant profiles (Appendix E) was collected to aid in the description of the sample (Appendix F). Detailed fieldnotes were recorded (both written and dictated) to document the researcher's perceptions during interviews and to ensure a more accurate and thorough recollection of the circumstances. The notes facilitated documentation of any personal opinions and reactions to the collected data. For example, upon completion of an interview, I recorded my own feelings about the interview process and what I had heard and observed. Other fieldnotes were made regarding the interview process itself, including but not limited to the interview environment, participant characteristics, observed non-verbal behaviors, and the dynamics of the interview (i.e., affect, the presence/absence of rapport, and eye contact). To ensure accuracy and consistency, fieldnotes were transcribed within three days following each interview. Furthermore, memos were kept throughout data analysis in order to document my thought processes and to note major turning points in my thinking. Diagrams were also generated to visually capture the relationships between categories. Memos and diagrams enabled

members of my dissertation committee to follow my decision-making trail as the analysis unfolded, and allowed me to revisit earlier analysis.

### ***Personal Journal***

As part of the ongoing process of data collection and analysis, I kept a journal to document my personal feelings during the study. I found the nature and substance of the interviews to be very emotionally and physically draining. I often needed quiet time following each interview in order to process what I heard, and to re-group so that I could re-enter my own life. I often felt overwhelmed by the participants' disclosures about their histories and how their experiences had shaped their lives. I had known from the outset that the stories would be difficult, but I had not anticipated the amount of time I would spend dwelling on their pain.

I realized in the early stages of data collection that I needed to find a way to contain my emotions, not just during and after interviews, but also throughout data analysis. I accomplished this through writing in my journal, talking with members of my committee, and taking breaks from the research. My journal writings reflected my immediate thoughts and feelings and also how these thoughts might influence data collection and analysis. Specifically I tried to bring to the surface any strong beliefs which moved me in a particular direction in the interviews or during analysis. For example, while many of my journal entries reflected my beliefs around men predominantly being the abusers in these situations, I was particularly struck by two participants' stories detailing abuse at the hands of their own mothers and other females. I realized then that I had assumed that all my participants were abused by males, when in fact this was not the case. In this way, I was able to examine the potential impacts of

subjectivity on research process.

### ***Focus Groups***

One focus group, occurring early in the data collection stage, was conducted with 16 health care professionals who work with women survivors of childhood sexual abuse. The rationale for the focus group was to draw on in-depth professional knowledge of the consequences of a history of child abuse for women. All participants in the focus group were staff at the Recruitment Center and had considerable experience working with survivors of abuse. Consent forms (Appendix C) were received by all participants prior to the start of the focus group and the session was audio-taped and transcribed. Additionally, consent from the Executive Board at the Recruitment Center was obtained prior to conducting the focus group. Information letters (Appendix B) were sent to each participant two weeks prior to the focus group explaining the research study and their role in participating should they consent. The information letters and consent forms were reviewed at the beginning of the focus group. An interview guide was used to facilitate the focus group (Appendix D).

While the focus group had many positive outcomes, it was the least productive form of data collection during this research study. Nevertheless, I was thankful that the group was conducted early in the data collection process, as these health care professionals proved integral to identifying some of the issues and challenges inherent in interviewing and working with survivors of childhood trauma. For example, the group was particularly focused on the dangers inherent within primary disclosure of childhood abuse and because of their expertise, they were aware of some of the consequences for women of disclosing without appropriate and adequate supports (i.e., self-abusive

behaviors). This strengthened my resolve to provide a safe, trusting, and non-judgmental environment in which to interview women. The members of the focus group also provided information regarding the importance of follow-up when interviewing women survivors about such intimate and sensitive matters in their lives. The focus group was beneficial in that the participants provided critical information on how to support women during the difficult interview and research process, and were able to suggest alternative support groups and resources for women in need. However, in retrospect, the focus group interview was not of particular benefit in elucidating the experience of childbearing for survivors of childhood sexual abuse.

My experience of the focus group in this study resonates with Denzin and Lincoln's (1994) comments on the advantages of focus groups in qualitative research, namely that they are "inexpensive, data rich, flexible, stimulating to respondents, recall aiding, and cumulative and elaborative over and above individual responses" (p. 365). I also attended to the notion that participants in focus groups should be of the same rank within an organization so that they feel free to talk openly and without constraint (Kruger, 1995; Morgan, 1995). The group provided rich data although it was not what I had originally expected. For example, whereas I had anticipated eliciting more data about the subject of survivors' experiences of childbearing, I instead received confirmation of the importance of the interview and research process itself in the context of women's experiences of living with the consequences of their childhood sexual abuse. On reflection, I do not feel that this information would have been elicited in as much depth in any other way.

### *Anecdotal Materials*

Other sources of data used in this analysis included non-fictional literature such as anthologies of writings by women who are childhood sexual abuse survivors and writings/artwork/legal documents belonging to participants. I analyzed these materials in the same way as the interview data. This information was particularly useful in helping me to focus on the research topic. For example, one of the participants in the study was an artist and much of her work reflected the violation of women's bodies. One poignant drawing showed a woman giving birth to "multiples." Multiples in this context referred to multiple personalities. This woman's own experience of childbearing was that one of her own multiples actually delivered her own child. Also vividly displayed in her home were images of vaginas and a sculpture of "mother-with-child" being ritually abused. Another example of anecdotal material was a series of legal documents written by one of the participants to her lawyer, detailing her financial and emotional issues around regaining custody of her child and describing the reasons why she cannot currently work (as a result of her need for intensive therapy related to her traumatic childhood history). These sources of data were helpful in exploring new ideas and in verifying different linkages between categories with participants.

### **Data Analysis**

In grounded theory method, analysis involves the constant comparison of data, looking for similarities and differences, with the ultimate aim of developing substantive theory (Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1990). Accordingly, data analysis and data collection proceeded simultaneously in this study. The analytic procedures used in this study were those laid out by Strauss and Corbin. According to

Strauss and Corbin, coding provides the grounding, builds the density, and develops the sensitivity and integration needed to generate a rich, tightly woven, explanatory theory that closely resembles the reality it represents. To conceptualize data, three types of coding were involved: open, axial, and selective coding. The boundaries between these stages are conceptual rather than rigidly temporal. Thus, while the research moved from the initial to the final stages of the analysis process, each stage of coding built upon the previous, but also overlapped and often occurred simultaneously. The management, coding, and analysis of transcribed fieldnotes, interviews, and focus groups were facilitated by a computer software program generated by a computer consultant. This program was designed specifically to meet the organizational needs of this research study.

Open coding enables the researcher to discover the analytical potential of the data and guides systematic data collection (Strauss & Corbin, 1990, 1998). This method of analysis required that the coded responses of each study participant be compared constantly until categories (i.e., themes, patterns) are identified. The conceptual name I assigned to a category reflected the data it represented. This process formed the basis for establishing relationships between categories and subcategories. To begin, analysis proceeded by examining fieldnotes and transcribed interviews, word by word, then line by line, highlighting important ideas and themes. Initially, I read and re-read a transcript to get an overall impression of the interview or a sense of the story shared by the study participant. I then read the transcript while listening to the audiotape to ensure that the data was consistent. I wrote codes in the margins of the interviews and color coded segments of the interview to correspond with the code name that I was assigning.

Fieldnotes, memos, and other documents were also used to generate codes.

Open coding is the process of breaking down, examining, comparing, conceptualizing, and categorizing data; it involves, through line-by-line analysis, the naming of any data points that arouse interest and identification of possible categories. A sample of raw data from an interview transcript is provided below. This example depicts the process of open coding using five lines of data from the transcript. In this example, my codes are identified in brackets and are written in bold and italicized.

It [labor and birth] was simply awful (*birth as negative experience*). I was alone (*feeling alone*) and scared (*fear*). I had no one but myself to rely on (*feeling alone, absence of support systems*). I asked my sister for help but she had her own stuff to deal with, and there was no one else I could ask for help (*seeking help*). I remember just keeping one thing in mind (*focused*) and that was that I was going to survive this (*determination to survive*) like I did all the other abusive things in my childhood (*connection made to childhood experience*). I could feel her coming and it was like he was inside me again (*body memory, physical reminders of abuse*). The pain (*physical pain*) was horrific (*negative experience*) but I was able to go away (*distancing self from experience, mental disconnection*). Like, not really even be there at all. I could feel (*perception*) like I was I was going away and it was OK (*perceived positive response*).

When open coding transcripts, I wrote memos documenting my thoughts about a code or category. Initially my memos were short and stimulated me to ask more questions of the data. As data collection and analysis progressed and I started to see common patterns or themes among the participants, my memos became more substantive.

These were coded (named) and then, as data collection and analysis proceeded, condensed and sorted into categories. In other words, data elements such as incidents or events that were recorded were given a conceptual label. For example, when the categories "feeling alone," "feeling supported," "seeking help," and "finding help" were combined together, the overriding category was labeled "support systems." The common thread was either the presence or absence of an individual(s) which contributed both positively and negatively to the women's experiences.

The next level of analysis involved axial coding, in which the researcher makes connections between a category and its subcategories (Strauss & Corbin, 1998). Verification and deduction were used as each category was compared based on its respective properties. The properties of the categories were then identified and located along dimensions. In order for the data to be reconstructed in theoretical terms (the process known as axial coding), the following questions were asked: (1) Under what conditions did healthy behavior occur, (2) within what contexts did specified behaviors occur, and (3) what were the contingencies and consequences of certain behaviors (Glaser, 1978). Once categories were developed in this way, they were challenged, revised, and modified to further examine and explore linkages between them. Further coding and analysis continued until saturation of a category was achieved, that is, "when additional analysis no longer contributes to developing anything new about a category" (Strauss, 1987, p. 21). Following this, attempts to integrate categories into substantive theory were made. That is, categories were evaluated for conceptual weight and their usefulness as building blocks in provisional schemes or theories. Through the repeated analysis of the data, efforts were made to condense, collapse, and refine categories into

concepts and explain the “action” through a theoretical scheme.

In theoretical or axial coding, relationships between concepts are sought. The conditions, properties, and dimensions pertaining to each concept are distinguished in order to further refine the concept. For example, when analyzing the category of abuse triggers experienced by the women in this study, the properties included perceived social support, control, decision-making and choice. How women coped with their abuse triggers became dimensions of each of these properties. For example, when women perceived that they had aspects of control and choice during their experience, the positive dimension was that they felt supported. Conversely, when women perceived that they did not have control or choice, they felt violated and unsupported.

The third level of coding was selective coding. Selective coding is the process of building a theoretical scheme by selecting the core category (a robust concept, construct, or process that appears to allow all the other categories to be integrated around it, thus explaining much of “what’s going on here?”). This is done by systematically relating it to other categories, testing those relationships, and further developing and refining as needed (Strauss & Corbin, 1990). It is important to note that this was not a linear process, as the researcher needed to move back and forth between the steps. Selective coding is similar to axial coding, but occurs at a more abstract level. To refine the theory, I returned to the participants to collect further data and fill some of the gaps that existed in the theory. For example, when exploring women’s coping strategies in labor, dissociation was identified as a form of control and pain management. In future interviews, I specifically discussed dissociation as a form of coping with participants in order to fill in the gaps which existed in the theory.

It was during the selective coding stage that I focused on the development and explication of the core category. At first it appeared that *(re) violation of self through birth* might be the core category because women's experiences of childbirth and their health care experiences both culminate in effects on women's health. In delineating these experiences and impacts, however, it became increasingly apparent that to understand the linkages between them, the strategies women themselves employed to mitigate their abuse triggers needed to first be comprehended. Selective coding involved moving between explicating the core category and relating categories at the dimensional level, validating relationships against the data, and filling in the categories. Describing and explaining "Protecting the Inner Child" forms the basis of the following chapter.

Theoretical memos were also made throughout the process of data analysis to document insights about the data and emerging conceptual linkages. In grounded theory method, memos have a specialized meaning--they are the written records of analysis related to the formulation of theory and represent the researcher's thinking (Strauss & Corbin, 1998). The use of memos assisted me in moving away from the specifics of the data to more abstract thinking and then returning to the data to assure that abstract theorizing was grounded in the data. Moreover, these memos facilitated the sorting, integration, and synthesis of the various components of analysis into substantive theory, defined as "the formulation of concepts and their interrelation into a set of hypotheses for a substantive area" (Glaser & Strauss, 1967, p. 25). Methodological memos regarding concerns about data collection and analysis, procedures, and ideas for changes in the research protocol were also made on an ongoing basis in a separate journal (Catanzaro, 1988). A journal was also kept which recorded my own subjective experiences and

examined tacit biases and assumptions and this was included as part of the analysis process.

### **Rigor**

Generating theory is a process that requires careful judgment about the significance and meaning of the data; there are no prescriptive rules in regard to questions such as “how much data is enough?” or “when is theory sufficiently developed?” These questions can only be resolved by the researcher, who must be convinced, through the careful application of the method, that the theory generated provides a credible explanation about the social psychological experience of childbirth for women who are childhood sexual abuse survivors.

The idea of what constitutes rigorous qualitative inquiry continues to be debated amongst researchers and scholars. However, there are accepted criteria for qualitative work upon which the conduct of this study was evaluated (Patton, 1990; Sandelowski, 1986). These criteria include truth-value or credibility, consistency or auditability, applicability or fittingness of the data, and neutrality or confirmability (J. M. Hall & Stevens, 1991; Sandelowski; Schutz, 1994). The importance of reflexivity as contributing to rigor is also examined.

### ***Credibility***

Credibility refers to the “truthfulness” of the theory or the extent to which the description of the theory reflects the multiple realities of those who participated in the study (Patton, 1990; Sandelowski, 1986). The criterion of credibility concerns the faithful interpretations of participants' experiences (Sandelowski). By validating my interpretations of the data with participants and by including the voices of women in the

research account, I have attempted to meet the criterion of credibility. In addition, credibility is enhanced when the researcher is able to spend time with participants and can thereby verify information from one interview to the next. In this study, I conducted up to three interviews with each participant. During subsequent interviews, I discussed my preliminary interpretations and analysis with the participants in order to support or refute the emerging theory. It has been suggested that the greater the degree of intimacy and credibility established between the researcher and the participant, the more accurate the information provided will be (Field & Morse, 1985; Oakley, 1981; Patai, 1991). In this regard, my experience as a nurse, researcher, and mother enhanced my credibility as an investigator.

Notes describing ongoing researcher self-awareness about the research process were recorded in a journal to further enhance the credibility of the generated theory. The journal documented rationales used in decisions about data analysis and collection, reflections, personal biases or reactions relevant to the study, and any strategies used to minimize research subjectivity (Rodgers & Cowles, 1993). The following reflexive questions were also asked and documented: In what ways does the researcher identify or not identify with the study participant(s)? To what extent do these similarities and differences, (i.e., in personality, experience, or character) affect the interview(s)? How does this interaction affect the research process? By accounting for researcher subjectivity, and validating interpretations of the data with study participants, the criterion of credibility was demonstrated.

### ***Auditability***

Auditability refers to the consistency of the research process. Guba and Lincoln

(1981) propose that the concept of auditability be used as the measure of consistency in qualitative research studies and that a study may be judged as auditable if the reader and other researchers can follow the decision trail of the research process. With this in mind, careful documentation of observations, events, and other factors related to the context of the data collection and the actual data collection process were made. I used the same approach with all women during the interview process and kept a record of each participant's profile (Appendix E). After each interview or follow-up discussion, I audio-taped my fieldnotes, reporting similarities and differences between the women (as well as overall impressions) and identifying what questions would need to be clarified in future interviews. Detailed memos to explain decisions were also made to account for the research process. In this way, a decision trail was well established and demonstrates the criterion of auditability. In addition, ongoing analysis was shared with members of the dissertation committee on a regular basis, or as needed, to enable them to follow the development of my ideas.

### ***Fittingness***

According to Glaser and Strauss (1967), a credible grounded theory should "fit" the applicable substantive area, be easily understood by laymen, and work for a variety of situations by explaining, interpreting, and predicting the phenomenon of interest. Fittingness refers to the extent that the categories, concepts, and ultimately the generated theory, reflect the experiences of the study participants. Fittingness in this study was evaluated through the participants' reactions to the emerging theory. When I returned to discuss the study findings with several of the participants, they agreed with the themes and developing theory and reflected how closely the interpretations of data represented

their own experiences. The developing theory evolved through subsequent conversations with the study participants prior to reaching the final conceptualization. The participants' critiques, questions, and feedback were critical to the refinement of the theory. These women particularly appreciated hearing that they were not alone in their experiences and many asked if they could connect with each other to form their own ongoing support group. Due to ethical issues surrounding anonymity and confidentiality, there was no platform from which to actualize this request, but guidance was given to contact the Recruitment Center or their own therapists to make independent arrangements for starting up a unique group for mothers who are sexual abuse survivors. In my own research, I have yet to locate such a group within Canada or the United States.

Despite the study limitations, the positive feedback from both the health care professionals and the study participants suggests that the proposed grounded theory is a credible explanation of the experience of childbearing for women who are childhood sexual abuse survivors. In addition, members of my dissertation committee with expertise in the content and methodology used in this study verified that the study demonstrated both meaning and relevance (Sandelowski, 1986). Two health professionals were also asked to evaluate the accuracy of the generated theory, both of whom had worked extensively in the perinatal field and had experience with women who had traumatic childhoods. Both agreed that the grounded theory fit with their experiences as clinicians.

### ***Confirmability***

Confirmability refers to the meaningfulness of the findings in light of what else is known or what is reasonable. Sandelowski (1986) contends that confirmability is

achieved when the other three criteria (i.e., credibility, auditability, and fittingness) are established. In this study, confirmability was achieved through meeting the above stated criteria. It should also be noted that my findings resonated with other reports in the literature, as will be explained in the final chapters of this dissertation.

### ***Reflexivity***

The notion of reflexivity is central to this study. J. M. Anderson (1991) states that reflexivity is the practice of reflecting upon, examining critically, and exploring analytically the nature of the research process. Reflexivity means to reflect upon, to examine critically, and explore analytically the nature of the research process (Wuest, 1995). J. M. Hall and Stevens (1991) define a reflexive approach to research as that which “fosters integrative thinking, appreciation of the relativity of truth, awareness of theory as ideology, and willingness to make values explicit” (p. 21). Reflexivity is about critically examining one’s effect as a researcher on the research process (Reay, 1996a, 1996b). It acknowledges the researcher’s contribution to the social construction of knowledge.

The concept of reflexivity relates to grounded theory’s notion of theoretical sensitivity, which refers to the researcher’s “knowledge, understanding, and skill, which foster his [sic] generation of categories and properties and enhance his [sic] ability to relate them into hypotheses” (Glaser, 1992, p. 27). Strauss and Corbin (1990) have referred to theoretical sensitivity as “the attribute of having insight, the ability to give meaning to data, the capacity to understand and the capacity to separate the pertinent from that which isn’t” (p. 42). This reflects the researcher’s ability to use personal and professional experience as well as existing literature to see the research situation and data

in new ways and explore the potential of the data for developing theory (Strauss & Corbin, 1990).

Reflexivity goes further than theoretical sensitivity to explicitly include attending to the effects of the relationship between the researcher and the participants as an important method for enhancing rigor (W. A. Hall & Callery, 2001; Sandelowski, 1986). A valuable means of self-reflexively exploring bias was obtained through repeated discussions with my supervisors, committee members, colleagues, and community advocates. In addition, I presented the emerging theory at four professional conferences. Through feedback and discussion, I was able to uncover untested assumptions that were influencing the data collection or analysis and was thus able to identify incongruencies in the developing theory. I did not labor under the pretence, however, that reflexivity would allow me to identify and address all of the assumptions influencing my work; rather, by recognizing many underlying assumptions, I was able to use them in the analytical process by asking respondents about them and exploring their foundations. Often, my assumptions about and personal reactions to the respondents or the data provided excellent "jumping off points" for further investigation and understanding. For example, my empathy for the women I was interviewing initially made it difficult for me to critically examine aspects of their stories that portrayed them as anything but "good" (i.e., substance use, disengagement with their children) or showed their abusers to be anything but "bad" (i.e., occasionally showing affection). Having this pointed out to me, and working to generate theory grounded in all the richness and variation in the raw data, allowed me to understand that these were all important aspects of a woman trying to cope with her traumatic childhood history and its subsequent health impacts on their

experiences of childbirth.

In order to further emphasize my reflexive stance and to let the reader know who I am, I write using predominantly the first person. During the course of my doctoral studies, many life events shaped my thinking, enabling me to relate to some of the life events described by the women in my study. Questions I found useful when reflecting upon and analyzing data were: (1) How is this woman like me? (2) How is she not like me? (3) How is my connection with her having an impact on the course of the research? (4) How is/has my own pregnancy, birth experience, and mothering experience affected my interactions with her, and the process of data collection and analysis? (5) How has my own childhood shaped my view of “normal” life outcomes? During this study I kept a journal in which I documented this reflexive accounting. First, being the mother of twins and experiencing a complicated pregnancy and postpartum period during the course of this study provided me with a personal perspective on some of the themes discussed by the women. For example, when my children were born, I found myself feeling vulnerable as a mother. One of my children was colicky, and I struggled with not being able to comfort her. At times, I interpreted this as a sign of disconnection between us, and this was very painful. I wanted to be a “perfect” parent and left myself no room for error. Reflecting back on this time in my life, I could identify with the participants’ stories of feeling vulnerable as a mother and the immense pain of not always “bonding” or “connecting” with one’s own child.

An additional consideration in relation to the study surrounds my own personal experiences. Although I am a nurse and certified nurse-midwife and therefore well acquainted with the childbearing cycle, I did not experience pregnancy, birth, and

mothering until after data collection had commenced. On reflection, I believe my experience as a mother helped to enhance the interviews as well as establish rapport and trust with the participants in that they felt I might understand, at least in some small way, a part of their mothering challenges. At times during the interview they would comment “well, you know how it is...” and I would have to be very careful not to make assumptions about what information was being translated, but instead to ask the participant to elaborate.

In addition to my professional roles and my own role as a mother, there was the question of my own childhood history of abuse. Over the past couple of years, it has become clear to me that although sexual abuse was not a part of my childhood, other forms of abuse were. This realization and the associated inner work made the external research work more difficult in some ways and easier in others. Most of the participants in my study wished to know whether or not I was a survivor of childhood sexual abuse at some point in the data collection process. The acknowledgment that I was not did not result in any participants refusing to share their stories. Most of the women had already discussed their histories with therapists who were not necessarily survivors themselves, and did not appear shaken when I shared my own personal abuse history (or lack thereof). However, I did communicate that one of my close female relatives had recently been sexually abused, and that part of my motivation in doing this research study was to gain insights into how best to support her as she dealt with her traumatic experience. The participants to whom I disclosed this personal information were noticeably empathetic and wanted to help in any way they could. All of the survivors shared with me that they wished they had had a family member who had taken the same interest in them as I did in

my own young relative.

Thus, despite the absence of sexual abuse in my own history, the participants were willing to share intimate and painful details of their lives. It was clear throughout that sensitivity regarding the phenomena of interest, effective communication, and adequate time to build a trusting relationship with the participants were critical to the research process and to maintaining my commitment to contribute to the healing of survivors, without violating them in any way. According to several of the women interviewed, the interviews themselves actually provided what they had wanted and needed as children: an opportunity to be heard.

### **Summary**

In this chapter, I have provided an overview of the premises of grounded theory method, a socio-demographic profile of the participants in this study, and an outline of my methods of sampling, recruitment, data collection, and analysis. I have also provided a detailed description of the processes instituted to ensure ethical research practices and concluded with the criteria for rigor appropriate to this study. The study findings are reported in the next two chapters. Chapter Four introduces the context of women's (survivors') lives. Chapter Five introduces the central themes developed from the accounts of mothers who are survivors of childhood sexual abuse and highlights the social psychological process of "Protecting the Inner Child." This theory explains how women who are survivors of childhood sexual abuse counter their vulnerability as mothers by drawing upon their personal resiliency and external support systems in order to manage their lives. Chapter Six locates the contribution of this research study in relation to other knowledge about the impact of childhood trauma on childbearing and

presents implications and directions for health and social policy, research, education, and clinical practice.

**CHAPTER FOUR: THE CONTEXT OF WOMEN'S LIVES**  
**MEANINGS UNVEILED AND CONNECTIONS MADE:**  
**THE SIGNIFICANCE OF CHILDHOOD SEXUAL ABUSE**  
**IN WOMEN'S AND MOTHER'S LIVES**

My purpose in this qualitative research study was to explore the experience of childbearing for women survivors of childhood sexual abuse by listening to and embracing survivors' life stories. In using grounded theory method, the primary objective of this study was to generate a substantive theory explaining the process used by these survivors to navigate the challenges of childbearing. "Protecting the Inner Child" was identified as the core social psychological process for mothers who are childhood sexual abuse survivors. In this theory, an awareness of the context of women's lives was critical to understanding the struggles and vulnerabilities inherent in living as a mother who is a survivor of childhood sexual abuse. Consequently, and in order to contextualize mother's experiences of childbirth and mothering, and to understand the process of "Protecting the Inner Child," it is necessary to discuss women's lives as children and survivors of childhood sexual abuse. In this chapter, I present an overview of the context of women's lives. These findings provide a foundation for the theoretical models of "Protecting the Inner Child" detailed in the next chapter. In this chapter (as well as in Chapter Five), I have integrated the findings and relevant literature in order to provide clarity, avoid redundancy, and remain authentic to grounded theory method.

With permission from the study participants, who are identified by code names (chosen by them), I used quotations from their interview transcripts to let the women speak for themselves about their experiences and to illustrate aspects of the theory.

Participant quotations in the text are distinguished by double quotation marks or indented. Throughout this research project, I have attempted to provide as authentic a representation of women's lives as possible. However, despite the accuracy of the text, the emotion with which the women told their stories is diminished and perhaps even lost. Nevertheless, it is my hope that through the analysis presented here, the reader will be able to feel, on some level, the intense emotion the women felt as they shared their life stories.

### **Setting the Landscape: The Context of Women's Lives**

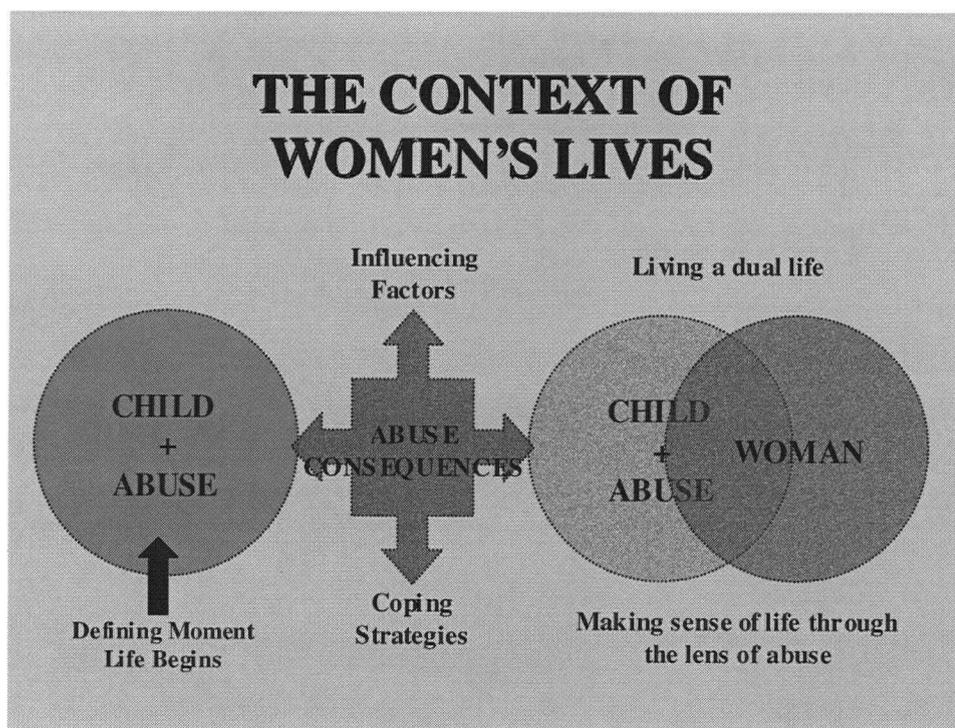
To understand the context in which children are abused, and the resources, both internal and external, that survivors draw on in dealing with their abuse, I asked the participants in the study to share some of their childhood experiences. Understanding their childhood histories was important in framing how their adult lives were shaped by their experiences of childhood trauma. It was made clear to the participants that the intimate details of their abuse were not of key importance, and did not need to be disclosed; rather, they were asked to share the meaning(s) the experience held for them.

From the participants' accounts of childhood and family life, it is clear that while survivors' circumstances do not reflect ideals of childhood or family life, they are not always extraordinary. The women's accounts revealed a range and diversity of experience, yet all the participants reflected on the profound impact that their trauma histories had had on their lives. Moreover, due to its dominance in their childhoods, the participants frequently described the onset of abuse as their "defining moment," often commenting that life began for them at the time of their abuse.

In exploring and reflecting upon the context of women's lives, I will present a

picture of the atmosphere in which survivors grew up and the lessons learned throughout their lives. Since the overwhelming majority of children were abused by members of their immediate families or individuals who were deemed close family acquaintances, I will describe family life in some detail (for more detailed characteristics of the sample, see Appendix F). Consequently, I focus on what the women shared regarding their relationships with parents, violence and authority in their homes, and relations with siblings and extended family members. These insights from the past can provide snapshots into the future in that the children of abuse and trauma eventually grow up to be parents themselves, and develop their own style of mothering based upon their childhood frame of reference.

Throughout the presentation of the women's accounts identifying the impact and consequences of their abuse to them as adults, close attention is also paid to what participants' descriptions reveal about the resources that were or were not available to them to help them deal with the abuse. Ultimately the participants communicated their sense that they (as adults) are always living a dual life—one in which the abused child and the adult woman are enmeshed and yet unable to free themselves of the ties that bind. These women have spent their lives trying to make sense of life through the lens of their abuse history. A visual representation of this journey is provided below.



**FIGURE 4.1: THE CONTEXT OF WOMEN'S LIVES**

#### **The Defining Moment of Self: The Beginning of the Abuse**

The women in this study had endured a range of personal assaults, some more aggressive than others and some more frequent and prolonged than others. As the women began to make sense of their experiences, they needed to collect the fragments of their lives piece by piece—a long and painful process. Many of the women described themselves as “shattered,” as “incomplete human beings,” as “damaged.” Although they attempted to talk about their lives prior to their abuse, it soon became apparent that they defined themselves through their abuse histories and perceived their lives as beginning when the abuse began.

The sexual abuse experienced by the women in this study was “simply a fact of life”; it had begun so early in their lives that they had no other reality to draw on to resist or counter the abuse, or sometimes even to recognize it as abuse. The average age of

onset of abuse for the women in this study was six years of age, with a range between infancy to 11 years of age. The participants reporting abuse prior to the developmental age of memory recall (i.e.: infancy) discovered through family reports or through therapy that their abuse began in infancy. The average length of abuse was seven years. All the women described their abuse as ongoing with no single episodes (one-time occurrences) of abuse being reported. Literature addressing the average age of onset of abuse varies, with Finkelhor and Baron (1986) reporting a median age of onset of abuse between 10 and 11 years of age, whereas J.C. Anderson et al. (1993) reported an average onset between four and eight years of age peaking at age 11, prior to the girls' onset of menstruation. A more recent study confirms that childhood sexual abuse is more likely to occur in pre-pubertal or peri-pubertal children than in sexually mature young girls (Fergusson & Mullen, 1999). The characteristics of the women in this study support J.C. Anderson et al. and Fergusson and Mullen's findings, in that all of their abuse commenced prior to their menstruation. However, although the abuse began prior to menstruation, for several of the participants, it continued throughout their adolescent years; consequently, sexual abuse was the dominant factor in both their childhood and young adulthood, and became a defining feature of who they were as both children and women. Kat explains:

I cannot really remember what life was like prior to being sexually and physically abused. It feels like that's when it all really started....how ironic really...to say that my life started out as an abused child...some beginning that was. In truth it wasn't a beginning at all, it really was the end of me.

Although participants defined themselves through their childhood sexual abuse

histories, they were also deeply resentful of the many ways that the abuse shaped the landscape of their adult lives. They often commented on the injustice of never being completely free of their memories of abuse:

Maggie: I feel like a prisoner of my own life. It's like my own little concentration camp. I shouldn't really say that since I wouldn't want to belittle any, like, Nazi camp survivors, but I am a survivor too and my wounds are still visible, even if only I can see them. I have a tattoo on me too, only mine is hidden and inside me, just like all the secrets of my family.

As an extension of feeling imprisoned by their memories of sexual abuse, many of the women in this study also described feelings of loss associated with their perceived lack of childhoods. One of the participants, Sue, made reference to being essentially "psychologically orphaned" by her family because of the secrecy, shame, and guilt associated with her abuse. Another, Marty, commented:

I still feel broken and just want to cry all the time. It's hard not to just shut down. I look at my own kids and can't even fathom taking away any part of the happiness and joy they are experiencing right now. They are so innocent, so happy. When I was their age I was always afraid and ashamed. My job wasn't to run around and play, I can't even remember what that was like because just when I would start making friends, I was brought back in again [isolated from outside family and friends]. I felt dirty and unworthy. I was robbed of my childhood and someone should have to pay for that. Why is it that when I have done nothing wrong, it is still me that pays the price?

The women in this study clearly shared parallel feelings about their abusive childhoods

and their sense of being defined by their abuse. They felt inseparable from, and imprisoned by, their childhoods. They alluded to feelings of shame, guilt, and self-loathing that followed them throughout their lives. The majority of the women in this study described being on a “never-ending” healing journey. Lynn explains:

It [childhood sexual abuse and its effects] is never-ending, it lowers your self esteem, your sense of identity, your playfulness, and your whole childhood is taken away from you...it's like this constant reminder. Recovery is not possible, but I can learn from this and heal from this.

Although the finding of being defined by their abuse was not evident in the literature regarding childhood sexual abuse, there is significant documentation within the current literature in support of survivors' feelings of shame and guilt (Bass & Davis, 1994; Beitchman, Zucker, Hood, da Costa & Akman, 1991; Kendall-Tackett et al., 1993; Mannarino, Cohen, & Gregor, 1989). Since the experience of being abused creates in children a feeling of being “wrong” and “bad,” the progression to deciding that they are guilty and therefore shameful is a small step. For the women in this study, feelings of being wrong, bad, guilty, and shameful seemed to be intrinsic to their sense of self:

Connie: I was ashamed of myself and guilty for everything that happened when I was young. I know that it wasn't my fault but I felt like I was to blame. You know when a dog feels guilty about stuff and you tell them “bad dog”...and they tuck their tail between their legs? That was me. It was like I was a bad dog. I just wanted to curl up and hide inside myself.

To contextualize the stories of the women in this study, an examination of the atmosphere in which they grew up is important. Family life was a huge contributing

factor in their experiences of abuse and in shaping their future lives as adult survivors, and as mothers living with a history of childhood sexual abuse.

### *Family Atmosphere*

A growing number of studies have examined the social and family characteristics of children exposed to childhood sexual abuse in an attempt to develop profiles of the particular social circumstances associated with elevated risks of childhood sexual abuse. These studies have specifically addressed the connections between social class and childhood sexual abuse (Connelly & Straus, 1992; Dubowitz et al., 1987; Fergusson, Lynskey, & Horwood, 1996; Finkelhor, 1993; Flemming, Mullen, & Bammer, 1997; Mullen et al., 1996; Whipple & Webster-Stratton, 1991) and family functioning and childhood sexual abuse (Fergusson, Lynskey, & Horwood, 1996; Finkelhor, 1993; Flemming, Mullen, & Bammer, 1997; Mullen et al., 1993; A. E. Stern, Lynch, Oates, O'Toole, & Cooney, 1995). In essence, the family profile of the child most at risk for childhood sexual abuse that emerges from these analyses is that of a child reared in a home characterized by multiple signs of difficulty and dysfunction spanning marital conflict, family change, step parenthood, and impaired parent-child attachments.

Participants in this study described relationships as they existed both within and outside their families. The relationship within their families refers to their parents (biological, adoptive, or step-parents) and siblings (biological, adoptive, or step-siblings). The relationship outside their families refers to extended family members (aunts, uncles, and cousins) and their social community (peer groups, neighborhood, school, and church). The women in this study also spoke of the economic circumstances in which they grew up, which they saw as contributing to many of their continuing life struggles.

Current research suggests that most perpetrators of abuse are not immediate family members (J.C. Anderson et al., 1993; Fergusson, Lynskey, & Horwood, 1996; Fergusson & Mullen, 1999; Statistics Canada, 1993). This was consistent with the findings in this research study, according to which 22 abusers were identified as inter-familial and 47 abusers were identified as extra-familial. However, it is important to note that more than half of the women in this study (n=27) had more than one abuser during their childhoods.

### *Relationships within the Family*

Participants expressed very clear notions of what a healthy family should be like, and their comments reflected the very elements which were missing in their own lives: “a sense of stability,” “knowing someone cares about you and wants what’s best for you,” “always being there for you no matter what,” “supporting you, believing you, loving you—and not sexually,” and “trust, pure and simple, trust.” None of the women in this study were able to report this as their own experience, despite mostly identifying their abusers as extra-familial. Generally the women felt that the climate in which they were raised was “inconsistent,” “secretive,” and “lonely.” Cathy’s narrative exemplifies this experience:

I felt really alone most of the time. Sure, I went to school and did some sports and stuff, but essentially I was all I had. I never had friends over to my house since that seemed so hypocritical. I wanted to have the Beaver Cleaver family but I never did, and even though other people seemed to think my family was great, I knew it was all fake. What the outside world saw was only what my father and mother wanted them to see. It was two different worlds for me.

Family atmosphere consisted of relationships with both parents and with siblings.

Because the dynamics of these relationships varied, largely due to the inherent differences in power relationships between parent-child and sibling-sibling, they are presented individually, rather than collectively.

### *Parents*

The majority of the participants indicated that affection within their families was the exception rather than the rule. In this respect, their families seemed to reflect the cultural and societal norms of their generation, which dictated that children should be “seen and not heard” and intimacy between adults should be kept hidden. The affection that was reported was mostly between parent and child rather than between two parents. Furthermore, physical affection was much more common between the children and their mothers than between the children and their fathers. It is interesting to note that the majority of the participants also described having relatively strained or distanced relationships with their mothers as adults.

The women’s perceptions of the relationships within their families became particularly important when interviewing them about their own mothering experiences. During the interviews, the women often referred to their own family relationships as children when talking about their own actions as mothers. The women’s accounts of their relationships with their mothers acknowledged that the strain between mothers and daughters became most apparent when the participants themselves became mothers. These reflections are further explored in the next chapter, which focuses on survivors’ experiences of childbirth and mothering.

The generalized lack of affection within the participants’ families had many women in the study describing feelings of being “starved for affection,” “always alone

and lonely,” and “surrounded by secrecy and silence.” In several cases, the women outlined how the abuser played on their hunger for affection and their desire to please, and disguised the abuse as affection. Consequently, several of the women did not initially recognize their experiences as abuse. The women’s descriptions of their manipulative abusers did not seem to differ even when the abuser was their father. In the following quotations, Lois describes her abuse by her father, and Dawn describes her abuse by a family acquaintance:

Lois: I had no reference point from which to understand that I was being manipulated and that it was wrong....It wasn’t until years later that I realized how constructed it all was.

Dawn: The nature of it was more controlling and manipulating, setting up situations and you know, very carefully calculating based on how much time I spent with the family...it was very difficult for me to sort those issues out or even to understand them...it wasn’t until I was an adult that I understood that it was in fact abuse.

According to Bohn and Holz (1996), “decreased self-esteem is common to survivors of interpersonal violence. Psychological manipulation of their victims is a common ploy of abuse perpetrators” (p. 444-445). A decreased sense of self-esteem was unquestionably an emotion expressed by all the women in this study. Several of the women also expressed feelings of shame and guilt associated with their craving for attention; they considered this to be incongruous because the nature of the attention was abusive, and therefore hurtful, and yet it was also something that they felt they needed. This perpetuated their feelings of low self worth and resulted in a measure of internal

dissonance.

In addition to the many reported instances of manipulation, the self-esteem of the children and mothers in these homes was undermined by their relative powerlessness. Several women recalled growing up with the sense that they couldn't do anything right; many defined themselves as "confused," "bewildered," and "uncertain about what was expected of them." They were confused by the fact that the same men who berated and abused them also appeared to be upstanding members of the community who were "loved" by their mothers and siblings. They felt emotionally disconnected from their fathers and other immediate family members. Kelly commented that "I didn't matter. I felt like I was a stranger amongst relatives... I just felt strange and others treated me like that." Jeannie reinforces this idea of being disconnected and alone: "I felt like I was in a constant state of not knowing where things stood....I was scared of everything and uncertain about everything...and I was really, really lonely."

Women's early experience of emotional distance, put downs, and lack of communication produced conflicts and confusion in their relationships with their parents. Some noted that their mothers tried to be supportive and loving but even their best efforts were viewed as inadequate. Often the women were caught in a struggle between their need to develop a sense of independence and autonomy on the one hand and their need for protection against sexual abuse on the other:

Oils: I closed off emotionally. I am naturally an emotional person but I minimized the situation and just pretended that it didn't bother me. It is what I needed to do to survive. I didn't get help from her....so I got it from within.

Kat: I needed my mom to protect me and she was incapable despite what I would

consider her smothering me. It was such an irony since all I could do was complain that I didn't have enough freedom while growing up. I didn't think it was all that complicated...being able to take care of your own kids...at least not until I had my own.

In addition to sexual abuse, many participants reported violence in the family as a key issue. They spoke about the physical and emotional abuse they suffered and witnessed in their families and the subsequent effects of that violence on their lives. Research noting the prevalence of physical and emotional abuse in addition to sexual abuse within families is common (Bass & Davis, 1994; Fiscella, Kitzman, Cole, Sidora, & Olds, 1998; Lesser & Koniak-Griffin, 2000; Runyon, Deblinger, Ryan, & Thakkar-Kolar, 2004; Statistics Canada, 1993; Stevens-Simon & McAnarney, 1994; Stevens-Simon & Reichert, 1994). These studies suggest that children who are exposed to childhood sexual abuse are also physically and emotionally abused. Mullen et al. (1996) report that women with histories of childhood sexual abuse were 5.3 times more likely to experience physical abuse and 3.0 times more likely to experience emotional abuse than women without such a history. Many of the women in this study described feelings of emotional abuse that they considered inherent within their experiences of sexual abuse. Experiences of physical abuse were also apparent in many of the women's stories, but seemed to occur in relation to sexual abuse rather than separately.

The experience of repeated violence made fear and uncertainty major issues for each of the women. As a result of living in an environment of physical, sexual, and emotional abuse, the women learned not to "rock the boat," even as children. This attempt to control the uncontrollable came at a cost to their sense of identity and self-

esteem:

Alex: I was very conscious about not making any mistakes around my parents. I didn't want them to get upset about anything, because there wasn't such a thing as "that's OK hon," it was high intensity no matter what. I knew that even if it was an accident, someone would be punished in some way. My dad would hit us, my mom would leave us...abandon us, and then at night I would have to pay penance for my "mistakes"—and you know what that means. So basically I tried to be as inconspicuous as possible—kinda like I wasn't there at all. Imagine having the goal as a child to become nothing...to disappear!

The violence reported by participants was frequently associated with the abuse of alcohol and drugs by family members, which was often also a precipitating factor for the sexual abuse:

Rhonda: We never knew if he was going to come home drunk or not. When we heard his car pulling into the driveway, we used to sneak into the living room and peek through the curtains. If he parked the car straight, we knew that it might be OK, but if the car was parked crooked, we were in trouble.

Ali: He's [father/abuser] the one who got me high the first time. I was only eight at the time and I remember him showing me how to roll a doobie [marijuana joint] so that I could do his too. I hated it at first but then it really helped with what came next...it didn't hurt as much anymore. During those times it was like we were buds or something. Trouble is that when he came down off the high, he was like super violent. I think it was all misdirected guilt for all the crap that happened when he was high.

One of the women in this study talked of eventually reaching a point within her own life where using violence in response to her father's violence became her coping mechanism. Her experience of reciprocated violence was unique to this study:

Jeannie: I used to hit the son-of-a-bitch back. He would just randomly swing at all of us and got pleasure when his fists connected. Although I was "just a girl," I was stronger emotionally and physically than my siblings. I think that it was hate that drove me which is what scares me most because I felt it in my very core. I hated him, I hated him, I hated him. It's really amazing I didn't kill him because I certainly thought about it.

The abuser's violence also frequently extended to family pets, and the threat of animal abuse was often enough to coax children into performing sexual acts or maintaining secrecy about these acts. Many participants explained that family pets were their only real "friends," such that this was the relationship they cherished the most. Some participants also spoke of relating to their pets more than anyone else, because these animals were the most vulnerable and, despite their abuse, were readily prepared to love and trust again:

Stephanie: That dog was the closest thing to a friend I ever had...I mean I loved her, really loved her. It was like she knew that I was hurt inside and she was simply there to make it all better....He was a bastard, a real bastard to do that to her [beat her with a stick]....she was just trying to protect me...all she did was growl at him. I would never forgive him for that. That was worse than anything he could throw at me. Bastard.

Terry: I overheard him tell my mom that he would kill the cat the next time it

came near him...I knew that he would do it and would make me watch...it wasn't enough to just do it. One day we were driving along a quiet road near our house and he just stopped the car with no warning, went to the trunk and pulled Mitts out by her back legs. I was hoping he'd just shoot her so it would be quick but the sick bastard pulled out a tire iron and held her up against a tree by her back legs. He just hit her in the head once and then threw her in the bushes...I will never forget that because I could hear her and I knew it was horrible for her...broken neck. He didn't say anything just got back into the car with a smirk. I didn't even shed a tear because I didn't want to give him the satisfaction but a part of me died right there. I wished it was me.

Within the literature, a significant link is made between violence against children and violence against animals (Ascione & Arkow, 1999; Boat, 1995). Awareness of the child abuse-animal abuse connection has become heightened with specific regard to domestic violence settings. Professionals working with domestic violence report similar stories of abuse of animals and children that is part of the power and control dynamics of the abuser (Jorgensen & Maloney, 1999); many men who resort to violence and abuse to control women and children enhance their control by harming or killing family animals or threatening to do so (Arkow, 1995; Straus & Gelles, 1990). As evidenced by the narratives of the women in this study, the abusers were successful in enhancing their control over the women with their animal abuse. Recent surveys addressing violence against animals (as witnessed by women in shelters for battered women) noted that between 71% and 88% of families who owned pets reported that their violent partners had threatened or actually harmed their pets as a form of control over them (Ascione,

1998). Furthermore, many of these women delayed seeking help for themselves and their children out of concern for their pets' welfare. Within my research study, I did not explore the animal abuse-child abuse connection further. Nevertheless, I believe it warrants further research. Its significance in this study is that violence perpetrated against family pets was clearly used as a form of power and control over the women concerned.

Further to feeling a need to protect the family pet, a staggering number of the women also felt that they were vulnerable to the sexual abuse because they were attempting to protect their own mothers from violence. They believed that by continuing to take part in the sexual abuse, they would in some way be sparing their own mothers from instances of physical violence. Some participants reported that the abuse of their mothers ended with the beginning of their own sexual abuse as children. A few of the women felt that this gave them a sense of value in an otherwise "value-less" family; others exemplified a parent-child role reversal:

Lola: When my mom asked me what was happening we had this huge scene...I couldn't talk to her about it and so she accepted that but she was really unhappy and then the next thing that happened is she went home to her mother and left me there and all the kids. I had four siblings and I was the oldest. So I was eleven and basically I was in charge....There were extended periods when he couldn't work so he was always at home. I had to take on the role of mother.

Kat also shared her experience of being "sold" as a sexual tool to neighbors to bring in money for her mother's drug addiction. She describes having multiple partners (n=12) prior to the age of 11. In many ways, Kat, like several of the women in this study,

felt that she became responsible for her family and in effect took on a parenting role.

The theme of mother-child role reversal emerges in existing child abuse literature, which notes that mothers who have been sexually abused may become overly dependent on children to meet their own emotional needs (DiLillo & Damashek, 2003). Although the mothers of the women in this study were not necessarily identified as sexual abuse survivors themselves, the question remains whether their own personal histories contributed to their daughters' experiences of parenting role reversal. An alternative explanation may be that as a result of the family's general dysfunction, these mothers were unable to care for themselves and their children. This suggests the possibility of an intergenerational connection in abuse experiences. One of the participants, Lynn, held her mother responsible for the sexual abuse she experienced at the hands of her step-father. She felt that her mother was incapable of being a parent because of her own issues of childhood sexual abuse. As a result, Lynn felt that she had to "grow up too early" and be the "mother" in her own family. Lynn described difficulties bonding with her own daughter which she felt were attributable, in part, to her negative feelings towards her own mother. She explains:

I didn't like her [her daughter] and I don't know whether it was because she was a forced, an unplanned pregnancy. I don't know whether it was my husband's reaction to her, I don't know whether I saw my mother in her, I don't know what it was but I didn't like her and I guess it really showed, it really showed.

One participant, Beesh, was sexually abused by her mother, her mother's siblings (both male and female), and by her own sister. Her case was unique to this study in that her sexual abuse occurred at the hands of her mother:

My mother physically and sexually abused me. She was quite aggressive. Ever since I can remember my father was out. We lived on a farm and he was outdoors all the time and I just remember the physical abuse from my mother...all the time. And then after my dad died the sexual abuse began....and that was from anyone from my mother's side of the family—her sisters and her brother...and then my cousins and one of my own sisters. I was only five or six and I think I was around thirteen or fourteen when it stopped. At fifteen I was put into foster care.

Beesh's experience in foster care was short-lived as she was returned to her mother's care after a short time. She did not feel supported by social services because despite her insistence that she did not want to go, she was reunited with her mother.

Social services...they grant mothers, biological mothers the right...these rights when really they don't listen to the children at all...I think sometimes there's this huge momentum to keep the children and mothers together in particular, and I suspect that sometimes that's not the best situation or many times it's not the best situation. But we overlook that for the sake of this momentum to keep the family unit together. It's not always right for the child.

Although the majority of participants were raised within their own biological families, three of the women in this study had been in foster care since infancy. As a result, their sense of family was defined by whatever circumstances they found themselves in. All three of these women described similar experiences of living in multiple foster homes prior to their "release" from care, and their stories did not reflect a need to "protect" those responsible for their care. Unlike some of the other women in this study, these three did not identify with the mothering role reversal.

Although it is relatively uncommon, a small number of abusers are, in fact, female (Bagley, 1995; Fergusson, Lynskey, & Horwood, 1996). These authors report that there is evidence of clear differences in the rate of male abusers depending on the gender of the sexual abuse victims. With female survivors, almost all perpetrators are male with estimates of between 97.5% to 99.2%. With male survivors, the rates of male abusers change to between 63.2% to 85.7%. Although retrieving statistics addressing mother-daughter sexual abuse is difficult, based on the above statistics, sexual abuse by female-to-female child is less than 3%. Peluso and Putnam (1996) speculate that although rates of sexual abuse by females is low, these rates are likely to be underreported because of a result of a lack of recognition of childhood sexual abuse by female abusers.

Most of the participants' mothers were not available to them as protectors or as adults they could talk to about the abuse; often their fathers were not resources they could call on either. Although the responsibility for protecting their children from sexual abuse and other harm is commonly ascribed to mothers, fathers cannot be exempted from this obligation. From what the women shared with me, however, even those fathers who were not abusers abdicated their parental responsibility. Those fathers who were abusers clearly demonstrated their authority within the family, and that authority, whether or not they used violence to enforce it, intimidated their families into submission and effectively removed the mothers as sources of protection and comfort for their children. This is a key finding in the women's stories, one that supports further investigation into the complex relationship between mothers and daughters.

### ***Mother-Daughter Relationships***

The women in this study frequently reported significant struggles in their

relationships with their mothers. Many women said they felt betrayed and angry when they thought about their mothers' failures to protect them from childhood sexual abuse. Their ways of dealing with these feelings varied. Several women said they had attempted to develop a positive mother-daughter relationship to no avail. One woman, Nelly, who had been sexually abused by her stepfather, found that the major stumbling block was her mother's inability to believe that the sexual abuse had actually taken place. She recalled her mother calling her a liar and she resented the fact that, even after the disclosure, her mother maintained a relationship with the man who had abused her. There was a brief period of reconnection when Nelly was first married but "when my daughter was born, we'd go there and mom would say, 'let your father hold her...let's take a picture'." Fear for her little girl and dismay at her mother's disbelief of her own abuse made it impossible to continue contact.

Some survivors stated that only superficial communication with their mothers was possible. They expressed ambivalent feelings: on the one hand they still loved their mothers and wanted closeness, on the other hand, they needed to protect themselves by holding back:

Lynn: I guess I blame mainly my mother...the fact that my mother allowed it and minimized it...our relationship became so bad that you know the idea that she would have saved herself and sacrificed me, rather than herself, is just so inconceivable to me. I never had a sense that she cared about me anyway and I think that I reminded her of my father and I think she placed the blame all on me.

It became clear from participants' accounts that significant tension was part of their relationships with their mothers, and this tension reoccurred as a central theme in

the women's accounts of their relationships with their own daughters. Plausible explanations for the tension may include women's perceptions of not being protected by their own mothers. The process of protection became more apparent in women's experiences of childbearing, as they identified the need to protect themselves or their children as central to their experience as a mother and survivor of childhood sexual abuse.

### *Siblings*

Participants described relationships with siblings that were almost as complicated as those with parents. Some participants found a measure of support in their relationships with their siblings; for a few of the women, their siblings (brothers) were the perpetrators of the abuse. One participant, Colleen, was sexually abused by both her father and brother. The abuse by her brother was first initiated by her father who wanted him to "try it out." Although Colleen describes her brother as being reluctant to participate at first, eventually sexual abuse at the hands of her brother (and later his friends) became a part of the norm, separate from her father's sexual abuse:

I don't think he wanted to at first, but I remember Dad making him do it. He would look at me and almost apologize with his eyes. It may sound strange but I felt close with him then because in a way it wasn't his fault and it wasn't my fault...like we were in it together. I don't know when that changed but eventually it did....He would sexually abuse me when my father was away...and his eyes didn't say I'm sorry anymore...they were void of emotion, except anger perhaps.

For Lisa, who was adopted and living with her adoptive family, the disclosure to her adoptive parents of her abuse at the hands of her adopted brothers was met with

disbelief, anger, and eventually resentment, as the parents tried to protect their biological children and dismissed Lisa's disclosure as evidence of her being a "difficult and manipulative" child. Lisa described first disclosing to her parents at the age of eight and being sent to a psychiatrist for "behaviour problems" as a result of her disclosure. When she disclosed her abuse to the psychiatrist as well, her father begged her not to talk about it anymore since it would further disrupt the family.

I was adopted and my adoptive brothers were my abusers. So in essence, my brothers weren't really my brothers and so I kept making that excuse my whole life. They were just curious I would say to myself....I can't grasp it all because all I remember is screaming in my bed 'ow, ow, ow, it hurts', and I remember the pain and I have felt that pain over and over again....then they brought their friends over too. I really liked their friends emotionally but I didn't like the sex, but it didn't matter to me anymore because I knew that it would be over soon. I knew that I had to do it because otherwise they wouldn't like me....I told them when I was eight or nine, and they sent me to a shrink....I told him [my father] that I told the shrink everything and he said "he never told us anything." He begged me and made me promise not to tell my mom because she already had three nervous breakdowns.

Most participants had positive relationships with their siblings but the dynamics were often strained when there was more than one female in the family. This strain centered on needing to protect the other sibling from sexual abuse. Renee commented that "If it wasn't going to be me, it would've been her...and she just seemed so sweet, so innocent. I couldn't let that happen." Shauna reported a similar need to protect her sister

from abuse:

In some ways I did what I did for her. I think I made the right decision because life for her would have been a lot worse than it was, and I am a stronger, harder person. She was way more delicate than I am.

For one participant, Pat, sexual abuse by her brother was a trade for protection from her older sisters who were “resentful” of Pat not attending boarding school and therefore having the “privilege” of staying home with their mother. Pat’s situation was unique to this study:

My older brother and two sisters were brought home from boarding school and then my brother started fondling me and it was kind of a trade off because...it was a case of my two older sisters having resented the fact that I got to stay home and my mother was feeling really guilty that she’d sent her kids to school...so there was this whole thing of believing anything they said because they couldn’t lie since they had been raised by nuns in the boarding school...so I got blamed for everything and it [sexual abuse] was a trade off. I told him “okay, you protect me if I let you touch me”... so I’ve lived with guilt all my life because it wasn’t something I could feel I could get angry with him about because in some ways, I had agreed to it.

Beesh was the only woman in this study to be sexually abused by her sister; this abuse coexisted with sexual abuse by her mother, aunts, and uncles. Beesh considered the sexual abuse by her sister as the most painful act of betrayal:

You know it [sexual abuse] was way worse when it was my sister, even worse then when it was my mother. I remember feeling so ultimately betrayed by her

[sister]. I already knew that my mom didn't like me and that was hurtful enough, but my own sister? That was worse than anything.

For the most part, in situations where there was no sexual abuse between siblings, relationships with siblings centered on needing to protect one another. While taking on this kind of responsibility is something no child should have to do, at times it had the effect of helping these women feel better about themselves. In some cases, it seemed to provide a sense of closeness and worth that they lacked in the rest of their lives. For many of the women in this study, no matter how close their bonds with their sisters and brothers were, the abuse and the emotional distance that pervaded their families affected what they could both take from and give to those relationships. While many participants described emotional connections with their siblings, they were also still children together and therefore relatively powerless to change their situations. As a result, the women in this study felt that ultimately they were not able to develop the kind of close relationships they wanted with their siblings.

### *Relationships outside the Family*

Family life was indisputably the major influence on participants' lives, but relationships outside their families were also significant. Many survivors shared that they did not have close friends, either because they moved around a lot or because they felt too ashamed to really get to know someone else: their "little secret" effectively prevented them from establishing close relationships outside their families. Many participants described barriers between themselves and their potential friends. Even as children, the women were acutely aware of the differences rather than the similarities between them:

Louise: I wasn't accepted anywhere...and this just added to my feelings of

inadequacy. I didn't know who I was, I didn't know where I was going. I didn't go out because I didn't have a lot of friends to go out with. I couldn't even go out with a group of people because I never felt like I connected with them...But I was more mature than everyone else anyways. I mean, everybody was complaining about school and their parents letting them go out on Saturday night and you know, I was dealing with what I had to deal with and just finding a way to get through every day...so it was like, "what do you have to complain about?"

Lisa: I remember testing my friends to see if it was OK to be really honest with them. I sort of told a few of them one night at a sleepover about what happened with my father, and I could tell...well I knew that they were all horrified. My life was never the same after that. It was like not only was I ugly on the inside, but everyone could see the ugliness on the outside. I made a total joke of it after that and had to tell them that I was just joking, but I don't think they looked at me the same.

Although participants described peer relationships as important, relatively few of them were able to share deep bonds with childhood friends. In large part, this was due to the shame and secrecy associated with their sexual abuse, which made them feel like outsiders. Finding a peer group to relate to was extremely difficult; a few of the participants described belonging to a group of "misfits." Although this group wasn't popular, it was, nevertheless, a group in which some of the women felt some sense of belonging:

Serenity: I was totally un-cool but at least I had someone to hang out with...like other kids that were also un-cool. I think we struggled with who were really were

so we ended up just creating this image outside ourselves. We wore all black everything and just went really “out there.” I guess it was like I couldn’t belong so I may as well really not belong. That was better than being on my own...because those kids were worse off than me, I think.

Some participants spoke of role models outside their families. These often included an elementary or high school teacher, a school guidance counselor, or a friend’s mother. In some instances, these women were members of their own extended families such as aunts, cousins, or grandmothers. Many of the participants commented on the greater closeness and warmth they noted in their friend’s families, in comparison to their own. Their observations included such thoughts as “the family seemed so solid, there was no drama apparent,” “everyone seemed to be really interested in each other, they actually talked,” and “they would hug goodbye and goodnight and stuff. It was really cool.” The qualities of the individuals whom they considered as role models included “independent,” “compassionate,” “powerful,” “safe,” “nurturing,” and “warm and patient.” These were also all qualities that the participants said they wished they had themselves. In essence, the women in this study shared that they had limited relationships outside their own families, but these relationships were important to them in terms of understanding that not all families were like their own and that there was life outside of their own existence. For many of the women in this study, this instilled a hope of better things to come.

### ***Socioeconomic Status***

For some of the women in this study, their family’s economic situation was not a problem. Their parents were middle class, owned their own home, and provided

adequately for their children. The majority of the women, however, were acutely aware that their parents struggled to provide for them and noted that money was a significant factor in their lives. Associated factors included situations of substance use, large rural families, extended unemployment, frequent family moves, divorce and subsequent single parenthood.

Although a family's financial status does not dictate whether child abuse occurs or not, the discussion of the family's financial security became important within this research study because many of the women alluded to remaining in a sexually abusive situation because their mothers did not feel able to adequately support themselves and their children should they leave. In these situations, the women had disclosed their abuse to their mothers and felt particularly betrayed when no action was taken. Their mothers were perceived to have chosen their abuser over them.

Amy: I knew that we were very poor and that times were tough. It seemed like everyone in the family was doing something to make money. I was very aware that we had no money and that most of my parent's fights were because of it. My mother always told us not to ask Dad for anything since we couldn't afford it and it would make him angry. Since we didn't have anything anyway, I couldn't understand why she didn't leave when I told her. She said we couldn't afford to leave but the way I see it, we couldn't afford to stay—not emotionally anyway.

One of the women in this study, Michelle, was abused by a neighbor whose children she was caring for on a weekly basis. Her family was poor and welcomed any added income, despite Michelle telling her mother about the sexual abuse. Michelle felt that her mother's reasons for not intervening, in addition to the financial gains, included a

concern with upholding a positive public image. The family already had a reputation for being poor and was ridiculed for this, so her parents made a concerted effort to maintain a respectable public image, one which certainly did not include “making trouble” by disclosing the abuse:

When I got into my teens I started to babysit. Every time I would babysit for him ... he'd always be handling me in my clothes, trying to force kisses on me and laughing about it. It was really creepy and I just wanted to go home but his wife was my mom's friend and when I did tell my mother about it, she got mad at me and said “like you are a problem child and I'm not going to let you make a problem in my friend's life, she's got enough problems as it is right now with her husband and we don't need anyone talking about us either.” It came out later that apparently there was another little girl around my age that was also doing babysitting for them that had gone to the police so my mother said “look, she's already got that going and that on her mind so she doesn't need you too.”

The relationship between financial status and increased risk of child abuse is recognized in many areas of child abuse research, (Connelly & Strauss, 1992; Dubowitz et al., 1987; Martin & Walters, 1982; Whipple & Webster-Stratton, 1991). However, extending the linkages of socioeconomic status or social class to childhood sexual abuse appears to be unwarranted. A growing number of research studies have reported a weak or no association between measures of socioeconomic status and the risk of childhood sexual abuse (Bergner et al., 1994; Fergusson, Horwood, & Lynskey, 1996; Finkelhor, 1993; Fleming et al., 1997; Mullen et al., 1996). This is consistent with the characteristics of the women in this study in that women from both economically

advantaged and disadvantaged families experienced childhood sexual abuse. However, it is important to note that vulnerability to abuse, in general, may increase with financial strain. Two plausible explanations may be that in circumstances of limited financial resources, (1) marital conflict increases and family dysfunction increases proportionally, thereby placing the child in a risk situation, and (2) the parents or caregivers may be physically unable to provide adequate supervision of the children because of needing to work additional jobs to support their family.

In addition to finances, public perception was a contributing factor in the disclosure of the abuse and the family's ultimate action. Many women noted that their abusive fathers were particularly concerned about maintaining positive public images, and sought to be perceived as good neighbors and family men who were good with children. In some cases, these men held positions of leadership in the community such as minister, high school teacher, and soccer coach. The women were particularly conscious of the father's public role because this role made disclosure even more difficult, by lessening the chance that they would be believed, in light of their father's reputation. These abusers seemed to have constructed and maintained a convenient lie that served to shield them and their abuse from exposure and to prevent their children from challenging their own violation.

In general, the women shared that the atmosphere in their homes was clearly controlled by their fathers. The mothers were "submissive" and "powerless" when it came to their fathers, who invariably held an authoritative position within the family. Most of the women recalled that any sense of being loved and cared for came from their mothers. Bobby commented "I know that my mother really did love me, she just didn't

show it very well, but I truly believe that the love was there.” The women also shared that feeling loved by their mothers was an inconsistency in that they experienced greater tensions in their relationships with their mothers, than with their fathers. Many of the women in this study shared that the emotional atmosphere of their families was confusing for them:

Louise: I found when I first told my mom about the abuse she was very angry.

But she was very angry at me and said it was my fault...and I shouldn't have told, and why did I have to go and ruin things for her. That really hurt. She was supposed to protect me.

Lynn: My abuser was my stepfather...my mother remarried and she was a very weak woman and had no sense of self, no sense of identity. She became this person's wife, got very involved in the church and sort of threw me to the wolves. I guess because in order to stand up to him or to tell him to get out, there would have been a scandal...and she just wasn't prepared for that. She was aware of the abuse. She minimized it and she called it “fondling.” Well it certainly went beyond that but she needed to justify it in her own head that way. I hated her for a long, long time.

The women in this study reported family dysfunction regardless of whether their abuser was intra-familial or extra-familial. Furthermore, despite the internal and external resources drawn upon to survive their abuse, the abuse always had consequences. These consequences are addressed below.

### **Aftermath: The Consequences of Abuse**

In discussing the consequences of sexual abuse for women survivors, I have summarized what participants described as their life consequences rather than providing extended and dramatic first person accounts of their sexual abuse. My rationale for this was to avoid the sensationalism that can often accompany such narratives and prevent the reinforcement of the “victim stereotype” for women and children. I did not want to focus on what sexual abuse acts occurred, but rather on the consequences of these acts, and ultimately on the meanings they carried. By listing some of the collective experiences of the participants, I am in no way attempting to distance myself (and others) from the real experiences, nor am I attempting to objectify or minimize women and children’s experiences. Rather, I am attempting to write respectfully and honestly about women and children’s experiences through emphasizing the connection between the abuse and its effects.

The women in this study went on to describe the profound impact the abuse had on their lives beyond childhood, citing physical, emotional, and psychological consequences. Some of the physical manifestations of the participants’ abuse included: sexually transmitted diseases; pelvic inflammatory disease; chronic pelvic pain; frequent bed wetting; crippling stomach aches; urinary tract infections; kidney infections; rectal fissures and bleeding; constipation; chronic fatigue; migraines; convulsions and seizures; self mutilation scars; eating disorders (anorexia nervosa, bulimia nervosa and overeating); multiple pregnancies, frequent pregnancy terminations, and recurrent pregnancy loss. Some participants also found themselves experiencing sexual violence outside the context of their child abuse, such as sexual assault and gang rapes. Many

participants also described histories of entering abusive relationships as adults.

The women in this study all described early experiences with emotional distancing. They learned from an early age not to trust or believe in the intentions of others. They learned not to be “vulnerable” to others. Each of the women described the tragic consequences of maintaining an internal emotional void. Although there were times when they didn’t “feel” anything, unquestionably the impacts of their emotional distancing surfaced in some way. Within the group of women I interviewed, the emotional consequences included profound nightmares, self estrangement, depression, anxiety and panic attacks, low self esteem and self worth, poor body image, severe behaviour disorders, suicidal thoughts and attempts, post traumatic stress disorder (PTSD), borderline personality disorder, and multiple personality disorder. The physical and emotional manifestations of childhood sexual abuse described by the women in this study are consistent with those reported in “The Effects of Childhood Sexual Abuse on Adult Women” section in Chapter Two of this dissertation.

The majority of the participants were abused by more than one offender: grandfather and father; brothers; stepfathers, stepbrothers, and uncles; babysitters; day care workers; neighborhood boys; foster fathers; and school teachers. The acts were not isolated incidents. Consequently, the women described living with the fear, and the knowledge, that the abuse would happen over and over again. The sexual abuse was a regular occurrence for some children, sporadic for others, and random for all. It was unpredictable and they never felt they had any control. In essence, they never felt safe.

Joleen: I have learned that one is never safe. It doesn’t matter whether the abuse is within your family or not because it’s not just adults who abuse....even kids

abuse other kids....for me it was a neighborhood boy who raped me...and then his friends....it's no surprise that it's happening because it's everywhere and even if you tell, nothing changes....so what's the use in making a big fuss about it.

Kat: In my opinion, every woman I meet is probably a survivor. I mean, the statistics are just so bloody high, I don't discount anyone. The ones that haven't been abused—I just used to sit there and listen to them and I would be marveled. I would be like, can you tell me more, would you explain that to me again, you know, how you lived in the same house for fifteen years and how your mom and dad didn't beat you, they didn't sexually molest you, that you had a safe childhood, that you knew the same kids all your life, that you had the same name all your life.

According to the women's accounts of how sexual abuse affected them, the consequences of sexual abuse were interconnected and cumulative. While respecting the fact that each survivor's experiences are unique, it was possible to identify experiences common to the women in this study. They felt confused about their physical and emotional boundaries and struggled with relationships both within and outside their families. As Kat explains in the above quotation, survivors attempted to identify the "line that had been crossed" in order to make sense of their abuse. How the women in this study managed their lives against a backdrop of sexual abuse was contingent upon various influencing factors and coping strategies, both internal and external.

### **Influencing Factors and Coping Strategies**

Various factors (mediated by the women's own coping strategies) influenced the consequences of abuse for the women in this study. The influencing factors identified

were categorized as either positive or negative factors. Although they appear to be opposite, the factors influencing the women were not dichotomous but rather existed along a continuum of positive (protective) and negative (harmful) factors, often landing somewhere in the middle. What some women described as a positive factor was interpreted negatively by others. Therefore, women's perceptions of the factors influencing their abuse consequences were individually determined. There were, however, some consistencies within their stories.

### ***Positive Influencing Factors***

The most prominent positive influencing factor in the women's lives was the role of secure attachment relationships during their childhood, or what the women referred to as "pivotal people." These consisted entirely of females and included their mothers, grandmothers, other female role models, and peer relationships. The presence of pivotal people in the women's lives made all the difference for them in terms of their sense of personal value as children. In turn, this sense of personal value contributed greatly to how profound the consequences of the abuse became for them as adults. The crucial qualities of those individuals identified by the women in this study as "pivotal people" is that they listened, believed, and instilled a sense of hope in them.

All of the women in this study wanted maternal support—to be loved and believed by their mothers when they told. Sadly, this was rarely their experience and they turned to others for support. For most of the participants who described positive people in their lives, having support from extended family members, such as an aunt or cousin, made the difference. Others spoke of a high school teacher, guidance counselor, or the role modeling of other women in their friends' families giving them hope. What

resonates most in their stories is not that they disclosed their abuse or even that they were believed if they did tell, but rather that there was hope that not all families were like their own:

Angie: I loved going over to Carrie's house because her sisters were so great.

They were older and beautiful...had boyfriends...were really popular. I wanted to be just like them... in some ways it reinforced for me just how much I missed out on things...The flip side is though that I knew not everyone lived like I did and that was really cool. It made me think that maybe there was a chance for me.

Two of the participants, Lynn and Lola, identified their grandparents as sources of hope and stability:

Lynn: By some fluke when my father died I spent five years with my grandparents and whatever stability I have and sense of achievement comes from their parenting, and certainly not my mother.

Lola: My mother was vicious and bitter and sharp and she hated having so many kids, she never wanted kids and she had five of us and we lived in a house with no running water, no electricity and the only way you could get around was in boats, my mother couldn't swim and she hated boats and she was just in a rage. We lived with her parents because her mother [Lola's grandmother] took care of us and she was happy and we were happy. Then we moved to the bush again and it was like somebody had just caught her by the throat and you know, threatened to kill her and she was in a rage for years.

Some of the participants described peer support as critical to their survival as children, although this finding was somewhat inconsistent with the women's stories of

lacking friends or never feeling like they completely belonged. Some of the women felt that their peer relationships were a reprieve from the abusive environments in which they lived, regardless of whether they felt truly close to their friends or not. Sarah explains:

They [friends] were all that I had at the time...and even if I wasn't a really big part of the group...at least it was something. For as pathetic as it sounds, I was kind of like a begging dog, I would have taken their scraps if it meant I could belong.

Some of the participants reported having boyfriends during young adulthood, but this was not the norm. Most of the women described their adolescence as a "lonely" time with no intimate relationships. Others described having multiple boyfriends or sexual partners during adolescence, but it was rare for boyfriends to be "long term." Very few of the women in this study reported having significant long-term monogamous relationships with male peers. Nevertheless, these women reported feeling some sense of belonging while being part of a peer relationship.

It is clear from these findings that support through family and/or friends was important in mediating the effects of the abuse. According to Romans, Martin, Anderson, O'Shea, and Mullen (1995), the nature of family relationships and peer and partner relationships is likely to play an important protective role in the development of psychopathology, with individuals reporting supportive relationships as potential risk-reducers. Conversely, growing up in an adverse family atmosphere with little support significantly increases the likelihood of long-term negative outcomes. Fergusson and Mullen (1999) identify personal resiliency as an additional factor in mediating the effects of childhood sexual abuse. For the women in this study described outside support

systems, albeit limited, and their own sense of personal resiliency, as contributory factors in their adaptation to their childhood sexual abuse experiences.

According to Fergusson and Mullen (1999), a substantial minority of sexually abused children do not develop significant adjustment difficulties in childhood and as adults. One explanation for the possibility that some children are asymptomatic is that they are resilient to childhood sexual abuse exposures and therefore do not develop adjustment difficulties in response to these experiences. Research into what makes children resilient is limited and it remains unclear what exactly defines resilient children. Some researchers suggest that adjustment difficulties are less for children experiencing non-coercive abuse that is limited in its duration (Friedrich, Beilke, & Urquiza, 1987). Others suggest that maternal support is most influential in determining responses to sexual abuse. Essentially, the more supportive and nurturing the mother is, the less likely the child is to exhibit difficulty (Oates, O'Toole, Lynch, Stern, & Cooney, 1994; Waterman & Kelly, 1993). It has also been suggested that children with negative attitudes and limited coping skills are more likely to feel the effects of the abuse (Kendall-Tackett et al., 1993). Experiences of coercive and on-going abuse were the norm for the women in this study, as was limited maternal support. A comparison of my findings with the relevant literature suggests that the women in this study may not possess significant resiliency factors that might mediate the effects of their abuse. For many of the women this statement is accurate. For a few others, stories reflective of resiliency were apparent, despite a lack of maternal or outside support.

In summary, factors influencing resilience to abuse included the severity of the abuse, the extent of family support and nurturance (predominantly maternal support), and

children's attitudes and coping skills. Few of the women described having feelings of personal resiliency as children. More commonly, they reported developing stronger coping strategies as they matured. The limited findings in this study regarding children's personal resiliency are not indicative of whether or not this exists for survivors of childhood sexual abuse. Rather, its absence in the women's lives as children may simply be explained by the fact that the women volunteering for this study were not, themselves, highly resilient children, and therefore the consequences of their abuse were profound. The question remains, whether resiliency is a learned trait developed over time, or whether it is inherent within certain children. What is clear is that the women in this study possessed a quality that ensured that they survived their abuse, however severe and prolonged.

### *Negative Influencing Factors*

The single most destructive factor in participants' experiences was not being believed when they disclosed their abuse. The women who did disclose were met with varying responses. Some participants described being told it was "really nothing," or "it's all in your head," or "it's your fault." Participants women discovered that disclosing was self-punishing and therefore learned to keep their secrets. Some of the women who disclosed were referred to social services. None of the women interviewed had positive experiences with the police or family social services:

Louise: After I told and the police got involved well, it actually didn't turn out very well. They brought in a social worker and she got me out of the house for the weekend. I went to a friend's house for the Friday and Saturday night. Then I went home on my own without them knowing it because I didn't know what was

happening. On the Sunday morning she was a little upset with me for going home. The police didn't offer me any counseling or anything and eventually I went and made a report and stuff. Then they came back to me a week later and basically told me that if I told them I was lying on one of the charges, then the charges would be lessened. And they said that would be the best way to go to protect everybody. They gave a big guilt trip and my parents did too. You know, my dad was a prominent guy in the community and stuff. So the charges were lessened and then that was it. That was the last I heard of the police...and I went and lived back home again. So telling doesn't help, it doesn't do much good.

Louise's experience was consistent with the experiences of the other women who received "support" from police or social services. Either it became a forgotten issue or the children were permanently removed from their parents' care, which was not always helpful. Although none of the participants reported "positive" interactions with social services, this is not to suggest that all interactions between social services and childhood sexual abuse survivors are negative. Nevertheless it is striking that none of the participants described positive experiences in this regard.

On a related note, this study brought to light the fact that less than 5 % of all the women recounted receiving intervention as a child, a finding analogous to the 5-7 % noted in the literature (A. H. Green, 1988). Similarly, Kolko, Seelyo, and Brown (1999) report that only 13 % of children who have been victimized receive any treatment following their disclosures. In general, most of the abused women who had shared their histories had met, at some point, with disbelief and other unsympathetic responses from families and professionals. Those women who did choose to disclose described

therapists, followed by partners, as the most helpful in coping with an abusive past. Social services were not viewed as helpful at all. Although a few participants identified it as a positive influencing factor, only a fraction of the women in this study had access to therapy as children (although most were receiving therapy as adults). Most of the women who received therapy as children did not feel that it was particularly useful for them, partly because even though they disclosed their abuse, they often remained in abusive situations. This reinforced their sense that they were powerless and meaningless, even after the truth had been disclosed. The inaction seemed to speak louder than their words:

Angie: I told them [therapist] everything that he did to me and yet it really was no big deal for anyone—it was like nothing happened and I had never said anything in the first place. I kind of got the sense I could be ordering burgers at a fast food joint and not talking about my life he showed that much interest.

Stephanie: I've been involved with psychiatry for a long time so I was seeing psychiatrists before my overdose. Once I overdosed, it was like I wasn't worth trying for anymore...after that I received nothing and everything fell apart. I stopped going to school and I was really depressed, I wasn't making new friends and I had many overdoses—all of them drugs. I was in and out of the hospital constantly until I was probably 18. My mom did have a counselor for me but not even she could handle it. It's like they stopped caring, just when I needed them most.

Although all of the women wanted the abuse to stop, none of them wanted to feel responsible for the breakup of their family. Some of the women who disclosed to their therapists their experiences of sexual abuse were removed from their homes and placed in

foster care. Although this stopped the abuse within their own families, some of the women who entered foster care found themselves in equally hostile and abusive situations. Not only did they feel the guilt of “family demise,” they also felt it was “all for nothing” since they still experienced abuse at the hands of another offender.

Leanne: He was a lay person in the church. I knew something was wrong when I first saw him, I just had a feeling. He was walking with this young boy and I just knew it, I just sensed it. A lot of perverts hide behind the cloth, you know, the religious cloak. And to think that he was my foster dad...sick.

It should be noted that, despite the action or inaction that followed, participants identified being believed when they disclosed as a positive aspect of therapy, and described the therapist’s acknowledgement of the abuse as critical to their journey towards healing and self-acceptance.

### ***Coping Strategies (Survival Skills)***

The women in this study developed numerous coping strategies (survival skills) to manage their fragmented lives, usually in response to a situation which they were powerless to change. These strategies became their way of taking some control of their lives. Inherent within the notion of coping strategies is that they are positive. Although in essence the coping strategies were positive in that they did indeed enable the women to survive, some of them resulted in varying degrees of self-harm, whereas others resulted in over-achievement and success. Participants shared that their coping skills often worked for only a limited period of time, and then had to be replaced by new ones. In this way, coping strategies evolved as circumstances dictated. The strategies were both physical and psychological in nature.

Many participants described using self-mutilation or “carving” as a form of coping. They viewed this as an effective method in that it temporarily replaced the emotional pain with a physical pain. It is not uncommon for survivors of child abuse to grow up hating their own bodies (Bass & Davis, 1994; Maltz, 2001). Survivors have not only been physically hurt and damaged as children, they also inherit a legacy of “your body is bad.” Some of the participants described acting out their anger towards their own bodies as a form of survival. Daphne illustrates her experiences of self-mutilation:

I hated myself from the inside out. I would stand in front of the mirror and scratch down the sides of my face with my nails until my cheeks were bleeding and my nails were filled with the skin that I had torn off. I would take my pen cap off and make lines across my body until scars were left. I would take a scrub brush in the shower and rub until I was raw. The weird thing is that I couldn't even feel the pain after a while...and sometimes I even got pleasure from the pain. It was a real adrenaline rush for me. I guess it took my mind off the other things. It really helped me make it through some tough times.

Other physical coping methods included substance use and abuse, and escaping by running away from home or withdrawing into a fantasy world from which they would tell others lies about their lives. Some women went so far as to change their names in the hope of in some way changing their identities and their histories. Many participants recall living in situations where they were constantly moving between homes, towns, and cities:

Kat: We just moved from place to place and each time I got a new name. I started to enjoy it after awhile. It's kind of like when you don't like who you are, you

just change it and for a little while, everything seems right again.

Many participants described using dissociation as another survival skill. While dissociation made it possible for them to endure the abuse at the time, it also had serious long-term implications, including memory loss, confusion, and self-estrangement. Splitting off from their experience and distancing themselves from the physical and emotional pain were the only recourse for some of the women to escape or resist their abusers. It became a sort of physical and intellectual boundary between the woman and her abuser. One survivor, Lola, stressed that “the best thing to come of my abuse was the ability to dissociate. Now I can do it on a dime. It was like a necessary learned behaviour.” When asked if dissociation was an asset or a liability, she commented that “it is the best thing going for a survivor....You can never take that away.” Archimedes’s dissociation developed into “multiplexity” or multiple personality disorder. She felt that she “created” other personalities within herself to avoid conscious knowledge of the abuse. Her other personalities, or “alters,” provided her with an ability to cope with her life situation:

...it was like a whole group of alters were created and most of them teenagers, and they were all created to deal with the abuse. We had this thing about the doors at the high school, we even went back there a couple of years ago and when we saw these doors it was like, the doors were so important because those were the doors when a switch would happen, those teenage alters knew, Ok, Ok, now I can go...and they would take over and go through all the crap...and get us home. So during the day we would have different alters that would have no knowledge that this abuse was going on. All they had was that feeling that something was

weird about me but put up the façade, “yeah, I’m a totally normal girl hanging around with my girlfriends, have a boyfriend or two.”

Archimedes further defined her multiplexity as a gift to herself:

I think multiplexity is a gift for people as a way cope and it’s a wonderful way to cope and I mean sure, it has its downsides and it causes all kinds of problems in itself as well that you have to deal with those problems, but in terms of dissociating to a point where you feel like it didn’t happen to me and you know I feel like we needed that for years...we needed to believe that it didn’t happen to me....It’s your body’s coping system and it’s an incredible one.

Participants often used depersonalization of their body parts as a way of coping.

This is reflected in many of their stories:

Hope: My body wasn’t mine anymore. Actually I am not sure if it really ever has been mine. When he used to touch me I kept telling myself—but not out loud so that he could hear me—just on the inside that he wasn’t really touching me because those parts didn’t belong to me. I hated when they started to get bigger....It was like my body was betraying me, making me more accessible to him. He used to tell me how much he loved them and how it was better when they were bigger. I hated him, I hated them, and I hated me. My developing, like getting breasts and hips and stuff was like...well, it was like a final surrender to him...like the body was his now and not mine because somehow it felt like they were growing and reaching out to him. God that’s sick. I wanted him to hate me the way I hated myself.

Another form of survival was the creation of a public persona. Some of the

women in the study described becoming “A” students, or class clowns, or “people pleasers.” The forms of “positive” attention garnered by these roles allowed the women to “hide the real me,” as one of the participants recalls. Some of the women talked about either being responsible for, or assuming responsibility for, the care and protection of others as their primary way of establishing and maintaining relationships. One participant spoke of feeling more like a mother than a sister to her siblings. Being a “people pleaser” is a trait which our culture encourages in female children, valuing it as a useful skill for women in adult relationships. Participants perceived that their emotional safety depended on everything and everyone around them being all right, and therefore learned the role of people pleaser particularly well. It became a source of personal value for many of them.

Many of the women also described becoming perfectionists. In some ways, this was a form of control that compensated for the lack of control in other areas of their lives.

Alexandra: I had to have my school desk perfect....It was spotless and all my school supplies were neat and clean and really organized. My room was exactly the same...absolutely spotless. I knew when anyone had been in my room or my desk because I was meticulous with the order of things. I remember one day noticing that my pencil had been moved. It was in the same spot but the letters had moved around so I knew someone had touched it. I literally lost it right there. I had like a major anxiety attack and ended up being sent to see the school nurse. I freaked out a lot a home too. I am still like that in my house now. It is like sacred for me to have everything in its place. It's like pathological.

The women who were perfectionist and attempted to seek acceptance through

their academic success still experienced exclusion. Rose points out that “being at the top of the class actually meant that I was different from everyone else anyways, so I never did belong, apart from maybe being a geek.” Nevertheless, Rose was able to keep her life together and achieving academic success enabled her to have some measure of control over her life.

Other women described becoming detached, acting out, or becoming the “outsider that I always knew I was.” They talked of trying to repel others rather than seeking their acceptance; the bravado was a way to mask fears and distract attention from their sense of being different. They feared that acceptance and belonging would never come, and found negative attention preferable to getting little or no positive attention. This attempt to deliberately alienate the people around them, while successful in terms of keeping their secrets and hiding feelings of guilt and shame, further reinforced their sense of unworthiness as human beings, and that “no one really understands.”

Avoiding the extremes of overachieving or acting out, some participants described survival strategies of “blending in.” For some women, learning how to withdraw, disappear, or fade into the group in order to avoid feeling too exposed was critical; they tried to avoid or disengage from most social interactions as a way of navigating through life without letting others see their secrets, shame, and unworthiness. The danger inherent in these strategies was that being invisible could become a way of life. One of the women interviewed spoke of living her life in isolation, a self-induced state of being in the world:

Gail: I have just figured out that what I do best is hide. I have spent years of my life trying to disappear and the sad thing is, I got what I wished for. I feel absent

from my life, and certainly from others' lives. It's like I am invisible.

Participants described the various ways they attempted to escape the reality of the abuse. Some recalled literally running away from home in an effort to stop the abuse; others tried to endure the abuse by escaping into a fantasy world or by telling lies about their lives. Since physically leaving their situations wasn't always possible, they attempted to run away from themselves and their feelings. This proved very unhealthy in that the more they had to hide, the more dishonest they felt within themselves and in their relationships with others. The more false they felt, the more their sense of personal integrity, worth and value diminished. As a primary consequence of the sexual abuse, the women in this study essentially felt estranged from themselves and from others.

### **Living a Dual Life: The Blurring of Child and Woman**

Dawn: I didn't really realize until going to therapy how much energy it took to live two lives. It was like there was two of me...the little girl who felt so unsafe in the world, and the woman who had to live in an unsafe world.

Survivors' descriptions of their lives showed that the confusion and self-hatred engendered in them by sexual abuse caused them to become detached from understanding or trusting their own thoughts and feelings. To survive childhood sexual abuse, many participants struggled to find sanctuary in the acceptance and approval of others, thereby failing to fully establish a sense of self. As they matured in age, they struggled with the additional burden of emerging as women:

Louise: I very much had two different lives going on and still feel like that now. Certainly if that's sort of what your norm has been growing up then that's kind of what you carry with you...I totally feel like I have these secrets and I have to keep

all of them inside. I've always had to keep secrets. I guess it's to protect myself and the part I don't want anyone to know. I have two different lives.

The participants in this study described feeling as if they had secrets from the rest of the world. They presented one persona in public, while knowing privately that they were different. They described this as "living a dual life." They struggled with differentiating between themselves as children and as women. As one participant, Lois, aptly put it, "I didn't know where she stopped and I began." In essence, participants described a blurring of child and woman, and a struggle for their integration. This became significantly more challenging when the women survivors entered into the childbearing and mothering phases of their lives, and the integration of child and woman was confounded by the introduction of mother.

It is clear that experiences of sexual abuse dominated participants' recollections of childhood and family life. They recurring themes of childhood for the women in this study centered on betrayal, powerlessness, and stigmatization. The women felt betrayed because a trusted person caused them harm. The perception of levels of adult betrayal varied between those who were abusers and those who allowed the abuse to happen (mostly mothers), and failed to protect the women as children. The degree of betrayal experienced was influenced by the women's relationship to the abuser, and the possible disbelief or dismissal of the abuse. The women in this study learned, through time, that they were powerless to change their childhood situations. This powerlessness had a considerable impact on their psyche and their sense of value in the world. Participants also experienced stigmatization as children of abuse. The negative connotations of the abusive behavior became incorporated into their psyche, including feelings of shame,

badness, or guilt (Finkelhor & Browne, 1985), which further manifested themselves as isolation (self-imposed or otherwise) or gravitation towards others who felt the same self-loathing.

Much remains to be learned regarding the impact of family dynamics on women's experiences. A detailed investigation into women's childhood family functioning was not the focus of this dissertation, and therefore drawing final conclusions based upon the limited data on family function would be premature. However, the analysis does support the following assertions. All of the women in this study experienced significant consequences as a result of their childhood sexual abuse experiences, regardless of whether the abuse was intra-familial or extra-familial. The majority of them expressed some degree of dysfunction within their families of origin. This was a certainty for those women who experienced abuse within their families, and most of the women whose abusers were extra-familial disclosed some degree of dysfunction within their own families as well. Fergusson, Lynskey, and Horwood (1996) contend that although evidence suggests that the majority of childhood sexual abuse episodes are extra-familial, intra-familial sexual abuse is more likely to be characterized by recurrent or severe abuse incidents. The data in this study neither supports nor refutes this claim. However, when comparing the family background of children who were exposed to intra-familial sexual abuse with that of children exposed to extra-familial abuse, Fergusson et al. found that the children in fact had similar backgrounds. This supports the findings within this study and the viewpoint expressed by Fergusson and Mullen (1999) that "measures of family functioning are linked to risks of childhood sexual abuse by generalized processes in which family dysfunction creates a social and family ecology that places children at risk

of both extra-familial and intra-familial abuse” (p. 38). In summary, parent connectedness was an issue for participants who were survivors of both intra-familial and extra-familial abuse.

In this chapter, I have provided a context for the participants’ lives that serves as a landscape from which to view survivors’ experiences of childbearing and mothering. In the next chapter, I present the findings of the survivors’ experiences of childbirth as they exist within the theoretical model profiled, namely “Protecting the Inner Child.”

**CHAPTER FIVE: THE CONTEXT OF SURVIVORS' CHILDBIRTH**  
**PROTECTING THE INNER CHILD: A PROCESS REFLECTING**  
**THE EXPERIENCES OF MOTHERS WHO**  
**ARE CHILDHOOD SEXUAL ABUSE SURVIVORS**

In this chapter, I explain how women who are survivors of childhood sexual abuse negotiate their experiences of childbirth and mothering. Within the theory of "Protecting the Inner Child," childbearing women attempt to keep themselves safe from harm despite feelings of violation and vulnerability brought on by their childbirth and mothering experiences. This theory explains how, as childbearing women progress through the phases of the childbearing cycle, they experience the increasing effects of their abusive pasts, and begin to feel increasingly vulnerable as reminders of their pasts surface. To manage this vulnerability, survivors draw upon their sense of personal resiliency and external support systems. I begin this chapter by presenting the theory itself, in order to provide the reader with an opportunity to understand the key elements of the theory prior to the introduction of the women's narratives. In this way, I aim to provide a theoretical context which allows the reader to understand the complex experience of childbirth for survivors of childhood sexual abuse.

The central feature of this theory is the core process of "Protecting the Inner Child." The term "inner" has a dual meaning here in that it initially refers to a woman's inner self, or inner child—namely, the child who experienced abuse—but subsequently refers to the woman's birth child who, throughout pregnancy, and the labor and birthing process, also lays claim to the term "inner" child. The perceived personal threat of harboring a child influences the extent to which women seek reassurance from others, as

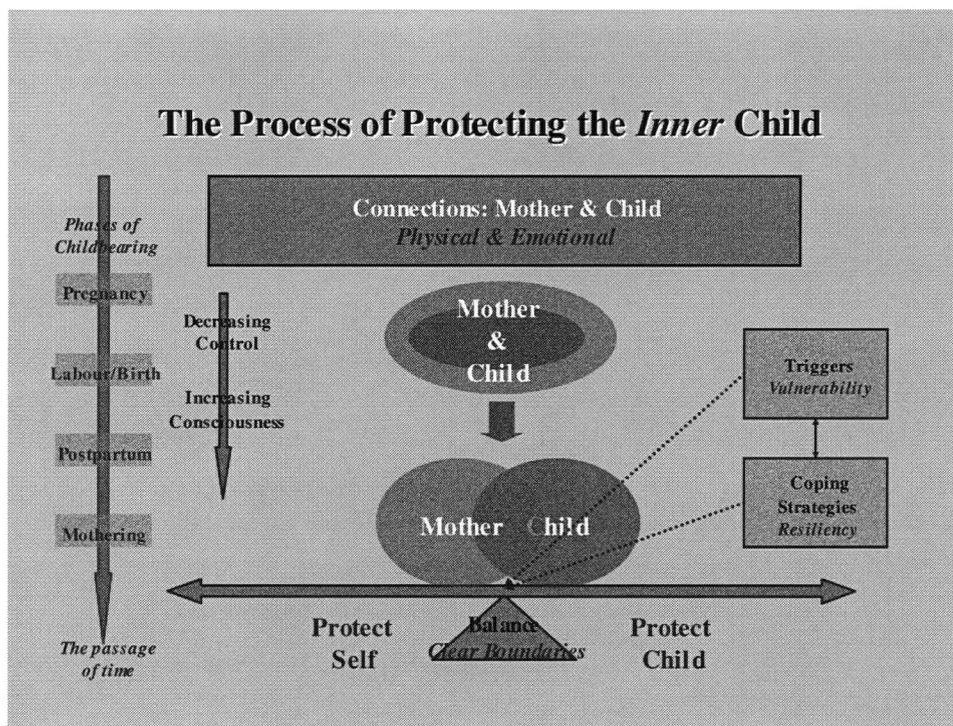
well as the ways in which they engage or fail to engage in protective behaviors of themselves or their children. Support for this theoretical model is demonstrated in both the participants' personal narratives (in relation to their experiences of childbirth within each of the phases of childbearing), and in the literature addressing the childbearing experiences of childhood sexual abuse survivors.

The process of "Protecting the Inner Child" consists of two seemingly competing elements: mothers' "(over) protecting self" and "(over) protecting their child." Women's sense of balance and personal boundaries exist between these two elements. These elements are not mutually exclusive, but rather enmeshed in such a way that women's experience of childbearing and mothering was either celebrated or feared. Two overriding core concepts, vulnerability and resiliency, affect this process. Other factors influencing the process include trigger points (specific events, actions, or other factors that elicited anxiety, fear, vulnerability, guilt, or other heightened emotions) and coping strategies (internal and external forces). According to Courtois and Riley (1992), "Abuse memories are often spotty or entirely absent and may be recalled by triggers within the individual or environment. They may return in many ways, some of which are obvious and some of which are coded" (p. 222). The coping strategies (internal and external forces) employed by the women in this study had an impact on the movement towards self over-protection or child over-protection on the continuum and served as mediating factors for the triggers. This movement was also dependent upon the ways in which the women interpreted and internalized the stressors in their lives, in essence whether they felt vulnerable or safe. A woman's sense of moving beyond survival was ultimately achieved through seeking and finding her own centerpoint—a sense of inner peace and

balance. In this theory, the context of women's lives, as presented in the previous chapter, is critical to understanding the struggles and vulnerabilities inherent in living as a mother who is a survivor of childhood sexual abuse.

Most of the women in this study talked about feeling "incomplete," "invisible," "empty," and "lost." Over the years, some maintained the hope that they could find the fulfillment, affirmation, and love they needed. In many ways, becoming a mother held the promise of such fulfillment. To elucidate this, and clarify the often vast discrepancy between the women's hopes and their subsequent reality, the upcoming chapter focuses on women's experiences throughout the childbearing phases, namely pre-conception, pregnancy, labor and birth, postpartum, and mothering. These experiences are framed within the context of women's lives as detailed in Chapter Four, and are presented as they exist within the theoretical model of "Protecting the Inner Child."

As previously mentioned, survivors' experiences throughout the childbearing phases serve as the foundation for the identification and development of the core process of "Protecting the Inner Child." An introduction to this theory is presented here to assist the reader in understanding the core elements of the theoretical models profiled within this chapter. A visual representation is presented below, followed by a detailed explanation of the key elements of the theory. After a detailed explanation of the various aspects of the theory, the phases of childbirth (pregnancy, labor and birth, postpartum, and mothering), their associated abuse triggers, and protecting coping strategies will also be discussed.



**FIGURE 5.1: THE PROCESS OF PROTECTING THE INNER CHILD**

### The Process of Protecting the Inner Child

It is not unusual for women to aspire to the ideal of being the perfect mother, and the women in this study were no exception. No participant set out to be a bad mother, and certainly not to be an abusive mother. However, as the women each set standards for themselves as mothers and attempted to meet these standards, it became apparent that due to their histories of childhood abuse, particular challenges existed which had an impact on their experience of childbirth and mothering. The social psychological process identified here by the women in this study is a representation of their experiences of childbearing and mothering against a backdrop of childhood abuse. Although two seemingly opposing views of protecting are presented here, this is not to suggest a straightforward dichotomous notion of motherhood. To suggest that there are good/bad mothers and under/over-protective mothers oversimplifies the lives of mothers who are

childhood sexual abuse survivors. The truth is that these mothers' lives are complex and their experiences of "protecting" exist along a continuum. In this context, protecting the inner child was an attempt by the women to protect themselves while simultaneously protecting their children. This process unfolded in response to triggers (events or emotions) exacerbated by unclear boundaries and mediated by women's coping strategies.

"Protecting the inner child" is an iterative and non-linear process, despite the bipolar nature of the model put forth here. It is not a passive process, but rather an active process whereby women take action (in the form of protecting the self or protecting the child) in response to various triggers of their childhood sexual abuse. Where a woman places herself on this continuum of protecting is contingent upon how she perceives the threat to her "inner" self versus her child.

The two overriding core concepts of vulnerability and resiliency further influenced the process of "Protecting the Inner Child." If a woman felt personally threatened and was vulnerable, she moved towards self-protection—or protecting her own "inner child" (or self). If she perceived a threat to her child but felt a sense of personal agency or resiliency, she moved towards (over) protecting her child. A woman's sense of moving beyond survival was ultimately achieved through seeking and finding her own centerpoint—a sense of inner peace and balance. Central to the achievement of balance for the women in this study was the definition, negotiation, and maintenance of healthy boundaries and a sense of personal control. The question of what was "normal" and "abnormal" in terms of behaviour was problematic for all the participants, as they struggled with clear boundaries in their lives. Balance, therefore,

was achieved through establishing and maintaining clear boundaries. The boundaries referred to both self and others in that the women in this study struggled within themselves and felt they were living with dual identities, viewing themselves as women and as children of sexual abuse. Participants also described struggling with boundaries with others, including their own children. As one participant, Lois, commented, "I didn't know where she stopped and I began." The majority of the women in this study reinforced this notion of blurred identities.

In their attempts to achieve balance within their lives, the women in this study were influenced by their relationships with self, child, and others. The concept of connecting, inherent within relationships, had two dimensions. Initially, when feeling threatened or vulnerable, the women made efforts to hold back from connecting with themselves (i.e., through dissociation), their born or unborn child (i.e., through emotional withdrawal or neglect) and others (i.e., by withdrawing). These efforts were either conscious or subconscious. Then, when they felt safe and had a strong sense of personal strength or resiliency, they made conscious choices to move toward connecting. Relationships with others included those with partners (if they had one), family, friends, community, and the health care professionals involved in their obstetrical care.

It became increasingly evident as participants shared their experiences of childbearing that issues of power, choice, and control were paramount. As will be illustrated by the data in the remainder of this chapter, an interesting finding in relation to the concept of power and control is that as women progressed through the various phases of childbirth, their need for control increased while their perceived or actual control decreased, thereby heightening their sense of vulnerability. Additionally, as women's

control decreased throughout their pregnancy (despite their greater need for control), their awareness of their childhood sexual abuse histories increased. The notion of progressively decreasing control and increasing consciousness for childbearing women survivors is exemplified in the women's narratives of their childbearing experiences. As visualized in the model, during pregnancy, labor and birth, the child is positioned within the mother. As the phases of childbearing progress to postpartum and mothering, mother and child have separate, yet connected identities. These "connections" are key in that imbalance occurs when women move towards protecting self or protecting child.

The women progressed towards connecting with self and others at different rates. Some were actively engaged in connecting with their inner selves and their children during the course of their childbearing experiences, whereas others struggled with their willingness and ability to connect. The women's ability to "connect" was attributed to several factors. Initially it was related to their childhood experiences of sexual abuse in that these experiences shaped how they interacted and connected with other people. Secondly it was related to the number of triggers encountered during their childbearing experiences, and the relative success or failure of their coping strategies in mediating the effects of these triggers.

The goal in the process of protecting is to achieve a state of balance between protection of self and protection of child. When the abuse triggers outweigh the coping strategies available to women, a state of imbalance occurs. Depending on how the trigger is interpreted, the women shift the balance towards protecting self or child. This is a transitory state and women can find themselves vacillating between the two extremes at any given time, depending upon the various abuse triggers and their available coping

strategies. When imbalance occurs, the triggers elicit increased vulnerability and a decreased effectiveness in coping strategies. The triggers were related to events experienced during the phases of childbirth. Some triggers were unique to the particular phases experienced, for example women's "tearing apart" was unique to birth and "leaking breasts" was unique to the postpartum stage of childbearing.

Coping strategies were those internal and external strategies employed to help the women mediate the effects of the triggers. Just as I strove to be inclusive in relation to abuse, I considered all coping strategies used by survivors to be valid. The women in this study shared that they often found it difficult to allow others to help them deal with their issues, yet they also described having support as crucial to their healing process. Some coping strategies were self-help mechanisms or drawing upon one's own personal resiliency, whereas others involved obtaining outside assistance or psychiatric treatment. My intent in this research was not to evaluate particular approaches to healing, but rather to identify the common themes regarding what worked or didn't work for the participants in this study, in order to provide a guideline for professionals working with women survivors. Participants in this study suggested that a sense of personal resiliency or support from partners (if they had one), family, friends, and community (health care providers, therapy and support groups) made the difference in their process of protecting. Most of the women in this study had some supports, although these were often limited or "lacked understanding." Their coping strategies are further explored later in this chapter.

To further assist the reader in understanding women's shifted balance towards (over) protecting self or (over) protecting child, I provide a visual representation of these models below. I now examine how the women in this study enacted the process of

“Protecting the Inner Child” throughout the various phases of childbirth. Particular attention will be paid to the various triggers experienced by the women and the coping strategies they employed to mediate their responses, thereby contributing to their place on the protecting continuum. Attention will also be directed towards the women’s relationships and connections to self, child, and others.

Many participants found it difficult to talk about their childbirth experiences, and this finding supports the belief that their histories of childhood sexual abuse have profoundly affected their experiences of childbirth and mothering. The literature reports that giving voice to women who are survivors of childhood sexual abuse is believed to contribute to the process of empowerment. For this purpose, women’s accounts are accepted as true and meaningful (Ashbury, 1996; Dijkstra, 1995; Smith, 1998). In this way, sharing one’s experiences can be seen as validation, or a way to seek support which can contribute to the process of recovery. Several of the women in this study described feeling empowered by the opportunity to share their experiences. Thus, although reflecting upon their childbearing experiences was difficult, it was also healing.

Lee: It’s like I can talk about the past, the abuse and all that. I don’t feel anything but the truth...just numb...but when I talk about my daughter it just brings it all back. It’s so hard. This is good for me though...I think it helps me to heal.

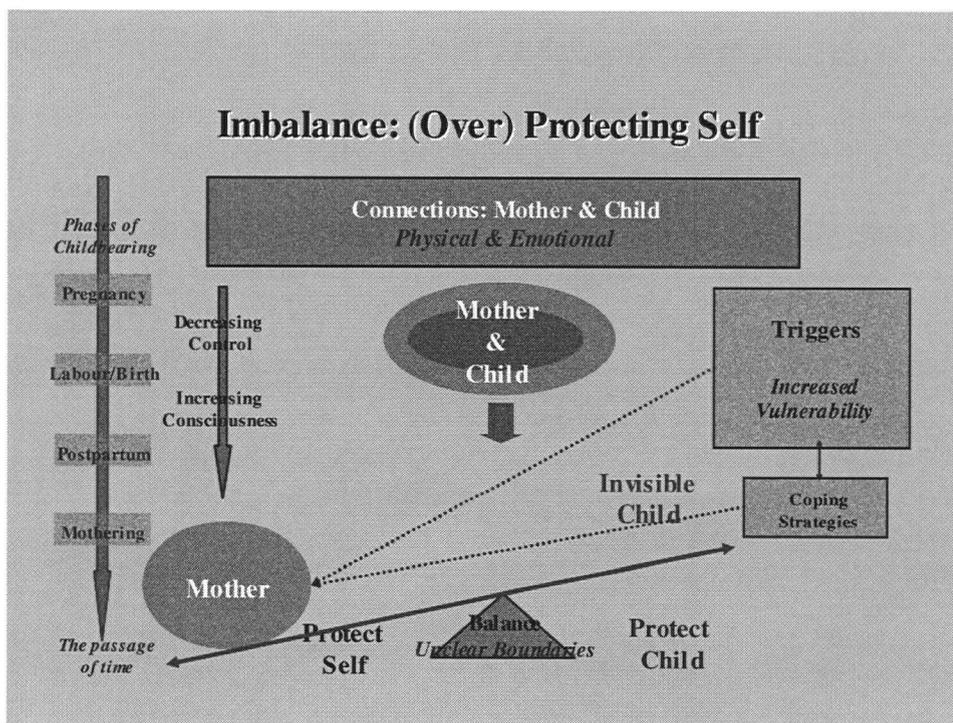
Lisa: It’s all starting to connect for me now...you know, the memories about my abuse and being a mom. It’s beginning to make sense for me why I am finding it so tough sometimes. It’s like I don’t know what’s normal or not and what’s right or wrong. I have always felt like I am half a person and now I have to connect with the other parts...the dark places that I have been unwilling to go, at least

consciously. Being a mom has made me go there, because I have to...but it hasn't been easy. I think talking about it is worthwhile though.

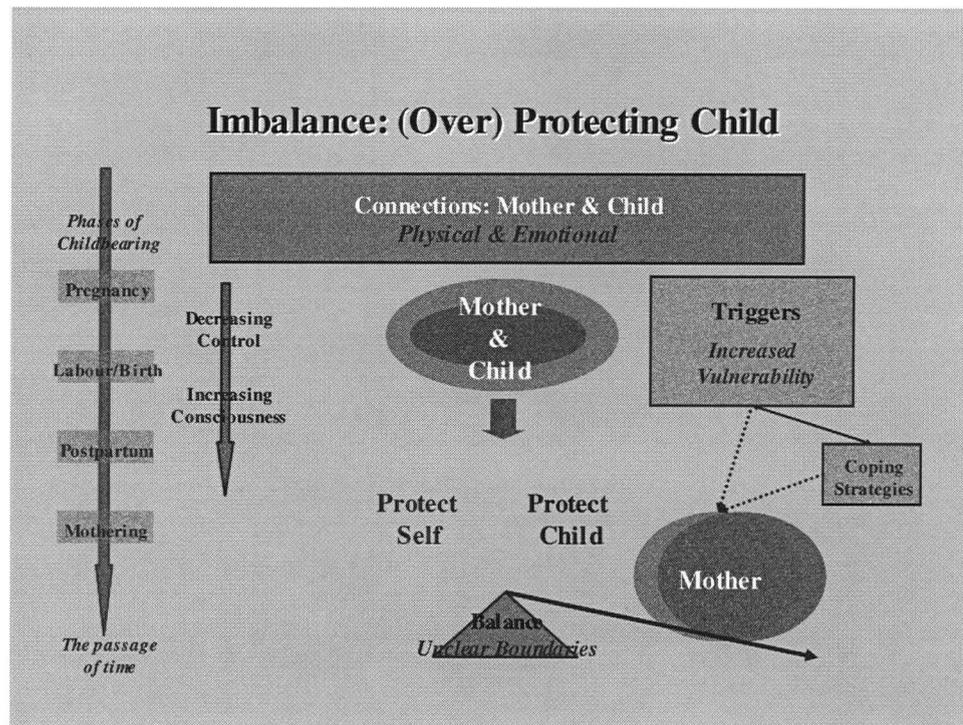
As described above, the process of protecting involved states of balance and imbalance. I now direct attention to the two states of imbalance occurring for the women in this research study.

### **Imbalances: (Over) Protecting Self and (Over) Protecting Child**

Based on the model presented in Figure 5.1: "Protecting the Inner Child," two subsequent models emerged, (Over) Protecting Self (Figure 5.2) and (Over) Protecting Child (Figure 5.3). Visual representations of the model are provided below, followed by an explanation of the key features of the processes identified.



**FIGURE 5.2: IMBALANCE: (OVER) PROTECTING SELF**



**FIGURE 5.3: IMBALANCE: (OVER) PROTECTING CHILD**

The “Imbalance: Over Protecting Self” and “Imbalance: Over Protecting Child” theoretical models presented here suggest that as the triggers in women’s lives become more prominent and women’s coping strategies are minimized, a state of imbalance occurs. This process occurs throughout the women’s lives, or, in this particular context, throughout the various phases of childbirth. When the balance is shifted towards protection of self, women have interpreted their triggers to be a threat to self, and consequently attempted to make themselves feel safe again through enacting the process of self-protection. When the balance is shifted towards protection of child, women have interpreted their triggers to be a threat to child (usually this means that the mother perceives a threat to her child based on her own childhood experiences) and consequently attempted to make their children safe through protecting child. The women’s sense of balance and clear, healthy boundaries are inherent within the notion of safety. When

women are in a state of imbalance, boundaries are unclear, heightening their feelings of vulnerability and reducing their ability to draw upon their internal (personal resiliency) and external (support systems) coping strategies.

In the following section, I discuss the triggers that influenced this process, and the coping strategies employed to assist the women in regaining a sense of balance in relation to the phases of childbirth. It is critical to note that as the women progress through their childbearing phases, 1) a sense of decreasing power and control is evident and 2) an increasing consciousness of the impact of their abuse histories on their childbearing experiences is evident. These two elements work interactively throughout the phases of childbirth.

In protecting self (Figure 5.2), women engage in self-protective mechanisms which they require (on some conscious or subconscious level) in order to survive in their world. Although this affects the woman herself, it also has a huge impact on her child. In this model, the child is referred to as the "invisible child" in that it is not dominant or in the foreground of the women's lives. However, it is important to note that the women do not intentionally attempt to withdraw from or neglect their children, indeed, in some ways (although difficult to interpret), they are actually attempting to protect them by withdrawing themselves. Perhaps by protecting themselves they were, in fact, also protecting their children. This may be true for the context of the women's lives, but in the context of our society, however, this is often viewed as child neglect. Many of the women were appropriately concerned about this, which further contributed to their feelings of guilt about their inability to be good mothers. For eight women in this study (and 18 of their children collectively), this process escalated into situations of child

apprehension.

In protecting child (Figure 5.3), women engage in protective mechanisms towards their child in response to a perceived threat to the child. Some of the women in this study acknowledged that these threats were more of a danger to their own “inner” child than potential harm to their children. The women were not able to identify the meanings behind these triggers at the time and therefore found themselves responding to their children in the ways that they, themselves, wished they had been treated in their own childhoods or abusive contexts. In this model, the children appear “consumed” by their mothers in the mothers’ attempts to protect them—or in the words of Beesh, “I think one of the big problems with me was I was enmeshed with my child.” To reiterate, the women’s intent is not malevolent, but rather a mother’s endeavor to make her child feel safe in a world which they believe (and have learned through experience) is unsafe. In essence, the women in this study were passionate about protecting their children from the violations they themselves experienced as children. In many ways, they were attempting to re-write their own histories as children.

A number of factors influenced the direction in which the women in this study consciously or subconsciously moved on the continuum of “Protecting the Inner Child,” including the phase of pregnancy they were in at the time, the presence or absence of personal resiliency and support systems, and the current stressors or triggers they were experiencing. The imbalance of (over) protecting self and (over) protecting child are discussed in relation to the various phases of childbearing, beginning with pregnancy, through to the mothering phases. Throughout the presentation of the findings within each of the phases of childbirth, I first outline the triggers experienced by the women and then

discuss the coping strategies employed.

Although not included as a visual part of the “Protecting the Inner Child” theoretical process identified in this study, the pre-conception period was included as a component of this research study as it contributes to further understanding of the context in which reproductive decisions are made by survivors of childhood sexual abuse. For the women in this study who chose to remain childless, this decision was attributable to their histories of childhood sexual abuse, and in fact constituted a choice to protect self.

### **PRE-CONCEPTION**

When this research study was first proposed, I did not think about including survivors who were not mothers. After all, the research was supposed to be about the childbearing experience of childhood sexual abuse survivors, a grouping that, from the outset, did not include women survivors who were not mothers. It wasn't until I began receiving phone calls from women survivors who were childless by choice and who wished to participate in the research study that I began to see the significance of hearing these women's stories. Each of these participants (n=4) shared with me that their sole reason for not becoming a mother was their history of childhood sexual abuse. This reason reflected both the physical and emotional scars that these women were living with in their adult lives. It also made me question whether the women in my study who were mothers experienced similar pre-conception issues and struggles around decision-making.

The women survivors who were childless by choice asked to be included in the research study because they felt they were not alone, that others shared a similar experience, and that their stories were worthy of sharing since they did, indeed, contribute to the understanding of childbearing for women who are sexual abuse

survivors. I agreed. What follows is a summation of the key themes developed from their personal narratives, namely (un) worthiness of motherhood and intimacy and fertility issues. I have not conceptualized the pre-conception period in terms of abuse triggers and coping strategies, given that the pre-conception period does not appear in the theoretical model of “Protecting the Inner Child” put forth in this research study. However, despite its absence on the model, I believe that the findings of the pre-conception phase warrant discussion. Where appropriate, quotations from mothers whose reflections resonate with the childless-by-choice women are included.

*(Un)Worthiness*

The choice not to become a mother was viewed as the “right” choice by the four participants in this study who were childless by choice. However, all of these women described feeling a societal judgment that they were somehow “less of a woman” than other women who were mothers. Their interviews included numerous stories of public inquiry into their reproductive decision-making and fertility. Although being questioned about childbearing intentions is not unique to these women, their experience is further complicated by the fact that their decision not to have children was made because of their traumatic childhoods, a factor which they did not feel prepared to share with others. The social assumption was never “if” they were having children, but “when.” When participants responded that they were not planning to have children, the question then became “why not?.” This placed the women in a vulnerable position in that they were not prepared to disclose the “real” reasons for their decisions. In some cases, they simply stated it was because they “couldn’t.” It is an interesting finding that some women would rather be considered infertile, than disclose a history of sexual abuse.

Donna: I used to just tell them that I couldn't have kids because of fertility problems. It just saved me from having to explain the whole thing [history of sexual abuse]. I wasn't prepared to do that and I am pretty sure that they weren't prepared to hear it.

Motherhood is inherently linked with femininity and assumptions are often made that womanhood equals motherhood (De Beauvoir, 1953; Nelson, 2003; Rich, 1976; Squire, 2003). In keeping with this notion, it is not surprising that these four women, childless by choice, felt some degree of "loss" over not being viewed by society as a "complete woman."

Tammy: Somehow they think I am not really a woman because I haven't harbored a child....it's not that I don't like kids, I just don't feel prepared to care for one....I know that I am missing out on some things but generally, I don't think I'll have any regrets. I really don't think I was meant to have kids.

Some of the women reported external sources reinforcing their feelings of being unworthy to be mothers. Beesh (who later became a mother) was told through counseling and therapy that her history as a sexually abused woman would forever affect her ability to be a "good" mother. Given the "authoritative and knowledgeable" role of her therapist, Beesh stated that "what I got out of counseling was quite frightening because counseling led me to believe that I would become a sexual predator so after that, I just thought...Okay, that's it. I'm not going to have kids." Another participant, Diane, was repeatedly told by her family members that it was a good thing she never had children. When asked to further describe the rationale behind these statements, Diane explained: "they always saw me as immature and incapable of managing anything in my

life—let alone a child.” Furthermore, she was viewed as a “poor role model” and “unable to provide financially and emotionally” for a child. Lola had similar thoughts regarding her ability as a mother:

I believe this is true for so many of us, we believe that there is something about us that made that [abuse] happen and that we are really at high risk....Almost everybody could be talked into thinking you can't possibly have children because you will do the same things to your kids that was done to you. Social services are not doing anybody a favor by considering survivors as high risk for continuing the abuse, right, my whole theory of the cycle of abuse. I believed that I was insane and that I would probably do the same to my kids that was done to me....I believed that I would either specifically harm him or sexually abuse him but when I was with a whole bunch of other survivors, we all talked about what we thought and I decided that I didn't have to be like that.

All four of the childless by choice women in this study spoke of feeling as if they were “damaged goods,” and therefore unworthy of becoming mothers. Much of this centered on their own lack of self-esteem and sense of identity:

Tammy: There is no way I could raise a family...I can barely get out of bed most days and it's everything I can do to feed my cat each day. I cannot even explain how exhausted I feel all of the time....I have this sense of dread with each day...I am not well enough to have kids—physically and especially emotionally.

Nancy: I shouldn't have kids....plain and simple...I shouldn't be allowed to. It's not that I think I would be abusive or anything, I just know that I wouldn't be able to care for them the way they deserve to be. I think my choice is an unselfish one.

In essence, the women in this study who chose not to become mothers felt “less than” women who were mothers, but nevertheless asserted that this was the right decision for them. The belief about being “less than” and “unworthy of motherhood” was both internally and externally motivated. It was internally motivated in that the women struggled with their own beliefs about their worthiness and abilities to become mothers. It was externally motivated in that the women were conscious of other people’s perceptions of their abilities to mother, most notably the perceptions of those individuals who were aware of their childhood histories (i.e., family and therapists). In many ways, the women felt disconnected from their reproductive selves and disconnected from others in relation to their childbearing choices. Interestingly, many of the women in my study who chose to become mothers shared similar thoughts about their worthiness to be mothers. Both choices were made against a backdrop of abuse, and yet the outcomes were different. Although it is beyond the scope and focus of this dissertation, it is important that reproductive decision-making by women survivors who choose to become mothers and those who choose not to be investigated at some point. An understanding of the factors influencing their reproductive decisions might be important for the provision of appropriate support services to both groups.

### ***Intimacy and Fertility Issues***

All four of the women in this study who were childless by choice reported concerns about intimacy; and some had concerns about fertility. Although this is not an unusual finding for women who are childhood sexual abuse survivors, it is significant that in this context it ultimately contributed to the women’s decisions not to have children.

Nancy: Having intercourse is still really painful for me—like physically painful so it makes it hard to have sex most times. My therapist is great and has been helping me work through my issues....I have been working on learning to relax and reframe my experience so that it's positive but it's a really long process....even if I wanted to have kids I don't think it would even be possible—like mechanically...it's just simple birds and bees kind of stuff.

Dawn and Stephanie, two participants who were mothers, expressed thoughts regarding their pre-conception experiences that were consistent with the comments made by the childless by choice women, in that they questioned whether or not they could either get pregnant or be “functional” mothers:

Dawn: Because of the sexual dysfunction I thought first, how am I going to get pregnant and then secondly how can I be a functional parent if I have this baggage...so those two things drove me to intensely deal with that because I wanted to be a very able parent and I knew I had to do it ahead of time.

Stephanie: I was never able to have a healthy relationship... I wouldn't let anyone get close to me. I was always so scared that they would hurt me so when I ended up getting pregnant for the first time, when we were only dating a couple of months, I was actually happy and I was considering keeping the baby...and then he told me that he was married and that in his last relationship he was with someone and he hit her, and that just scared me right off and I totally broke away and went down and had an abortion. I never thought I could get pregnant, so it was that much more devastating to end it [the pregnancy] when that happened. I just knew I couldn't do it [stay in another abusive relationship].

Although none of the women in this study reported infertility (some of the childless by choice women and mothers alike reported fertility challenges but not diagnosed infertility), according to Bohn and Holz (1996), “Infertile women with abuse histories may view their infertility as a punishment for early sexual experience” (p. 447). This was not a finding within this research study, although future research regarding the backgrounds of women diagnosed with infertility warrants further attention. The women in this study who reported “fertility issues” were referring more to the length of time required to conceive than the actual inability to conceive. Their emotional issues notwithstanding, many of them had histories of physical injuries or physical consequences from their abuse that may have contributed to the length of time required to conceive, such as sexually transmitted diseases, pelvic inflammatory disease, severe vaginal dryness, and pain with intercourse. No participants in this study disclosed histories of recurrent pregnancy loss, although I was contacted by two women members of a recurrent pregnancy loss support group who shared with me that a history of childhood sexual abuse was common to many of the members of their group. I was unable to locate any literature to support or refute this information but further investigation seems warranted.

The miracle of pregnancy and the transformation from woman to mother remains a distant thought for the four women in this study who were childless by choice. These women courageously shared their stories of reproductive decision-making and are to be commended for highlighting an area of women’s reproductive health which remains as yet unexplored. Further research is warranted on women’s reproductive decision-making framed against a backdrop of childhood sexual abuse.

In summary, although not attributable to any one theory or theoretician, the inference that womanhood equals motherhood remains prevalent. This presents an ideal that negates the choices of women who do not wish to become mothers, or who are unable to conceive or maintain a pregnancy. The assumption is made that women want to have children and are physically capable of doing so. For the women in this study who chose not to become mothers because of their childhood experiences, these assumptions implied that they were not properly feminine. As a result, the women's beliefs regarding their worthiness as individuals was challenged, echoing their experiences of childhood sexual abuse, and leaving them feeling guilty and ashamed of themselves.

### **PREGNANCY**

Pregnancy has been characterized as a life crisis, or a time of stress requiring new or enhanced coping skills (Benedict et al., 1999; J. E. Thompson, 1990) and this was true for the women in this study who also viewed pregnancy as a significant life transition. According to Buist (1998a), "when a woman becomes pregnant, the attitude to her fetus will be shaped by a set of values, beliefs and biases from her current and past experiences" (p. 371). Similarly, Nelson (2003) asserts that having a child represents deeply felt hopes, fantasies, and fears for those involved. Furthermore, Nelson adds:

Old anxieties and powerful, primitive emotions are stirred as the expectant parents are reminded of their own early experiences. Long-buried childhood desires and ideas about sexuality and reproduction rise to the surface in disturbing ways. Childhood experiences of dependency and vulnerability, closeness to and separation from their mother are vividly recalled. (p. 30).

Attachment between the mother and baby is said to begin prior to conception

(when the mother is contemplating pregnancy), and further develops during pregnancy when the woman is beginning to come to terms with being a mother (Rowan, 2003). In order for this attachment to occur, however, mothers need to be both physically and emotionally available for their infants. Herein lies the challenge for mothers who are survivors of childhood sexual abuse. The mother's feelings about her baby depend on both her individual situation and whether or not she has a support system available to her. Pregnancy was particularly challenging for the women in this study in that it entailed a growing awareness or consciousness of their own abuse issues. This, in combination with limited supports and feelings of powerlessness, influenced the women's ability to attach to their unborn children.

Research on the consequences of childhood sexual abuse and pregnancy-related issues is still in the early stages. The existing literature addressing pregnancy and a prior history of sexual abuse is largely anecdotal and has yet to be subjected to scientific scrutiny. However, various clinicians working in the perinatal or midwifery fields, including Kitzinger, Simkin, and Seng, have established the clinical significance of their work with childhood sexual abuse survivors. Their work, and others', suggests that during pregnancy (and subsequent labor and birth, etc.), women who are sexual abuse survivors often experience body memories or flashbacks in relation to events surrounding prenatal care, labor, and birth (Courtois, 1993, 1997; Courtois & Allman, 1992; Grant, 1992; Holz, 1994; Kitzinger, 1992; Seng & Petersen, 1995; Simkin, 1992). Within the constructs of this study, these events are considered abuse triggers for women in that they initiate the process of protecting their "inner" child. The triggers identified by the women in this study are presented below.

### *Triggers experienced in Pregnancy*

In relation to the childbearing phases, pregnancy was the stage in which women experienced the least number of external triggers requiring them to engage in self-protection behaviors. However, participants also found pregnancy to be a time when issues regarding their abuse began to surface, or their consciousness of their abusive histories was heightened. Participants found making connections between their past experiences of abuse in light of a promising future very difficult. For many, this was the first time that such issues had to be addressed. Triggers during pregnancy were largely internal, rather than external.

Participants did not describe any significant physical triggers during this phase; rather they reported that routine clinical care was “not such a big deal...it just had to be done.” They talked mostly about the psychological or emotional components of being pregnant rather than the physical triggers; it was almost as though the pregnancy experience itself was a trigger for their recollections of their child abuse histories. Pregnancy forced women to think about themselves as mothers, and this, for many, elicited great fear. According to Bohn and Holz (1996),

Abuse issues often surface during pregnancy and childbirth as women contemplate what life will be like for their unborn children. They review the ways in which they were parented and begin to evaluate their own parenting abilities....If they were sexually abused as children, they begin to strategize ways to protect their unborn daughters. (p. 448).

This quotation supports the theory that the process of “protecting the inner child” commences in pregnancy and that women’s awareness regarding their own abuse

histories becomes prominent during this time. The findings in this study, as illustrated below by Lee, are consistent with Bohn and Holz's report of women beginning to strategize ways to protect their children while pregnant:

I found out I was pregnant and I had this really sinking feeling, a really heavy fear...I wasn't happy at all. I was worrying that I couldn't be a good mother and things were happening to me now that I had no control over. I didn't want a girl for sure! I worried that I couldn't protect her and I really didn't want anything bad happening to her. It was like I was living in the past all of a sudden. I think I decided ahead of time that if I did have a girl, my dad would never see her. Into this pregnancy I also got really, really depressed.

The range of emotions experienced by the women in this study included feelings of abandonment that reflected their strained relationships with their own mothers. This is consistent with research suggesting that pregnant women begin to reflect upon their relationships with their own mothers to assist them in preparing to mother their own infants (I. E. Campbell & Field, 1989; Coleman & Coleman, 1971; Raphael-Leff, 1991; Stainton, 1985). Since the participants' relationships with their mothers were often conflicted, and most participants wanted to be unlike their mothers, the women found thinking about their mothers highly stressful during this time. Such reflections reinforced their fears of becoming mothers since they did not wish to model their own upbringing:

Dawn: I often describe my body as being poisoned or I envision that it was like black...and I thought I do not want to grow a baby inside me if this is how I feel about myself and certainly when I was pregnant you feel that pure love, white light and all that kind of good stuff. I was able to feel that I was consciously

choosing to grow the child and do well at that and not share that...not be sharing my physical body with the bad memories or the poison side of that stuff....and I wasn't going to be like my mother.

Tally: I remember when I was ten years old thinking when I have a child, you know, I'm never going to do this to them and this is what I'm going to do totally different...it comes from my own experience. It's part of my healing....I'm going to be the one that breaks the cycle. I am going to do it totally different.

For Lola, carrying her father's last name was a reminder of the abuse, and she "dis-associated" from her father as a way to avoid future reminders:

I changed my name two months before my son was born because I did not want to go into the hospital and have a baby that had my father's name. It's because my first baby I had, had my father's name. I didn't even remember that at the time that my son was born, but who knows, she might have been my father's baby and I changed my name so that my baby would not have that name.

A few of the women in this study reported physical triggers of abuse during pregnancy. Some were related to the physical changes in their bodies brought on by pregnancy and others were related to prenatal care. These participants felt disconnected from their own bodies and found it difficult to reconcile their physical symptoms with the pregnancy itself. Some participants reported first suspecting that they were pregnant when they identified symptoms such as breast tenderness and nausea (in the absence of abuse) and just "knowing," which led them to confirm their suspicions. These suspicions were situated against a backdrop of childhood sexual abuse:

Jessica: I knew that I was pregnant for some reason. I can't really explain it. I

guess it is because I wanted it so bad...I was kind of scared though, thinking that maybe I had talked myself into it...but you know when you just get this gut feeling. I just knew it....My breasts hurt too, I mean they were really tender. Unlike other times when I was assaulted, I took that as a good sign.

Carol: My breasts were really sensitive too. I hated that because it reminded me that they were there. I have never liked my breasts and now here they were, making nuisances out of themselves, reminding me of dirty things, of times past....It was my husband who suggested maybe I was pregnant. Once he said that I just knew.

Although the initial emotional response to the diagnosis of pregnancy varied among the participants, there were two common responses: feelings of being “overwhelmed” and “out of control.” Feelings of being overwhelmed by the discovery of being pregnant were common to all of the participants in the study and were accompanied by other intense emotions such as fear, shock, and surprise. Such reactions to the diagnosis of pregnancy are not unusual among expectant women in general. However, for the women in my study, they were framed by the context of childhood sexual abuse and therefore became a significant finding:

Dawn: I remember distinctly being upset because I was not done my therapy yet. I had this idea that I had to successfully complete my therapy so I would be capable of living my everyday life....I thought I can't do this pregnancy and devote the time like I wanted in order to be centered ...I needed now to be focused on the child...and have a relatively stable family life ready for a child. I knew I wasn't ready because I needed to deal with my past first.

One participant, Lee, denied her pregnancy as a part of her coping strategy. Unfortunately, when she attempted to connect with others about her experience, it was suggested to her that she might be unable to bond with her baby because of her feelings of denial. This experience then became Lee's trigger to self protect:

I remember when I was pregnant telling the social worker that when the baby was kicking that I was kind of in denial, like I felt well but it was like I had gas or something because there's nothing in me, there's not a baby. I remember her [social worker] telling me then that she was worried that I wouldn't bond.

According to Cassin (1996), pregnancy sometimes triggers the re-emergence of traumatic childhood memories and women respond by using psychological defense mechanisms such as denial of the pregnancy itself, or of the feelings associated with being pregnant. Cassin points out that this denial also means that some mothers neglect the unborn child. In this study, this "neglect" is considered a survivor's way of protecting self. Philipp and Carr (2001) suggest that the normal ambivalence of early pregnancy may be protracted and may therefore delay acceptance of the pregnancy. As a result, these women may have greater difficulties attaching to their unborn children. Furthermore, Philipp and Carr stress that in the final stage of pregnancy, nesting behaviors may be delayed or even absent, dependency may be heightened, and that these difficulties often persist into the postpartum period.

Addressing the emotional denial of pregnancy for childbearing women, Miller (2001) maintains that difficulties with recognizing and accepting pregnancy occur on a continuum from disavowal of the emotional reality of pregnancy, through suppression of awareness of pregnancy, to psychotic denial of pregnancy. Miller suggests that it is

typical for women with a history of sexual abuse to deny the pregnancy by suppressing awareness. Women who deny pregnancy in this way are said to have an increased risk of experiencing dissociation during labor and delivery. Miller relates this to profound interpersonal isolation and lack of intimacy with significant others, and contends that the consequences of this can be the eventual loss of custody of the child. Among the women in this study who talked about denying their pregnancies, two had lost custody of their children. All participants experienced dissociation during labor and found bonding with their children problematic. Although one cannot draw any conclusions regarding women's experiences of pregnancy denial and their eventual loss of custody of their children based on these limited findings, this clearly warrants further investigation.

In contrast to denial of the pregnancy, whereby some participants disconnected from their pregnancy experience, other participants experienced feelings of profound violation during their pregnancies. Hope described feelings of being violated by the baby and being out of control and powerless. She believed that "the baby was inhabiting me, I felt like I was possessed by something from within...like my baby." Seng and Hassinger (1998) suggest that the concept of boundaries is critical for survivors of sexual abuse and that the fetus may be the most significant boundary violator for survivors:

Hope: Once again I didn't feel like my body was mine anymore. When I was sexually abused I felt that way....it was weird feeling violated by a baby! It was like this baby was going to take over my body without my control. When he used to take over my body, I just let it go because I could remove myself from it...but I couldn't do that with a baby....This baby was inside me, needing me, and I was no longer in control. It was really scary.

Feelings of violation and being out of control were also part of Lola's prenatal care experience. The violations of her body during her prenatal care experience were reminders of her childhood sexual abuse experiences:

The worst part was that we [other pregnant adolescents] were also guinea pigs for the student doctors at the hospital. What they would do is go in for a check up but the check up involved six women beside each other with maybe three feet in front, they would have a green sheet that came up around here [chest] and right in front of your face, the rest of your body was sticking out into this room and they would take six or eight doctors that you couldn't see, they couldn't see your face and they would go by and do intro exams—check your breasts, check your stomach, check your body one after the other every single time. That's what we got for care...you were nothing, you were just this thing you know...and you were going to be useful to somebody so the student docs would learn on you about pregnancy. There was no preparation for the birth, no teaching whatsoever. You knew it was going to be forceps and all the drugs.

Many of the women in this study experienced feelings during pregnancy that were reminiscent of their abuse. Several talked about their discomfort with having certain parts of their bodies touched or commented on during pregnancy, and noticed that they received additional attention when they were pregnant, which also centered on the physical changes in their bodies. For many, this was uncomfortable:

Eva: I didn't want to be like a pregnant woman. Like I didn't want to have breasts, to have big hips and a big tummy...because then that would make them [men] notice me that much more...because they would make comments about it

[body parts] which always makes me feel uncomfortable. I wanted them to stop.

Becoming pregnant brings on a flood of emotions for all women, regardless of their history. No matter what the situation may be—planned or unplanned—the knowledge of one’s body harboring a tiny new life can be overwhelming. All participants recalled having intense emotions when they discovered they were pregnant. They experienced feelings of being overwhelmed, out of control, shocked, afraid, and surprised. These reactions, however, are no different than the range of feelings identified amongst women in general when pregnancy is first diagnosed. Rubin (1970) reports that a woman experiences an element of surprise when discovering a pregnancy, even though the pregnancy may be desired or even planned. These feelings of surprise produce mixed reactions of pleasure and displeasure, which disappear at the time of quickening. Similar feelings of surprise and intensification of maternal emotion are described by other writers addressing a woman’s early pregnancy experience (Bergum, 1989; I. E. Campbell & Field, 1989; Trad, 1991; Valentine, 1982). The women in this study shared many of the same initial emotions as other expectant mothers, however, unlike other expectant mothers, the participants did not report their initial feelings subsiding as their pregnancies progressed. In fact, many of them found that their feelings intensified as the pregnancy progressed, often centering on the overwhelming sense of not being worthy or capable of being a mother.

The feeling of being “out of control” does not appear to be an experience generally common to pregnant women, but it was a very real and common emotion for the women in this study. Pregnancy also brought on a sense of powerlessness and/or violation. These emotions are not usually associated with pregnancy but appear to be

common to the women in this study. This emotional response to the diagnosis of pregnancy was also not found in the research related to a childhood trauma history and childbearing.

Although the abuse triggers were not perceived as being “overwhelming” and “unmanageable” during pregnancy, participants began to draw upon a variety of coping strategies as their consciousness of their abuse increased and their perceived power and control over their lives and their pregnancy situations decreased. The women felt increasingly vulnerable as their attempts to maintain healthy boundaries were infringed upon by their own unborn children. The women’s attempts to “connect” with their unborn children were adversely affected by the women’s own need to protect themselves and the boundaries they had worked so hard to establish. Survivors’ experiences of pregnancy were particularly challenging in that they experienced a degree of internal dissonance during this time. Although the participants’ ways of coping with their abuse triggers varied, all their coping strategies had one thing in common: healthy or unhealthy, they protected the women, as best they could, from perceived threats or harm.

### ***Coping Strategies employed in Pregnancy***

The coping strategies most frequently enacted by the women in this research study centered on exercising control and choice in the form of “independent” decision-making. During pregnancy, women are asked to make a series of decisions. For the women in this study, the decisions most paramount to them related to their histories of abuse and included deciding whether or not to continue the pregnancy, and figuring out which support systems they would draw upon to assist in the childbearing process.

The initial emotional response to the diagnosis of pregnancy left some

participants feeling that they needed to make fundamental decisions about the pregnancy itself. One participant, Bonnie, experienced a range of intense emotions when she considered her choices:

I guess it was...it was more because...this may sound awful but I couldn't have an abortion only because I didn't want to feel guilty about one more thing in my life. I didn't want that to be another thing that I would go to my grave with...and I thought if I could have given this baby a chance that maybe things would...I don't know...be better somehow, I don't know. At first having that decision and knowing that I was going to be pregnant because of that made me feel bad in some ways and in other ways I felt kind of strong because I...no one else had that control but me. I was able to say, 'yes, I'm going to keep this baby' or 'no, I'm not going to.'

Bonnie's choice to keep the baby was influenced by her support system:

People would have been understanding and supportive either way, which helped a great deal because I don't think I could have made that decision knowing that I didn't have any support. That was very important.

Often participants reported that having a support system in place was of critical importance. Carol asserted: "He [husband] was beside me every step of the way...even when I pretended that I didn't need him, he stayed with me. I don't think I could have done it without him." Carrie's support system was a friend:

I had a really special girlfriend that I could share everything with...so she was a life-saver when it came to my pregnancy. I don't know how many times I called her crying my eyes out...she never judged me or said I was bad, she just came

over and listened. She listened! Wow...how she knew that's what I needed, I'll never know...but God bless her because I truly believe she's an angel.

Most of the women in this study were neither married nor in partnerships, so that gaining support from a significant other was not always possible. Consequently, these women often looked to their health care providers for support. Interestingly, some participants described themselves as always wanting children, but never seeing themselves with a husband. This may help to explain why so few of the women in this study were partnered. One participant, Pat, went on to have children yet describes having "deprived my husband of having experiences with the kids. On some level I wanted him to be diminished as a man and father." Further to this, she describes that even after she left her husband, she continued to have children living with her since this had always been her goal (in addition to her own birth children, she also cared for foster children).

Many women talked about terminating their pregnancies, given that at the time this seemed to be the only rational decision based upon their perceptions of their (in)ability to be good mothers. As a result, several of the women in this study (n=15) had prior experiences with therapeutic abortions:

Michelle: When I found out for sure that I was pregnant, I actually bawled my eyes out and wanted an abortion. I felt this huge loss of control...and I thought that I would be weaker because I was pregnant.

Some women also reported placing their babies for adoption (n=3) in an attempt to protect both themselves and their children:

Lola: The baby was a girl and I knew that I couldn't take that baby home...because she was a girl, because she wouldn't be safe because my daddy

lived at home and he was on to my sister at this time. I just knew that I couldn't bring that baby home....Most of us women gave up our kids for adoption...there was no support in the family, you were just fucked up for the rest of your life just because you were a dirty little slut.

For several of the women in the study, deciding to keep the pregnancy was also about "doing good." Lisa stated that "It was because I was clean and sober and this was the only time I have ever done anything good in my life." For Dawn, pregnancy was about having a purpose apart from being sexual, and this assisted her in enacting the process of protecting self and child:

I would have a negative impression of my body and I carry that with me most often, especially during the pregnancy...but it was different because my body was being used to grow a baby and so for the first time I didn't feel that, like I wasn't a sex object, I wasn't being judged on my appearance, people have their opinions about what you look like when you are pregnant...but to me it totally took the focus off because I wasn't like this sexual prize anymore...my purpose was to grow a baby and to be a mother so that was a huge shift.

Many of the women in this study described making deliberate choices about who their health care providers would be in order to enact the process of protecting. As mentioned earlier, many participants needed to draw on support from their health care providers because they were not in relationships. For some women the criteria for support during pregnancy included having a female doctor, for others it was more intensive such as needing a midwife or doula to manage their care. According to Simkin (1994), "a woman who has been victimized by a man, as is most often the case,

sometimes chooses a female caregiver in the belief that being in the care of another woman will feel safer” (p. 21). While the support received by participants from health care providers was seen to be predominantly positive, for many of the women having to interact with men was problematic. Louise asserted: “If I ended up having a man...that was really, really hard for me. I didn’t want a man anywhere around me. It’s amazing that I even got pregnant.” Bonnie reported:

It was difficult to see a male obstetrician. I had all these sexual abuse issues that were still kind of fresh to deal with and some of them are still surfacing...I was pretty raw. I was kind of scared. I didn’t feel safe.

Many of the women in this study coped in pregnancy by exercising control through their choice of care providers. According to Burian (1995), survivors often seek alternative medical care through more holistic providers such as midwives, nurse practitioners, and alternative care providers. It is interesting to note that the women in this study viewed midwives as powerful. According to Weaver (1998), this is not surprising given that midwives represent knowledge, and knowledge is power. Rosenthal, Marshall, MacPherson, and French (1980) assert that control and power are two members of a closely linked triad, with the third member being knowledge.

Dawn: Why I had midwifery care? Cause you know to me doctors will say you do this and this and this and this and then, too bad, so sad if you don’t want it.

Midwives would say these are the advantages, disadvantages, this is a possible risk if you don’t and this is what will happen if you do...OK, I can always make informed choices and I am willing to live with my decision if I understand it.

Jennifer: I wouldn’t have felt comfortable with a male doctor and further to that, I

didn't feel particularly supported by a medical model. I trusted that innate wisdom that I think midwives have...they have that quality you know. The midwives were very supportive...I needed to be informed of what they were doing, I needed to be asked for permission to do things and clearly they did that...and I think the critical piece of information is that I was able to explain why, why I needed to know what was going to happen to me and they were very, very good about that...they implicitly understood why I needed that.

In relation to both establishing control during pregnancy and seeking support from members of the health care system, only one woman in the study, Joleen, talked about creating a birth plan for herself which focused on many of her abuse issues. Joleen was unique in this study in that she had been receiving specialized prenatal care from a therapist who had frequently worked with childbearing women who were survivors of childhood sexual abuse. Joleen developed her birth plan with her therapist's guidance and discussed it with her caregivers. Her perception of having received "great pregnancy care" was unique to her situation:

I think the birth plan made it really positive and we discussed it with my doctor...about certain issues in the birth plan and then I would go over it myself and then talk with my mom and then during the prenatal classes...I loved my prenatal class, I thought it was great. I talked about it at prenatal class and this class was taught by a doula, which was great.

Some of the women in this study avoided health care altogether as a self-protecting strategy:

Lori: Basically I just didn't go to see a doctor or take prenatal classes or anything

like that. I really didn't want to get all caught up in the pregnancy thing...I had enough going on already and I didn't want to have to be all nice and cheery and tell everyone that everything was wonderful, because it wasn't wonderful. I hated being pregnant but that's just not something you say. People would think that I was a bad mom and I already felt that inside...I didn't need to feel it from others.

For many participants who had spent a lifetime feeling that they had to be someone other than who they were in order to be accepted, pregnancy was perceived as an opportunity to re-focus and engage in healthy behaviors for the sake of the baby's health, and indirectly for their own health as well. Participants feared disclosure and labeling since this would make them accountable to others for their behaviors. Women with traumatic childhood histories have spent their lives enveloped in secrecy and shame, and exposing the "secret" is not only profoundly unsettling but also risks having demands and judgments placed on them. Labeling signified being different, and this was perceived as threatening by these women, as they had worked throughout their lives to be accepted.

Several participants sought reassurance from others immediately following the diagnosis of pregnancy and continued to do so throughout the pregnancy. Participants received reassurance from a variety of sources including health care providers, family, and friends. The majority of participants did not disclose their childhood sexual abuse histories to others and were careful about what information they provided while seeking reassurance. The women who had previously disclosed their sexual abuse histories had experienced judgment-based care as a result of having disclosed. They believed that a label had been attached to them and that as a result they were treated "differently."

Consequently, few participants disclosed their traumatic histories to their caregiver during their pregnancy. Experiences varied among those that did. Some participants found that health care providers, although lacking in knowledge about the subject matter, were nevertheless sensitive in their approach, whereas others found that health care providers were judgmental and insensitive, thereby reinforcing their sense that they were “bad,” “dirty,” and “unworthy” of having a child.

When participants were asked about screening for a history of past or current abuse during pregnancy, their responses varied. In general the women felt that screening for abuse was important and they were supportive of this process. However, there were considerable discrepancies in their opinions of when and how such screening should be performed. Many women felt that it was a “good idea” during pregnancy, although many weren’t sure whether they would disclose or not. In contrast, some felt that pregnancy was not an ideal time to screen for an abuse history. Caitlyn explains:

Pregnancy is a time for purity. I want my pregnancy to be pure and not tainted with memories of a dirty past...even though it wasn’t my fault. I don’t want to be talking about horrible stuff like what happened to me as a child and I certainly don’t want to feel like I am going to do the same to my child. I just don’t think pregnancy is a good time to talk about it. I just didn’t even want to think about it then.

The notion of pregnancy as “pure” and “free” of abuse memories contrasts strongly with the women’s reported experiences of an increasing consciousness of their abusive pasts throughout the childbearing phases. When clarifying this finding with Caitlyn and the other participants who expressed the same notion, it became clear that experiencing a

pregnancy that was pure and free was the ideal, but the reality was far different. The women did not want to have to face their issues, but these became more and more pressing as the pregnancy progressed and the women came closer to becoming mothers. In light of this, participants shared that although discussing their abusive pasts was not desirable for them during pregnancy, having health care providers open the door to the dialogue was important.

Some of the women in this study also felt that pregnancy was actually a way of keeping themselves safe. For example, Joleen commented, “no one hurts a pregnant woman.” These thoughts were echoed by Cathy, who stated: “I felt like nobody would touch me because she is a pregnant woman—that kind of thing. Like nobody would attack you...you are treated with more kid gloves. I felt safe somehow and special.” The current literature on violence against women contradicts these women’s perceptions of pregnancy as a safe time for women. According to Statistics Canada (1993), 21 % of the women in Canada who reported being abused by an intimate partner were abused during pregnancy. In fact, violence may even begin and/or escalate during pregnancy: Statistics Canada noted that, of the Canadian women who reported being abused by a partner during pregnancy, 40% stated that the abuse actually began in pregnancy. In a recent report by Health Canada (1999), it was observed that abuse during pregnancy is an under-recognized problem. Although none of the women in this study reported having experienced abuse during their pregnancy, it is nonetheless important to recognize in passing that pregnancy does not exclude women from experiences of violence and abuse.

It has been reported that survivors of childhood sexual abuse are more likely to use illicit drugs and alcohol in general (Briere & Runtz, 1988; Epstein, Saunders, &

Kilpatrick, 1997; Langeland & Harters, 1998) and during pregnancy (Stevens-Simon & McAnarney, 1994). Additionally, survivors of childhood sexual abuse are more likely to experience eating disorders (Bachmann, Moeller, & Nenet, 1988; McClelland, Mynors-Wallis, Fahy, & Treasure, 1991). Follette, Polusny, and Bechtle (1996), reported that approximately one third of previously abused women had lifetime alcohol problems compared with approximately 20% of women in the general population. Although many of the women in this study had been using substances or developed eating disorders to cope with their lives prior to pregnancy, they reported that substance use or disordered eating did not play a significant part in their pregnancy experiences. In this sense, it appears that pregnancy served as a motivation for them to enact healthier ways of coping, despite their abuse triggers. Moreover, some participants who perceived that they were placing their baby at risk modified their behavior in order to have a healthy baby. This modification of behavior, a process of "doing things right" (McGeary, 1991) has been noted previously (Corbin, 1987; Lever Hense, 1989; Penticuff, 1982). This willingness to modify maternal behavior is closely aligned to two of Rubin's (1975) maternal tasks of pregnancy, "giving of oneself" and "ensuring safe passage."

The women in this study also used their bodies as a means of addressing pain, the pain of issues that were deeply rooted in their psyche. Pregnancy seemed to be an opportune time for the participants to begin the healing process since many of them were highly motivated to be healthy and to make a "fresh start." They wanted pregnancy to be "pure," and this meant utilizing positive coping behaviors rather than self-abusive behaviors in order to deal with their emotional pain. However, ceasing or decreasing some of the self-abusive survival behaviors, such as eating disorders and substance use,

also left the women feeling vulnerable, exposed, and fearful. Although the vulnerability did not appear to manifest itself in physical coping strategies, questions remain about what emotional impacts influenced the pregnancy. Some of the women talked of denial and others of disconnection to the fetus. This coping strategy became increasingly more apparent and problematic for women as they progressed through the phases of childbearing. According to Buist (1998b) and Buist and Barnett (1995), the mother-child relationship is impaired in women who have a history of childhood sexual abuse, and they are more likely to suffer from postpartum depression. This finding resonates with the women in this study, as will be discussed later in this chapter.

A study by Farber, Herbert, and Riviere (1996) reported an association between a history of childhood abuse and suicidality in pregnant women. Additionally, a history of sexual abuse alone or in combination with physical abuse was associated with a history of suicide attempts prior to the current pregnancy. Farber et al. also reported that pregnancy is an extremely vulnerable time for women and, by extension, women also fear for the vulnerability of their newborn infant. These vulnerabilities, coupled with feelings of inadequacy in mothering or protecting their child, may manifest themselves in fantasies of death of self and unborn infant. Although several participants reported previous suicide attempts, none of them reported suicide attempts during their pregnancy. Their coping strategies involved self-harm in the form of marking or cutting, but this did not escalate to attempts to take their own lives or the lives of their unborn children.

However, depression during pregnancy was a significant behavioral response:

Jasmine: I think they should call it pre-partum depression...I found pregnancy very difficult...I was very depressed throughout the entire pregnancy. I felt like I

was in a fog the entire time and this certainly didn't help with me feeling like I was going to be a good mom. Isn't pregnancy supposed to be a happy time for expectant mothers?

Despite the research addressing the long-term outcomes of sexual abuse in childhood, relatively little attention has been paid to the possible association of past sexual abuse with depressive symptoms during pregnancy and/or adverse pregnancy outcomes. The prevalence of depressive symptoms during pregnancy is usually explored as these symptoms relate to depression in the postpartum period, rather than in isolation. The women in this study experienced depression in the pregnancy period which continued into the postpartum period as well. Although it was beyond the scope of this dissertation to address experiences of depression in pregnancy specifically (and particularly how they impact on postpartum depression), further investigation into women's past experiences of sexual abuse in relation to depressive symptoms during pregnancy seems warranted. Few studies directly address the possible relationships between past sexual abuse and adverse pregnancy outcomes. Stevens-Simon and McAnarney (1994) found that women who were abused were more likely to have premature or low birth weight infants than non-abused women. Evans, Kotch, and Ringwalt (1989) found tentative associations between past sexual abuse and prematurity and "medical problems" in the perinatal period. Jacobs (1992) found that women who had been abused experienced longer gestational periods, longer labors, higher birth weights, more pregnancy terminations, more medical problems, and greater stress (there were no differences reported in cesarean deliveries). My findings were more consistent with studies that did not find any direct relationships between stress, violence, and other

psychosocial indicators and birth outcomes (McCormick, Brooks-Gunn, Shorter, Holmes, Wallace, & Heagarty, 1990; O'Campo, Gielen, Faden, & Kass, 1994). This area of research is still in the early stages and although this study found no associations, the theoretical and empirical literature suggests that further investigation is required to fully understand the relationship between adverse childhood experience and current pregnancy, labor, and birth outcomes.

The participants' pregnancy experience demonstrated that connections are made between histories of childhood sexual abuse and women's experience of pregnancy. Participants responded to various triggers of their abuse histories that ultimately influenced their need to self protect. Forms of self-protection or coping strategies were predominantly comprised of women's personal agency (enactment of control), decision-making, and support from others. Protection of the child, in this context, was somewhat inherent in that the child was in-utero and there were no obvious external threats to the child. Evidence of bonding challenges, however, became apparent even at this early stage of childbirth.

### **LABOR AND BIRTH**

Each woman brings to her labor and birth a plethora of past experiences, not only from her impressions of pregnancy, but also from her childhood. According to Trad (1991), with each developmental milestone of the fetus, the sense of the unrelenting push toward separation is reinforced. At no point is this more true than with the delivery of the infant. Birth is a profound culmination of much of the physical and psychological preparation of the mother (Philipp & Carr, 2001). In one brief moment, one becomes two, and the course of both lives moves onto a new path.

The labor and birth process proved to be a traumatic experience for the women in this study. Current research suggests that it is not possible to determine whether a traumatic event or experience will trigger a post-traumatic response for any given individual. However, the literature suggests that there are a few common triggers, which include feelings of not being in control and traumatic childhood histories (Howarth, 1995; Lyons, 1998). Both of these “triggers” resonate with the findings and the women sampled in this research study. Participants reported experiencing a variety of triggers of their childhood sexual abuse that ultimately had an impact on their labor experiences. According to Miller (2001), the experience of childbirth and associated obstetric interventions can reactivate memories of childhood sexual abuse. Some women experience flashbacks and/or sensations analogous to forced intercourse and/or overwhelming feelings that their bodies are out of control, that they must depend on others in a way that frightens them (Rhodes & Hutchison, 1994). It is suggested that these feelings can result in difficulty collaborating with labor, so that there is a “failure” to progress. Labor and birth inherently involve situations of increasing vulnerability and decreasing control. In connection with a history of childhood sexual abuse, the possibility arises that laboring women may experience some kind of posttraumatic response. The specific triggers to labor and birth are presented below, followed by participants’ coping strategies.

### ***Triggers experienced in Labor and Birth***

The focus to self protect became more prominent in the labor and birth phase of childbirth, as participants' bodies were subjected to greater numbers of abuse triggers, largely physical in nature. This is in contrast to the women's pregnancy experiences, during which the abuse triggers were largely emotional in nature. According to Tidy (1996), survivors of childhood sexual abuse are especially vulnerable during labor. Tidy equates labor and birth with sexual abuse in that the muscular structures that were once involved during the sexual abuse are once again being stretched and torn in ways that mimic the abuse experience. Waymire (1997) supports Tidy's assertion by stating that "birth can recall or re-enact previous violations of their body because the anatomy involved in childbirth is typically the same anatomy involved in sexual abuse" (p. 47). These "body memories" are, in essence, traumatic memories that are triggered by events similar to the original traumatic events. Warshaw (2002) suggests that this encoding of memories may be enhanced by the increased levels of stress hormones and neuromodulators present during intense emotional arousal, such as during labor and birth. In addition to the physical triggers experienced by the women, situational triggers were also prevalent, such as the gender of caregivers and feelings of institutional disempowerment.

### ***Body Memories***

Body memories of previous trauma are said to be stored in sensory rather than narrative form (Shobe & Kihlstrom, 1997; van der Kolk, 1997). Therefore, since childhood sexual abuse often occurs before the development of complex language capacities, memories may be more fragmented and resurface as sounds, bodily

sensations, smells, childhood affect states, or images (Warshaw, 2002). Participants reported that the physical triggers in labor and birth involved stimulation of all five senses; touch, sound, sight, taste, and smell.

### ***Touch***

For the women in this study, the most common sense trigger in labor and birth involved touch. Seng and Hassinger (1998) contend that touch may constitute a boundary violation for women in labor, such that touch, while intended as a means of soothing nonverbal communication, may be counterproductive. Many participants associated touch with vulnerability and lack of choice and control. For example, Cathy states: "I felt like I had no choice, it's like whomever came in had a right to touch me. It's a pretty vulnerable place to be in." Suzanna reports similar feelings of vulnerability:

God I was so vulnerable when she was coming...with all the people touching me and stuff...like being in all that pain and not being able to control the pain and being at the mercy of everybody else. I didn't like them touching me so I just went away...like in my head, I just went away and watched from above.

Touch was sometimes necessary, specifically when vaginal exams were required to assess the condition of the cervix and progression of fetal descent. Kitzinger (1990) found in her study of 39 survivors of childhood sexual abuse that vaginal examinations were particularly traumatic and reminiscent of the abuse. The experience of childbirth left my participants feeling as if they had experienced the abuse all over again, and once again found themselves powerless.

Archimedes: It is so much about loss of control...feeling somebody is invading your body with their hands or instruments of some sort and you don't have control

and you are totally vulnerable...so giving the woman some control that she can have in a labor situation makes it a whole lot easier.

Archimedes's feelings of vulnerability and loss of control were common to all participants in this study. Many abused women fear loss of control of their bodies (Howarth, 1995), and the women in this study were no exception. Some felt reassured by touch during labor and birth, but most did not. The issue of appropriate touching for survivors of sexual abuse was therefore individual. Participants reported that the key element regarding touch was that they be given an element of control over their experiences. Sherry explains:

It really helped when she [nurse] told me what she was doing, why she had to do it, and where she would be touching me. It just helped me to prepare for it better. It was really important for me to feel like I had some choice in all of it and it was really helpful when she asked me if it was OK for her to touch me. It was like she was respecting me.

In Sherry's case, a trusting relationship developed between her and the nurse, because the nurse allowed her a degree of control, and treated her with respect.

### *Sound*

Some of the triggers of abuse for the women in this study involved sounds, most often in the form of language or jargon used by health care providers during their labor and birth:

Lisa: The nurse kept telling me to just "let it happen" to just "let go." I couldn't...I wouldn't...I was scared and alone. He used to say that to me and horrible things would happen. I didn't want that to happen again.

Marcy: I remember hearing “surrender to it” and I wanted to hit her. Surrender! I have been surrendering my whole life and what has that done for me? Nothing but cause me pain...and here I was all over again...being told to surrender.

The importance of the language used in childbirth has been briefly addressed in the literature (Bergstrom et al., 1992; Simkin, 1992; Tidy, 1996; Weaver, 1998). According to Hunt and Symonds (1995), communication is the underlying issue in both control and choice during childbirth. Participants in my study found language both empowering and disempowering, depending on the words used and on the ways in which the words were spoken. Bergstrom et al. examined the language used during vaginal examinations during the second stage of labor, and although their inquiry did not focus on childhood sexual abuse survivors, its findings are relevant to the women in this study. In essence, Bergstrom et al. observed that caregivers communicate an overall message about their power over laboring women. Features of power and control were paramount to the women in this study, and the use of specific words that implied “power over” them triggered their abuse memories. Other terminology frequently used in childbirth to describe women’s situations, for example, “failure to progress,” was also problematic. Although this term is not meant to suggest that the woman herself has somehow failed, women who feel vulnerable, such as sexual abuse survivors, may inadvertently internalize the term “failure.”

Tina: They told me I was going in to surgery because of “failure to progress” and I remember thinking, how did I fail? What more could I have possible done? I have done everything short of dying to get this baby out.

In addition to the language used to describe women’s progression in labor, some

comments used by health care providers to “encourage” the women to remain positive or to push during the second stage of labor were also viewed as problematic. Nika explains:

He [doctor] came in [to the birthing room] to check on me and to do a vaginal exam to see if the baby was coming soon and I remember saying things like “I can’t do this, I can’t do this, make it stop.” I remember him looking at me while his hand was up my vagina and he said “Don’t worry honey, you could drive a Mac truck through here.” I was horrified.

In addition to language used during childbirth, elements of noise (and sometimes lack thereof) were also potential triggers of abuse. Several women commented that the amount of noise in their hospital rooms was in direct contrast with their childhood experiences of abuse, which commonly occurred in moments of “profound silence.” This would seem to suggest that quieter delivery rooms might be more reminiscent of childhood abuse experiences; however, several of the women stated that they enjoyed the quiet because they found chaotic rooms more problematic. Stacey’s labor experience was reminiscent of her gang rape. She reports that “It felt like I was being raped all over again....I was nothing....and everyone was standing around cheering it on.” Janice also reports feeling distressed when her birthing environment was chaotic:

I really enjoyed the moments of darkness and quiet and calmness. Even though parts of that were uncomfortable for me, it was mostly OK. When the room was really busy I felt overwhelmed, more out of control, more specimen-like. I felt like I was an object being studied.

I could find no literature which directly addressed this finding. However, it is intuitively appealing that feelings of being out of control are more likely to arise in chaotic

situations than in situations of calmness and quiet. In general, participants associated sounds, such as the language used during the labor and birth, with their own lack of power and control.

### *Sight*

Some physical triggers also involved sight. Some were related to the physical outcomes of the birthing process whereas others were related to the birthing atmosphere. Karen's visual triggers were related to the physical outcomes of her birth. She commented that "The blood was everywhere...and I was ripped open from the inside before...so it was just as terrifying as back then." Louise found the birthing atmosphere problematic:

All I remember is this bright light. It reminded me of the light in my bedroom when I was a kid and when the contractions were coming and she was coming, I just stared at that light. I don't know whether it was helpful or not because it reminded me of when I was back in my bedroom and there was that light above me. I used to stare at it and it helped back then...and I think it made a difference there.

It is interesting to note that Louise considered the bright light to be both a trigger and a coping strategy. This was the only "sense" trigger that held a dual role for a participant. Lola found it problematic to have everyone around her looking at her, so she covered her eyes in order to manage:

I didn't feel like the labor part was a problem because what happens is that I, I find myself, I always get into the same position, I cover my eyes and I feel like I can't have anybody look at my face, it like goes way back to the need to be really

invisible and it's just, well, I don't like it.

Many participants commented that they were concerned about what others in the room were seeing. In essence, they felt violated because their "private parts" were so readily exposed, and this made them feel ashamed and self-conscious:

Kat: In the beginning there was a lot of shame...I felt really awful, sick to my stomach when I had to put my feet in those stirrups and expose my body parts and I felt really self conscious and shameful. It felt really personal.

One participant, Lynn, attributed the onset of labor pains to seeing her abuser:

I was at the hospital in early labor but I remember them [nurses] saying that things weren't progressing very well....The first person through that door was my stepfather and as soon as I saw his face, labor began, like hard labor...isn't that strange? The first pain I had was when I saw his face.

Lynn's story of labor being initiated by seeing her abuser's face was unique to this study and unique to the literature. Like touch and sound, sight triggers reflected issues of power and control for the women in this study, and contributed to their feelings of increasing vulnerability and powerlessness during labor and birth.

### ***Taste and Smell***

Although not as common as the other sense triggers, taste and smell were also reported as abuse triggers. Taste was connected with smell in this context given that women described sensations of "I could almost taste it..." when referring to various smells that served as triggers of their abuse:

Abby: Body secretions have a really distinctive smell to them...they just smell really bad and without using foul language, well...it just smells bad. I was really

embarrassed of how I smelled...like after it happened [abuse] and you have to go wash off...that's how it was....As soon as they put the gel on my stomach to listen to the baby, I just wanted to pass out. I remember those smells and it made me sick. I just wanted to have a shower and scrub all the stench off me.

Among the women in this study, sense triggers elicited a biological stress response. The idea that the psychological effects of trauma are stored in somatic memory and expressed as changes in the biological stress response is not new. Van der Kolk (1994) reports:

In 1889, Pierre Janet postulated that intense emotional reactions make events traumatic by interfering with the integration of the experience into existing memory schemes. Intense emotions, Janet thought, cause memories of particular events to be dissociated from consciousness and to be stored, instead, as visceral sensations (anxiety and panic) or visual images (nightmares and flashbacks). Janet also observed that traumatized patients seemed to react to reminders of the trauma with emergency responses that had been relevant to the original threat but had no bearing on current experience....They became fixated on the past, in some cases by being obsessed with the trauma, but more often by behaving and feeling as if they were traumatized over and over again without being able to locate the origins of these feelings. (p. 253).

Janet's observations over a century ago resonate with the findings in this research study. Participants experienced psychological and physical responses to triggers of traumatic childhood events during their labor and birth experiences. The majority of the women did not connect their stress responses to their histories of childhood sexual abuse so they

felt traumatized without understanding the underlying reasons for their feelings.

### ***Gender of the Caregiver and Institutional Disempowerment***

The gender of the caregiver was also a trigger for women in this study; it was predominantly male care providers who triggered memories of the abuse. Female caregivers were implicated through the way in which they did or said something, rather than by their gender. Caregivers were also perceived as representing authority and power, which further contributed to the women's sense of vulnerability.

Michelle: I was just like a huge tornado of emotions going on inside me. And the loss of control and all this stuff right from the start, from the vaginal exams and everything touching...it just kept escalating. I starting vomiting all through it...and screaming to the doctor "you can't stare at my crotch." I was probably making him feel really bad because I could tell by the way he looked down and away but I was still screaming "Can't he get out of the room...I want him out of the room." And the nurses and everyone were just looking at me kind of hurt and they didn't understand. One of the nurses actually said to me, "what's wrong with you? We expect better of you than this." She probably realized something more was going on but I was hysterical. I'm supposed to enjoy this moment and it was stolen from me because I feel like I was going through that again. So I didn't even get to enjoy the birth of my own baby. It was hell.

Cindy: The one major trigger I had was when I asked her specifically if she worked as a team with other doctors and if she was unavailable, that another doctor would be there and I wanted to know specifically that it would be another female doctor. She said she would ensure that but when I went into labor they

needed to call in a pediatrician and he was a man and I was basically standing up and leaving because I wasn't staying with another man in the room. Up to that point it was all women and so that to me it was a big trigger having a strange man walk into the room when I was like exposed like you are in delivery and that was not a good time for him to walk in.

Only one of the participants in this study, Joleen, described having a male caregiver as a positive experience:

I think it is healthy for me to deal with men on that level. I think it's really healthy. It pushes me a little bit further and it encourages me to be comfortable with men in this situation. Because not all men abuse women...I think it's important to realize that there are good men and there are not so good men...just like women abuse—there are good women and there are not good women.

Lynn described male physicians as a “hurdle” for survivors of childhood sexual abuse:

I think obstetricians, male obstetricians are one of the biggest hurdles. Men touching you, you know not in a sexual way but if that is all you have known, I think that is huge. Even though I liked my doctor, I still found it huge, really huge. I have no male doctors, none. Actually my dentist is a male, but he's gay, so that's his saving grace.... Survivors would always go for a female.

Lynn's perceptions of abusers are thus that they are male and heterosexual. In this way, she suggests that sexual abuse is about sexual desire and not strictly related to power.

Participants reiterated the theme of powerlessness again and again, explaining that this powerlessness was experienced on both internal and external levels: they felt powerless over their bodies (internal) and powerless over the institutional policies of their

hospital (external). They experienced an associated fear of individuals in positions of authority stemming from years of sexual abuse at the hands of someone viewed as more powerful. Participants reported struggling with their ability to trust and believe in their own perceptions and good judgment as well as their ability to remain in charge of their own situations. They described feeling that they had “no authority.” Personal authority is developed through experiences which teach a child that she can trust her own thoughts and feelings. The issues of trust and self-control are reportedly paramount for survivors of childhood sexual abuse (Grant, 1992).

The women in this study lacked confidence in their ability to develop an accurate understanding and appropriate response to situations and conditions in their lives. Their abusers’ repeated lies and/or dismissals instilled a sense of self-doubt within them, so that, instead of learning to trust themselves, they came to distrust their own thoughts, feelings, and their own developing sense of authority and rights. In the birth context, this actualized itself in such a way that women felt powerless and subsequently unable to trust their caregivers:

Kimberly: I didn’t want the doctor down there [perineum] looking at me...touching me...I felt so dirty just spread out like that for everyone to see...I didn’t want them to have anything to do with my body but they kept touching me and telling me to just breathe through it. I puked right then and there...just like I used to do when he was touching me. I was so ashamed. I tried to tell them but they just didn’t listen. I felt so vulnerable and I had no one to turn to.

The association between abuse triggers and women’s need to self protect and protect their unborn children has been indirectly addressed in the literature. According to

Bohn & Holz (1996), "Many women fear labor and fear that they will be unable to protect their child from abuse once it is born, so they may be unable to go into labor and require interventive postdates management" (p. 447). Survivors are reportedly at higher risk for surgical procedures including caesarean section (Drossman, Talley, Leserman, Olden, & Barreiro, 1995; Jacobs, 1992; Kirkengen, Schei, & Steine, 1993; Stevens-Simon & Reichert, 1994). Recent research has also asserted a relationship between preterm labor and a history of childhood sexual abuse (Horan et al., 2000; Stevens-Simon, Kaplan, & McAnarney, 1993; Stevens-Simon & McAnarney, 1994). There have been clinical reports of women who are childhood sexual abuse survivors having longer labors, and severely increased pain in labor and delivery (Bohn & Holz, 1996; Rose, 1992; Tidy, 1996). Data regarding postdates management, choice of childbirth method (vaginal versus planned cesarean section), and experiences of preterm labor were not collected in this study. However, participants did report feelings of trauma and violation related to their birthing experiences:

Lisa: I felt violated...it triggered something when I started with contractions...I felt the pain but I couldn't come back to my feelings because I learned so well how my survival techniques could shut everything off once any part of me was violated from here up to here [thighs to shoulders].

Archimedes: I found the labor very traumatic....I remember not recognizing myself in the mirror after I had my son and I wonder now, I feel like it was probably there was some kind of switch that had happened...because there was another alter inside me and we had arguments about who his real mother is....she is the one we both thought of as the mother because she gave birth to so many

child alters.

Archimedes, the only survivor in this study to identify herself as having a multiple personality disorder, reported that it was her other personalities who had conceived, carried, and in some cases given birth to her child. Although Archimedes's story of experiencing birth through one of her "alters" is unique to this study, it does lead one to question the impact of multiplexity on the childbearing cycle. It may be that multiplexity and the use of other personalities to give birth was, in fact, a way for Archimedes to cope with her traumatic labor and birth experience.

### ***Coping Strategies employed in Labor and Birth***

As pregnancy progressed into the later phases of labor, birth, and mothering, women's coping strategies in relation to the process of protecting generally manifested themselves as dissociation. Participants used dissociation as a coping strategy to endure the pain of childbirth. Although published reports suggest that sexual abuse survivors experience severe pain in labor (Grant, 1992; Kitlinger, 1990; Rose, 1992), many of the women in this study report a contradictory experience in that their ability to dissociate helped to "numb the pain of labor and birth." Thus, the pain of childbirth was viewed as manageable, because dissociation was available as a coping strategy.

A study by Van Der Leden and Raskin (1993) has suggested that the ability to dissociate from painful experiences caused shorter labors, but this was not a finding within this research study. However, specific details relating to length of labor were not sought. One participant's response to the flashbacks was to use the same survival skills she had used as a child: she cut off sensation and dissociated herself from her physical self. It was a creative solution for a child who had no other way to protect herself:

Lynn: I dissociated when I delivered my son. I could see my body, I could see me screaming but I also knew I couldn't move and I just had this out of body experience just watching over me and I stayed out of my body, I had no feeling then...I stayed out of my body for about five minutes which is a long time I think. I think for me then it was an asset but I also think dissociating is a major liability because I allowed a lot of abuse to happen when I wasn't there in my body.

In contrast, Lisa described birth as especially challenging because, while dissociation was a tried and tested way for her to shut down painful moments in her life, and she experienced a disconnection from her body during her labor and birth, she also felt her heart was "in there." Giving birth involved feeling deep emotion and love for her child, so dissociation was problematic:

From my thighs to my shoulders or below my shoulders is not mine, it never has been so go ahead and take it. I believe that's what happened when I had A...something is sort of going on down there and everything wasn't mine anymore...Too bad my heart was in there. It really sucks that my heart was in there with A. It was like I was fighting to have my own body back but just couldn't. It seems like whatever I could do I have been ripped off, I mostly just shut down, I just do everything that I am supposed to do that came naturally but my heart was in that part of my body...in this frozen part of my body, In that part of the body that isn't mine anymore...he was in there, and I couldn't use it even though I knew I could deal with my heart, I couldn't deal with the feelings....I was raped in a sense...not that I was physically raped, I was raped of the whole experience...I was ripped off...it was taken away from me because I brought up

so much resistance to anything that happens to that part of my body that I couldn't experience it because I didn't know what was going on...I didn't know the difference...I didn't know that having this baby was any different than anything else going on with me from the waist down. Maybe if I knew and it was told to me continually through my pregnancy that this is because of your abuse, this is different because of it...then it'd be OK.

Lisa's equation of rape with birth is echoed in similar studies by Christensen (1992) and Lipp (1992). According to Nelson (2003), "Some women feel invaded, exploited or taken over, and this may culminate in an experience of labour as a kind of rape. The exposure and loss of dignity and control that are experienced when giving birth may leave the woman feeling damaged, helpless and frightened" (p. 31). Lisa pointed out that this was not the first time in her life she had "shut down":

When I was a prostitute there were times that I shut down and just left myself. There was this caring part of me and there was Lisa who is a survivor, who takes over when anything sexual happens. She's great, she's tough, she's hard-core, she can handle anything like that. I can't.

When asked if this meant that she described herself as being a multiple personality, she responded:

No, it's just a part of me that is survival mode. It's not like I split up except that the part of me that's compassionate, kind, wonderful, loving person is just pushed down and it's not as though I am watching what is going on, but I know I'm not there but I don't know I am not there...like when I was a prostitute...from the moment I left my house to the moment I remember walking up the pathway...I

don't remember anything after that...I have flashes of the room, like flashes of what happened...but all I see is the ceilings and the side walls...and then all of a sudden I am cooking in the kitchen.

Lisa described her dissociation as an asset, in particular when she was triggered by threatening events:

I think as soon as something was wrong with the baby it triggered something where I couldn't deal with it and I needed her [a stronger, more dominant version of Lisa]. She needed to be tough, I needed her to be tough, hard core, whatever, I just kind of sat back in the background, did everything that I knew what to do but I just let the stronger part of me take over to deal with the crap.

Lynn echoed Lisa's perception of dissociation being an asset, and conversely a liability:

I dissociated when I delivered my son. I could see my body, I could see me screaming but I also knew I couldn't move and I just had this out of body experience just watching over me and I stayed out of my body, I had no feeling then...I stayed out of my body for about five minutes which is a long time I think. I think for me then it was an asset but I also think dissociating is a major liability because I allowed a lot of abuse to happen when I wasn't there in my body.

According to van der Kolk and Fisler (1995), people who have learned to cope with trauma by dissociating are vulnerable because they continue to dissociate in response to minor stresses. The continued use of dissociation as a way of coping with stress interferes with the capacity to fully attend to life's ongoing challenges.

Archimedes equated labor, specifically the transition stage, with other vulnerable times in her life:

...a feeling like you're losing sense of yourself [labor and birth] because it is a scary place to be psychologically...because you really do accept the pain it's just you are way over the edge. You think you are going to just rip apart...you know, be totally open and you don't have normal boundaries to compare it to.... certainly the transition stage is definitely the most vulnerable. But there is something too that happens...it's something that when I freak out with memories coming up and some inside...it's feelings like the transition stage of labor itself. I remember being in labor and what I am going through now feels like that...it's just that kind of connection over and over again....there is nothing subtle about it.

Within the literature, the suggestions for nursing care for clients who dissociate in labor is to “give verbal encouragement to the woman to stay in the present, to assure her of safety, and to distinguish past from present” (Courtois & Riley, 1992). Burian (1995) also recommends keeping the laboring woman focused on the present. Although health care interventions such as providing verbal encouragement, assuring safety, and supporting survivors in distinguishing past from present are supported by the women in this study, the notion of encouraging the woman to stay in the present by not dissociating was not supported by my study findings. Several of my participants reported dissociation as an asset to their childbirth experiences and felt that “taking that away” would be damaging for them given that it was, for some, their only coping strategy. Simkin (1994) addresses the dilemma of whether or not dissociating is a good way for survivors to cope with the stresses of labor, but fails to offer a solution for nurses:

If they perceive their ability to dissociate as an indicator of strength, they might welcome dissociation during labor, and may find it is their only way to cope with

the pain. If dissociating reminds them of their victimization, or if they fear that returning to an awareness of their bodies after dissociating might be disorienting, they may want to remain completely present and aware of the pain (p. 23).

Rhodes and Hutchinson (1994) identify four labor styles among childhood sexual abuse survivors: fighting, taking control, surrendering, and retreating. Fighting is said to be the classic reaction of survivors and refers to women actively engaging in battle with their own body sensations. Taking control is an attitude whereby women demand control over their labor. Surrendering is the opposite of fighting and entails women's submission to the labor. Retreating is an attempt by the survivor to remove herself emotionally or mentally from the sensations that replay the abuse, given that she cannot remove herself physically. The labor styles of fighting, taking control, surrendering, and retreating, as described by Rhodes and Hutchinson, were all described by the women in this study. Their most common coping strategy was retreating, or dissociating during labor, while fighting was the least frequently identified coping strategy. This finding contrasts with Rhodes and Hutchinson who report that the fighting style is the "classic" style for survivors.

Miller (2001) reports that, as an added coping strategy, some women may attempt to control every aspect of delivery to the point where they may be perceived as overly controlling by obstetric staff. If the reasons for the controlling behavior are not understood, health care providers may come to regard the mother as an adversary who must be managed in order to provide care to the baby (Josephs, 1996). The women in this study repeatedly expressed feeling the need to have control in their laboring experiences, but did not describe many instances in which they found themselves in

adversarial situations with health care providers, apart from issues around the gender of the caregiver.

J. M. Green, Coupland, and Kitzinger (1988) found that a woman's sense of satisfaction, fulfillment, and emotional well-being were associated with control in labor. Simkin (1991) reported that the psychological effects of control in childbirth can be long-lasting. Among the women in this study, those who had a sense of control over what happened to them and over decisions in their care during labor expressed greater satisfaction with their birth experiences, despite the challenges they experienced. Participants described a sense of powerlessness and vulnerability in response to some of the procedures encountered in labor and birth, such as vaginal examinations, episiotomies, and suturing. On a related note, they did not frequently describe the use of pain medications as a form of control or coping in their labor and birth experiences. The increased use of epidurals and pain medications in labor by survivors of childhood sexual abuse has been reported in the literature (Simkin, 1994), but this was not a significant finding within this research study.

The women identified support from partners and friends as important in their positive birth experiences. Interestingly, health care providers were not identified as being particularly helpful during this time. Although obvious reasons for this were evident in the findings, several of the women in this study described not feeling "supported" by their nurses and doctors. The lack of emotional connection may be explained by the fact that the women in this study did not have time to establish a trusting relationship with any of their caregivers. It may also be explained by the women's primary coping strategy of dissociating which, in and of itself, requires women to

disconnect from their immediate circumstances, and by extension, from their health care providers. Despite their descriptions of lack of emotional support, participants did suggest that their health care providers were helpful in providing information about the labor and birth process, and, in this way, were viewed as supportive. Stephanie commented that her hospital support in general was good, in large part because her nurses were females:

I would say the support of having the hospital support was really good...Talking to them was helpful. I found talking to N. and L. was easier because they were females...females have probably dealt more with sexual abuse issues because more females face that struggle every day.

Only one participant, Archimedes, was able to describe a positive supportive interaction with her health care provider. Interestingly, Archimedes had a midwife for her perinatal care:

Like you could just feel like her attitude was just common sense, down to earth, trust your body and also I'm not going to do anything that you don't want me to do, you tell me about how this has happened, where do you feel it and you could just feel that the way she was talking to me she was just totally respectful and she was like you are the expert here in some ways...you know, that kind of feeling. She made me feel safe...she made me feel like I'm not stupid here, she's not just the expert here telling me don't do this, do that, that kind of thing...but this is your body and I know that we are talking about your body and that the kind of thing that was great. Yeah, this is my body and it has been traumatized.

Archimedes was able to develop a trusting relationship with her care provider in the

months during which she received prenatal care. During this time, she had also disclosed her childhood sexual abuse history to her midwife. Thus, care was likely provided that was sensitive to her unique needs. When support is offered that is perceived to be lacking in understanding, it is likely to be ineffective and therefore, not helpful (McCourt, 2003; Oakley, 1992a). As evidenced by the above quotation, Archimedes's midwife provided care that was sensitive and appropriate to her specific needs. In brief, Archimedes felt that she had not only been given information, but had also been listened to and treated with respect. Central to her positive experience was also a sense of choice and control with regard to what happened to her, as well as a sense of trust and confidence both within herself and in her midwife. These are all qualities that other women in the study described as being desirable in a health care provider. Whereas these qualities focused on dynamics of power and control, the women's experiences of support from family and friends appeared to be more about the provision of physical comfort measures.

According to Wheatley (1998), one influential source of psychosocial support that is potentially available to the majority of pregnant women is that of the partner. Although this was not available to the majority of the women in my study, those partners that were involved were predominantly viewed as positive contributors to the childbirth experience. Friends were also viewed as a strong support structure because they were well known to the women and were able to provide specific physical comfort measures:

Bonnie: I just loved having her there [friend]. She knows me so well and just held my hand and somehow that seemed to make it all OK. I just knew that I would make it through. She helped me feel capable.

Leslie: She rubbed my back during contractions and it was just what I needed. I didn't even need to tell her to do it...she just knew that it was what I needed. I felt really safe having her there since she knows me and loves me no matter what.

McCourt (2003) describes three distinct components of social support: emotional support, which conveys esteem and provides security; informational support, which involves the transference of relevant information, and implies the ability to make positive choices, increase confidence, and provide a sense of security; and practical or tangible support, which may include the provision of physical comfort measures or even financial assistance. Participants in this study received informational support from their health care providers and emotional and practical support from their family and friends.

Beyond simply coping with labor and birth, three of the women in this study described their experiences as a success and a part of their life-healing journey:

Dawn: Labor was probably my biggest success. I was present all of the time, natural, complete, and supported...certainly aware of the pain and the changes and all of that, but it was very empowering because of that "hey, I can do this" feeling. It is maybe the first thing that I can do completely, be in charge of and that really was a drive for me. It turned out to be positive that I could focus so clearly on that. I guess my fear before was that I would feel overwhelmed that I would feel violated, that I would feel this was being done to me and out of control. Those were my fears around giving birth so by actively working around those issues, that I could turn them around and that I was able to do that. I could feel that I was being violated somehow but surrounding myself with a support network and realizing that they were all there honoring what I was doing it just

helped. It made it positive as opposed to you know, going there to all those negative feelings, you know certainly after the birth you have physical injury and I was worried about that too, that it was going to bring it back and you know, maybe partly I dissociated that after but my focus was on the child at that point, not myself and at that point that was helpful not to focus on my physical ailments. I was focusing on nurturing the child and that helped me through.

Archimedes paralleled the experience of labor with her healing journey:

I have thought of it as being like in labor and especially during times of transition where you are really losing it and you are way out there and you know comparing some of the times when I have gone through healing that's what this is like, and we would have even at times felt like we were physically pushing memories out and we would actually almost bear down and it would just be like, yeah, this is like giving birth and we're giving birth to our memories.

Kitzinger (1992) acknowledges that childbirth is not always traumatic for mothers who are survivors of childhood sexual abuse. It can also be an "opportunity for women to relate to their bodies in new ways, to experience them as powerful, competent, and creative" (p. 220). Bohn and Holz (1996) assert that "for a sexual abuse survivor, to know that her body did something right is often a powerful and sometimes transforming experience" (p. 453). One of the participants in this study, Joleen, supported this notion of a transforming experience, stating: "It was just the most wonderful, magical experience of my whole life. I feel like things changed for me right there."

Only one participant, Lois, spoke directly of "protecting her child" during her pregnancy and labor. She found her labor and birth quite emotional because they

symbolized a loss for her in that she was no longer able to “really protect” her child:

I remember that it felt good to have her with me, in me, and I remember that when I gave birth it was worse because I missed her. It’s interesting because I felt safer when she was in me because she was with me, like I knew I was protecting her, I just knew it. Nobody could hurt her.

In summary, the labor experiences of the women in this study were traumatic and involved numerous triggers that reminded them of their abusive histories. While their consciousness of their abuse histories was increasing, conversely their feelings of power and control were decreasing. As a result, the women needed to draw upon a variety of coping strategies in order to negotiate their labor and birthing experiences, such as dissociation and external support systems. In this way, they attempted to protect themselves by maintaining a sense of perceived control over their experience. They were either supported or hampered in this process by those charged with their care, and their additional support systems.

### **POSTPARTUM**

Patty: It [postpartum period] was such a difficult time for me. I just remember it being a really black place...almost like I was living in a fog. It was all a blur. I do remember that I had a really hard time. I just couldn’t cope with a demanding baby and still take care of myself. I just felt lost and had nothing left to give. I think that’s when it [feeling disconnected with her child] all started. I knew then that I wouldn’t be a good mom.

Postpartum adjustment was difficult for the women in this study. In general, adjusting to the demands of new motherhood is a daunting task for any new mother. However, for

mothers who are survivors of childhood sexual abuse, particular issues related to their childhood sexual abuse histories and their adjustment to motherhood are apparent. These issues are highlighted below in both the postpartum triggers of abuse memories and women's subsequent coping strategies.

### ***Triggers experienced in Postpartum***

During the postpartum phase, the most prevalent triggers affecting the process of protecting were the gender of the baby and breastfeeding. As a result of the women's increasing vulnerability at this time, their motivation to self protect was further enhanced. At this stage they were faced with an additional dynamic since, for the very first time in their lives, they were mothers, and consequently held the responsibility of caring not only for themselves, but also for their children. Thus, the dynamics of protecting self and child became increasingly more complicated.

#### ***Gender of the Baby***

Participants had both positive and negative reactions to the gender of their baby. For example, some women were thrilled about giving birth to a girl whereas others were disappointed. In turn, some women were thrilled about giving birth to a boy, while others experienced feelings of fear and resentment. It should be noted that participants spent considerable time during their pregnancies struggling with what the final outcome (gender) might be. Some desperately wanted a detailed ultrasound or an amniocentesis in order to confirm the gender of the baby. When asked to elaborate on what the knowledge would mean in terms of both emotion and action, they were able to share that it would help them to prepare for how they would handle their expectations, specifically their feelings of disappointment. Some of the participants felt strongly that if they knew the

child was of the gender they did not want, they would have made the decision to terminate the pregnancy. Participants' feelings about having either a girl or a boy are presented below.

### *Girls*

Some of the women were delighted that the baby was a girl. This was the mother's opportunity to "do it right," "protect something," "nurture someone," and "teach her how to look after herself." To this end, participants were motivated to protect both self and child:

Kat: I had a fantasy even as a young girl that I wanted to have a girl just like me, a little blonde haired girl and treat her right, and do it right and in many ways, I reflect now because this is really about my inner child....with a girl, I could shelter her, protect her and educate her and keep her safe.

Where the reaction to having a girl was negative, the most common underlying belief involved the mother's insistence that the girl would become a victim; in essence that being a victim would be her "cross to bear." The real danger in this belief was that the women found themselves distancing themselves from their newborn daughter:

Lynn: After she was born, I didn't even want to see her. I felt I was a bad mother so I disengaged...I withdrew. On some level I knew that this would mean I couldn't protect her and I knew this meant I had failed—I wasn't worthy of being a mother. I was not always as kind to her as I could have been and it was my own insecurity that did that to her.

Because of their belief that their own sexual abuse had made them "damaged goods," and the underlying fear that they would be powerless to protect their female children from

harm, the women in this study distanced themselves from the source of their vulnerability—their infants. This type of reaction is common in parents of premature infants who attempt to delay forming attachments because of a fear that their baby may die (Contole, 1981; Goldberg & Taylor, 1988; MacArthur & Dezoete, 1992). This fear manifests as poor attachment and the mother's seeming lack of interest in her baby. Although the context is different, the findings of poor attachment and apparent lack of interest resonate with the findings of this study. The women in this study also struggled with early attachment with their children and reacted by distancing themselves from their newborns. This struggle was interpreted by both the women themselves and by health care providers and external support systems

Some of the participants described their thoughts about having a girl as motivating them to self protect. Having daughters frightened them because it reminded them of themselves as children, and they did not want their own children to be vulnerable to traumatic childhood experiences such as sexual abuse:

Selena: I was scared to death about having a girl once I found out because I didn't want a repeat of history. I look at everyone suspiciously now and don't trust anyone to be alone with her. I am also scared to death that if I let her out of my sight she will be alone with an abuser. I can't let that happen. I plan out every conceivable scenario in my head. It plagues me almost every day. I don't want to deal with it. Sometimes I just want to get away from all of it.

Another of the women, Lisa, talked candidly about not wanting a female child, not only for the obvious reasons of her being vulnerable, but also because she would be "competition":

I know what girls are capable of, what they can do with sex and stuff...and I thought about competition, all the time I thought about her as competition. I don't know if I could be with that person....I know she would be competition for how beautiful she is or how skinny she is, or how sexy she is, or even what kind of sex she does...and I mean, how many women have relationships where they weren't totally insanely jealous with everything, and I would be jealous of her youth, her beauty. I mean that's a real hard-core hurt in my stomach, hurt in my chest feeling.

Lisa was not alone in her feelings; other women in the study also expressed similar concerns about being in competition with their female children. The idea of competing with their female children contributed to the women's feelings of guilt and shame. They felt they were bad and unworthy mothers for feeling this way, and this, in turn, contributed to their need to distance themselves from their daughters, and self protect.

### ***Boys***

For one participant, Dawn, having a boy was an opportunity for her to feel good about her purpose in life. In this sense she was also motivated to protect self:

I was never one of those people who would say they only wanted a girl or a boy,...but certainly as my therapy progressed, through different visioning techniques, then I clearly knew that I would have a boy child and as part of my purpose in life to be able to raise a boy successfully, healthy, balanced because I realize somehow that you know coming out of that abuse experience that one could certainly have very negative opinion of males and at times I would just generalize that all male species were like that...and then I thought, Oh, I'm

having a boy child and I know now I'm destined to have a boy child and knew from the moment I conceived that it was a boy. I just knew it. This was a huge opportunity to raise a young man...and know that all men are not pigs...because I am his parent there is going to be that special component somehow...he will have a different sensitivity just by the fact that he's part of us and I feel good about that, I have some hope about that...rather than just bare fear with a girl.

Lynn spoke of wanting a son because she felt that "a woman wasn't complete until she has a son." This was a unique finding in this study in that no other participants expressed similar thoughts of achieving completion by having a male child. It is interesting to note that Lynn talked openly of having a "far healthier and uncomplicated" relationship with her son. This may have been, in part, because he was the youngest child--Lynn had three older daughters--and she had developed some confidence as a mother by the time he was born. Lynn talked of having enjoyed the postpartum period with her son, especially breastfeeding, but she did not feel the same regarding her postpartum adjustment with her three older daughters:

He was a pleasure to have as a baby. I just loved him completely and didn't have any weird feelings about wanting to have him or not. It was completely different with the girls. I didn't feel close to any of them, even as babies. I used to nurse T. and always felt really connected to him when we were together. The girls were difficult and nothing ever seemed to go right, especially breastfeeding.

In contrast to Lynn, Oils shared a different experience:

We found out by ultrasound that C. was going to be a boy and it was disappointing. It did help me to know though. I was able to talk about some of

my concerns with my midwife and that was helpful. I was really worried about the breastfeeding issue. It bothered me that he was going to be a boy and I didn't know how I would react to that, but I decided that I would try and if I couldn't do it then I would pump, so it helped to have a back up plan. I did have a hard time at first. I also had some problems emotionally but I was determined to continue knowing that these feelings were not "bad" feelings. I had the hardest time at night when he would wake for his night feedings....I think the negative feelings I had when I first started breastfeeding made it more difficult to bond. I loved him I just didn't have those "warm fuzzies" inside.

A few of the women in this study expressed pleasure that their baby was a boy, wrongly believing that boys are not likely to be sexually abused. Conversely, some of the women believed that their male child would grow up to become an abuser. Paige explains:

I just don't trust men. Sadly my boys are also going to grow up and be men and I don't think I'll be able to trust them either. I haven't met a man yet that I trust or feel safe with, so why would I think it would be any different with my children?

The beliefs that some of the women held, although seemingly irrational, were real for them and often had an impact on their mothering abilities. These beliefs often caused them to feel contaminated, or to fear that they might harm the baby simply by touching it. They expressed confusion about what constituted "normal" and "abnormal" touching of their baby, particularly when they were struggling with issues regarding the baby's gender. The women in this study had considerable issues with boundaries in that they did not feel comfortable with providing care for their children, particularly when the child

was of the gender they feared the most.

It is not uncommon for women expecting a child to desire a baby of a particular gender. Rubin (1977) notes that disappointments related to a desired gender take time to overcome and may delay or limit the attachment process. Having a baby girl helped some participants to embrace their “inner child” and begin to deal with painful issues. In contrast, having a baby boy helped others to stop fearing men in the ways they previously had. In essence, although gender was a significant factor for women in this study, overall the participants desired a healthy baby regardless of gender.

### ***Breastfeeding***

Breastfeeding is often seen as an instinctive and natural facet of motherhood (Smale, 1998). For a survivor of childhood sexual abuse, however, breastfeeding may trigger unexpected feelings reminiscent of their abuse. The women in this study reported many such triggers including the sensations of leaking breasts, newborn suckling, and the let-down reflex. Several participants found the manual expression of breast milk particularly distressing. The women in this study did not report a lack of knowledge regarding the benefits of breastfeeding, nor did they have a physical inability to breastfeed, rather their challenges in breastfeeding were related largely to psychological blocks triggered by the similarities between the physical sensations of breastfeeding and their abuse experiences.

Stacey: I loved all my babies but I didn't really want them near me...not near my breasts or near my body...I just pushed them away. When the nurse tried to show me how to breastfeed she squeezed my breasts and the milk came out...and I wanted to gag...throw up...it made me really sick. I felt really dirty then. I

tried to breastfeed, I really did...and I felt really horrible that I was so repulsed by it all...but I just couldn't do it. It physically made me sick.

Research addressing women's choices in infant feeding have identified a number of factors associated with breastfeeding, but women's childhood histories are rarely mentioned. Some research suggests that women with no clear sense of identity were more likely to bottle-feed (Barnes, Leggett, & Durham, 1993). These same associations reflect, in part, commonly held views of what "ideal" mothers should be like. This poses a particular challenge for survivors of childhood sexual abuse given their feelings of having blurred identities.

When the women in this study chose not to breastfeed, they felt that health care professionals and their social networks viewed this decision as selfish. However, such judgments clearly fail to take into account women's psychological needs regarding breastfeeding situated against a backdrop of childhood sexual abuse. Those women in the study who chose to breastfeed felt they were viewed as "good mothers" by health care professionals and their social networks; again, this view did not take into consideration women's psychological challenges around breastfeeding. Splitting women into polarized groups of those who breastfeed and those who do not, perpetuates the overly simplistic myth of the "good mother" versus the "selfish or bad mother." This is unhelpful for women in general, and particularly unhelpful for survivors of childhood sexual abuse.

The physical sensations of breastfeeding in connection with the gender of the baby often resulted in the mothers reacting negatively to their child. This was often viewed poorly by the women's health care providers, which only added guilt to the shame the women were already feeling. Unfortunately, this issue has been minimally

addressed in the literature, with only three references being cited that specifically address the issue of breastfeeding and a history of childhood sexual abuse.

Prentice, Lu, Lange, and Halfon (2002) examined the association between self-identified childhood sexual abuse and breastfeeding initiation. Interestingly, women who reported childhood sexual abuse were more than twice as likely to initiate breastfeeding compared with women who did not report childhood sexual abuse. This finding is contrary to what may be expected in light of the association between childhood abuse, the intimacy of breastfeeding, and the risk factors for not breastfeeding. The authors explain the association by stating that survivors “may be more concerned about parenting than non-sexually abused women” (p. 224). Although the findings of this research study did not specifically focus on the breastfeeding experiences of survivors of childhood sexual abuse, the majority of the participants shared that they initially tried to breastfeed their infants. Many described doing so for “only a short time,” but a few of the women reported breastfeeding past their child’s first birthday.

The World Health Organization (WHO, 1998) has launched a concerted and commendable effort to encourage every woman to breastfeed. According to the WHO, breastfeeding contributes to the health and well-being of mothers, helps to space children, reduces the risk of ovarian cancer and breast cancer, increases family and national resources, and provides a secure way of feeding that is safe for the environment. The WHO maintains that while breastfeeding is a natural act, it is also a learned behaviour. An extensive body of research has demonstrated that mothers require active support for establishing and sustaining appropriate breastfeeding practices. WHO and UNICEF launched the Baby-friendly Hospital Initiative (BFHI) in 1992, to strengthen maternity

practices to support breastfeeding.

Although I support the WHO's BFHI cause, I have learned that this may be problematic for many women who were sexually abused as children. Most survivors, both male and female, find touching difficult and even frightening. Most survivors also have a strong dislike of their own bodies. In addition, many hold cognitively immature but strong beliefs about their skin and body fluids, including breast milk, being contaminated. The idea of breastfeeding a baby, with the intimate, tactile contact between mother and baby that this entails, together with the belief that breast milk is contaminated, are potentially terrifying for mothers who are survivors of childhood sexual abuse. Another factor is the woman's response when the baby suckles. These feelings may be sexual and outside her control—replicating the situation of being abused as a child. These feelings then perpetuate the mother's feelings of guilt and shame and reinforce her sense of unworthiness as a mother. In these situations, the mother is at risk of distancing herself from her child since she feels that she is, in a way, abusing her child because of the physical sensations she is experiencing. Consequently, she begins to self protect.

Lois: One of my first experiences that struck me related to the abuse is that I could not breastfeed her. She suckled on my breasts like a little bit and I got freaked out, it was disgusting and I couldn't reconcile you know, that part of my body which was for sexual purposes should be for nourishment of this child that I had already loved by the time she was conceived....I bottle fed her and it's interesting because what I know now is she was allergic to her formula and to think that she would cry and cry and I didn't know why. That could've all been

avoided if I hadn't been abused. There's a sadness now that I couldn't even begin to bond with her that way but I was able to hold her, to kiss her.

Some of the women in this study experienced difficulties with breastfeeding because of the exposure of their "private parts":

Louise: When I was breastfeeding I was all exposed but they [nurses] didn't seem to care. They were like, "we've got to get this baby to eat so we're going to do whatever we have to, we need to make sure the baby eats." And they didn't seem to care about the fact that they were pushing my body around. I never enjoyed breastfeeding. It never seemed to be a bonding thing to be and it never seemed really beautiful....it ended up being a chore and I hated it. I feel guilty about that.

A few of the women in this study could no longer breastfeed because of antidepressant medications. Cathy explains: "I wanted to breastfeed her longer but I think I only ended up breastfeeding her for about three months because I ended up having to go on antidepressants." Lee found breastfeeding especially challenging in light of her history of sexual abuse. She had visions of being physically abusive with her newborn daughter although expressed emphatically that she would never act on them. She spoke of feeling overwhelmed, exhausted, and unsupported during her postpartum experience. These feelings were echoed by many of the other women in this study. Lee differed, however, in that she expressed her feelings to her postpartum nurse:

I was trying to breastfeed her and one nurse came in and she was going to help to show me how to do it and the baby was sick, screaming and crying and I thought she was being really rough and all this stuff. I was just...this is where the trouble started. I had just a thought. Just a vision in my head of taking this baby and just

throwing her against the wall. And the biggest mistake I had made was telling somebody. I just felt like that because from that point on they wouldn't let me go get her from the nursery. I wasn't allowed to be alone with her. It's not something I would do, it was just a vision of fright, you know.

Lee's cry for help to her postpartum nurse spiraled into years of court battles for custody of her child that are still ongoing. Although her situation was extreme, Lee's story is not uncommon among survivors of sexual abuse. In this circumstance, Lee required a level of health care support that was not made available to her. It is vital to consider the social and psychological aspects of breastfeeding, and to situate these within the context of women's lives. It is recognized that women are open to a variety of conscious and unconscious psychological influences (Raphael-Leff, 1991). My participants' history of childhood sexual abuse contributed to their desire for or apprehensions about breastfeeding. Breastfeeding needs to be understood both in the context of childbirth and in the context of a history of childhood sexual abuse. The women's ways of coping with their breastfeeding issues and gender issues are discussed below.

### ***Coping Strategies employed in Postpartum***

Detachment was the primary form of coping in the postpartum phase and postpartum depression was a primary response. The link between postpartum depression and a history of childhood sexual abuse is only now receiving attention in the literature (Buist & Barnett, 1995). Previous research has concluded that a history of childhood sexual abuse predisposes women to depression. According to B. V. Cole et al. (1996), rates of depression are very high for women who have been abused. L. Hall, Sachs, Rayens, and Lutenbacher (1993) report that survivors of abuse are 4.5 times more likely

to experience severe depression. For the women in this study who developed postpartum depression, which was the large majority of the women interviewed, the illness is reportedly more likely to be long-term and to have a significant impact on subsequent mothering.

Buist and Janson (2001) suggest that while childhood problems and/or poor early parenting may result in similar sequelae postpartum, a history of childhood sexual abuse has potentially longer-term effects. The identification and management of depression during childbirth is a significant issue for mothers who are survivors of childhood sexual abuse. For survivors of childhood sexual abuse, depression as a form of coping may be a response to Post Traumatic Stress Disorder (Miller, 2001; Rhodes & Hutchinson, 1994; Runyon et al., 2004; Seng, 2002; Seng et al., 2004). The women in this study who experienced postpartum depression found that no consideration was given to the impact of their histories on their experiences of postpartum depression. This was true even for those participants who had disclosed their childhood abuse history, despite depression being recognized as the most common universal reaction to all types of abuse (Bohn & Holz, 1996; Holz, 1994). The women's struggles with bonding further contributed to their postpartum depression and post-traumatic stress responses:

Pat: I was overjoyed that I had a healthy child but anytime in those first three weeks that she was born, if somebody had come up to me and said "I'm sorry, the hospital made a mistake, here's your little boy, we'll take this little girl," I would have said "okay." It took me really long to bond with her and even though I breastfed until she was about fourteen months old, there was always that kind of holding back I think...and I think she felt it because she was a kid that acted

up...babysitters would say what a gorgeous child she was and how happy she was, but she was a witch for me.

Ethological theory claims that mothering is essentially rewarding and that the bonding or attachment between mother and child compels mothers to enjoy caring for their children (Bowlby, 1969; Klaus & Kennel, 1976). However, for approximately 40% of primiparous women, the experience of mild detachment or negative feelings toward their infants in the immediate postnatal period (with a gradual increase in the strength of maternal feelings over the ensuing few weeks) is normal (G. E. Robinson & Stewart, 2001). These authors further contend that in more severe, persistent attachment disorders, the mother expresses disinterest, neglect, and failure to protect, nurture, or interact with the baby. As has been discussed earlier in this dissertation, painful and difficult childhood experiences can be linked to maternal detachment.

Selena: It took a while before I felt any flashes of love for my daughter, and that seems a terrible thing to say but its accurate. It wasn't until I brought her home that it happened. She looked at me a certain way and then the rush I felt was great, it was what I was waiting for. I was scared that it wouldn't happen, that I wouldn't love her like I thought I should. That fear stuck with me and I still get it from time to time. I feel that I'm too selfish to have children and that I won't do a good enough job. I want to be perfect, it seems like a waste of time because I won't be.

Pat: I had postpartum depression and it wasn't until I got pregnant with my second child, 2 ½ years later that the depression went away. It wasn't severe because I could cope; I just seemed to look at the world through a lens. I wasn't

quite participating in life and I think my daughter felt that. It's my one regret in my life because I don't feel that we're as close as we could be and part of that, even if I apologized for it, it doesn't take it away. It's this constant regret.

Women's experiences of postpartum depression are echoed in their narratives of attachment and bonding challenges. Many of the women referred to themselves as being "mechanical" in nature:

Lee: They put me on antidepressants right away. I just remember when everybody was gone, all the help was gone and my husband went back to work and all that. I just did the things for her that I had to do. Like I feed her, I changed her and all this stuff but I never really spent any extra time with her, any special time. Like holding her or talking to her. I just went through the motions. I ended up in the psychiatric ward when she was six months old.

Lisa: I absolutely snapped...I just went into like a really deep depression. I yelled out to see him...They told me he would be taken upstairs and that is when I started freaking out and I started fighting with the doctors and nurses...I got thrown on my back and they held me down while they were taking him and I guess I snapped....I ended up with lots of support. I had a doula, I had therapy, I had everything, I just thought that I couldn't cope. I did everything mechanically. I knew exactly what to do, I had all the emotions, the feelings to do it, I mean I knew exactly what to do and I would do it religiously...like pump and feed him and sleep...I don't even know what went on. But the thing is that I had held my son but I didn't know that I had held my son until about three months later. I was in rough shape.

The existing literature describes an association between depression in the mother and insecure attachments (Martins & Gaffan, 2000). According to Rowan (2003), mothers who are depressed may create insecure attachments to their infant because they are afraid of violating their baby's expectations (when mothers are able to interact normally, they set up expectations in their baby). Their later emotional withdrawal is said to leave the baby in a similar state of depression and hopelessness. Research studies on the impact of postpartum depression on the maternal-child relationship have shown that depressed women have greater difficulties with sensitively attuning their responses to their infants and keeping their infant's experience in mind, rather than being preoccupied with their own concerns (Murray, 1992; Rowan, 2003).

Cassin (1996) asserts that for a survivor of childhood sexual abuse, her own needs may be using up all her emotional resources and therefore meeting the demands of a new baby are difficult. Becoming a mother and dealing with a dependent infant require a transition to adulthood. Many of the women in this study needed to deal with the issues from their childhood before they could successfully negotiate this step.

Recent research studies have addressed issues of impaired bonding between mother and child and maternal post traumatic stress disorder caused by a traumatic birthing experience (M. M. Cohen et al., 2004; Creedy, Shochet, & Horsfall, 2000; Lyons, 1998; Reynolds, 1997; Wijma, Soderquist, & Wijma, 1997). For the women in this study, challenges to bonding with their infants did not appear to occur as a result of traumatic births. Rather, for many of the survivors in my study, connections with their infants were in jeopardy throughout the pregnancy. This challenge in connecting with their unborn child was related to their childhood sexual abuse histories and their

subsequent thoughts about their own ability to be good mothers. Connecting with their infants was also influenced by the gender of the child and their reactions to the gender.

Interestingly, one participant, Bonnie, described breastfeeding her daughter as a coping strategy opposed to her own strained relationship with her mother, an opportunity to bond and start their mother-daughter relationship off right:

I chose to nurse...I really wanted to nurse J. because I thought it was the right thing to do and I thought it would do a good bonding thing for us because my own mother-daughter relationship wasn't good...and I wanted to give us the best start possible.

Bonnie struggled when her daughter stopped breastfeeding:

It's when she quit nursing...then I had to go through this whole thing...I have to find another way to connect with her...I was so scared she would pull away from me and I was devastated when she quit nursing—I almost felt like she was rejecting me in some way...and I was deathly afraid that that was a sign of things to come...that she and I would never really be close or connected. It was a nightmare because I didn't want her to be so separated from her mother like I am from mine. I am sure I had a few panic attacks over all of it.

For Kat, breastfeeding was a positive motivator as well:

I think right at the birth it wasn't a reality for me yet, but nursing, that's when it all came in, little head suckling on my breast, mewling and looking up at me with these foggy eyes and that's when I got it, I mean when I was nursing my child, my first child, that's when I really got the whole thing—this is my son and my child, and the suckling of the breast and the hanging on and that real close

intimate contact with my body with my child, nurturing and nourishing—that's when I got hugely interested in the welfare of the children, the child and subsequent children.

Unique to Kat's story, however, was the experience of an orgasm while breastfeeding:

I had an orgasm once when I was nursing and I had shame-based feelings around that. Oh my God that's terrible but I mean it just happened. It was just something that happened and I thought, Oh my God, I have sexualized my child...and the whole other part came back to my mind. I felt like an abuser. I had an orgasm with my child when it was absolutely 100% natural...I'm like bad...I didn't share it for quite a while...maybe a year later with some moms and they said 'actually me too'. It's not really common but I did hear other people say that it happens and it's not sexual.

An interesting finding with respect to the postpartum phase of childbearing was that the women did not describe any external support systems that they found beneficial at this time. The resources upon which they had to draw were largely internal.

Participants found the postpartum period a difficult one. In light of their limited support systems, they described feeling overwhelmed and exhausted when trying to meet the demands of their new infants in addition to their own needs. The majority of the women described challenges with breastfeeding and bonding and responses of dissociation, depression, thoughts of physical abuse, and withdrawing from their children. These issues followed the women through to their mothering experiences.

## MOTHERING

The concept and experience of motherhood are complex and influenced by many factors, such as a woman's personal history, cultural context, current life circumstances, perception of self as mother, overall health, and the quality of her relationships with her children, family, friends, and external supports. For some women, the task of mothering is overwhelming and frustrating because they themselves have never experienced quality mothering or secure attachment as children. The women in this research study all described wanting to be the "ideal mother." When asked about these notions of "ideal," it became clear that they viewed motherhood almost as a form of sainthood. Participants idealized and romanticized motherhood despite their less than optimal childhood experiences with their own mothers. The perception of, and aspiration to become, the "ideal mother" often contrasted sharply with the diversity of actual maternal experiences shared in this study. These experiences perpetuated feelings of guilt and shame within participants, as well as their beliefs about their own lack of worthiness to be mothers.

The purpose of this research study was not to address the mothering characteristics of women with a history of childhood sexual abuse, but participants were forthcoming about their experiences of motherhood. A significant finding in this study was that women's experiences of mothering were more problematic than expected, more so than their experiences of labor and birth. The women shared the sense that they had failed to develop autonomy early in life, predominantly due to their "abnormal" childhoods, and consequently felt vulnerable and perceived themselves as unable to cope with the multiple demands of mothering. This moved participants towards a state of imbalance, needing to either engage in protection of self or protection of their children.

In this section, I discuss the triggers experienced by mothers that caused them to enter into either self-protection or child-protection mode, and the coping strategies used by the women to protect themselves and/or their children.

### *Triggers experienced in Mothering*

The most significant trigger of abuse memories for the women in this study centered on issues related to boundaries, specifically, what constituted a “normal” or healthy boundary. The women in this study had spent years attempting to establish their own sense of personal boundaries, mostly without success. Upon becoming mothers, they became responsible not only for the establishment of their own healthy boundaries, but also for the establishment of their children’s boundaries. In some ways, the children themselves became triggers. Bonnie explained her struggle with “normal” boundaries:

It’s just that I don’t know what’s normal and not normal and I didn’t have a normal childhood so there’s nothing I have to base normal on....it’s very frightening for me and I get really quite anxious about the whole thing [mothering].

By virtue of their dependent status, the children were a representation of vulnerability for their mothers and accordingly demanded an increased level of responsibility from them. A sense of unclear boundaries increased the women’s feelings of vulnerability. One of the greatest challenges to the women’s sense of personal boundaries was that of physical touch. Touch is an essential aspect of any mother’s role, but it poses a tremendous challenge for survivors of childhood sexual abuse, especially with regard to children (Douglas, 2000). It is not difficult to understand that survivors of childhood sexual abuse may have issues with touch, but such understanding is rarely

extended to survivors when they become mothers and are required to care for their infants. Everyday routines such as bathing, diaper changes, potty training, and showing affection in general all require touch and a level of intimacy. These routines were often triggers for the women in this study:

Selena: Sometimes when I am bathing her I wonder if my touch is appropriate, am I doing any unforeseen damage? I try to be as normal as possible. Even when I massage her after her bath I'm conscious of her genitals at all times and try to be careful not to touch them unnecessarily. I worry about teaching her about appropriate touch when she is older. I just worry like any mother would.

The triggers were not necessarily connected to one particular gender although the women mostly talked of the triggers involved in routine care of their daughters. When referring to their sons, many of the women commented that they didn't feel the same anxiety with normal boundaries and touch. In contrast, when providing routine care for their daughters, the women in this study described being overly conscious of "appropriate" touch.

Beesh: After we had the baby it all began again, like all these nightmares about being abused and it was quite difficult after she was born. Even little things, like changing her diapers I would wonder if this was appropriate. And I would be afraid to do anything. With my son I haven't any of these fears....I was very reluctant to change the little girl's diaper and I was very reluctant to bath the little girl and being near the little girl...I was scared. The little boy I didn't ever worry about.

For one participant, Amanda, being the mother to six boys was challenging at best. She

felt a level of responsibility to raise them to be different than the men she was accustomed to, despite the triggered memories:

When my boys do daily things, it triggers memories. Those memories stick and make it difficult to deal with daily tasks. At times I find myself uncomfortable with my children. There are seven of us and I'm the only female. I find this difficult because of my troubled past, mostly from the men I grew up around. Now I live with six of them. I really want to raise my boys differently. Stop the cycle of abuse before it begins again.

It wasn't just physical touch from mother to child that was problematic. Lola describes the challenges she felt when her child responded to her with physical affection:

The part that was hard was really about the abuse [history of childhood sexual abuse], it was when he was really little...probably only about eight or nine months old standing up in his crib. I said "he's standing up" and I when I went in to get him he put his arms around my neck and he kissed me in the mouth and I practically threw him against the wall because it was like "you too!." You know, it was like he was doing something sexual to me, it was the most horrifying moment. I mean I really had to stop myself from throwing him, this tiny little boy, it was a boy and was doing this sexual thing to me, I was just horrified and so I put him back in the crib and I made his dad go and get him...I just shook and had to go back to bed. I just thought, "Oh my God, he's sick, I'm sick, I'm going to do something to him, he just wants to have sex with me"....It was horrifying to me and it was also hard for me when he got to be ten or eleven when he started to smell like my brothers and boys smell bad...there's a disgusting boy smell that

goes with them and boys smell like my family, just like being abused, and so there was this period between 11 or 12 where it was just hard to be around him.

The women in this study reported that regular, routine interactions between mother and child could act as triggers. Events which would not have been difficult for mothers without a history of sexual abuse (i.e., diapering, bathing, hugging, kissing), were highly problematic for the mothers in this study. In order to manage these triggers, the women engaged in coping behaviors that contributed to either protecting themselves or their children. These are discussed below.

### ***Coping Strategies employed to Protect Self***

In relation to mothering, the women's need to self protect became less about external triggers, and more about their own internal questioning of their ability to be a mother and their perceptions and expectations of personal boundaries. When they felt as though they were incapable of being "good" mothers, and perceived their boundaries as insecure, the women in this study moved towards self-protection and disengaged from their infants. They became increasingly confused about their personal boundaries, specifically what was "normal" and "abnormal" when interacting with their children. When the mothers in this study felt uncomfortable with interacting and physically touching their children, they responded by distancing themselves.

Lee: I feel really bad about all the time I missed when she was younger. I feel bad about not loving her...feeling like I loved her. I just feel really bad because she's ten years old now and I wish I could turn back time....I knew that I never wanted to hurt her.

The women in this study used withdrawing and distancing themselves from their children

and parental responsibilities as one strategy to self protect. This attempt to protect themselves sometimes made their children more vulnerable, which was the very opposite of the mothers' intentions. According to Douglas (2000), being withdrawn or neglectful can make a child more vulnerable to experiences of abuse. The author suggests that children whose mothers have been sexually abused are themselves at increased risk of being sexually abused. This was not a finding in this study, although two of the women shared that their children experienced sexual abuse when not in their care.

Mothers with a history of childhood sexual abuse are reported to demonstrate low levels of maternal involvement with their infants. Moreover, these mothers reportedly spend less time with their infants and exhibit disengagement and flat affect while interacting with them (Douglas, 2000; Ruscio, 2001). Douglas's study of parenting in women sexually abused as children found that these women were significantly more anxious about their parenting than women without an abuse history. This anxiety may be related to a lack of confidence in mothering abilities, a common finding within this research study. The women in this study described feeling "inept" as mothers and unclear about appropriate expectations and boundaries. Consequently, many of the women in this study described having a "hands off" approach to mothering. They described having difficulty setting limits for their children because they were unclear about how to discipline or parent:

Hannah: I really didn't have the skills to be a parent. I had no idea what to do. My house was complete chaos because there was no structure, no rules, no expectations and no consequences. It was a free for all. I guess I didn't want to be the bad guy. I really wanted my children to like me.

Another participant, Pat, experienced similar issues around setting limits for her children.

I have a lot of boundary issues in that I wasn't good as a parent at setting boundaries in lots of ways. I think I gave them maybe too much freedom too young...when I talk to the kids and I say to them "what would you have had me do differently," they all say "stronger boundaries," more often. I think I really wanted strong kids and strong adults so I thought that if I gave them choices early that that might give them the chance to develop on their own. I think in some ways it worked because they know what they want, they know what they don't want and they will not tolerate people infringing on their stuff.

What was unique to Pat's story was her children's reported desire for stronger boundaries. Other participants did not necessarily recognize their role in permissive parenting. Permissive parenting has been addressed in the sexual abuse literature, which has theorized that mothers who experienced sexual abuse may avoid invoking parental authority because of their own negative experiences as victims of adult power, or because they lack the confidence necessary to set appropriate limits with their children (P. M. Cole, Woolger, Power, & Smith, 1992; Ruscio, 2001).

Research by Banyard (1997) found that mothers who were sexual abuse survivors exhibited greater physical discipline strategies and that a sexual abuse history was a risk factor for more negative parenting outcomes. She related this finding to women's poor self-esteem as parents and their subsequent inability to cope with child discipline. As a result, survivors who are mothers are at greater risk of being physically abusive to their children (Whipple & Webster-Stratton, 1991). This was not a finding within this research study. Although many participants spoke of feeling rage as women and as

mothers, and infrequently described reactions that were “physically aggressive” with their children, none of the women in my study reported being physically abusive to their children. Lynn and Lee share their stories below:

Lynn: I felt like I was stunted and she cried and cried and cried...finally I went berserk, I got up and I started shaking her and shaking her ...I could have killed her....My mother ended up having her for three months and then started talking about adopting her and I was quite content at that point because I really didn't miss her, for quite a while. When I think back I didn't bond with the girls, I didn't bond and it took me a long time to even get comfortable hugging them. I couldn't do it.

Lee: I guess they knew that I wasn't bonding with her. I used to get so frustrated with her. She's only six months old and I remember this one time...I was supposed to feed her and put her in her highchair and I am getting frustrated with her because she's not sitting up...she's like sliding down and messing around, and I remember picking her up, straightening her up in her chair and kind of like plunking her down kind of firm. I'm thinking, “oh my God, I don't know what I've just done!”

In response to her fears of not being a good or capable mother, “protecting” for Bonnie meant initiating a more permanent solution--not having any more children due to the stresses of being a mother:

I am not going to have any more children. I have decided to actually have a laparoscopic sterilization...I don't think that it's because I fear anything in particular...well, no, it's because I fear the depression and I fear the slides...the

time periods when things are too rough and I start marking [body carving/self mutilation] and doing bizarre behaviors. I want to be there for J. I chose to have her. If I have two, three, four kids, how far will I be able to spread myself? For me, having her is enough. I went through a very hard time last year as a mom and was very afraid. I had...we got social services involved because they were so afraid I was going to hurt her or hurt myself. I think this would be really important. I don't know if it's for everybody but for me...when my baby went from being a baby and nursing to being this little person and starting to talk and having an opinion and telling me off and getting control...I was totally afraid. I thought, 'Oh no, I can't do this anymore'. When she was an infant, I had control...I was still mom and I was being able to nurture her and look after her...and suddenly she was breaking away into that independence thing and I got...I was scared. I still am scared.

Bonnie was not the only participant who mentioned taking permanent measures to prevent having more children. Kat shared a similar experience:

After my second child I knew I had personally had enough children and I tried to get my tubes tied at that point but I was denied twice. Two separate doctors said that it was against health care policy to tie the tubes of a woman under twenty five and that maybe one of my kids would die they told me and I might want more kids or I might remarry and want the option of more kids. I was very serious and said 'no, I absolutely want no more children, two is more than enough for me to cope with my own life, my own history and my own ability and they denied me. I had four pregnancies in five years and I think that the authority that was projected

onto me that they are the best, that they know better, that the policies they need to act by but that's such bull shit. A lot of things have happened to me and my kids that was 100% consequences of having four young children. This is another example of how my body was not my own...now it belongs to the government or the health care system.

According to DiLillo and Damashek (2003), one theme emerging from the literature is that of mother-child role reversal. In this situation, mothers who have been sexually abused become overly dependent upon their children to meet their own emotional needs. They exhibit greater focus on themselves and less focus on their children, less affirmation of independence in their children, and greater reliance on their children for companionship and emotional support (Ruscio, 2001). In this way, role reversal or "boundary dissolution" takes place. The consequence for the children is that they take on a more mature persona than their peers and ultimately, their own development may suffer (Chase, 1999). Rhonda explains:

I think I relied upon him [her son] to be my friend, my buddy, my confidante. I know that I never acted like his mother, like a role model or anything. It was like I had someone to be with me all the time so I was never alone. The trouble is that I don't think it was fair to him because he learned about things, adult things, long before he was ready. It was like I would tell him my problems and details about things in my life and he would just listen to me. I think he knew that I needed him and he is such a kind kid. I guess I got what I wanted because I needed someone to listen...the problem is it wasn't stuff that was right for a little boy to hear. I was so selfish thinking back on it now. I was wrong but I guess I just

needed someone, and he was there.

In relation to mother-child role reversal, Burkett (1991) notes that role reversal between abuse survivors and their children may be partly attributable to the mother's inability to successfully meet her needs for emotional closeness through her adult intimate relationships. This statement resonates with the findings in this study, as most participants were not partnered or had limited emotional support from their partners.

***Coping Strategies employed to Protect Child***

Archimedes: The abuse really puts in you that fierce determination that my kid's not going to have the same childhood that I had...I'm going to love him as best I can. I am also really determined to give him emotional support.

Having children was an impetus for many of the women to become over-protective of their children, an experience often unfamiliar to them in their own families of origin. The idea that mothers who are survivors may be over-protective of their children is not new in the literature. According to Bohn and Holz (1996):

Survivors may be overly protective of their children and unable to let them out of sight, even after the age when it is safe to begin giving them some limited freedom. They may feel the world and most people are unsafe and will harm the child. They may not feel comfortable leaving the child with a loving, responsible partner, wondering if he will abuse the child. Conversely, some abuse survivors may abuse or neglect their child or seem unable or unwilling to protect them effectively (p. 448).

The overwhelming majority of the women in this study described coping strategies consistent with being over-protective of their children. Apart from using

“over-protective” as a descriptor, other common expressions used by the women included “hyper-vigilant,” “enmeshed,” “consuming,” “overwhelming,” “smothering,” and “engulfing.”

Kat: You are always watching everything, every minute, all the time you know...you just become hyper-vigilant in your own life about being aware of the littlest details, the littlest nuances about what’s going down, what’s coming next...you have to prepare when your child is heading into a dangerous situation...there’s some shifting of soul and psyche and stuff.

Issues of control have been shown to be paramount for the women in this study. Although a preoccupation with control is an understandable reaction to abuse trauma, it can set up unrealistic goals when applied to mothering:

Colleen: I know that I can’t protect him every minute of his life, although that’s what I intend to do. That’s a scary feeling as a parent. Certainly there are gifts in life and my child is one of them, being able to parent him is one of the best opportunities I’ll ever have. But I know I will need to control a lot of his world to keep him safe. That’s just the way it has to be. I know his nature and the things that I can teach him, but even with that, he still needs me to protect him.

For Dawn, understanding control within the context of raising her son was important in understanding her role as a mother:

Children cause you to be very realistic about life. It took me about three months to get over that I can’t be perfect and I can’t control my child. The only thing I can control are the big things you know, there are many things in my life that I insist on control or would like control over and I try to do that in a healthy way

because there have probably been unhealthy balances before that. The realization is that this is another human being and its not my place to control him. I'm there to nurture him and support him and when I look at it that way, he's not crying to torture me somehow, he is trying to tell me something, he knows what he needs so I had better listen. That distinctly changed my parenting style or formed my parenting style, that I listen to the child, I follow the child and that has worked well for us. I'm talking instinctively, it's not that he gets his way every, on everything but it's sort of the theory or the theme of our style is listen to that innate wisdom that the child has.

Many participants had issues of abandonment in their own childhood histories. Lois stated "I abandoned her...I did what was done to me and it makes me so sad." The survivors in this study did not want to be emotionally and physically unavailable for their own children. However, eight women in this study lost custody of their children at an early age. Although Family Social Services took the choice out of their hands, they internalized this as abandonment on their part.

The women who lost custody of their children felt a profound sense of loss and guilt over what had transpired. None of these women reported physically abusing their children, rather they felt consumed by their own issues to the degree that they struggled with taking care of themselves, let alone their children. This was viewed as child neglect by Family Social Services and consequently, the children were removed from their care. All but one of these women were single with few social supports. One of the participants was in a common-law relationship, but because she disclosed feelings of wanting to physically abuse her child (although reportedly she did not actually physically abuse her

child), even the support of a partner was not sufficient to maintain custody.

For the majority of their lives, the women in this study felt guilty and responsible for events and actions over which they had no control. Although they were able to recognize that their self-blame was irrational, their guilt feelings persisted. Once the women were pregnant, they began to experience guilt over their perceived responsibility for the health of their unborn child. Guilt continued to be prevalent throughout the phases of childbirth, and increased as time progressed, culminating in motherhood. Guilt is a deep-rooted emotion and participants found that it ran deep into their subconscious—so much so that one of the participants dreamed about it: “It was awful. I couldn’t get away from feeling ultimately responsible.” She feared that something was wrong with her baby, that this was her fault, and that she would have to live with that for the rest of her life. The studies by Brady-Fryer, Diachuk, McGeary and Lever-Hense in Field and Marck’s *Uncertain motherhood: Negotiating the risks of the childbearing years* (1994) all report findings of maternal guilt, despite the women recognizing that they were not to blame for their situations. Participants were apprehensive about expressing their guilt feelings for fear that their “worst nightmares” would come true. Discussing their feelings of guilt with others also meant disclosing that they had a history of childhood sexual abuse, which in itself created an additional threat. Participants felt guilty about not being perfect, not feeling worthy, not being “pure” etc....They described guilt as a constant in their lives.

Baumrind (1989) theorizes that there are three distinct parenting styles, authoritarian, authoritative, and permissive. In authoritarian parenting, the behaviors and attitudes of the children are strictly controlled in accordance with absolute standards,

using punitive methods to punish deviation from the rules. Authoritative parents are said to consistently enforce high standards for their children while being highly supportive, responsive, and respectful. Permissive parents, in contrast, allow their children to self-regulate without holding them to any particular standards of behavior. Ruscio's (2001) study predicting the child rearing practices of mothers sexually abused in childhood found high levels of permissive parenting with decreased authoritarian practices. She concluded that mothers who are survivors of childhood sexual abuse find it difficult to provide their children with the structure, guidance, clear expectations, and consistent discipline necessary for successful socialization of the child. In this research study, mothers demonstrated both authoritarian and permissive styles of parenting. When they were authoritarian, they shifted towards over protection of their child. Conversely, when they were permissive with their children, they were attempting to over-protect themselves. Authoritative parenting appeared to be the goal of the women in this study. When the women demonstrated authoritative parenting, they found themselves in balance with neither overprotecting self, nor overprotecting child. Most of the women struggled with states of imbalance, but had the ultimate goal of achieving a healthy balance.

### **A Summary of Protecting Imbalance**

In common with other survivors of childhood sexual abuse, the women in this study used denial, repression, minimization, detachment, and dissociation, all of which are psychological defense mechanisms, to cope with sexual abuse at the time it occurred, and at other times throughout their lives when they were psychologically and physically vulnerable, such as during the childbearing phases (Bass & Davis, 1994). A number of authors have related coping theories to sexual abuse trauma (Johnson & Kenkel, 1991;

Lazarus & Folkman, 1984; Long & Jackson, 1993). However, these studies have tended to problematize women's coping strategies as emotion-focused and avoidant (Banyard & Graham-Bermann, 1993). Banyard and Graham-Bermann emphasize the need to examine power and control as mediators in the coping process. For the women in this study, power and control were inherently linked to coping strategies. As the women enacted their sense of personal agency as a strategy for coping, they felt increased power and control in their experiences. When they were vulnerable and had fewer coping strategies, they felt increased powerlessness and an absence of control.

A number of authors have expressed the view that childbirth has the capacity to stimulate repressed memories of childhood abuse (Parratt, 1994; Rhodes & Hutchinson, 1992; Rose, 1992). The findings from this study support this view. The triggers that most frequently elicited a self-protecting response from the women in this study were both physical and psychological in nature. They included such things as being naked and exposed, presence of bodily secretions, vaginal exams, sensation of tearing during birth, sounds of pushing, lactating breasts, and a suckling newborn. The women employed coping strategies which mediated these triggers in order to self-protect. Strategies for coping were developed in response to triggers that were overwhelming and perceived as threatening. The women in this study described feeling helpless, powerless, and lacking control. Most of the strategies described by the participants were internally oriented and emotion-focused. Although social support was sometimes available, the women in this study did not readily draw upon these resources. One of the main reasons for this was their reluctance to disclose their childhood sexual abuse histories for fear of stigmatization and labeling. Once the baby was born and women entered the postpartum

and mothering phases, these coping strategies often resulted in the child being viewed as “invisible” and, at times, subjected to maternal “emotional and physical absence.” For the majority of women in this study, this resulted in profound feelings of maternal guilt, which, in turn, fueled their need to self protect and withdraw. For some, this even resulted in situations of child apprehension. As the pregnancy progressed, the women in this study experienced greater feelings of vulnerability, which were generally heightened during labor and birth and continued through the postpartum and mothering phases.

Once the women entered the mothering phase, the triggers that most elicited a child-protecting response were largely emotional in nature, or based on mothers’ perceived threats to their children. As previously described, the women in this study acknowledged, in retrospect, that their perceptions of threat to their children were not “real” in the sense of an actual danger posed to their children, rather they represented the possibility of what could happen, and ultimately what had happened to them as children. The key condition of a threat to child was that the mother was not present. In contrast, however, the threat to child in some cases was the mothers themselves. None of the women in this study reported physically abusing their children, however, they did describe confusion around normal developmental stages and boundaries. Some of the women confessed struggles with maternal anger which, at times, resulted in them being “physically aggressive” with their children. Some specific triggers for mothers included such things as the child being naked and exposed, the child being cared for by others, and a sense of discomfort as the child developed into a stronger, more independent force.

The findings in this study extend current theoretical perspectives of motherhood in a variety of ways. Motherhood is often viewed as the gold standard for women, the

biological destiny and final fulfillment of what it means to be a woman. It is both idealized and romanticized. However, the images of the perfect mother often contrast sharply with the diversity of maternal experience and the realities of childrearing, including the experiences of many of the participants in this research study. According to Greaves, Varcoe, Poole, Morrow, Johnson, Pederson (2002),

Mothering has been both revered and denigrated over the centuries. While mothers have, at times, been romanticized and idealized, there have also been patterns of control over mothers exercised by patriarchal systems of law and custom. The prism of discourses surrounding motherhood incorporates a range of approaches, all subject to shifts in social and cultural attitudes, and reflective of political and historical events....Mothers are routinely subjected to high expectations and unrealistic standards of behaviour and nurturance in relation to their children. (p. 3).

The dominant theoretical perspectives on motherhood reflect the ideal of the “good mother.” A good mother is portrayed as self-sacrificing, with no needs or wants of her own. She is thus totally available to her children (Grabowska, 2003). Women survivors of childhood sexual abuse have limited resources and therefore being “totally available” to their children is rarely possible. The women in this study felt “emotionally drained” from having to meet their own needs as a sexual abuse survivor and many found it difficult to provide the care required of a new baby, thus inhibiting their ability to connect and bond with their children.

The main process identified within this research study focused on “Protecting the Inner Child.” This translated into the women survivors needing to self-protect or needing

to protect their child. Their experiences of childbirth and mothering were profoundly influenced by their histories of childhood sexual abuse and consequently the women in this study struggled with being “good mothers” and found achieving healthy balance and healthy boundaries in their lives highly problematic. This perpetuated their feelings of failing as mothers.

According to Bergum (1989), all pregnant women experience feelings of protectiveness towards a fetus in varying degrees. Rubin (1975) also alludes to pregnant women’s experiences of protectiveness when identifying “giving of oneself” and “protecting the well-being of the unborn child” as essential tasks that a woman must achieve in the prenatal period in order to establish an identity as a mother. Failure to achieve these tasks can interfere with the woman’s ability to establish a caretaking relationship with her baby and adapt to future parental roles (R.L. Cohen, 1979; Raphael-Leff, 1982; Rubin, 1975; Tanner, 1969). In this study, the women described early experiences with disengagement and disconnection with their children, both unborn and born. Both Rubin’s theory and Bergum’s phenomenological descriptions have limited usefulness in understanding survivors’ experiences of childbirth unless they are situated within the context of the women’s lives. By this, I am suggesting that in order for survivors to achieve the tasks outlined by Rubin, specialized support is required.

Zuravin and DiBlasio (1992) found that mothers who were survivors of childhood sexual abuse were more likely to neglect their own children. They experienced reduced confidence in parenting, more negative views of self as a parent, less emotional control, and used greater physical discipline strategies. These findings do not resonate with my study findings in that participants neither described experiences of too much autonomy,

nor expressed diminished loyalty to their children. Although some withdrew from their children when they needed to self protect, this did not mean that they were lacking in loyalty to their children. The women in this study experienced reduced confidence in their parenting abilities but did not report using physical discipline with their children.

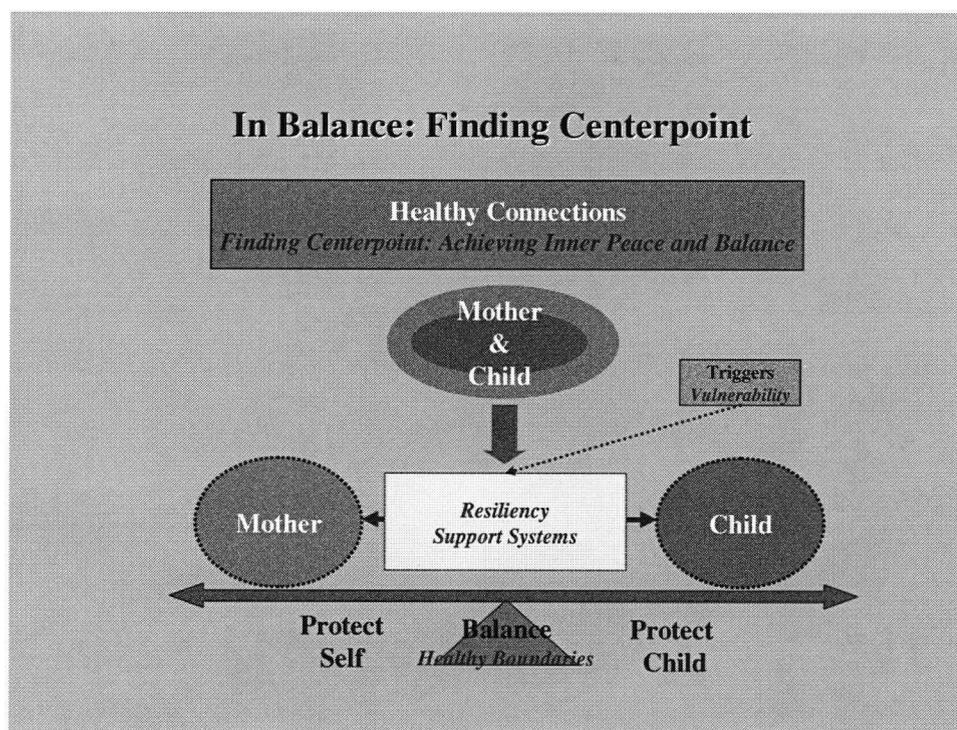
In summary, current theoretical perspectives on motherhood do not adequately capture the complexities of motherhood in the context of a history of childhood sexual abuse. The findings of this study suggest that women's experiences of motherhood are shaped by their histories of childhood sexual abuse. As a whole, the findings around women's experiences of mothering in this study suggest that survivors of childhood sexual abuse have some degree of difficulty coping effectively with the emotional demands involved in raising children. Participants' stories reflect feelings of inadequacy as mothers and lack of confidence related to increasing consciousness of their own sexual abuse histories, unclear boundaries, unclear expectations, feelings of powerlessness and lack of control, and limited supports--all of which may serve as a possible explanation.

The women in this study shared with me that, as children, they desperately wanted to be rescued and protected, to be removed from the abusive situation they were in. They also stated that they needed someone to recognize the abuse they were experiencing. Such acknowledgment would have helped to offset their confusion and powerlessness and would have communicated the critically important message that the abuse was not their fault. Unfortunately, their disclosures were almost invariably met with disbelief, denial, or minimization of what the abuser had done to them. All of the mothers in this study talked of wanting their children never to experience sexual abuse, and for several participants, this manifested as a deliberate intention to prevent abuse at

all costs—even if this meant over-protecting their children. As some of the women evolved into healthier emotional states in their lives, they set themselves the goal of finding balance. To this end, the women needed to establish healthy connections and healthy boundaries within themselves, and with others, most notably their children.

### **Finding Balance: Healthy Connections, Healthy Boundaries**

Dawn: Physically having a child was a really profound experience for connecting with my inner child, it was profound. I thought I wasn't prepared for that or I didn't understand the magnitude until you actually give birth and you see this child and that sense of being overwhelmed. This it also helped me to honor that inner child and imagine what I was like as an infant type thing so it helped melt it together and you know again the innate wisdom that babies have like how smart they are about what they need and I was being able to live with a child who knows innately what they need and this has taught me so much, how they survive and how they thrive. I feel like I have finally made it. I feel safe. I feel balanced.



**FIGURE 5.4: IN BALANCE: FINDING CENTERPOINT**

The goal for the women in this study was to achieve a sense of inner peace and balance, so that the impacts of their childhood sexual abuse histories did not consume either themselves or their children. Some women were able to describe this as their experience, but this was not always consistent. The achievement of balance was contingent upon two factors: the women's enhanced coping strategies (personal resiliency and support systems), and minimized triggers. When participants were able to achieve this balance, they spoke of the ability to create and maintain healthy boundaries in their lives. Establishing healthy boundaries was pivotal to the women maintaining balance, given that when boundaries were "crossed," either knowingly or unknowingly, the triggers were increased and the women subsequently felt more vulnerable.

The women in this study constructed boundaries to protect their well-being. As children who had been sexually abused, their boundaries were repeatedly violated due to

their inherent vulnerability. A boundary violation is one which causes feelings of betrayal and a perceived breach of trust (Gasker, 1999). As a result, establishing healthy boundaries in adulthood is often problematic in that survivors have a skewed view of their personal boundaries. When the women felt they had been violated and boundaries had been crossed, they moved to states of imbalance. When they felt that their boundaries had been respected, trust was developed and supportive relationships could be established. In a sense, by setting boundaries, participants were claiming the authority and self-determination that the abuser had denied them.

Given that imbalance seems to be the norm for survivors of childhood sexual abuse, the question remains, how do women survivors achieve a sense of balance? Is it possible? The women in this study who felt balanced were clear that it was possible, although it involved a long and difficult journey. The major element that enabled these women to achieve a sense of balance was their coping strategies, which, critically, were stronger than the triggers associated with their abuse. A sense of inner peace and balance was achieved through clear, healthy boundaries supported by the women's connections to self and others. For the women in this study, connection to self was about personal resiliency (internal resources) and connection to others was about the social structure supporting them.

While not all childhood sexual abuse survivors who were inadequately parented develop psychopathology or become abusive or inadequate parents themselves, research evidence consistently identifies them as being at high risk for both (Buist, 1998a, 1998b). Similarly, it is important to recognize that not all survivors of childhood sexual abuse report significant difficulties in their adult life or in their childbearing experiences. This

raises the question of whether this is due to a lack of awareness of the connection between childhood and adult or childbirth experiences, or to some internal factor within the individual survivor, namely resiliency, which mitigates the effect of their own vulnerability related to childhood sexual abuse and its effects. For the women in this study, childbearing and motherhood were ongoing struggles, and they enacted their personal agency and accepted outside support to deal with these struggles.

### ***Resiliency***

Resiliency refers to a dynamic process encompassing positive adaptation within the context of significant adversity (Luther, Cicchetti, & Becker, 2000). Luther et al. showed vulnerability and resiliency to be interactive in their relationship to women's experiences of childbirth. Therefore, vulnerability and resiliency are both discussed as they relate to the findings in this study.

All the women in this study experienced some sense of vulnerability inherent within their pregnancy, birth, and mothering experiences. The concept of vulnerability is also reported in other work in the field of maternal child health (Brady-Fryer, 1994; Lever-Hense, 1994; Marck, 1994; Marck, Field, & Bergum, 1994; McCain & Deatrick, 1994). Colman and Colman (1991) refer to pregnancy as a time of personal crisis: "familiar patterns have to be changed, thus invoking vulnerability and fear of the unknown" (p. 91). The work of these theorists lends credence to my finding that during pregnancy, the women experienced a sense of vulnerability because they were not in full control of their pregnancies. For women with a history of childhood sexual abuse, the issue of control is paramount; when their control was challenged, as it is during childbearing, these women were left feeling extremely vulnerable.

The findings in this study add new meaning to the concept of vulnerability in the context of survivors' childbearing experiences. The women's accounts indicate that the sense of vulnerability provokes increased vigilance, which further motivates them to (over) protect themselves or their children. Mercer (1990) has also explored vulnerable families and their adaptation to threat and loss. She discusses parents whom she refers to as "at risk," namely substance abusers, single mothers, lesbian mothers, and poverty-stricken mothers. Many of these descriptors were applicable to the women in my study. Mercer suggests that adapting to a crisis involves psychological and environmental readjustment that leads to an increased ability to cope. She defines threat as "any event or series of events that places a desired or valued person or outcome in jeopardy, thus creating dis-equilibrium for the individual" (p. 39). This is echoed to a large extent in my findings, which show that the women experienced a sense of threat as a result of their childhood trauma experiences.

Resiliency is an important concept within this research study in that it was a contributing factor to the process of "Protecting the Inner Child." Some of the women in this study evidenced a strong sense of personal agency, even in childhood. They did not believe that it was their destiny to be victims, and accordingly lived their lives to the very best of their ability:

Pat: Not everybody that gets abused ends up on skid row. We can make choices. We can...I am a very single minded woman and I think that part of that comes from the abuse. I did really well in school and did really well in anything that I have endeavored to do because I concentrate. Getting over sexual abuse is a life long process. There isn't sort of an end point...the road to healing is life long. I

think that maybe you were a victim when it happened but you know, you're not a victim now. And even survivor...I have trouble with being called a survivor because that sounds like you are just treading water. I'd like to be called "the Victor."

Those women who described having resiliency in childhood seemed to exhibit greater self-esteem as adults. In their stories, they were able to identify at an early age that the abuse was not their fault, and did not feel responsible for the actions of their abusers. However, the majority of the women in this study developed resiliency over time. Lois explained that "I had to realize my own strength...and that's a big part of the journey." Cindy further reflects:

One of the best learning experiences I have had is becoming a mother. I have learned what I can handle, what I can deal with, how to better relate with other people through that whole state of exhaustion and you can still handle life. It's also been one of the greatest challenges that I have ever had to face which at first, yeah it's like a panic that you don't ever get away from but then as you realize what you can do, and have to do, then you become a stronger person for it as well. It was when I started having a real sense of confidence that my history started, that I started remembering things. So whether I became stronger as a person myself to feel like I could handle memories of that kind or that sort of thing.

The women who described "developing" resiliency reported that their sense of self evolved over time, having been influenced by various experiences of success in adult life. Additionally, having a wider social support system seemed to contribute to the women's feelings of resiliency. Thus, it seems that resiliency is not an inherent quality

that some children possess whereas others do not. Rather, resiliency can be developed over time and with the help of outside supports. Another consideration is that resiliency is a dormant ability that can be activated by certain triggers. For the women in this study, resiliency was both a personal trait encompassing sturdiness of character in response to an adverse environment, which some participants possessed, and a dynamic process in that some of the women adapted positively despite the adversity encountered as children. This process often continued well into the women's adult years. Although "resiliency" was significant in the women's negotiation of their childbirth and mothering experiences, few of the women in this study described themselves as resilient.

Judging what counts as a positive or negative adaptation is largely subjective and relative within the context of the women's lives. Positive adaptation meant maintaining an "A" average in school for some of the women in this study, whereas for others it meant not committing suicide. The evolution of criteria to evaluate the quality of adaptation or developmental outcome as positive therefore poses a significant challenge for researchers. According to Masten (2001), "There is little debate about whether such a criteria exist, but much controversy remains about who should define resilience by what standards" (p. 228). Masten concludes that this is a highly complex issue that is only beginning to be addressed empirically. She supports the application of the concept of resiliency to situations of child maltreatment or sexual abuse, but also notes the challenges inherent within quantifying subjective experiences. In an attempt to identify factors which contribute to a child's resiliency, Fonagy, Steele, Steele, Higgit, and Target (1994) cite younger age, easy temperament, higher IQ, good problem-solving, internal locus of control, higher self-esteem, a warm relationship with at least one caregiver, and

competent parenting as resiliency factors which protect against later psychopathology. It was not possible within the scope of this research study to adequately explore these resiliency factors and their relationship to the women's experiences of childbearing and mothering. However, future research exploring these relationships is clearly warranted.

In the model presented in this study, the vulnerability or resiliency factors operate interactively with the triggers, thereby affecting the women's position on the continuum of protecting. In the context of childhood sexual abuse and childbearing, vulnerability and resiliency proved to be different ways of describing a woman's experience, with resiliency describing how positive adaptations to trigger events decreased her risk of over-protecting (self or child), and vulnerability describing how negative adaptations to trigger events increased her risk of over-protecting (self or child). When vulnerability and resiliency are in balance, women are at their "centerpoint," or "a place of inner peace." This study introduces the concept of resiliency to the experiences of childbearing women and further contributes to a contextualized understanding of some women's experiences of pregnancy, labor, birth, and mothering. Further research in the area of resiliency and childbearing, as situated within the context of women's lives, is needed.

### ***Support Systems***

Within the mental health literature, maternal outcomes including high rates of depression, anxiety, dissociation, and other symptoms of psychological distress have been reported (Beitchman et al., 1991; Jumper, 1995; Kendall-Tackett et al., 1993). Attention has also turned to understanding the interpersonal consequences of child abuse, including adults' experiences as mothers (Banyard et al., 2003). Most of these studies have examined the direct relationship between childhood sexual or physical abuse and a

variety of parenting outcomes. The primary finding was that parents' own abuse histories are risk factors for negative consequences in the parenting role. Furthermore, the research noted that connections to social supports and taking care of one's own needs were protective factors of mothers who were survivors.

All of the women in this study reported that support systems were of primary importance. Support in pregnancy and during childbirth has been shown to significantly enhance women's emotional well-being (Oakley, 1992a; Wheatley, 1998). Conversely, numerous studies have identified poor social support as a factor associated with postpartum depression (Ball, 1987; Elliott, 1989; Oakley, 1992b). According to Elliott, postpartum depression has serious consequences and may fundamentally and enduringly undermine a woman's self esteem, particularly her confidence in her ability to be a "good enough" mother; be a permanent source of regret since women feel they have missed a part of their child's life; delay the development of mother-infant attachment; lead to long-term effects on the child's behavior or cognitive ability, as well as the mother-child relationship, especially if the mother's "withdrawal" is not adequately compensated for by the father or other significant support person; and lead to marital stress, which if unresolved, will end in divorce.

Mercer (1986) reported that the successful accomplishment of Rubin's tasks of pregnancy was influenced by the partner's emotional support. For the majority of participants in this study, emotional support from partners was not available because of their single status. Additionally, of those women with partners, few remained in relationships with the biological fathers of the children. Buist (1998a) has asserted that the quality of a woman's partnership will have a profound effect on the transition to

motherhood. Marital dissatisfaction and inadequate supports have also been linked as factors for difficulties in transitioning to motherhood. The idea of partner support is significant for women and the health care providers charged with their care given that survivors may require specialized care and additional supports related to their traumatic childhood histories. Therefore, in the absence of partner support, the provision of additional supports becomes all the more imperative.

Support systems identified within this research study had two primary functions that often operated in unison. First, they provided emotional support to the survivors. This support included reassurance, the knowledge that they were loved and cared for, listening, and advice provided as needed. Secondly, they provided practical support. This type of support involved active assistance: for example, some participants identified getting a break from their children as a type of support. In the absence of support, the women in this study were particularly vulnerable to guilt and self-blame. Several talked about feeling guilt even though they were doing everything they could to keep themselves together and protect their children. Participants found support in four key places: partners, family, friends, and their larger community. Some women found that their families were helpful in providing emotional support and, in some cases, financial support to fight court battles to regain access to their children or gain long-term disability assistance. Others found friends they could talk with; one woman expressed her appreciation for the woman friend who “stood by me all the way,” phoned her every day and was just “a terrific listener.”

For other participants, the important process of talking about what they were going through worked best with the help of therapists or in support groups. Support

groups for sexual abuse survivors ranked high on the list of the women's resources for keeping strong in order to help themselves and their children, although there was a notable absence of support groups for mothers who had experienced childhood sexual abuse. Several of the women in this study asked if I would initiate a support group specifically for them, but ethical considerations prevented this in the context of this research study. However, I was able to direct the participants to the Recruitment Center to formally request that this service be facilitated. Groups were a way for the women in this study to realize that the abuse was not something that happened only to them or their children, that they were not alone with their experiences. Talking with other women or with sympathetic therapists provided welcome relief and was a source of strength, because in this context the women were believed and accepted, and received some practical advice.

Kat: Right from the beginning I attended mothers' groups and parenting crisis groups and Project Parent...I really tried to find out what was normal, what wasn't acceptable but you know it was really difficult because everybody projected a different story—there was no book

Cindy: In the area that I live they have a program called "Healthy Babies, Healthy Children" and they have these home visitors and it is basically an experienced mom that comes around and just sits and talks with you for awhile. She was very helpful just letting me know that it's normal and just sitting and talking with me...

Support groups were not positive for all the women in this study. Some women found them "disturbing" and "not helpful" because of the group dynamics.

Lola: I know it's insane, it's like how many groups do you have to talk to before

you actually 'qualify', it's what I call a victim Olympics...OK, so if you are raped up the ass by three baboons then you get the gold medal, right...well, that's a gold I don't want, but I might get it you know. It just sends the whole thing in the wrong direction, it hurts, it makes people lie about their experience and that's the part that's really hard to face as a practitioner...because if you set it up so that the only way that one qualifies to be a victim then that's a problem start—they will be a victim. Then they will go home and feel like a victim and so you better figure out how to give care that doesn't require them to do that...disclosure. How do we set up disclosure so that first of all it doesn't kill the person because they are going to kill themselves if it's not done properly. I am tired of believing that telling fixes it, it doesn't.

Support from partners, family, and friends were reported as being influential in helping the women through the childbearing experience. Effective support was non-judgmental, understanding, and involved simply listening to the women's concerns:

Bonnie: I was fortunate to have a very loving spouse and that made a very big difference because he is not the type of person to babysit me as far as "Bonnie do this and Bonnie do that," because that's just dependency and control again...but he was encouraging...there was a difference, a big difference.

Dawn: I was able to stay centered and grounded with those support networks—my husband, my parents. I also had a friend, a massage therapist, come to support me and this had been a person who had been part of my journey and knows my husband and I and to me that was a vital piece to have her there as well...that's what kept my body in check so that I wasn't going to go there, so I wasn't going

to freak out or have those bad memories and I could just stay focused on bringing the child into the world and that was huge.

In summary, support systems varied for the women in this study—both in quality and quantity. Regardless of the characteristics, support was both valued and appreciated when received; for many of the women it was pivotal in their negotiation of their childbirth experiences as survivors of childhood sexual abuse and significant in their experiences of achieving balance in their lives. The achievement of balance is challenging for all women given that they are presented with powerful images of motherhood that create unrealistic societal and individual expectations. This dominant discourse results in the majority of women feeling as if they have failed as mothers, and perhaps even failed as women. Feeling like failures as mothers was a common finding among the women in this study. Therefore, in order for survivors to achieve a state of inner peace and balance in their lives, it is essential to reframe motherhood within the specific context in which it is experienced, and to draw upon women's internal powers of resiliency and their external support systems. Movement beyond survival towards "thriving" may thus become a possibility for mothers who are survivors of childhood sexual abuse.

### **Making Connections: Moving Beyond Survival**

Childhood sexual abuse can take a dreadful toll on a woman's life. For the women in this study, the consequences have been lifelong and, in many cases, devastating. Yet what participants shared with me about their lives reveals that there are some ways to alter, if not undo, the damage. Their experience demonstrates that it is possible to reclaim one's life. Finding those internal resources and building on them is a

crucial part of the process of finding one's centerpoint—a place of inner peace and balance. The support received through partners, family, friends, and community (including health care providers) can contribute to this process.

This process is not linear in nature, nor is it circular or step-by-step. Rather, each woman must find her own path through it, in whatever way works best for her. In order to move beyond being a survivor, women need to gain an increasing understanding of their own experience, make sense of the various ways in which they have been affected by the abuse, and recognise the various strategies they use/have used to cope. As the women in this study have shared, the process is difficult and each survivor faces serious struggles when trying to make sense of her experience in order to build on those “untouched” parts of herself and break free of the cycle of abuse.

The women survivors in this study found and used what was helpful, and rejected what was not. Realizing that the abuse was not their fault was for many of the women a key to understanding their own responses to the abuse. They began to recognize that their behaviors, positive or otherwise, constituted strategies for coping with the abuse, and were not signs of fundamental flaws in their personalities. Recollecting their childhood experiences was a key for many of the women in understanding or even acknowledging how they felt as mothers and why they felt as they did. The process of uncovering the whole self began in various ways. For some, depression and unhappiness with their lives prompted them to try to understand more about their past; for others, bits of memories of their childhoods surfaced (often during their childbearing experiences) and propelled them into more remembering and into finding experiences, feelings, and beliefs they hadn't known existed. Unfortunately, blocking memory of the abuse, a

copied strategy that had served so many of the women as a survival strategy in childhood and beyond, stood in their way when they wanted and needed to remember in order to sort out the totality of their experience. Participation in this research study was one way for the women to begin to understand their experiences of childbirth and mothering.

In this chapter, I discussed participants' experiences of childbirth and mothering against a backdrop of childhood sexual abuse. The social psychological process of "Protecting the Inner Child" was also presented to help explain survivors' experiences of childbirth and mothering. In the next chapter, I discuss the findings of this chapter in relation to the implications and recommendations for health and social policy, research, education, and clinical practice. The limitations of this research study are also discussed.

## **CHAPTER SIX**

### **BEYOND SURVIVAL: MAKING SENSE OF EXPERIENCE**

#### **IMPLICATIONS AND CONCLUSIONS**

The theory of "Protecting the Inner Child" proposed in the previous chapter offers a framework for understanding survivors' experiences of childbearing and mothering. In my analysis of women's stories of childhood abuse and mothering, I came to understand how complex motherhood is, particularly when situated against a backdrop of childhood sexual abuse. Apart from the many ways in which the women's lives were affected by their abusive pasts, what remained consistent was their inherent desire to be the best mother that they could possibly be. The women in this study gave of their time and personal experiences because they believed that their experiences of motherhood were not fully understood. The women shared their stories with two goals in mind: the desire to instill hope in other survivors and the perceived need to generate better knowledge and understanding about their experiences.

In this chapter, I examine the contribution of this dissertation with regard to existing knowledge about the childbearing experience of childhood sexual abuse survivors, and provide implications for health and social policy, research, education, and clinical practice. I begin with a discussion of the limitations of this study.

#### **Study Limitations**

This research study had some important limitations. The analysis used broad categorizations of sexual abuse experience because information about such things as frequency and forms of sexual abuse (for example, touching versus intercourse) was not gathered. This information may be important in identifying some of the relationships

between certain types of trauma and childbearing experiences. For example, do women who experience sexual penetration at an early age have greater difficulty in childbirth than women who experience inappropriate touching at a later age? Does intra-familial abuse have a greater impact on women during childbirth than extra-familial abuse? More information about the survivors' family of origin might also have been useful in analyzing the variables influencing their experiences of childbirth. Damage to women survivors is reported to be more severe where the abuse continued for longer periods, where penetration was involved, and where the abuser was a father or father figure within the family (Trickett, Noll, Reiffman, & Putnam, 2001).

This study is also limited in terms of the sample, and this will affect generalizability of findings. For example, the majority of participants heard about the research study through the Recruitment Center, Today's Parent, or by word of mouth from other participants, mothers, survivors, or therapists. Consequently most of the participants were already thinking about the impact of their histories on their lives or trying to make meaning out of their abuse histories. These participants had access to services that other potential participants may not have had, and it was through these services that they not only learned about the research study but perhaps also felt secure enough in their back-up support systems to share intimate and painful details about their lives.

Another limitation of the study relates to the generalizability of the theory proposed. More variation in subjects and greater range of interview data can result in the wider applicability of a grounded theory (Carpenter, 1995; Chenitz & Swanson, 1986; Glaser & Strauss, 1967). In this study, attempts were made to test the categories, the

links between categories, and to develop interpretations by recruiting women with different life experiences. Unfortunately, it was not possible to recruit additional survivors who did not, for example, have clear memory of their childhood traumas prior to their pregnancies and births. Therefore, it was not possible to observe and research the impact of childbirth as a trigger event for the surfacing of traumatic sexual abuse memories. Additionally, it was not possible to assess the depth and degree of repressed memories for any of the participants - in fact, they may have recalled more memories following data collection that were not included in the study findings. The notion of repressed memories connected with, and triggered by, the experience of childbirth warrants its own research study at a later date. Additionally, although the diversity of the participants in terms of age and life experiences was a strength of the study, it is important to acknowledge that memories of the childbearing experience could be different as a result of time and life experience. Therefore, some mothers whose childbearing experiences were more recent may focus on their labor and birthing experiences whereas mothers whose childbearing experiences were more distant may focus on their mothering experiences.

Although there was some ethnic diversity in the sample, the participants were overwhelmingly of Western European Heritage. Different ethnic groups may have different notions or beliefs surrounding child sexual abuse. One of the participants, Moe, (self defined as East-Indian), stated:

You see sexual abuse in my culture all of the time. It is female children and women that are abused. It is a part of our cultural norm. You don't even question it because you are not meant to question it. I remember being amazed when I

finally understood that what happened to me was sexual abuse. Everyone knew about it when it was happening, but I guess it was no big deal since it was happening to everyone else too—at least all us girls. Crazy, just crazy. And I look back on it now and I think why did I think I was different...or wrong...or damaged somehow when I was like so many of my sisters and cousins. No one called it child abuse. It was just how it was.

It would be important to address the unique experiences and needs of particular ethnic groups in future research studies. Within this study, similarities and differences between the experiences of the ethnic groups represented were not addressed.

### **Implications**

The ever-changing health care system presents a challenge to efforts to develop a system that provides comprehensive care to women who have been abused in childhood. Conceptualizing women's health in terms that are pertinent to women's lives helps to better measure women's health status and thus enables us to provide better care. Over the past ten years, intense research has brought substantial progress in our understanding of the phenomenon of childhood sexual abuse and its variable impacts on those involved. We now have some consensus about its prevalence, with a firm understanding that it occurs in most societies that have been studied (Finkelhor, 1994). It is clear that child sexual abuse is often followed by adverse psychological and social effects (Beitchman et al., 1992; Finkelhor, 1994; Green, 1993; Mullen, Martin, Anderson, Romans, & Herbison, 1993, 1994, 1996). However, there remains a notable lack of information regarding the impact of childhood sexual abuse on the childbearing and mothering years. Clinicians, educators, researchers, and policy makers are now turning their attention to

learning about the ways in which survivors of childhood sexual abuse cope with both the daily challenges of life and crisis situations. The findings of this study are therefore particularly timely, and can be made useful through their translation into relevant implications. In the following section I explore the implications of the study findings for health and social policy, research, education, and clinical practice.

### **Implications for Health and Social Policy**

Over the past 20 years, a wide range of health, social service, criminal justice, and community programs have emerged to address the identification, treatment, and prevention of childhood sexual abuse. The majority of these programs, however, have not been systematically evaluated (Crowell & Burgess, 1996). This has largely been due to limited funding directed at program evaluation and to the distrust between grass roots and research communities regarding research motivation and program priorities. This configuration has begun to change with recent federal funding opportunities, such as the Canadian Institute for Health Research (CIHR)'s request for joint applications that explicitly require the collaboration of researchers with service providers and community agencies. The needs of women, children, and families affected by sexual abuse necessitate the collaboration of a variety of professionals and agencies to ensure successful prevention and intervention, and will require systemic changes at many different levels. The first step toward enabling more successful interventions is improving the methods of identification and assessment of children and families at risk for sexual abuse or violence. More effective intervention with families also requires a shift in the process of referring adult survivors to mental health professionals. Rather than focusing on crisis management after parenting practices have already reached a level

which meets the criteria of child neglect or abuse, professionals need to focus on providing mothers with non-judgmental support and assisting them in obtaining mental health services in an effort to prevent future difficulties. A system directed towards continuous care for vulnerable families must be instituted. This would require increased funding for training and expansion to allow for a greater focus on prevention. In addition, mental health services may require increased funding to service those clients who might not be covered by provincial health care. To best serve the needs of children and families, increased resources need to be made available for prevention, intervention, and research.

Clearly, issues related to childhood sexual abuse and childbearing fall under women's health issues, and many barriers exist with respect to advancing a women's health agenda. These include resistance to a gendered understanding of health on the part of many policy makers, and resistance to rearrangement on the part of the fiscal and service delivery agencies of health care. In this dissertation, I respond to the first barrier by advancing an understanding of women's experiences through eliciting the women's life stories. I respond to the second barrier by critically examining the issues and consequences affecting women's (survivors') lives and offering guidance regarding future directions of health care service delivery for women. I advocate for both change from within and for a transformative vision of what women's health care could be. I recommend reforms that will help the current system to respond better to the needs and concerns of women, and at the same time to advocate for a paradigm shift that acknowledges the inadequacy of biomedical explanations for understanding women's health, in particular, women's mental health.

All participants agreed that changes are needed in the social welfare and criminal justice systems. The women in this study expressed two key concerns: barriers in accessing services for treatment and support, and re-victimization of survivors within the system, specifically around apprehension and fostering issues. The participants expressed frustration around their experiences with the social welfare and criminal justice systems and felt they were typically ignored or abandoned by the agencies that might have intervened. The participants were also very clear about the fact that when sexually abused children try to tell others about the abuse, they are rarely understood or believed. The survivors and mothers in this research study demand that we listen for a child's disclosure, and believe it when it comes. Abusers rely on secrecy in order to continue the abuse, and consequently it is critical that an end be put to such secrecy. The real key to stopping child abuse is stopping the abusers. Disclosure warrants serious legal action and our society must hold abusers accountable. In addition to more stringent criminal sentences, abusers must be required to attend on-going therapy.

Women's roles as mothers must be recognized and supported in health care treatment and planning. Health care service delivery must provide appropriate and sensitive care to women facing apprehension and custody issues since research suggests that the ability to maintain custody of their children is often critical to women's recovery (Zemenchuk, Rogosch, & Mowbray, 1995). Where full custody is not possible, women should be empowered as much as possible and provided with minimally traumatic separation plans with follow-up and support. A woman's state of mental health during childbearing raises questions about a woman's ability to care for her baby. Assessment of parenting capability, followed by provision of extra social support and parenting

rehabilitation when needed, may ultimately decrease the possibility of custody loss and improve the lives of the mother, the child, and the rest of the family.

Current research on vulnerable children suggests that the important factors for child development are “parenting skills, the cohesiveness of the family unit, the mental health of the mother, and the extent to which parents engage with their children; and that these features affect and are affected by the neighborhood, the school, and the wider community” (Willms, 2002, p. 366). All of these child development factors resonate with the findings reported in this research study. Willms suggests that in addressing the social policy mandate, we need to “envisage a family-enabling society and renew social policy such that families and communities receive the support they need to raise their children” (p. 366). Willms offers the following four recommendations: (1) shared responsibility for social policy; (2) investment in human capital that enables families; (3) increased social inclusion; and (4) increased capacity for program evaluation, monitoring, and research. Although these recommendations are not directed specifically at women survivors of childhood sexual abuse, they clearly resonate with the findings of this study, and their implementation could contribute significantly to breaking the cycle of abuse.

It is encouraging to note that there is now greater public awareness of child sexual abuse, that more professionals in the health care and criminal justice systems are better informed, and that more programs and services have been created; however there is still a long way to go. Research can profoundly influence health and social policy directed at improving the lives of vulnerable women, children, and families, by bringing issues to the attention of the government, and helping to create solutions by increasing knowledge and evaluating programs. In the following section, I present implications for research based

on the findings of this study.

### **Implications for Research**

Several possible avenues for future research based on the theory proposed here suggest themselves. The next logical step would be to substantiate the study findings with a more defined group of survivors who are mothers or expectant mothers (e.g., by examining the childbearing experiences of women experiencing pre-partum or postpartum depression). This kind of research could extend the boundaries of the substantive theory and strengthen its specificity and clinical relevance. The identification of variables such as bonding challenges, breastfeeding challenges, and maternal depression, which may be amenable to intervention, permit us, as nurses and researchers, to go beyond simply documenting the impact of childhood sexual abuse trauma on mothering to developing intervention and prevention efforts. Roche, Runtz, and Hunter (1999) assert that identification of mediating factors engenders optimism in health care providers working with trauma survivors, as it provides information about important areas for targeting interventions, which, in the case of mothering, may facilitate the discontinuity of abuse. The emphasis in health research and policy needs to shift to prevention. In order to shift the emphasis in ideology and resource allocation to prevention programming and funding, we must pay more attention to the structures that help to maintain the present emphasis on, and resource allocation for, curative research and services.

This study highlighted several areas that warrant future research, such as survivors' choices of caregivers, delivery method, and place of birth; breastfeeding experiences of survivors; postpartum depression and survivors; mothering challenges;

issues around disclosure for survivors; and the experiences of partners of survivors—how do we as nurses and allied health care professionals provide support to partners?

Research directed at nurses should include an examination of the personal or institutional barriers around asking about abuse. We need to ask nurses what their needs are in relation to screening, and furthermore we need to address the impact that disclosures may have on nurses (i.e., vicarious traumatization).

Given the prevalence of childhood sexual abuse and the extent of its impact, it is critical that research address the implications of sexual abuse for the children of survivors. According to Ruscio (2001):

As survivors reach adulthood, many have children of their own, and these children may be vulnerable to the negative consequences of their parents' prior abuse. Past findings suggest that sexual abuse—and the impairment with which it is associated—may exacerbate the stresses of parenting, reduce available energy for parenting activities, and weaken important social supports, making the tasks of child-rearing particularly difficult (p. 370).

Research directed specifically at children might include: the experiences of children whose mothers are survivors, for example what was their experience of overprotection or their experiences of emotional unavailability of their mothers?; prospective or longitudinal studies working with child survivors; individual differences and variables in children's response to abuse, in particular the notion of resiliency in children; and child therapy benefits—what worked and did not work for children. Continued research into what makes children vulnerable, and, conversely, what makes children resilient, needs to be carried out. Due to the major socializing role mothers play for children and the

possibility that a personal history of childhood sexual abuse may influence mothering behaviors, it is crucial to examine whether the children of survivor mothers face unique challenges or perhaps experience negative developmental outcomes related to their own mothers' history of sexual abuse trauma.

In this study, I focused on the childbearing experiences of childhood sexual abuse survivors. It would also be beneficial to explore the experiences of mothers whose children have been sexually abused. Only two of the women in this study reported that their children had been sexually abused. One of these mothers reflected that this might perhaps be a developmentally normal exploration of bodies between two young boys rather than a sexually abusive situation. The other described her children's situation as "without question, child abuse." Her children were in the care of the Ministry of Social Services when the abuse occurred. Although these mothers were survivors themselves, research could be directed at all mothers whose children have been abused, survivors and non-abused mothers alike.

The limited research into the area of parenting and childhood sexual abuse has traditionally focused on the question of why women are inadequate mothers. However, in recent years researchers have attempted to capitalize on women survivors' strength and personal agency in their mothering experiences. Although this study uncovered the many strengths and abilities of mothers, it is important to extend the research to ask how health care professionals can best support survivors through their childbearing and mothering experiences. The focus thereby shifts away from the further pathologizing of women towards an acknowledgement and celebration of their strengths and abilities. Nurses are in a pivotal position to support these women and assist them in improving their own

health and lives, as well as the health and lives of their children.

Many questions remain regarding the different contexts in which reproductive decisions are made, why most women choose to become mothers, and (albeit in far fewer cases) why others choose to remain childless. More attention needs to be devoted to fully understanding the process of reproductive decision-making and its implications for the women who remain childless by choice (Currie, 1988). There is also a limited amount of research on the notion of body knowledge and memory. More research in this area is required as it is crucial to understand how women use their body knowledge during the experiences of pregnancy, labor, birth, and mothering. Furthermore, it may be beneficial to investigate the reported neurobiological hormonal responses of survivors in childbirth. Research related to women survivors of sexual abuse and stress disorders from a physiological perspective may lend insight into this complex issue.

The women in the study reported struggles with bonding and attachment with their children, which may be a form of intergenerational transmission, although not manifested in the ways one might typically expect, such as physical or sexual abuse. For example, children experiencing family situations where mothers or parents were emotionally unavailable, as was the case for many of the women in this study, were more vulnerable as a result. In this way, then, there is a form of intergenerational transmission and the children remain affected by their mothers' histories of abuse. Although this idea does not fit within the typical criteria for intergenerational transmission of abuse, it would be useful to revisit this framework in light of this study's findings and consider expanding the criteria to include emotional unavailability. A more detailed account of the characteristics of mothers who are sexual abuse survivors is needed to support this

recommendation and therefore future research is warranted.

Research can make important contributions to advancing a women's health agenda and influencing health and social policy. Another crucial component in the advancement of women's health is the education of our present and future researchers and health care providers. Implications for education are presented below.

### **Implications for Education**

Nursing education is directly relevant to clinical practice, but it must also be relevant to research and health policy development. Nursing courses must include an interdisciplinary focus that will assist nursing in bridging the gap between themselves and other stakeholders in research and health policy. I advocate for making multidisciplinary courses on abuse and violence against women a part of the nursing curriculum. A collaborative effort on behalf of all professions working with women and children would advance the cause more rapidly than working in isolation. Offering multidisciplinary courses at advanced levels, or through directed studies, would also be a way to support nurses in meeting their learning needs regarding the social factors affecting the health of women, children, and families.

It is essential that self-reflection and awareness be a part of the core courses required as an integral part of the nursing curriculum. Nursing students must come to understand their own experiences and consider the effect these experiences may have on their clinical practice. Although the current educational processes in nursing education demand that nurses critically reflect upon their clinical practice, they do not provide for an exploration of values, beliefs, and assumptions around such health issues as a history of childhood sexual abuse, so that nurses are often ill prepared to fully understand how to

support and care for survivors. It is critical that nurses become both aware of and knowledgeable about their own personal values, beliefs, and assumptions as they frame their provision of care to women, who may or may not have abuse histories.

It is likely that there will be survivors of sexual abuse in every nursing class; many nurses and nurse educators are themselves survivors. Many nurses and educators may find it difficult to teach certain topics given their own personal histories. As professionals, we need to be sensitive to the needs of educators regarding sensitive material. The provision of guest lecturers may become necessary (or be more appropriate) in situations of an educator's personal history of abuse, or lack of knowledge regarding presentation of sensitive materials. As allies in nursing education, we must support each other in our teaching practices. As nursing educators, we have a responsibility to not only educate our nursing students about the importance and significance of traumatic histories, but also to provide support for those nursing students whose personal experience may be traumatic. In order to provide support as a routine part of all nursing classes on abuse and violence, all students should be given resource information on where to access support services for their clients. In the case of a nursing student who is a survivor, such information can be provided without the student needing to disclose. The nursing educator must also be prepared for the possibility that students might disclose their own personal histories, and I recommend that a caution regarding the sensitive (and perhaps personal) nature of the material be stated at the beginning of any presentation. Although disclosure of the abuse may be desired by the student, it is important to support and facilitate appropriate disclosure.

Health care institutions can support nurses in their awareness of abuse issues by

providing on-going information sessions on the health consequences of abuse, identifying ways in which health care interactions can themselves be barriers to care, offering guidelines on how to provide sensitive and effective care for women, and providing direction on appropriate responses to minimize potential re-traumatization of women during their health care experience and/or appropriate referrals. In essence, health care providers must provide supportive care that takes into account a woman's need for privacy, safety, confidentiality, and respect. Supportive and sensitive care may increase the possibility of survivors seeking health care, and may therefore reduce the health impacts of the abuse.

Nurses must be educated about the impact of violence against women and the various forms it can take. Although there are some clear indicators of childhood sexual abuse, other forms of childhood abuse, such as emotional neglect, are more problematic to identify. The women in this study often described situations of "distancing" themselves from their children in efforts to protect themselves. Although this does not in itself indicate child emotional neglect, nurses must be aware of the complexity of childhood neglect and abuse as our professional responsibilities extend beyond the mothers to their children as well.

Clearly the findings of this study demonstrate that childhood sexual abuse has important implications for health and social policy, research, and education. However, the most significant implications resulting from this research study are those for clinical practice. It is through direct clinical practice that survivors' experiences of childbirth and mothering are most directly and profoundly felt. Thus, implications for clinical practice are key here in directing health care providers to provide effective support to women

survivors during their childbirth and mothering experiences. The implications for clinical practice are presented below.

### **Implications for Clinical Practice**

The implications for clinical practice presented in this paper are two-fold. The first represents “best care” nursing practice for clients who are mothers and survivors of childhood sexual abuse, and the second represents implications for “self care” for nurses themselves. The women’s suggestions, in addition to relevant recommendations in the literature reviewed, provide the foundation of the implications for clinical practice that follow. Nurses and allied health care professionals have a responsibility to develop guidelines for practice based on systemic inquiry. This research study offers a beginning guideline for nursing practice.

#### ***Nursing Care for Women Survivors***

The women in this study had no way to predict when or why memories of their abuse might be triggered, or how they would manifest themselves. Although this uncertainty poses a considerable challenge for nurses and other health care professionals in terms of how to provide the best possible care for survivors, nevertheless there are beginning steps we can take. According to Simkin (1992), “A first step for caregivers is to be aware that recollections of sexual abuse can come up unexpectedly and unconsciously during pregnancy and childbirth and can exert powerful effects on the woman (p. 225).”

The findings of this study suggest that it is critical that health care providers be aware of the potential triggers for survivors (although there may also be other triggers not identified in this work), and be understanding and supportive of the coping strategies

employed by mothers who are survivors. Clear directives to accomplish this are presented below. Additionally, health care providers must be aware that as survivors progress through the phases of childbearing, they may become increasingly conscious of their abusive pasts, and simultaneously feel an increasing need to control their experience. For ease of reference, the implications and recommendations for clinical practice are presented according to each phase of childbirth highlighted in the previous chapter.

### *Pre-Conception*

The experiences of childless-by-choice survivors was not the focus of this study and therefore recommendations for clinical practice are limited. However, the women in this study who did not have children were clear that their decision to remain childless was a conscious one made as a result of their childhood sexual abuse history. This decision was often made after years of careful consideration and consultation. Consequently health care providers who work with childbearing women pre-conceptually, including women accessing fertility clinics or recurrent pregnancy loss clinics, need to be aware that women's decisions and attempts to become mothers (or not), are influenced by the context of their lives, which for some includes a history of childhood sexual abuse.

Disclosure of childhood sexual abuse is not the norm. However, for women who have disclosed a sexual abuse history, respect and support for their reproductive decision-making is paramount. Some of the women in this study who had prior disclosures had experienced judgment-laden care, as health care providers suggested to them that they would be "incapable mothers" given their abusive pasts. This reinforced the women's feelings of unworthiness as women and mothers. Thus, it is important that health care

providers understand that by virtue of their position, they may be viewed as “authoritative and knowledgeable,” and that they have the power to either affirm or negate a woman’s sense of self. It is important that childhood sexual abuse survivors (and health care providers) understand that a future of abuse (in whatever form) is not an inevitable “destiny”; rather, through enhanced awareness of abuse triggers and an understanding of coping strategies, survivors can arrest the potentially devastating effects of abuse, and health care providers can support them in doing so.

### *Pregnancy*

The childhood sexual abuse and childbirth literature has largely focused on the experiences of women during labor and birth. In this study, one of the most significant findings was that pregnancy itself was also a pivotal time for survivors. Many of the coping strategies exhibited by women in labor and birth, postpartum, and mothering, such as withdrawing from their baby (difficulty bonding) and withdrawing from self (depression and dissociation) could be seen in the early stages of pregnancy. This is a significant finding, which has important clinical implications and is amenable to early intervention.

Overall, although pregnancy was the “quietest” time in relation to external abuse triggers, the women reported an increased level of consciousness regarding their abuse histories. It was at this time, as motherhood drew nearer, that the women began to reflect upon their own childhood experiences, and also began the process of “protecting their inner child.” Although most of the participants in this study did not disclose their sexual abuse history to their health care providers, they did, nonetheless, seek care during their pregnancy. Therefore, the care provided to women prenatally provides health care

professionals with an opportunity to develop trusting relationships with survivors.

During this time, comprehensive care can be put into place, including the provision of additional support systems even without disclosure. This is an ideal time for health care providers to assess for childbirth and mothering triggers, such as prenatal depression and detachment from their unborn child.

There is some evidence that when children are sexually abused at a young age, they are more vulnerable to the development of posttraumatic stress symptoms (such as dissociation and withdrawal) and depression (Cicchetti & Lynch, 1993; Wolfe, Sas, & Wekerle, 1994). Most of the women in this study were sexually abused at a young age, and this may explain the significant number of stories that reflect both post traumatic stress symptoms and depression. According to Courtois (1997), although many women who have been victimized do not develop psychiatric disorders, few are unaffected by their experiences. The majority of the women in this study reported experiences of depression and difficulty bonding with their unborn child. For a few of the women this meant denial of the pregnancy altogether; for most it meant that depression and disconnection began early in pregnancy. The identification of pre-partum depression in its early stages permits us to intervene and provide effective supports and referrals, thereby possibly preventing future crisis. Of course, assessing for depression in pregnancy is challenging given the wide range of changes, physical and emotional, that pregnancy entails.

The women in this study have provided us with clues as to what pre-partum depression looks like, but recognizing these clues requires comprehensive, ongoing care. The most profound identifier of pre-partum depression is the women's difficulty in

bonding with their unborn child. According to Rowan (2003), attachment between a mother and baby begins prior to conception and further develops during pregnancy. The women in this study described finding it difficult to think of themselves as mothers, particularly “good mothers,” and subsequently struggled with early attachment. They reported becoming “more depressed and withdrawn” in response to this struggle. It is important that during prenatal care, health care providers inquire about women’s feelings regarding their transition to motherhood and assess for early attachment disturbances and depression. Given the significance of support systems for survivors of childhood sexual abuse, it is important to assess for the nature and quality of support for each survivor at this early stage of childbearing. Drawing upon support systems, both internal and external, at this early stage may prevent difficulties in the post pregnancy phases.

Although most of the women in this study described routine clinical care as “not such a big deal...it just had to be done,” this was not true for all participants. Lola described being used as a “guinea pig for student doctors at the hospital” while pregnant. Her experience of feeling re-violated by her health care providers has important implications for health care providers working in teaching hospitals. While it is valuable to provide new learners with opportunities to reinforce their clinical skills, this cannot be allowed to surpass women’s need for privacy. A recommendation for educators working in clinical settings is to consistently ask permission from clients to have students work with them. This is vital to providing women with some sense of choice and control in otherwise overwhelming circumstances. Not only must health care providers provide choice about accepting students, we must also respect women’s decisions and choices regarding their health care provider. Many of the women in this study coped in

pregnancy by exercising control through their choice of health care provider. Because of their belief that midwives could provide more “sensitive and personalized” care, some of the women accessed this service. They described the formulation of birth plans as beneficial for them in their anticipation of what to expect. In all prenatal practices, the introduction and development of a birth plan may be useful for all women. This would provide women with an opportunity to voice their fears and engage in enacting some control (and choice) over their experience. Survivors need to be given a sense of what to expect in order to gain some degree of control over their experience. Many of the women wished to have access to midwives but found that this option was not available to them, either because midwives were not accessible or because they could not afford the service.

As a component of prenatal care, nurses can offer childbirth education classes that are sensitized to the needs of expectant women who may be survivors. An introduction to the potential impacts of childhood trauma histories can be presented alongside additional supports and referrals for those women who wish to seek further care with their primary health care providers. Simkin and Klaus (1996) recommend exploring with the woman how she has dealt with stressful, difficult, or physically demanding experiences in the past. The woman’s health care provider can then assist her in describing the phases of labor, hospital procedures, and caregiver routines. An awareness of what to expect during childbirth coupled with support for the woman’s own coping style may assist her in having a positive birthing experience.

Recent research supports the universal screening of abuse in maternity settings—in essence questioning every woman about abuse, rather than only those women whose situations raise suspicions of abuse (Bohn, 1990; Bohn & Holz, 1996; Cole, Scoville, &

Flynn, 1996; Janssen, Holt, & Sugg, 2002; King, 1993; King & Ryan, 1989, 1996; King et al., 1993; McFarlane & Gondolf, 1998; McFarlane, Parker, Soeken, Silva & Reel, 1997; Parker & McFarlane, 1991; Seng & Hassinger, 1998; Seng, Low, Sparbel, & Killion, 2004; Seng et al., 2001; Seng, Sparbel, Low, & Killion, 2002; Seng & Petersen, 1995). The views expressed by the women in this study were unanimous in terms of the need for support for women should they disclose their trauma histories. However, they were split in their views of if, when, and how best to screen for childhood sexual abuse during the childbearing years. Some women thought pregnancy was an opportune time whereas others felt that their pregnancies were “pure” and did not want them “tainted” by reminders of their childhood histories of abuse. In support of not screening for a history of abuse, Briere (1989) asserts that confronting a history of abuse can awaken a survivor to abuse memories which may increase distress. Jacob (1992) suggests that increased stress is contraindicated in pregnancy and childbirth and therefore pregnancy may not be a preferred time to address abuse issues. Although the development of a screening tool was not the goal of this research study, the suggestions made by the study participants may prove useful in guiding future clinical practice. Lynn described what she would have wanted to be asked: “Maybe it could be phrased ‘have you had any sexual experiences in the past that might bring up some negative emotions during childbirth?’” Lynn’s suggested question initiated a conversation with all the participants about how health care providers might best introduce the idea of childhood abuse with their clients. Suggestions (from myself and the study participants) for possible questions are offered below:

We bring to our birthing experience a lifetime of history and some of those experiences may have been traumatic. Is there anything in your past experiences which have profoundly affected you that you would like to share with me or feel is important for me to know? Are there any other personal issues you would like us to be aware of with your care? In what ways does your experience make this challenging or difficult for you? Is there anything you would you like me to do to help make you more comfortable? Is there anything I need to know to help make this birth a positive experience for you?

The above formulations require that women be provided with a context for the screening question, a choice in how they answer it, and respect for the personal meanings held by their histories. Many of the women in this study expressed the fear that simply acknowledging that they were survivors would subject them to misconceptions and prejudice. Within the framework offered above, women would not necessarily need to name their experiences as childhood sexual abuse if they did not wish to or did not feel safe in doing so. Many of the women in this study did not feel safe in disclosing for a variety of reasons, most predominantly their fears around stigma and labeling. By asking the woman to define for herself what her needs are, the health care provider charged with her care could provide specifically sensitized care as directed by the woman herself. The findings in this study suggest that each woman may have different needs based on her particular experiences and therefore we, as health care providers, need to be willing to adapt to our individual client's needs. We need to ask ourselves how we can help people reframe their histories, particularly when it comes to their prior experiences with health care.

### *Labor and Birth*

Labor and birth was the phase of childbirth in which the women's bodies were subjected to the largest number of abuse triggers. The women in this study considered control to be a paramount "need" for a positive birth experience. This is consistent with other research findings with mothers who are survivors of childhood sexual abuse (Grant, 1992; Lipp, 1992; Lowe, 1992; Parratt, 1994). Choice during labor and birth consisted of choice of caregiver, choice or permission granted to health care providers to touch, and choice of and respect for how the women labored.

As mentioned in the pregnancy discussion, women must have the freedom to choose the type of health care provider that best meets their needs. Having health care providers who share similar views regarding holistic health would benefit women and contribute to establishing trusting relationships. The establishment of midwifery and doula services as well as nurse practitioners for all provinces would allow women more freedom in their choice of health care provider. Certified nurse midwives and other nurses have shown that they positively affect pregnancy outcomes and may be the preferred choice for survivors of childhood sexual abuse (Piechnik & Corbett, 1985; Seng & Hassinger, 1998; Slager-Earnest, Hoffman, & Beckmann, 1987; Smoke & Grace, 1988; Wagner, 1998). According to Sampsel, Petersen, Murtland, and Oakely, (1992), a higher proportion of expectant mothers who are survivors of childhood sexual abuse have been found in midwifery care compared with obstetrical care (12.2% versus 8.5%). A small number of women in this study (n=4) chose midwifery care specifically because they felt this would provide more sensitive care; their decision was made in light of their abuse histories and their apprehensions around becoming mothers. For those women

who present themselves to the hospital in labor without a midwife or doula, it is important that health care institutions respect women's choices regarding gender of their caregiver. Many of the women in this study found having a male caregiver problematic. Whenever possible, it is important that women be offered a choice, particularly when the long-term ramifications of having a male physician might be devastating. The preference of caregiver (specifically gender) could be assessed prenatally and documented on the woman's birth plan to pre-empt discomfort or awkwardness during labor. Although choice of caregiver is a gold standard, it is not realistic to expect that this option would be available to all women in all communities. However, when possible, women's choices should be respected.

As this study shows, touch and language were significant for survivors. For women in labor, touch often constitutes a boundary violation. With this in mind, health care providers must ask permission to touch and always explain to the woman what she can expect from each procedure. It is important to acknowledge here that it is unrealistic to expect that health care providers always ask permission to touch, and that there are situations, such as emergency situations or procedures (i.e., vaginal exams) that necessitate touching. Nevertheless, the general recommendation is that permission be asked to touch and the woman be consulted as to what works for her in terms of respecting her body. Language used in childbirth was also a key finding. Many of the women in this study experienced "disempowering" and "disrespectful" language during their birth experiences. While what is perceived to be "disempowering" and "disrespectful" may vary between women, there are some fundamental principles that need to be instituted in all client-caregiver interactions. First, terminology that is

negatively worded must be addressed, for example “failure to progress” or “unsuccessful vaginal delivery.” Second, the use of “encouraging” language directed at women’s body parts may be inappropriate, for example, “Don’t worry honey, you could drive a Mac truck through here [vagina]” or “you’ll return to your teenage form in no time.” The encouragement could be redirected away from women’s bodies to women’s ways of coping, for example “you are working really well with your baby right now, you can do this.” Lastly, non-verbal language is also important to consider. The women in this study described feeling like “all everyone looked at was my vagina...did they forget that I was here?” It is important for health care providers to remain focused on the woman as a whole, rather than on her specific body parts.

In contrast to Rhodes and Hutchinson’s (1994) recommendation to keep the woman “focused and grounded in the labor experience...to minimize memory or the re-experience of sexual abuse” (p. 219), many of the women in this study reported dissociation as an asset to their coping in labor and birth. Consequently, they did not want to be “grounded in the labor experience” by their health care providers. There is currently no data regarding supportive language around dissociation in labor and birth. This poses a challenge for health care providers when attempting to deliver effective support to laboring women experiencing dissociative episodes. While future research addressing language around dissociation is warranted, a more immediate recommendation is for health care providers to debrief with all women following their birthing experience, in order to elicit important suggestions from women and sexual abuse survivors regarding preferred language during labor and birth.

As an extension of post traumatic stress disorder (PTSD), dissociative disorders

are often associated with a PTSD diagnosis (Spiegel, 1994). Given that many PTSD characteristics were reported by the women in this study (i.e., dissociation, fear, re-experience of the traumatic event, numbed responsiveness), and that recent research has found PTSD to be associated with physical complications of pregnancy for survivors of childhood sexual abuse, PTSD theory could be used to inform clinical practice (Reynolds, 1997; Rhodes & Hutchinson, 1994; Seng, Low, Sparbel & Killion, 2004; Seng, 2002; Seng et al., 2001; Seng & Hassinger, 1998). It remains paramount, however, that nurses also take into account the notion of personal agency or resiliency, which mediates women's experiences of trauma. Addressing other potentially mediating factors related to the larger context of mothering is also important, for example, social supports, demographics, economic status, maternal age, and relationship quality. Low marital relationship quality has been identified as a risk factor for more negative parenting outcomes, and this points to the need to examine the relationships outside the mother-child relationship and their influences on survivors' own mothering experiences (Alexander, Teti, & Anderson, 2000; Banyard, Williams, & Siegel, 2003).

### *Postpartum*

Bonding difficulties (often related to gender of the baby and challenges with breastfeeding) and depression dominated the women's postpartum experiences, as they did the pregnancy. According to Buist and Janson (2001), women who were childhood sexual abuse survivors exhibited more impaired mother-infant relationships postpartum and had higher incidences of postpartum depression.

A possible strategy to assist with early attachment might be to keep women focused on the baby immediately following birth. According to Rhodes and Hutchinson

(1994), this may help women feel a sense of accomplishment and subsequently associate their baby with a positive focus. In turn, this positive focus may counteract past negative associations. Although there is no way to alter the gender of the baby, understanding the reasons behind mothers' positive or negative reactions to their baby's gender is important in providing support. Allowing women to acknowledge their fears and apprehensions is one first step in reinforcing for women that they are not alone and that they are not "poor mothers" because of their feelings. It is important that health care providers focus on the positive interactions between mother and baby and encourage continued attachment behaviors. A second step would be to spend increased time with women struggling with their transition to motherhood or advocate for their support systems to assist. Beyond the obvious benefit of spending time with a new mother, an added benefit is the early assessment for postpartum depression. Without exception, community health nurses should make a home visit within the first few days to assess for mother-baby attachment and postpartum depression. Where nursing assessments indicate a potential issue, follow up in the form of home visits, support phone calls, and referral to community resources is indicated. Collaboration with a family physician is also indicated. Previous research has concluded that a history of childhood sexual abuse predisposes women to depression (Buist & Barnett, 1995; Cole, Scoville, & Flynn, 1996; Hall, Sachs, Rayens, & Lutenbacher, 1993). The combination of attachment difficulties and postpartum depression for mothers who are survivors is worrisome. The findings of this research study extend beyond the postpartum phase to survivors' experiences of mothering. The findings make it clear that women's early postpartum struggles did not end there; rather they continued through the women's mothering experiences. For some women, this

involved continued depression which resulted in their emotional and physical withdrawal from their children. It is not difficult to deduce that this may be problematic (in both the short and long term) not only for the women themselves, but also for their children.

Again, this underlines the necessity of early assessment, support, advocacy, and intervention for mothers who are survivors.

The dynamics that enable abuse of children are those of power and control. As adults, survivors of childhood sexual abuse strive to gain and maintain control over their lives. It is important that we, as nurses, do not usurp their control by making decisions for them; it is critical that we work in partnership with the woman to identify appropriate resources, supports, and referral sources. The women in this study expressed complex expectations and desires for control during childbirth. Tidy (1996) addresses this by acknowledging that past experiences may have strong effects upon survivors' attitudes towards control, either making them totally pliable, or giving them an overriding need to be in command. For this reason alone, health care providers must treat each woman as an individual and always bear in mind that a woman's expectations of control come from somewhere. If these expectations seem unreasonable, there may well be a good explanation. For example, several of the women in this study wanted to bottlefeed exclusively despite pressure from health care providers espousing that breastfeeding was the best choice. Although the women understood the rationale behind breastfeeding as a feeding method, because of their abuse histories, bottlefeeding was their chosen method. This particular instance highlights the need for health care providers to avoid judgments and guilt-ridden statements, and instead provide support appropriate to the individual client.

It is important for researchers and practitioners to examine the social milieu in which particular stressors are experienced. In relation to the findings, an examination of social forces, such as hospital policies and culture, helps to shift the focus of coping for survivors from purely an individual analysis to an individual-in-context analysis, thereby normalizing survivors' childbirth experiences and reducing self blame (Banyard & Graham-Bermann, 1993).

### *Motherhood*

The women in this study all wanted to be "good mothers," although many of them felt they lacked the tools and resources to be the best mothers they could be. The findings of this study suggest that despite their struggles, survivors are willing to develop skills to assist them in being the best mothers possible. Although it is beyond the scope of this paper to explore the treatment modalities used in childhood sexual abuse therapy, it is important to highlight that further research on survivors' experiences of motherhood is needed. Given that motherhood was not the primary focus of this study, the resulting implications are limited. Nevertheless, certain important arise.

Parenting programs were viewed as helpful by those women in the study who accessed them. Nurses and allied health care professionals facilitating mothering and parenting support groups should be made aware of the impact of a history of childhood sexual abuse on mothering, so that they can be in an informed position to assist mothers/survivors to manage their abuse triggers, to facilitate the further development of their coping strategies, and to provide support as directed by the client herself. The women in this study directly inquired about specific survivor support groups and sadly, none specific to their needs were available. The development of such parenting groups

would lessen the social isolation of mothers who are survivors while providing knowledge and skills to support women in their mothering journeys.

Mothering can be difficult at the best of times. It is also difficult for health care providers to intervene at this stage given that the assessment and identification of vulnerable children and families are often problematic. It is for this reason that survivors' positive experiences with the health care system must begin early in childbearing, at a stage where trusting relationships can be developed and the principles of continuity of care and caregiver can be maintained. The establishment of trusting, long-term relationships between primary caregivers and women and their families makes it possible to address issues before a point of crisis is reached. The women in this study described feeling vulnerable as mothers, and by extension, these women have vulnerable children. In order to provide support to childhood sexual abuse survivors and their children, it is important to promote healthy family functioning and prevent future crises. The implications for clinical practice presented in this chapter provide beginning steps for health care providers working with mothers who are survivors of childhood sexual abuse. In order to adequately care for others, however, nurses must also care for themselves.

### ***Care for Nurses***

As health care providers confront their own feelings, they may identify with either the survivor or perhaps even the abuser, depending upon their own past experiences. In response to this, both educational and personal directives need to be introduced. The reality of health care providers (self or other) identifying with abuse, supports the need for curricula regarding abuse to be built into educational and personnel services for nursing students and nursing professionals. This would help to foster a climate for

appropriate disclosure and accountability, providing planned avenues for peer or professional support, and support for scheduled breaks for self care during the presentation of the material.

Nurses must also be prepared for the personal feelings that may arise in response to their clients' disclosures. Research in the area of vicarious traumatization asserts that "helpers," such as nurses, may find a long-term alteration in their own cognitive schemas, beliefs, expectations, and assumptions about self, others, and the world at large (McCann & Pearlman, 1990). Clark and Gioro (1998) state that "the insidious nature of indirect trauma can disrupt nurses' mental and emotional well being to such an extent that troubling changes begin to insinuate themselves into their personal lives....One does not have to be in a relationship with survivors to be caught unknowingly in their net of coping strategies" (p. 86). Assisting women who are facing and coping with the effects of childhood sexual abuse requires enormous energy, and it may be additionally difficult for providers who are themselves survivors of sexual abuse to listen to and help other survivors (Heritage, 1998). Therefore, it is critical that health care providers establish their own support systems to assist them with their own difficult emotions.

Vicarious traumatization is defined as the process through which the helper in her experience is negatively transformed through empathic engagement with the client's material (Fischer, 2000). The warning signals may include increasing thoughts of trauma and pain; a diminished sense of safety and trust in the world; a decreasing sense of competency, cynicism, isolation and withdrawal from others; changes in ability to establish and maintain healthy boundaries; feeling numb; changes in eating and sleep patterns; questioning personal values; and difficulty in managing usual stress responses

(Fischer). The potential for such traumatization to occur when nurses listen to survivors' disclosures is considerable. Nurses who are not practicing self care may simply stop listening (Jackson, 1999). The realities of abuse in its various forms need to become part of the curriculum thread, rather than being presented as isolated material. Additionally, an enhanced understanding of nurses' experiences following client disclosures is needed and warrants further investigation.

In summary, creating an environment in which it is safe for all women to discuss their concerns is critical. The women in this study identified respect and sensitivity as the cornerstones of effective support. This study suggests that health professionals must realize that only the woman herself can identify what her needs are and how she can best be supported. By listening to the woman, the health professional can individualize care and foster a supportive and reflective process. Boundaries and boundary violations must be carefully outlined and frequently revisited to create a truly safe environment for the disclosure of traumatic life events. Sensitivity to the woman's level of vulnerability, coupled with an appreciation of her resiliency, may assist health care professionals in caring for childbearing women who are childhood sexual abuse survivors. Developing a practice around principles embedded in a woman-centered approach requires the development of collaborative methods of working with childbearing women, methods that emphasize their abilities rather than their "deficiencies." Understanding strength from the perspective of women survivors can change the way nurses view their clients; helping women to identify their strengths may assist them in realizing their emancipatory potential (Ford-Gilboe & Campbell, 1996; Lather, 1986).

The legacy of childhood sexual abuse may surface in many ways, many of which

have been addressed in this research study. Some women may disclose the abuse but many will not. Some women will not have a conscious memory of the abuse until the time of childbirth, or following birth. As nurses and allied health care providers, we are in an ideal position to become advocates for women survivors of childhood sexual abuse, especially during the childbearing period. Attention to the clinical practice implications identified in this study provide first steps in advocating for survivors who are mothers.

### **Concluding Comments**

The theory proposed here suggests an enhanced understanding of the complexity of the childbearing experience for survivors by considering their social contexts in addition to their trigger points and coping strategies, such as their personal resiliency and external support systems. All of these have been shown to impact survivors' perceived need to protect themselves and/or their children. Participants expressed the desire to find a balance, but this was often difficult to achieve given the lack of support currently available for childhood sexual abuse, particularly in childbirth. The theory generated in this study addresses some of the limitations of extant knowledge by recognizing the importance of contextual factors in women's experiences of childbearing.

Childbirth is an important experience, but it is only one experience embedded in the larger context of a woman's life. The current study represents a first exploratory step towards the integration of our understanding of how a variety of risk and protective factors may operate in the lives of mothers who are survivors of childhood sexual abuse. In this study, I build upon theoretical models of mothering and previous research on parenting outcomes among women sexually abused as children to examine both the potential mediating role of vulnerability and resiliency factors in mothering challenges

and protecting processes within a sample of women survivors of childhood sexual abuse. I found that traumatic experiences in childhood, namely sexual abuse, influenced the childbearing and mothering experiences of women survivors. These findings are consistent with a variety of earlier research studies presented in this dissertation. However, the findings go beyond these studies by underscoring the importance of attending to the various phases of childbirth as well as to the evolving nature of mothering, examining not just the impact of childhood sexual abuse on adulthood, but also the particular stresses experienced during childbearing. The findings of this study also suggest that childhood traumas such as sexual abuse may place some women at higher risk for experiencing adult traumas such as substance abuse, depression, physical illness and domestic violence, which in turn, may also impact mothering. This is consistent with recent research that links childhood trauma to later re-traumatization in adulthood (Banyard, Arnold, & Smith, 2000; Banyard et al., 2001). This study also moves beyond the physical to include the impact of psychological stressors on women's health as impacted by their social-cultural histories. Through the process of "Protecting the Inner Child", women were able to negotiate their childbearing and mothering experiences. The main contribution of this study, however, lies in the questions and issues it raises for future work. Much has been learned but there is still a long way to go.

Despite the horrors and discomforts of thinking about the injustices experienced by women survivors of childhood sexual abuse, we cannot afford to distance ourselves from their experience. Rather, by understanding women's and mothers' experiences of childhood sexual abuse and its interface with childbearing, we can recognize the commonalities shared and gain respect for the specific struggles each of these women has

faced. In recognizing and respecting survivors' courage and strength, it must not be forgotten that there are many women and children who continue to live with abuse and violence. It cannot be stressed enough that survival is possible, but that, as survivors have shared within this study, it is a "long and difficult journey where recovery is not the goal, rather inner peace." However, there is hope. With this research project, I aim to further contribute to this notion of hope. It is my belief that weaving together the patterns in women's experiences of abuse and childbearing supports survivors in developing perspective on their lives, helping them to understand how and why the abuse was not their fault, to recognize the connections between mothering and their abuse histories, to know they are not alone, and to learn more about how it is possible to survive. Some women even discover that they can move past survival and learn to thrive. As one woman in the study explained, "I wish not only to be a survivor, I want to thrive, to be the victor and not the victim...it is my time to be powerful." It is my hope that the women in this study, in addition to all other childhood sexual abuse survivors, discover their own sense of power and inner peace, and experience what it means to be a victor.

## REFERENCES

- Alexander, P. C. (1992). Application of attachment theory to the study of sexual abuse. *Journal of Consulting and Clinical Psychology, 60*, 185-195.
- Alexander, M. J., & Muenzenmaier, K. (1998). Trauma, addiction and recovery: Addressing public health epidemics among women with severe mental illness. In B. Levin, A. Jennings, & A. Blanch, (Eds.), *Women's mental health services: A public health perspective*. Thousand Oaks, CA: Sage Publications.
- Alexander, P. C., Teti, L., & Anderson, C. L. (2000). Childhood sexual abuse history and role reversal in parenting. *Child Abuse and Neglect, 24*, 829-838.
- Alpert, J. L., Brown, L. S., Ceci, S. J., Courtois, C. A., Loftus, E. F., & Ornstein, P. A. (1996). *Final report of the working group on the investigation of memories of childhood abuse*. Washington, DC: American Psychological Association.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4<sup>th</sup> ed.). (DSM-IV). Washington, DC: Author.
- Anderson, J. C., Martin, J. L., Mullen, P.E., Romans, S. E., & Herbison, P. (1993). The prevalence of childhood sexual abuse experiences in a community sample of women. *Journal of the American Academy of Child and Adolescent Psychiatry, 32*, 911-919.
- Anderson, J. M. (1991). Current directions in nursing research: Toward a poststructuralist and feminist epistemology. *The Canadian Journal of Nursing Research, 23* (3), 1-3.
- Arkow, P. (1995). *Breaking the cycles of violence: A practical guide*. Alameda, CA: Latham Foundation.

- Armsworth, M. W., & Stronck, K. (1999). Intergenerational effects of incest on parenting: Skills, abilities and attitudes. *Journal of Counseling and Development, 77*, 303-317.
- Ascione, F. R. (1998). Battered women's reports of their partners and their children's cruelty to animals. *Journal of Emotional Abuse, 1* (1), 119-133.
- Ascione, F. R., & Arkow, P. (1999). *Child abuse, domestic violence, and animal abuse: Linking the circles of compassion for prevention and intervention*. Purdue Research Foundation.
- Ashbury, J. (1996). *Crazy for you: The making of women's madness*. Melbourne, Australia: Oxford University Press.
- Bachmann, G., Moeller, T., & Nenett, J. (1988). Childhood sexual abuse and the consequences in adult women: A review. *Obstetrics & Gynecology, 71* (4), 631-642.
- Bagley, C. (1990). Is the prevalence of child sexual abuse decreasing? Evidence from a random sample of 750 young adult women. *Psychological Reports, 66*, 1037-1038.
- Bagley, C. (1995). *Child sexual abuse and mental health in adolescents and adults*. Aldershot, England: Avebury.
- Bagley, C., Wood, M., & Young, L. (1994). Victim to abuser: Mental health and behavioral sequels of child sexual abuse in a community survey of young adult males. *Child Abuse and Neglect, 18*, 683-697.
- Ball, J. A. (1987). *Reactions to motherhood*. Cambridge: Cambridge University Press.
- Banyard, V. L. (1997). The impact of childhood sexual abuse and family functioning on

- four dimensions of women's later parenting. *Child Abuse and Neglect*, 21 (11), 1095-1107.
- Banyard, V. L., Arnold, S., & Smith, J. (2000). Childhood sexual abuse and dating experiences of undergraduate women. *Child Maltreatment*, 5, 39-48.
- Banyard, V. L., & Graham-Bermann, S. A. (1993). Can women cope? A gender analysis of theories of coping with stress. *Psychology of Women Quarterly*, 17, 303-318.
- Banyard, V. L., Williams, L. M., & Siegel, J. A. (2001). The long-term mental health consequences of child sexual abuse: An exploratory study of the impact of multiple traumas in a sample of women. *Journal of Traumatic Stress*, 14, 697-715.
- Banyard, V. L., Williams, L. M., & Siegel, J. A. (2003). The impact of complex trauma and depression on parenting: An exploration of mediating risk and protective factors. *Child Maltreatment*, 8 (4), 334-349.
- Barnes, J., Leggett, J., & Durham, T. (1993). Breastfeeders versus bottlefeeders: differences in femininity perceptions. *Maternal Child Nursing Journal*, 21 (1), 15-19.
- Bass, E., & Davis, L. (1994). *The courage to heal: A guide for women survivors of child sexual abuse* (3<sup>rd</sup> ed.). New York: Harper & Row.
- Baumrind, D. (1989). Rearing competent children. In W. Damon (Ed.), *Child development today and tomorrow* (pp. 349-378). San Francisco: Jossey-Bass.
- Beck, C. T. (1998). The effects of postpartum depression on child development: A meta-analysis. *Archives of Psychiatric Nursing*, 1, 12-20.
- Beeghly, M., & Cicchetti, D. (1994). Child maltreatment, attachment and the self

system: Emergence of an internal state lexicon in toddlers at high social risk.

*Development and Psychopathology*, 6, 5-30.

- Beitchman, J. H., Zucker, K. J., Hood, J. E., da Costa, G. A., & Akman, D. (1991). A review of the short term effects of child sexual abuse. *Child Abuse and Neglect*, 15, 537-556.
- Benedict, M. I., Paine, L. L., Paine, L. A., Brandt, D., & Stallings, R. (1999). The association of childhood sexual abuse with depressive symptoms during pregnancy, and selected pregnancy outcomes. *Child Abuse and Neglect*, 23 (7), 659-670.
- Bergner, R. M., Delgado, L. K., & Graybill, G. (1994). Finkelhor's risk factor checklist: A cross-validation study. *Child Abuse and Neglect*, 18, 331-340.
- Bergstrom, L., Roberts, J., Skillman, L., & Seidel, J. (1992). "You'll feel me touching you, sweetie": Vaginal examinations during the second stage of labor. *Birth*, 19 (1), 10-20.
- Bergum, V. (1989). *Woman to mother: A transformation*. Granby, MA: Bergin & Garvey Publishers, Inc.
- Berliner, L., & Briere, J. (1999). Trauma, memory, and clinical practice. In L. M. Williams, & V. L. Banyard (Eds.), *Trauma and memory* (pp. 3-18). Thousand Oaks, CA: Sage Publications.
- Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Englewood Cliffs, NJ: Prentice-Hall.
- Boat, B. W. (1995). The relationship between violence to children and violence to animals: An ignored link? *Journal of Interpersonal Violence*, 10, 229-235.

- Bohn, D. (1990). Domestic violence and pregnancy: Implications for practice. *Journal of Nurse-Midwifery, 35* (2), 86-98.
- Bohn, D., & Holz, K. (1996). Sequelae of abuse: Health effects of childhood sexual abuse, domestic battering and rape. *Journal of Nurse-Midwifery, 41* (6), 442-456.
- Bowlby, J. (1951). Maternal care and mental health. *WHO Monograph Series, 2*.  
Geneva: World Health Organization.
- Bowlby, J. (1969). *Attachment and loss* (Vol. 1). Geneva: World Health Organization.
- Bowlby, J. (1984). Violence in the family as a disorder of the attachment and caregiving systems. *American Journal of Psychoanalysis, 44*, 9-27.
- Bowlby, J. (1988). *A secure base: Clinical application of attachment theory*. London: Routledge.
- Brady-Fryer, B. (1994). Becoming the mother of a preterm baby. In P. A. Field, & P. B. Marck (Eds.), *Uncertain motherhood: Negotiating the risks of the childbearing years* (pp. 195-222). Thousand Oaks, CA: Sage Publications.
- Briere, J. (1989). *Therapy for adults molested as children: Beyond survival*. New York: Springer Publishing Co.
- Briere, J., & Runtz, M. (1988). Symptomatology associated with childhood sexual victimization in a non clinical adult sample. *Child Abuse and Neglect, 12*, 51-59.
- Briere, J., & Runtz, M. (1990). Differential adult symptomatology associated with three types of child abuse histories. *Child Abuse and Neglect, 14*, 357-364.
- Brody, S. (1993). The concepts of attachment and bonding. In T. B. Cohen, M. H. Etezady, & B. L. Pacella (Eds.), *The vulnerable child*. Madison, CT: International Universities Press.

- Browne, A., & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the literature. *Psychological Bulletin*, 99, 66-77.
- Buist, A. (1998a). Childhood abuse, postpartum depression and parenting difficulties: A literature review of associations. *Australian and New Zealand Journal of Psychiatry*, 32 (3), 370-378.
- Buist, A. (1998b). Childhood abuse, parenting and postpartum depression. *Australian and New Zealand Journal of Psychiatry*, 32 (4), 479-487.
- Buist, A., & Barnett, B. (1995). Childhood sexual abuse: A risk factor for postpartum depression? *Australian and New Zealand Journal of Psychiatry*, 29, 604-608.
- Buist, A., & Janson, H. (2001). Childhood sexual abuse, parenting and postpartum depression: A 3 year follow-up study. *Child Abuse and Neglect*, 25, 909-921.
- Burian, J. (1995). Helping survivors of sexual abuse through labour. *The American Journal of Maternal Child Nursing*, 20 (5), 252-256.
- Burkett, L. P. (1991). Parenting behaviors of women who were sexually abused as children in their families of origin. *Family Process*, 30, 421-434.
- Campbell, I. E., & Field, P. A. (1989). Common psychological concerns experienced by parents during pregnancy. *Canada's Mental Health*, 37 (1), 2-5.
- Campbell, J.C. (1993). Woman abuse and public policy: Potential for nursing action. *Clinical Issues in Perinatal and Women's Health Nursing: Domestic Violence*, 4 (3), 503-512.
- Campbell, J.C., & Sheridan, D.J. (1989). Emergency interventions with battered women. *Journal of Emergency Nursing*, 15 (1), 12-17.
- Carpenter, D. R. (1995). Grounded theory research approach. In H. J. Steubert & D. R.

- Carpenter (Eds.), *Qualitative research in Nursing* (pp. 145-161). Philadelphia: J. B. Lippincott.
- Cassin, A. (1996). Sexual abuse and motherhood. *Nursing Times*, 92 (15), 38-39.
- Catanzaro, M. (1988). Using qualitative analytical techniques. In N. Woods & M. Catanzaro (Eds.), *Nursing research: Theory and practice* (pp. 437-456). St. Louis, MO: C. V. Mosby.
- Chase, N. D. (1999). *Burdened children: Theory, research, and treatment of parentification*. Thousand Oaks, CA: Sage Publications.
- Chenitz, W. C., & Swanson, J. M. (1986). Qualitative research using grounded theory. In W. C. Chenitz & J. M. Swanson (Eds.), *From practice to grounded theory* (pp. 3-15). Menlo Park, CA: Addison-Wesley.
- Chew, J. (1999). *Women survivors of childhood sexual abuse: Healing through group work, beyond survival*. New York: The Haworth Press.
- Cicchetti, D., & Lynch, M. (1993). Toward an ecological transactional model of community violence and child maltreatment. *Psychiatry*, 56, 96-118.
- Cicchetti, D., & Rogosch, F. A. (1997). The role of self organization in the promotion of resilience in maltreated children. *Development and Psychopathology*, 9 (4), 799-817.
- Cicchetti, D., Rogosch, F. A., Lynch, M., & Holt, K. (1993). Resilience in maltreated children: Processes leading to adaptive outcomes. *Development and Psychopathology*, 5, 629-647.
- Christensen, M. (1992). Birth rape. *Midwifery Today*, 22, 34.
- Clark, M., & Gioro, S. (1998). Nurses, indirect trauma, and prevention. *Image: Journal*

- of Nursing Scholarship*, 30 (1), 85-87.
- Clarke, L. (1998). Perinatal care for survivors of sexual abuse. *Nursing BC*, 16-19.
- Cohen, M. M., Ansara, D., Schei, B., Stuckless, N., & Stewart, D. E. (2004). Posttraumatic stress disorder after pregnancy, labor and delivery. *Journal of Women's Health*, 13 (3), 315-324.
- Cohen, R. L. (1979). Maladaptation to pregnancy. *Seminars in Perinatology*, 3 (1), 15-24.
- Cole, B. V., Scoville, M., & Flynn, L. T. (1996). Psychiatric advance practice nurses collaborate with certified nurse midwives in providing health care for pregnant women with histories of abuse. *Archives of Psychiatric Nursing*, 10 (4), 229-234.
- Cole, P. M., Woolger, C., Power, T. G., & Smith, K. D. (1992). Parenting difficulties among incest survivors of father-daughter incest. *Child Abuse and Neglect*, 16, 239-249.
- Coleman, A. D., & Coleman, L. (1971). *Pregnancy: The psychological experience*. New York: Herder & Herder.
- Colman, L. L., & Colman, A. D. (1991). *Pregnancy: The psychosocial experience*. New York: Farrar, Straus and Giroux.
- Connelly, C., & Straus, M. (1992). Mother's age and risk for physical abuse. *Child Abuse and Neglect*, 16, 709-718.
- Contole, J. (1981). *Coming home*. Knox premature support group newsletter, 3.
- Corbin, J. M. (1987). Women's perceptions and management of a pregnancy complicated by chronic illness. *Health Care for Women International*, 8, 317-337.
- Courtois, C. (1988). *Healing the incest wound: Adult survivors in therapy*. New York:

W.W. Norton Company.

- Courtois, C. (1993). Adult survivors of sexual abuse. *Primary Care, 20*, 433-437.
- Courtois, C. (1997). Healing the incest wound: a treatment update with attention to recovered memory issues. *American Journal of Psychotherapy, 51*, 464-496.
- Courtois, C., & Allman, M. (1992). The imperative for professionals to be knowledgeable about sexual child abuse. *Moving Forward, 6-7*.
- Courtois, C., & Riley, C. (1992). Pregnancy and childbirth as triggers for abuse memories: Implications for care. *Birth, 19* (4), 222-223.
- Creedy, D. K., Shochet, I. M., & Horsfall, J. (2000). Childbirth and the development of acute trauma symptoms: incidence and contributing factors. *Birth, 27*, 104-111.
- Creswell, J. W. (1998). *Qualitative inquiry and research design: choosing among five traditions*. Thousand Oaks, CA: Sage Publications.
- Crowell, N. A., & Burgess, A. W. (1996). *Understanding violence against women*. Committee on Law and Justice, Commission on Behavioral and Social Sciences and Education. National Research Council. Washington, DC: National Academy Press.
- Currie, D. (1988). Re-thinking what we do and how we do it: A study of reproductive decisions. *Canadian Review of Sociology and Anthropology, 25* (2), 231-253.
- Daly, K. (1992). The fit between qualitative research and characteristics of families. In J. Gilgun, K. Daly, & G. Handel (Eds.), *Qualitative methods in family research* (pp. 3-11). Newbury Park, CA: Sage Publications.
- De Beauvoir, S. (1953). *The second sex* (H. M. Parshley, trans.). New York: Knopf. (Original work published 1949).

- Denzin, N. K., & Lincoln, Y. S. (1994). *Handbook of qualitative research*. Thousand Oaks, CA: Sage Publications.
- Desai, H.D., & Jann, M.W. (2000). Major depression in women: a review of the literature. *Journal of American Pharmacy Association, 40* (4), 525-537.
- Dey, I. (1999). *Grounding grounded theory: Guidelines for qualitative inquiry*. London: Academic Press.
- Diachuk, M. G. (1994). When a child has a birth defect. In P. A. Field, & P. B. Marck (Eds.), *Uncertain motherhood: Negotiating the risks of the childbearing years* (pp. 223-267). Thousand Oaks, CA: Sage Publications.
- Dietz, P., Spitz, A., Anda, R., Williamson, D., McMahon, P., Santelli, J., Nordenberg, D., Felitti, V., & Kendrick, J. (1999). Unintended pregnancy among adult women exposed to abuse or household dysfunction during their childhood. *Journal of the American Medical Association, 282* (14), 1359-1364.
- Dijkstra, S. (1995). Two mothers abused as children on raising their children: Making a plea for a differentiated approach. *Child Abuse Review, 4*, 291-297.
- DiLillo, D., & Damashek, A. (2003). Parenting characteristics of women reporting a history of childhood sexual abuse. *Child Maltreatment, 8* (4), 319-333.
- Donaldson, S. K. (1995). Introduction: nursing science for nursing practice. In A. Omery, C. E. Kasper, & Page, G. G. (Eds.), *In search of nursing science*. London: Sage Publications.
- Douglas, A. R. (2000). Reported anxieties concerning intimate parenting in women sexually abused as children. *Child Abuse and Neglect, 24* (3), 425-434.
- Drossman, D. A., Talley, N. J., Leserman, J., Olden, K. W., & Barreiro, M. A. (1995).

- Sexual and physical abuse and gastrointestinal illness. Review and recommendations. *Annals of Internal Medicine*, 123, 782-794.
- Drummond, J., Kysela, G. M., McDonald, L., & Query, B. (2002). The family adaptation model: Examination of dimensions and relations. *Canadian Journal of Nursing Research*, 34 (1), 29-46.
- Dubowitz, J., Hampton, R.L., Bithoney, W.G., & Newberger, E.H. (1987). Inflicted and non inflicted injuries: Differences in child and familial characteristics. *American Journal of Orthopsychiatry*, 57, 525-535.
- Elliott, S. A. (1989). Psychological strategies in the prevention and treatment of postnatal depression. *Clinical Obstetrics and Gynecology*, 3 (4), 879-903.
- Enns, C. Z., McNeilly, C. L., Corkery, J. M., & Gilbert, M. S. (1995). The debate about delayed memories of child sexual abuse: A feminist perspective. *Counseling Psychologist*, 23, 181-279.
- Epstein, J. N., Saunders, B. E., & Kilpatrick, D. G. (1997). Predicting PTSD in women with a history of childhood rape. *Journal of Traumatic Stress*, 10, 573-588.
- Ericksen, J. R., & Henderson, A. D. (1992). Witnessing family violence: the children's experience. *Journal of Advanced Nursing*, 17, 1200-1209.
- Evans, G., Kotch, J., & Ringwalt, C. (1989). *Child abuse and reproductive outcomes*. American Public Health Association, Boston, MA.
- Famularo, R., Fenton, T., Kinscherff, R., Ayoub, C., & Barnum, R. (1994). Maternal and child posttraumatic stress disorder in cases of child maltreatment. *Child Abuse and Neglect*, 18, 27-36.
- Farber, E., Herbert, S., & Riviere, S. (1996). Childhood abuse and suicidality in

- obstetrics patients in a hospital-based urban prenatal clinic. *General Hospital Psychiatry, 18*, 56-60.
- Fergusson, D. M., Horwood, L. J., & Lynskey, M. T. (1996). Childhood sexual abuse and psychiatric disorders in young adulthood: Part Two. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*, 1365-1374.
- Fergusson, D. M., Horwood, L. J., & Lynskey, M. T. (1997). Childhood sexual abuse, adolescent sexual behaviours and sexual revictimization. *Child Abuse and Neglect, 21*, 789-803.
- Fergusson, D. M., Lynskey, M. T., & Horwood, L. J. (1996). Childhood sexual abuse and psychiatric disorders in young adulthood: Part One. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*, 1355-1364.
- Fergusson, D. M., & Mullen, P. E. (1999). *Childhood Sexual Abuse: An evidence based perspective*. Thousand Oaks: Sage Publications.
- Field, P. A., & Morse, J. (1985). *Nursing research: The application of qualitative approaches*. Rockville, MD: Aspen.
- Finkelhor, D. (1993). Epidemiological factors in the clinical identification of child sexual abuse. *Child Abuse and Neglect, 17*, 67-70.
- Finkelhor, D. (1994a). The international epidemiology of child sexual abuse. *Child Abuse and Neglect, 18*, 409-417.
- Finkelhor, D. (1994b). Current information of the scope and nature of child sexual abuse. *Future of Children, 4*, 31-53.
- Finkelhor, D., Hotaling, G., Lewis, I., & Smith, C. (1990). Sexual abuse in a national

- survey of adult men and women: prevalence characteristics and risk factors. *Child Abuse and Neglect*, 14, 19-28.
- Finkelhor, D., & Baron, L. (1986). High risk children. In D. Finkelhor (Ed.), *A sourcebook on child sexual abuse* (pp. 60-88). Beverly Hills, CA: Sage Publications.
- Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: a conceptualization. *American Journal of Orthopsychiatry*, 55, 530-541.
- Firsten, T. (1991). Violence in the lives of women on Psychiatric wards. *Canadian Women Studies*, 11 (4), 45-48.
- Fiscella, K., Kitzman, H. J., Cole, R.E., Sidora, K. J., & Olds, D. (1998). Does child abuse predict adolescent pregnancy? *Pediatrics*, 101, 620-624.
- Fischer, L. B. (2000). *Vicarious traumatization: The effects of working with survivors of Violence* (unpublished paper). Ending Violence Against Women Conference. Vancouver, BC.
- Fisher, P. (1998, Winter). Women and mental health issues: The role of trauma. *Visions: British Columbia's Mental Health Journal-Special Edition on Women's Mental Health*, 3, 7.
- Fleisher, W. (1994). Recognition and treatment of sexual abuse. *Medicine North America*, 17 (7), 459-462.
- Fleming, J., Mullen, P. E., & Bammer, G. (1997). A study of potential risk factors for sexual abuse in childhood. *Child Abuse and Neglect*, 21, 49-58.
- Follette, V. M., Polusny, M. A., & Bechtle, A. E. (1996). Cumulative trauma: the impact

- of child sexual abuse, adult sexual assault, and spouse abuse. *Journal of Traumatic Stress, 9*, 25-35.
- Fonagy, P., & Target, M. (1997). Attachment and reflective function: Their role in self organization. *Developmental Psychopathology, 9*, 679-700.
- Fonagy, P., Steele, H., & Steele, M. (1991). Maternal representations of attachment during pregnancy predict the organization of infant-mother attachment at one year of age. *Child Development, 62*, 891-905.
- Fonagy, P., Steele, M., Steele, H., Higgit, A., & Target, M. (1994). The theory and practice of resilience. *Journal of Child Psychology and Psychiatry, 35* (2), 231-257.
- Ford-Gilboe, M., & Campbell, J. (1996). The mother-headed single-parent family: A feminist critique of the nursing literature. *Nursing Outlook, 44*, 173-183.
- Friedrich, W., Beilke, R., & Urquiza, A. (1987). Children from sexually abusive families: A behavioral comparison. *Journal of Interpersonal Violence, 2*, 391-402.
- Garnezy, N. (1990). A closing note: Reflections on the future. In J. Rolf, A. Masten, D. Cicchetti, K. Nuechterlein, & S. Weintraub (Eds.), *Risk and protective factors in the development of psychopathology* (pp. 527-534). New York: Cambridge University Press.
- Garnezy, N. (1991). Resilience in children's adaptation to negative life events and stressed environments. *Pediatrics, 20*, 459-466.
- Gasker, J. A. (1999). "I never told anyone this before": *Managing the initial disclosure*

- of sexual abuse re-collections*. New York: The Haworth Maltreatment and Trauma Press.
- Geffner, R. (1992). Current issues and future directions in child sexual abuse. *Journal of Child Sexual Abuse, 1* (1), 1-13.
- Gibbons, J. (1996). Services for adults who have experienced child sexual assault: Improving agency response. *Social Sciences and Medicine, 43*, 1755-1763.
- Glaser, B. (1978). *Advances in the methodology of grounded theory: Theoretical sensitivity*. Mill Valley, CA: Sociology Press.
- Glaser, B. (1992). *Basics of grounded theory analysis*. Mill Valley, CA: Sociology Press.
- Glaser, B., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago, IL: Aldine Publishers.
- Goldberg, J., & Taylor, P. (1988). *Premature infants: Their continuing care at home*. Melbourne, Australia: Longman Cheshire.
- Gorey, K. M., & Leslie, D. R. (1997). The prevalence of child sexual abuse: Integrative review adjustment for potential response and measurement biases. *Child Abuse and Neglect, 21*, 391-398.
- Grabowska, C. (2003). Unhappiness after childbirth. In C. Squire (Ed.), *The social context of birth* (pp. 233-245). Oxford: Radcliffe Medical Press, Ltd.
- Grant, L. J. (1992). Effects of childhood sexual abuse: Issues for obstetric caregivers. *Birth, 19* (4), 220-221.
- Greaves, L., Varcoe, C., Poole, N., Morrow, M., Johnson, J., Pederson, A., & Irwin, L. (2002). A motherhood issue: Discourses on mothering under duress. *Policy Research: Status of Women Canada*. Ottawa, ON: National Library of Canada.

- Green, A. H. (1988). Child maltreatment and its victims. *Pediatric Clinics of North America, 11*, 591-610.
- Green, A. H. (1993). Child sexual abuse: Immediate and long term effects and intervention. *Journal of the American Academy of Child and Adolescent Psychiatry, 32*, 890-902.
- Green, J. M., Coupland, V.A., & Kitzinger, J. V. (1988). Great expectations: a prospective study of women's expectations and experiences of childbirth. *Childcare and Development Group*, Cambridge: University of Cambridge.
- Greenwald, E., & Leitenberg, H. (1990). Post traumatic stress disorder in a nonclinical and nonstudent sample of adult women sexually abused as children. *Journal of Interpersonal Violence, 5*, 217-228.
- Grimstad, H., & Schei, B. (1999). Pregnancy and delivery for women with a history of child sexual abuse. *Child Abuse and Neglect, 23* (1), 81-90.
- Grych, J. H., Jouriles, E. N., Swank, P. R., McDonald, R., & Norwood, W. D. (2000). Patterns of adjustment among children of battered women. *Journal of Consulting and Clinical Psychology, 68*, 84-94.
- Guba, E. G., & Lincoln, Y. S. (1981). *Effective evaluation*. San Francisco, CA: Jossey-Bass.
- Hall, J. M., & Stevens, P. E.. (1991). Rigor in feminist research. *Advances in Nursing Science, 13* (3), 16-29.
- Hall, L., Sachs, B., Rayens, M., & Lutenbacher, M. (1993). Childhood physical and sexual abuse: their relationship with depressive symptoms in adulthood. *IMAGE: Journal of Nursing Scholarship, 25* (4), 317-323.

- Hall, W. A., & Callery, P. (2001). Enhancing the rigor of grounded theory: incorporating reflexivity and relationality. *Qualitative Health Research, 11* (2), 257-272.
- Haugaard, J. J., & Emery, R. E. (1989). Methodological issues in child sexual abuse research. *Child Abuse and Neglect, 13*, 89-100.
- Health Canada. (1999). *A handbook for health and social service professionals responding to abuse during pregnancy*. Ottawa, ON: Author.
- Health Canada. (2001). *Canadian incidence study of reported child abuse and neglect—Final report*. Ottawa, ON: Author.
- Hedin, L. W. (2000). Physical and sexual abuse against women and children. *Current Opinions in Obstetrics and Gynecology, 12* (5), 349-355.
- Heise, L. L. (1994a). Gender-based abuse: The global epidemic. In A.J. Dan (Ed.). *Reframing women's health: Multidisciplinary research and practice* (pp. 233-250). Thousand Oaks, CA: Sage Publications.
- Heise, L. L. (1994b). Gender-based violence and women's reproductive health. *International Journal of Gynecology and Obstetrics, 46*, 221-229.
- Heritage, C. (1998). Working with childhood sexual abuse survivors during pregnancy, labor, and birth. *Journal of Obstetrics, Gynecology and Neonatal Nursing, 27* (6), 671-677.
- Herman, J. L. (1992). *Trauma and Recovery*. New York: Basic Books.
- Herman, J., Russell, D., & Trocki, K. (1986). Long-term effects of incestuous abuse in childhood. *American Journal of Psychiatry, 143*, 1293-1296.
- Himelein, M. J., & McElrath, J. V. (1996). Resilient child sexual abuse survivors:

- Cognitive coping and illusion. *Child Abuse and Neglect*, 20, 747-758.
- Holz, K. A. (1994). A practical approach to clients who are survivors of childhood sexual abuse. *Journal of Nurse Midwifery*, 39 (1), 13-18.
- Horan, D., Hill, L., & Schulkin, J. (2000). Childhood sexual abuse and preterm labor in adulthood: An endocrinological hypothesis. *Women's Health Issues*, 10 (1), 27-33.
- Howarth, A. (1995, June 5). Child sexual abuse, labour and delivery. *Modern Midwife*, 6, 20-22.
- Hunt, S., & Symonds, A. (1995). *The social meaning of midwifery*. Basingstoke, England: Macmillan.
- Jackson, C. (1999). Carrying more than a baby: Women survivors of child abuse and child bearing. In L. Heber, & George, T. (Eds.), *International perspectives in women, health & culture: A world-wide anthology*. London: Quay Books.
- Jacobs, J. L. (1992). Child sexual abuse victimization and later sequelae during pregnancy and childbirth. *Journal of Child Sexual Abuse*, 1 (1).
- Janssen, P., Holt, V., & Sugg, N. (2002). Introducing domestic violence assessment in a postpartum setting. *Maternal and Child Health Journal*, 6 (3), 195-203.
- Johnson, B. K., & Kenkel, M. B. (1991). Stress, coping and adjustment in female adolescent incest victims. *Child Abuse and Neglect*, 15, 293-305.
- Jorgensen, S. & Maloney, L. (1999). Animal abuse and the victims of domestic violence. In F. Ascione & P. Arkow (Eds.), *Child abuse, domestic violence, and animal abuse: Linking the circles of compassion for prevention and intervention*. Purdue Research Foundation.

- Josephs, L. (1996). Women and trauma: a contemporary psychodynamic approach to traumatization for patients in the Ob/Gyn psychological consultation clinic. *Journal of Pspychosomatic Obstetrics and Gynecology, 15*, 133-139.
- Jouriles, E. N., Norwood, W. D., McDonald, R., Vincent, J. P., & Mahoney, A. (1996). Physical violence and other forms of maternal aggression: Links with children's behavior problems. *Journal of Family Psychology, 10*, 223-234.
- Jumper, S. A. (1995). A meta-analysis of the relationship of child sexual abuse to adult psychological adjustment. *Child Abuse and Neglect, 19*, 715-728.
- Kaufman, J., & Zigler, E. (1987). Do abused children become abusive parents? *American Journal of Orthopsychiatry, 57*, 186-192.
- Kelly, L. (1988). *Surviving sexual violence*. Minneapolis, MN: University of Minnesota Press.
- Kendall-Tackett, K. (1998). Breastfeeding and the sexual abuse survivor. *Journal of Human Lactation, 14* (2), 125-132.
- Kendall-Tackett, K., Williams, L. M., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin, 113* (1), 164-180.
- King, M. (1993). Changing women's lives: The primary prevention of violence against women. *Clinical Issues in Perinatal and Women's Health Nursing: Domestic Violence, 4*, 449-457.
- King, M., & Ryan, J. (1989). Abused women: dispelling myths and encouraging intervention. *Nurse Practitioner, 14* (5), 47-58.
- King, M., & Ryan, J. (1996). Woman abuse: The role of nurse midwives in assessment.

*Journal of Nurse-Midwifery*, 41 (6), 436-441.

King, M., Torres, S., Campbell, D., Ryan, J., Sheridan, D., Ulrich, Y., & McKenna, L.

(1993). Violence and abuse of women: A perinatal health care issue. *AWHONN:*

*Clinical Issues*, 4 (2), 163-172.

Kirkengen, A. L., Schei, B., & Steine, S. (1993). Indicators of childhood sexual abuse in gynecological patients in a general practice. *Scandinavian Journal of Primary*

*Health Care*, 11, 276-280.

Kinzl, J. F., Traweger, C., & Biefl, W. (1995). Sexual dysfunctions: Relationship to childhood sexual abuse and early family experiences in a non clinical sample.

*Child Abuse and Neglect*, 19, 785-792.

Kitzinger, J. V. (1990). Recalling the pain. *Nursing Times*, 86 (3), 38-40.

Kitzinger, J. V. (1992). Counteracting, not reenacting, the violation of women's bodies:

The challenge for perinatal caregivers. *Birth*, 19 (4), 219-220.

Klaus, M. H., & Kennell, J. H. (1976). *Maternal infant bonding*. St. Louis, MO: C. V. Mosby.

Kolko, D. J., Seelye, J., & Brown, E. J. (1999). The treatment histories and service involvement of physically and sexually abusive families: Description,

correspondence, and clinical correlates. *Child Abuse and Neglect*, 23, 459-476.

Koverola, C., Foy, D., Heger, A., & Lytle, C. (1990). Post traumatic stress disorder as a sequelae of child sexual abuse. *Psychological Bulletin*, 113 (1), 164-180.

Kruger, R. A. (1995). The future of focus groups. *Qualitative Health Research*, 5 (4), 523-530.

Langeland, W., & Harters, C. (1998). Child sexual and physical abuse and alcoholism:

- A review. *Journal of Studies of Alcohol*, 59, 336-348.
- Lather, P. A. (1986). Research as praxis. *Harvard Educational Review*, 56 (3), 257-277.
- Lather, P. A. (1986). Issues of validity in openly ideological research: between a rock and a soft place. *Interchange*, 17 (4), 63-84.
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer Publishing Co..
- Lesser, J., & Koniak-Griffin, D. (2000). The impact of physical or sexual abuse on chronic depression in adolescent mothers. *Journal of Pediatric Nursing*, 15 (6), 378-387.
- Levendosky, A. A., & Graham-Bermann, S. A. (1998). The moderating effects of parenting stress on children's adjustment in women-abusing families. *Journal of Interpersonal Violence*, 13, 383-397.
- Lever-Hense, A. (1989). *Livebirth following stillbirth: Maternal processes*. Unpublished master's thesis, University of Alberta, Edmonton.
- Lever-Hense, A. (1994). Livebirth following stillbirth. In P. A. Field, & P. B. Marck (Eds.), *Uncertain motherhood: Negotiating the risks of the childbearing years*, (pp. 163-194). Thousand Oaks, CA: Sage Publications.
- Lindsay, D. S., & Read, J. D. (1994). Psychotherapy and memories of childhood sexual abuse: A cognitive perspective. *Journal of Applied Cognitive Psychology*, 8, 281-338.
- Lipp, D. (1992). Mothering after incest. *Mothering, Spring*, 63, 114-120.
- Loftus, E. F. (1994). The repressed memory controversy. *American Psychologist*, 49, 443-445.

- Long, P. J., & Jackson, J. L. (1993). Childhood coping strategies and the adult adjustment of female sexual abuse victims. *Journal of Child Sexual Abuse, 2* (2), 23-39.
- Loveland Cook, C. A., Flick, L. H., Homan, S. M., Campbell, C., McSweeney, M., & Gallagher, M. E. (2004). Posttraumatic stress disorder in pregnancy: Prevalence, risk factors, and treatment. *American College of Obstetricians and Gynecologists, 103* (4), 710-717.
- Lowe, C. (1992). Childhood sexual abuse and birthing women. *Midwifery Today, 22*, 35-36.
- Luther, S. S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development, 71* (3), 543-562.
- Lyons, S. (1998). Posttraumatic stress disorder following childbirth: causes, prevention and treatment. In S. Clement, & L. Page (Eds.), *Psychological perspectives on pregnancy and childbirth* (pp. 123-143). Edinburgh, Scotland: Harcourt Brace & Company Ltd.
- MacArthur, B., & Dezoete, A. (1992). *Early beginnings: Development in children born preterm*. Auckland: OUP.
- Maker, A. H., & Bутtenheim, M. (2000). Parenting difficulties in sexual abuse survivors: A theoretical framework with dual psychodynamic and cognitive behavioural strategies for intervention. *Psychotherapy, 37*, 159-170.
- Maltz, W. (2001). *The sexual healing journey*. New York: HarperCollins Publishers.
- Mannarino, A. P., Cohen, J. A., & Gregor, M. (1989). Emotional and behavioral difficulties in sexually abused girls. *Journal of Family Violence, 4*, 437-451.

- Marck, P. B. (1994). Unexpected pregnancy: The uncharted land of women's experience. In P. A. Field, & P. B. Marck (Eds.), *Uncertain motherhood: Negotiating the risks of the childbearing years*, (pp. 82-138). Thousand Oaks, CA: Sage Publications.
- Marck, P. B., Field, P. A., & Bergum, V. (1994). A search for understanding. In P. A. Field, & P. B. Marck (Eds.), *Uncertain motherhood: Negotiating the risks of the childbearing years*, (pp. 268-298). Thousand Oaks, CA: Sage Publications.
- Martin, M. J., & Walters, J. (1982). Familial correlates of selected types of child abuse and neglect. *Journal of Marriage and the Family*, *44*, 267-276.
- Martins, C., & Gaffan, E. A. (2000). Effects of early postnatal depression on patterns of infant-mother attachment: a meta-analytic investigation. *Journal of Child Psychology and Psychiatry*, *45*, 737-746.
- Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist*, *56* (3), 227-238.
- Masten, A. S., Hubbard, J. J., Gest, S. D., Tellegen, A., Garmezy, N., & Ramirez, M. (1999). Competence in the context of adversity: Pathways to resilience and maladaptation from childhood to late adolescence. *Development and Psychopathology*, *11*, 143-169.
- Matsakis, A. (1992). *I can't get over it: A handbook for trauma survivors*. Oakland, CA: New Harbinger Publications.
- Mawby, R. I., & Walklate, S. (1994). *Critical Victimology*. London: Sage Publications.
- May, K. A. (1991). Interview techniques in qualitative research: Concerns and

- challenges. In J.M. Morse (Ed.), *Qualitative nursing research: A contemporary dialogue* (pp. 188-201). Newbury Park, CA: Sage Publications.
- May, K. A. (1994). Abstract knowing: The case for magic in method. In J. M. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 10-21). Newbury Park, CA: Sage Publications.
- McCain, G. C., & Deatrick, J. A. (1994). The experience of high risk pregnancy. *Journal of Gynecological and Neonatal Nursing*, 23 (5), 421-427.
- McCann, L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3 (1), 131-145.
- McClelland, L., Mynors-Wallis, L., Fahy, T., & Treasure, J. (1991). Sexual abuse, disordered personality, and eating disorders. *British Journal of Psychiatry*, 158 (10), 63-68.
- McCloskey, L. A., & Bailey, J. A. (2000). The intergenerational transmission of risk for child sexual abuse. *Journal of Interpersonal Violence*, 15, 1019-1035.
- McCormick, M., Brooks-Gunn, J., Shorter, T., Holmes, J., Wallace, C., & Heagarty, M. (1990). Factors associated with smoking in low income pregnant women: Relationship to birth weight, stressful life events, social support, health behaviors, and mental distress. *Journal of Clinical Epidemiology*, 43, 441-448.
- McCourt, C. (2003). Social support and childbirth. In C. Squire (Ed.), *The social context of birth* (pp. 187-209). Thames Valley University, England: Radcliffe Medical Press.
- McDevitt, S. (1996). The impact of news media on child abuse reporting. *Child Abuse*

*and Neglect, 20, 261-274.*

- McFarlane, J., & Gondolf, E. (1998). Preventing abuse during pregnancy: A clinical protocol. *Maternal Child Nursing, 23, 22-26.*
- McFarlane, J., Parker, B., Soeken, K., Silva, C., & Reel, S. (1997). Safety behaviors of abused women after an intervention during pregnancy. *Journal of Obstetrics, Gynecological and Neonatal Nursing, 27 (1), 64-69.*
- McGeary, K. (1991). *The process of connecting: The mother child relationship in a high risk pregnancy.* Unpublished master's thesis, University of Alberta, Edmonton.
- McGeary, K. (1994). The influence of guarding on the developing mother-unborn child relationship. In P. A. Field, & P. B. Marck (Eds.), *Uncertain motherhood: Negotiating the risks of the childbearing years* (pp. 139-162). Thousand Oaks, CA: Sage Publications.
- McNulty, C., & Wardle, J. (1994). Adult disclosure of sexual abuse: A primary cause of psychological distress? *Child Abuse and Neglect, 18, 549-555.*
- Mead, G. (1934). *Mind, self, and society.* Chicago, IL: University of Chicago Press.
- Mercer, R. T. (1986). *First time motherhood: experiences from teens to forties.* New York: Springer Publishing Co.
- Mercer, R. T. (1990). *Parents at risk.* New York: Springer Publishing Co..
- Merry, S. N., & Andrews, L. K. (1989). Doing research in the real world—A case history and some implications for medical research. *New Zealand Medical Journal, 102, 351-353.*
- Miller, L. J. (2001). Psychiatric disorders during pregnancy. In N. L. Stotland, & D. E.

- Stewart (Eds.), *Psychological aspects of women's health care: The interface between psychiatry and obstetrics and gynecology* (pp. 51-66). Washington, DC: American Psychiatric Press, Inc.
- Moeller, T., Bachmann, G., & Moeller, J. (1993). The combined effects of physical, sexual, and emotional abuse during childhood: Long-term health consequences for women. *Child Abuse and Neglect, 17*, 623-640.
- Morgan, D. L. (1995). Why things (sometimes) go wrong in focus groups. *Qualitative Health Research, 5* (4), 516-523.
- Morrow, S. L., & Smith, M. L. (1995). Constructions of survival and coping by women who have survived childhood sexual abuse. *Journal of Counseling Psychology, 42* (1), 24-33.
- Morse, J. M. (1991). Strategies for sampling. In J.M. Morse (Ed.), *Qualitative nursing research: A contemporary dialogue* (pp. 127-145). Newbury Park, CA: Sage Publications.
- Moyer, D., DiPietro, L., Berkowitz, R., & Stunkard, A. (1997). Childhood sexual abuse and precursors of binge eating in and adolescent female population. *International Journal of Eating Disorders, 21* (1), 23-30.
- Muenzenmaier, K., Meyer, I., Streuning, E., & Ferber, J. (1993). Childhood abuse and neglect among women outpatients with chronic mental illness. *Hospital and Community Psychiatry, 44*, 666-670.
- Mullen, P. E., Martin, J. L., Anderson, J. C., Romans, S. E., & Herbison, G. P. (1993). Childhood sexual abuse and mental health in adult life. *British Journal of Psychiatry, 163*, 721-732.

- Mullen, P. E., Martin, J. L., Anderson, J. C., Romans, S. E., & Herbison, G. P. (1994). The effects of child sexual abuse on social, interpersonal, and sexual function in adult life. *British Journal of Psychiatry, 165*, 35-47.
- Mullen, P. E., Martin, J. L., Anderson, J. C., Romans, S. E., & Herbison, G. P. (1996). The long-term impact of the physical, emotional, and sexual abuse of children: A community study. *Child Abuse and Neglect, 20*, 7-21.
- Muller, R. T., Hunter, J. E., & Stollak, G. (1995). The intergenerational transmission of corporal punishment: A comparison of social learning and temperament models. *Child Abuse and Neglect, 19*, 1323-1335.
- Murray, L. (1992). The impact of postnatal depression on infant development. *Journal of Child Psychology and Psychiatry, 33*, 543-561.
- Nelson, S. (2003). Women and sex. In C. Squire (Ed.), *The social context of birth* (pp. 21-36). Thames Valley University, England: Radcliffe Medical Press.
- Noll, J. G., Trickett, P. K., & Putnam, F. W. (2003). A prospective investigation of the impact of childhood sexual abuse on the development of sexuality. *Journal of Consulting and Clinical Psychology, 71* (3), 575-586.
- Notman, M. T., & Nadelson, C. C. (2002). Reproductive choices and development: Psychodynamic and psychoanalytic perspective. In N. L. Stotland, & D. E. Steward (Eds.), *Psychological aspects of women's health care: The interface between psychiatry and obstetrics and gynecology* (pp. 365-378). Washington, DC: American Psychiatric Press, Inc.
- O'Campo, P., Gielen, A. C., Faden, R. R., & Kass, N. (1994). Verbal abuse and physical

- violence among a cohort of low income pregnant women. *Women's Health Institute, 4*, 29-37.
- Oakley, A. (1981). Interviewing women: A contradiction in terms. In H. Roberts (Ed.), *Doing feminist research* (pp. 30-61). Boston, MA: Routledge & Kegan Paul.
- Oakley, A. (1992a). *Social support and motherhood: The natural history of a research project*. Oxford.: Blackwell.
- Oakley, A. (1992b). Measuring the effectiveness of psychosocial interventions in pregnancy. *International Journal of Technology Assessment in Health Care, 8* (1), 129-138.
- Oates, R. K., O'Toole, B. I., Lynch, D. L., Stern, A., & Cooney, G. (1994). Stability and change in outcomes for sexually abused children. *Journal of the American Academy of Child and Adolescent Psychiatry, 33*, 945-953.
- Oates, R. K., Tebbutt, J., Swanston, H., Lynch, D. L., & O'Toole, B. I. (1998). Prior childhood sexual abuse in mothers of sexually abused children. *Child Abuse and Neglect, 22*, 1113-1118.
- Olafson, E., Corwin, D.L., & Summit, R. C. (1993). Modern history of child sexual abuse awareness: Cycles of discovery and suppression. *Child Abuse and Neglect, 17*, 7-24.
- Parker, B., & McFarlane, J. (1991). Identifying and helping battered pregnant women. *Maternal Child Nursing, 16*, 161-164.
- Parratt, J. (1994). The experience of childbirth for survivors of incest. *Midwifery, 10*, 26-39.
- Parsons, L. H., Zaccaro, D., Wells, B., & Stovall, T. G. (1995). Methods of and attitudes

toward screening obstetrics and gynecology patients for domestic violence.

*American Journal of Obstetrics and Gynecology*, 173 (2), 381-387.

Patai, D. (1991). U. S. academics and third world women: Is ethical research possible? In

S. B. Gluck, & D. Patai (Eds.), *Women's words: The feminist practice of oral*

*history* (pp. 137-154). New York: Routledge.

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). London:

Sage Publications.

Peluso, E., & Putnam, N. (1996). Case study: Sexual abuse of boys by females. *Journal*

*of the American Academy of Child and Adolescent Psychiatry*, 35, 51-54.

Penticuff, J. H. (1982). Psychological implications in high-risk pregnancy. *Nursing*

*Clinics of North America*, 17 (1), 69-78.

Peterson, G. (1993). Unlocking the door to healing. *Midwifery Today*, 28, 25-27.

Petterson, S. M., & Albers, A. B. (2001). Effects of poverty and maternal depression on

early child development. *Child Development*, 72, 1794-1813.

Philipp, D. A., & Carr, M. L. (2001). Normally and medically complicated pregnancies.

In N. L. Stotland, & D. E. Stewart (Eds.), *Psychological aspects of women's*

*health care: The interface between psychiatry and obstetrics and gynecology* (pp.

1-50). Washington, DC: American Psychiatric Press, Inc.

Piechnik, S. L., & Corbett, M. A. (1985). Reducing low birth weight among

socioeconomically high risk adolescent pregnancies. *Journal of Nurse-Midwifery*,

30 (2), 88-97.

Polk, L. V. (1997). Toward a middle range theory of resilience. *Advances in Nursing*

*Science*, 19 (3), 1-13.

- Prentice, J. C., Lu, M. C., Lange, L., & Halfon, N. (2002). The association between reported childhood sexual abuse and breastfeeding initiation. *Journal of Human Lactation, 18* (3), 219-225.
- Raphael-Leff, J. (1982). Psychotherapeutic needs of mothers-to-be. *Journal of Child Psychotherapy, 8*, 3-12.
- Raphael-Leff, J. (1991). *Psychological processes of childbearing*. London: Chapman & Hall.
- Reay, D. (1996a). Insider perspectives or stealing the words out of women's mouths: Interpretation in the research process. *Feminist Review, 53*, 57-73.
- Reay, D. (1996b). Dealing with difficult differences: Reflexivity and social class in feminist research. *Feminism and Psychology, 6* (3), 443-456.
- Reynolds, J. L. (1997). Post-traumatic stress disorder after childbirth: The phenomenon of traumatic birth. *Canadian Medical Association Journal, 156*, 831.
- Rhodes, N., & Hutchinson, S. (1994). Labor experiences of childhood sexual abuse survivors. *Birth, 21* (4), 213-220.
- Rich, A. (1976). *Of woman born. Motherhood as experience and institution*. New York: W. W. Norton.
- Rickert, V., Edwards, S., Harrykisson, S. D., & Wiemann, C. M. (2001). Violence in the lives of young women: clinical care and management. *Current Women's Health Report, 1* (2), 94-101.
- Roberts, R., O'Connor, T., Dunn, J., & Golding, J. (2004). The effects of child sexual abuse in later family life; mental health, parenting and adjustment of offspring. *Child Abuse and Neglect, 28* (5), 525-545.

- Robinson, J. L. (2000). Are there implications for prevention research from studies of resilience? *Child Development, 71* (3), 570-572.
- Robinson, G. E., & Stewart, D. E. (2001). Postpartum disorders. In N. L. Stotland, & D. E. Stewart (Eds.), *Psychological aspects of women's health care: The interface between psychiatry and obstetrics and gynecology* (pp. 117-139). Washington, DC: American Psychiatric Press, Inc.
- Roche, D. N., Runtz, M. G., & Hunter, M. A. (1999). Adult attachment: A mediator between child sexual abuse and later psychological adjustment. *Journal of Interpersonal Violence, 14*, 187-207.
- Rodgers, B. L., & Cowles, K. V. (1993). The qualitative research audit trail: A complex collection of documentation. *Research in Nursing & Health, 16*, 219-226.
- Rogers, K. (1994). Wife assault: The findings of a national survey. *Juristat: Service Bulletin, Canadian Center for Justice Statistics, 14* (9), 1-22.
- Romans, S. E., Martin, J. L., Anderson, J. C., O'Shea, M. L., & Mullen, P. F. (1995). Factors that mediate between childhood sexual abuse and adult psychological outcome. *Psychological Medicine, 25*, 127-142.
- Root, M., & Fallon, P. (1988). The incidence of victimization experiences in a bulimic sample. *Journal of Interpersonal Violence, 3*, 161-173.
- Rose, A. (1992). Effects of childhood sexual abuse on childbirth: One woman's story. *Birth, 19* (4), 214-218.
- Rosenthal, C. J., Marshall, V. W., MacPherson, A. S., & French, S. E. (1980). *Nurses, patients, and families*. London: Croom Helm.

- Roussillon, J. A. (1998). Adult survivors of childhood sexual abuse: suggestions for perinatal caregivers. *Clinical Excellence Nurse Practitioners*, 2 (6), 329-337.
- Rowan, C. (2003). Maternal infant attachment. In C. Squire (Ed.), *The social context of birth* (pp. 153-171). Thames Valley University, England: Radcliffe Medical Press.
- Rubin, R. (1970). Cognitive style in pregnancy. *American Journal of Nursing*, 70 (3), 502-508.
- Rubin, R. (1975). Maternal tasks in pregnancy. *Maternal Child Nursing*, 4 (3), 143-153.
- Rubin, R. (1976). Maternal tasks in pregnancy. *Journal of Advanced Nursing*, 1, 367-376.
- Rubin, R. (1977). Binding-in in the postpartum period. *Maternal Child Nursing*, 6 (2), 67-75.
- Rubin, R. (1984). Maternal identity, maternal tasks. In R. Rubin (Ed.), *Maternal identity and the maternal experience* (pp. 38-69). New York: Springer Publishing Co..
- Runyon, M. K., Deblinger, E., Ryan, E. E., & Thakkar-Kolar, R. (2004). An overview of child physical abuse: Developing an integrated parent-child cognitive-behavioral treatment approach. *Trauma, Violence, & Abuse*, 5 (1), 65-85.
- Ruscio, A. M. (2001). Predicting the childrearing practices of mothers sexually abused in childhood. *Child Abuse and Neglect*, 25, 369-387.
- Russell, D. E. H. (1983). The incidence and prevalence of intrafamilial and extrafamilial sexual abuse of female children. *Child Abuse and Neglect*, 7, 133-146.
- Russell, D. E. H. (1986). *The secret trauma: Incest in the lives of girls and women*.

New York: Basic Books.

- Rutter, M. (1990). Psychosocial resilience and protective mechanisms. In J. Rolf, A. S. Masten, D. Cicchetti, K. H. Nuechterlein, & S. Weintraub (Eds.), *Risk and protective factors in the development of psychopathology* (pp.181-214). New York: Cambridge University Press.
- Rutter, M. (1993). Resilience: Some conceptual considerations. *Journal of Adolescent Health, 14*, 626-631.
- Rutter, M. (1995). Clinical implications of attachment concepts: Retrospect and prospect. *Journal of Child Psychology and Psychiatry, 36*, 549-571.
- Sampsel, C. M., Petersen, B. A., Murtland, T. L., & Oakley, D. J. (1992). Prevalence of abuse among pregnant women choosing certified nurse-midwife or physician providers. *Journal of Nurse-Midwifery, 37*, 269-273.
- Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science, 8* (3), 27-37.
- Sandelowski, M., Davis, D. H., & Harris, B. G. (1989). Artful design: Writing proposals for research in the naturalistic paradigm. *Research in Nursing and Health, 12*, 77-84.
- Schutz, S. (1994). Exploring the benefits of a subjective approach in qualitative nursing research. *Journal of Advanced Nursing, 20*, 412-417.
- Scott, D. (1992). Childhood sexual abuse: Impact on a community's mental health status. *Child Abuse and Neglect, 16*, 285-295.
- Scott, D. (1995). The social construction of child sexual abuse: Debates about

- definitions and the politics of prevalence. *Psychiatry, Psychology, and Law*, 2, 117-126.
- Seifer, R., & Dickstein, S. (1993). Parental mental illness and infant development. In C. H. Zeanah (Ed.), *Handbook of infant mental health* (pp. 120-142). New York: The Guilford Press.
- Seng, J. (2002). A conceptual framework for research on lifetime violence, posttraumatic stress, and childbearing. *Journal of Midwifery & Women's Health*, 47 (5), 337-346.
- Seng, J., & Hassinger, J. (1998). Relationship strategies and interdisciplinary collaboration: Improving maternity care with survivors of childhood sexual abuse. *Journal of Nurse Midwifery*, 43 (4), 287-295.
- Seng, J., Low, L., Sparbel, K., & Killion, C. (2004). Abuse related post traumatic stress during the childbearing year: issues and innovations in nursing practice. *Journal of Advanced Nursing*, 46 (6), 604-613.
- Seng, J., Oakely, D., Sampsel, C., Killion, C., Graham-Bermann, S., & Liberzon, I. (2001). Post traumatic stress disorder and pregnancy complications. *Obstetrics and Gynecology*, 97 (1), 17-22.
- Seng, J., & Petersen, B. A. (1995). Incorporating routine screening for history of childhood sexual abuse into well-woman and maternity care. *Journal of Nurse Midwifery*, 40 (1), 26-30.
- Seng, J., Sparbel, K., Low, L., & Killion, C. (2002). Abuse related post traumatic stress and desired maternity care practices: Women's perspectives. *Journal of Midwifery and Women's Health*, 47 (5), 360-370.

- Shobe, K. K., & Kihlstrom, J. F. (1997). Is traumatic memory special? *Current Directions in Psychological Science, 6*, 70-74.
- Siegel, K. (1983). Research issues in psychosocial oncology. *Journal of Psychosocial Oncology, 1* (1), 101-104.
- Silverman, A. B., Reinherz, H. Z., & Giaconia, R. M. (1996). The long term sequelae of child and adolescent abuse: A longitudinal community study. *Child Abuse and Neglect, 20*, 709-723.
- Simkin, P. (1992). Overcoming the legacy of childhood sexual abuse: The role of caregivers and childbirth educators. *Birth, 19* (4), 224-225.
- Simkin, P. (1994). Memories that really matter. *Childbirth Instructor Magazine*, 20-39.
- Simkin, P., & Klaus, P. (1996). *Helping sexually and physically abuse women*. (Audio cassette.). Eugene, OR: Midwifery Today.
- Smale, M. (1998). Working with breastfeeding mothers: The psychological context. In S. Clement, & L. Page (Eds.), *Psychological perspectives on pregnancy and childbirth* (pp. 183-204). Edinburgh, Scotland: Harcourt Brace & Company Ltd.
- Slager-Earnest, S. E., Hoffman, S. J., Beckmann, C. J. A. (1987). Effects of a specialized prenatal adolescent program on maternal and infant outcomes. *JOGGN- Journal of Obstetric, Gynecologic, & Neonatal Nursing, 16* (6), 422-429.
- Smith, M. (1998). Childbirth in women with a history of sexual abuse II: A case history approach. *The Practicing Midwife, 1* (6), 23-27.
- Smoke, J., & Grace, M. C. (1988). Effectiveness of prenatal care and education for pregnant adolescents. *Journal of Nurse Midwifery, 33* (4), 178-184.
- Spiegel, D. (1994). Multiple personality as a post traumatic stress disorder. *Psychiatric*

*Clinics of North America*, 7, 101-110.

- Squire, C. (2003). Women and society. In C. Squire (Ed.), *The social context of birth* (pp. 1-20). Thames Valley University, England: Radcliffe Medical Press.
- Stainton, M. C. (1985). The fetus: A growing member of the family. *Family Relations*, 34 (3), 321-326.
- Stark, E., & Flitcraft, A. (1991). Spouse abuse. In M. Rosenberg & M. Fenely (Eds.), *Violence in America: A public health approach* (pp. 205-217). Saskatoon: University of Saskatchewan.
- Statistics Canada. (1993). *Statistics Canada Survey on Violence Against Women*. Ottawa, ON: Author.
- Statistics Canada. (2003). *Family Violence in Canada: A Statistical Profile*. Ottawa, ON: Author.
- Steele, H., Steele, M., & Fonagy, P. (1996). Associations among attachment classifications of mothers, fathers and their infants. *Child Development*, 67, 541-555.
- Stern, P. N. (1980). Grounded theory methodology: Its uses and processes. *Image, Journal of Nursing Scholarship* 12 (7), 20-23.
- Stern, A. E., Lynch, D. L., Oates, R. K., O'Toole, B. I., & Cooney, G. (1995). Self esteem, depression, behavior and family functioning in sexually abuse children. *Journal of Child Psychology and Psychiatry*, 36, 1077-1089.
- Stevens-Simon, C., Kaplan, D. W., & McAnarney, E. R. (1993). Factors associated with preterm delivery among pregnant adolescents. *Journal of Adolescent Health*, 14, 340-342.

- Stevens-Simon, C., & McAnarney, E. R. (1994). Childhood victimization: relationship to adolescent pregnancy outcome. *Child Abuse and Neglect, 18* (7), 569-575.
- Stevens-Simon, C., & Reichert, S. (1994). Sexual abuse, adolescent pregnancy, and child abuse: A developmental approach to an intergenerational cycle. *Arch Pediatric & Adolescent Medicine, 148* (1), 23-27.
- Strauss, A. (1987). *Qualitative analysis for social scientists*. New York: Cambridge University Press.
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage Publications.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Grounded theory procedures and techniques* (2<sup>nd</sup> ed.). Newbury Park, CA: Sage Publications.
- Straus, M. A., & Gelles, R. J. (1990). *Physical violence in American families*. New Brunswick, NJ: Transaction Publishers.
- Swett, C., & Halpert, M. (1993). Reported history of physical abuse histories in relation to dissociation and other symptomology in women psychiatric inpatients. *Journal of Interpersonal Violence, 8* (4), 545-555.
- Tanner, L. M. (1969). Developmental tasks of pregnancy. In B. Bergensten, E. Anderson, M. Duffey, M. Lohr, & M. Rose (Eds.), *Current concepts in clinical nursing* (pp. 292-297). St. Louis, MO: C. V. Mosby.
- Terr, L. C. (1985). Psychic trauma in children and adolescents. *Psychiatric Clinics of North America, 8*, 815-835.
- Thompson, J. E. (1990). Maternal stress, anxiety, and social support during pregnancy:

- Possible directions for prenatal intervention. In I. R. Merkatz, & J. E. Thompson, (Eds.), *New perspectives on prenatal care* (pp. 319-336). New York: Elsevier Science Inc.
- Thompson, L. (1992). Feminist methodology for family studies. *Journal of Marriage and the Family*, 54, 3-18.
- Tidy, H. (1996). Care for survivors of childhood sexual abuse. *Modern Midwife*, July, 17-19.
- Trad, P. V. (1991). Adaptation to developmental transformations during the various phases of motherhood. *Journal of the American Academy of Psychoanalysis*, 19 (3), 403-421.
- Trickett, P. K., Noll, J. G., Reiffman, A., & Putnam, F. W. (2001). Variants of intrafamilial sexual abuse experience: Implications for short and long term development. *Development and Psychopathology*, 13 (4), 1001-1020.
- Valentine, P. (1982). The experience of pregnancy: A developmental process. *Family Relations*, 31 (2), 243-248.
- van der Kolk, B. A. (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. *Harvard Review Psychiatry*, 1 (5), 253-265.
- van der Kolk, B. A. (1997). The psychobiology of posttraumatic stress disorder. *Journal of Clinical Psychiatry*, 58 (suppl), 16-24.
- van der Kolk, B. A., & Fisler, R. (1995). Dissociation and the fragmentary nature of traumatic memories: Overview and exploratory study. *Journal of Traumatic Stress*, 8 (4), 505-525.

- Van Der Leden, M. E., & Raskin, V. D. (1993). Psychological sequelae of childhood sexual abuse: Relevant in subsequent pregnancy. *American Journal of Obstetrics and Gynecology*, 168 (4), 1336-1337.
- Wagner, M. (1998). Midwifery in the industrialized world. *Journal of the Society of Obstetricians and Gynecologists of Canada*, 20 (13), 1225-1234.
- Waller, G. (1992). Sexual abuse and bulimic symptoms in eating disorders: Do family interaction and self-esteem explain the links? *International Journal of Eating Disorders*, 12, 235-240.
- Warshaw, C. (2002). Women and violence. In N. L. Stotland, & D. E. Steward (Eds.), *Psychological aspects of women's health care: The interface between psychiatry and obstetrics and gynecology* (pp. 477-548). Washington, DC: American Psychiatric Press, Inc.
- Waterman, J., & Kelly, R. J. (1993). Mediators of effects on children: What enhances optimal functioning and promotes healing? In J. Waterman, R. J. Kelly, M. K. Oliver, & J. McCord (Eds.), *Behind the playground walls: Sexual abuse in preschools* (pp. 222-239). New York: The Guilford Press.
- Waymire, V. (1997). A triggering time: Childbirth may recall sexual abuse memories. *Lifelines*, April, 47-50.
- Weaver, J. (1998). Choice, control and decision making in labour. In S. Clement, & L. Page (Eds.), *Psychological perspectives on pregnancy and childbirth* (pp.81-99). Edinburgh, Scotland: Harcourt Brace & Company Ltd.
- Webster Encyclopedic Unabridged Dictionary of the English Language. (1989). New York: Portland House.

- Werner, E. E. (1994). Overcoming the odds. *Journal of Developmental and Behavioural Pediatrics, 2*, 131-136.
- Werner, E. E. (1995). Resilience in development. *Current Directions in Psychological Science, 3*, 81-85.
- Wheatley, S. (1998). Psychosocial support in pregnancy. In S. Clement, & L. Page (Eds.), *Psychological perspectives on pregnancy and childbirth* (pp. 45-59). Edinburgh, Scotland: Harcourt Brace & Company Ltd.
- Whipple, E. E., & Webster-Stratton, C. (1991). The role of parental stress in physically abusive families. *Child Abuse and Neglect, 15*, 279-291.
- Widom, C. S., & Morris, S. (1997). Accuracy of adult recollections of childhood victimization: Part II. Childhood sexual abuse. *Psychological Assessment, 9*, 34-46.
- Widom, C. S., & Shepard, R. L. (1996). Accuracy of adult recollections of childhood victimization: Part I. Childhood physical abuse. *Psychological Assessment, 8*, 412-421.
- Wijma, K., Soderquist, J., & Wijma, B. Posttraumatic stress disorder after childbirth: A cross-sectional study. *Journal of Anxiety Disorders, 11*, 587.
- Williams, L. M. (1994). Recall of childhood trauma: A prospective study of women's memories of child sexual abuse. *Journal of Consulting and Clinical Psychology, 62*, 1167-1176.
- Williams, L. M. (1995). Recovered memories of abuse in women with documented child sexual victimization histories. *Journal of Traumatic Stress, 8*, 649-673.
- Willms, J. D. (2002). Implications of the findings for social policy renewal. In J. D.

- Willms (Ed.), *Vulnerable children: Findings from Canada's national longitudinal survey of children and youth* (pp. 359-377). Edmonton: The University of Alberta Press.
- Winslow, E., & Jacobson, A. (1998). The effects of childhood sexual abuse on women. *American Journal of Nursing, 98* (8), 67-68.
- Wolfe, D. A., Sas, L., & Wekerle, C. (1994). Factors associated with the development of post-traumatic stress disorder among child victims of sexual abuse. *Child Abuse and Neglect, 18*, 37-50.
- Wolfe, V. V., Gentile, C., & Wolfe, D. A. (1989). The impact of sexual abuse on children: A PTSD formulation. *Behaviour Therapy, 20*, 215-228.
- World Health Organization (WHO). (1998). *Evidence for the ten steps to successful breastfeeding*. Family and Reproductive health: A division of child health and development. Geneva, Switzerland: Author.
- Wuest, J. (1995). Feminist grounded theory: an exploration of the congruency and tensions between two traditions of knowledge discovery. *Qualitative Health Research, 5* (1), 125-137.
- Wyatt, G. E. (1985). The sexual abuse of Afro-American and White-American women in childhood. *Child Abuse and Neglect, 9*, 507-519.
- Wyatt, G. E., & Newcombe, M. (1990). Internal and external mediators of women's sexual abuse in childhood. *Journal of Consulting and Clinical Psychology, 58*, 758-767.
- Zemenchuk, J. K., Rogosch, F. A., & Mowbray, C. T. (1995). The seriously mentally ill woman in the role of parent: Characteristics, parenting sensitivity and needs.

*Psychosocial Rehabilitation Journal*, 18 (3), 77-92.

Zuravin, S., & DiBlasio, F. (1992). Child neglecting adolescent mothers: How do they differ from their nonmaltreating counterparts. *Journal of Interpersonal Violence*, 7, 471-489.

**Appendix A**  
**Recruitment Brochures and Advertisements**

## WHO IS THE RESEARCHER?

Becky Palmer is a Registered Nurse and Certified Nurse Midwife with years of experience working in Maternity. She is currently a PhD Student in Nursing at UBC with a research focus on childhood sexual abuse survivors' experiences of pregnancy, childbirth and mothering.

Becky's most recent clinical experiences have focused on working with women whose pregnancies were complex, either physically and/or emotionally. As a result of these clinical experiences and the gift of sharing in the life stories of these courageous women, Becky has spent the past years learning about sexual abuse issues and how being a survivor of childhood trauma may affect pregnancy, giving birth, breastfeeding, mothering...

*If this is your personal story, Becky would like to hear from you! What you have to say is important and worth sharing!*

**FOR MORE  
INFORMATION ABOUT  
THE RESEARCH STUDY  
PLEASE CONTACT**

**BECKY PALMER**

**604-XXX-XXXX**  
(confidential research line)

**OR E-MAIL:**

**XXXXXXXXXXXX**

**CONFIDENTIALITY**

**GUARANTEED**

**ARE YOU A  
MOTHER AND  
A SURVIVOR OF  
CHILDHOOD  
SEXUAL ABUSE?**



**YOUR STORY IS  
IMPORTANT**

✓ **ARE YOU A MOTHER, AN EXPECTANT MOTHER, OR THINKING ABOUT BECOMING A MOTHER?**



✓ **ARE YOU A SURVIVOR OF CHILDHOOD SEXUAL ABUSE?**



**WOULD YOU BE WILLING TO SHARE YOUR PERSONAL EXPERIENCE BY PARTICIPATING IN A RESEARCH STUDY?**

**CONFIDENTIALITY & ANONYMITY ARE GUARANTEED**

### **YOUR STORY IS IMPORTANT**

The stories of childhood sexual abuse survivors are important, inspiring and worth sharing. Their powerful stories of pain, fear, loss, joy and healing are incredibly moving. Survivors who are mothers, expectant mothers or thinking about becoming mothers may find that their history of childhood trauma significantly affects their childbearing experience.

The goal of this research study is to support mothers and infants through gaining an enhanced understanding of survivors' experiences of pregnancy, childbirth and early mothering and to improve: (1) the health care delivered to survivors and (2) the services made available to survivors.

Your participation in this study will help make a difference in understanding the unique childbearing experiences of sexual abuse survivors.

By sharing your story, you can make a difference in the lives of other women and families!

### **HOW TO PARTICIPATE**

You may contact the researcher, Becky Palmer, at the private number or e-mail address provided. She will tell you more about the study and answer any questions that you may have.

If you decide that you want to participate, Becky will arrange a time to talk with you further, either in person or via the telephone (your choice). During this conversation, Becky will ask you questions about your childbearing experience and how your personal history of childhood trauma may or may not have impacted your experience. This conversation may last 30-90 minutes.

Your participation in the study is voluntary and will in no way affect your current or future health care. You are also free to withdraw from the study at any time if you wish.

Confidentiality and anonymity are guaranteed.

Thank you for your interest in this research study.

# ARE YOU A MOTHER AND A SURVIVOR OF SEXUAL ABUSE? YOUR STORY IS IMPORTANT!

## YOU ARE INVITED TO SHARE YOUR EXPERIENCE BY PARTICIPATING IN A RESEARCH STUDY

My name is Becky Palmer and I am a registered nurse with years of experience in maternity. I am also a Doctoral Student in the UBC School of Nursing. I have spent the last few years trying to learn as much as I can about sexual abuse issues and how childhood sexual abuse survivors experience pregnancy, childbirth and mothering.

I have learned so much from women survivors about the many ways in which being a survivor has and has not affected them - being pregnant, giving birth, breastfeeding, mothering....Their powerful stories of pain, fear, loss, joy and healing are moving, important and inspiring.

If you are a survivor of childhood sexual abuse and are a mother, an expectant mother, or a woman whose decision to become a mother has been affected by your personal history of sexual abuse, I would be very interested in talking with you about your experiences. Please be assured that your privacy is of the utmost importance to me. **Confidentiality and anonymity are guaranteed.**

Your participation in this research study will contribute significantly to understanding the unique childbearing experiences of survivors of childhood sexual abuse. I thank you for your time and willingness to share.

For more information, please contact:

Becky Palmer, RN

**604-xxx-xxxx**  
(Private Research Line)

# ARE YOU A CAREGIVER WHO WORKS WITH SURVIVORS OF CHILDHOOD SEXUAL ABUSE?

## YOU ARE INVITED TO SHARE YOUR EXPERIENCE BY PARTICIPATING IN A RESEARCH STUDY

My name is Becky Palmer and I am a registered nurse with years of experience in maternity. I am also a Doctoral Student in the UBC School of Nursing. I have spent the last few years trying to learn as much as I can about sexual abuse issues and how survivors experience pregnancy, childbirth and mothering. In addition to speaking with sexual abuse survivors, I am also interested in hearing the stories of health care professionals who have cared for women with this experience.

If you are a health care professional who has cared for a survivor of childhood sexual abuse who is a mother, an expectant mother, or a woman whose decision to become a mother has been affected by their history of sexual abuse, I would be very interested in talking with you about your experiences. Please be assured that your privacy is of the utmost importance to me. **Confidentiality and anonymity are guaranteed.**

Your participation in this research study will contribute significantly to understanding the unique childbearing experiences of childhood sexual abuse survivors. I thank you for your time and willingness to share.

For more information, please contact:

Becky Palmer

**604-xxx-xxxx**  
(Private Research Line)

**Appendix B**  
**Information Letters**

## CHILDHOOD SEXUAL ABUSE SURVIVORS EXPERIENCES OF PREGNANCY, LABOR, AND CHILDBIRTH

**Researcher:** Becky C. Palmer, RN, MN, CNM  
Doctoral Student,  
UBC School of Nursing  
604-xxx-xxxx

**Supervisor:** Angela Henderson, RN, PhD  
Associate Professor, UBC School of Nursing  
604-822-7426

### INFORMATION LETTER FOR CHILDBEARING WOMEN WHO ARE CHILDHOOD SEXUAL ABUSE SURVIVORS

I am a registered nurse and a student in the PhD program in the School of Nursing at the University of British Columbia. For my dissertation, I am studying the experiences of pregnancy, labor, and childbirth for women who are childhood sexual abuse survivors. There is little research about the complex process of pregnancy, labor, birth and postpartum adjustment for women who have experienced sexual abuse. By sharing your experiences of pregnancy, labor, and childbirth, you will help nurses and other health care professionals to provide better care for women living with this experience. Talking about your experiences may also be difficult at times, but most people find it helpful to discuss them.

If you participate in the study, interviews will last one to two hours and between one to three interviews are anticipated. I will arrange to interview you at a time that is convenient for you and in a place of your choice. The interview will be audiotaped and then transcribed. If you wish, you may refuse to answer any questions during the interview. Open-ended questions about your experience as a women who is a sexual abuse survivor and your experience of pregnancy, labor and birth will be asked during the first interview. For example, I will ask, "Tell me what your pregnancy was like for you." The second interview, if desired, will give you an opportunity to share any further thoughts with me. I will summarize what you told me during the interviews to check that I understood you correctly. We may decide to meet a third time to conduct an interview with your primary support person who is most involved in your childbearing experiences. You may also be invited to participate in a focus group discussion. At this meeting, the preliminary results of the study will be shared so that they can be reviewed, corrected, and further developed by group participants. You will also be asked to respond to a short questionnaire that includes background information about yourself and your primary support person.

Your participation in the study is voluntary and will in no way affect your current or future health care. You are free to withdraw from the study at any time, ask for any audiotaped information to be erased in your presence, and ask for any sensitive information not to be divulged. Confidentiality will be strictly maintained. You will be asked to choose a code name that can only be accessed by me. Fieldnotes, transcripts, and audiotapes will be kept in a locked filing cabinet. Selected sections of data that will not compromise confidentiality will be shared with my dissertation committee. Only I can access the data that will be kept for future publications, presentations, and possible secondary analysis. Biographical details will be altered as necessary in published and unpublished work to conceal identifying characteristics of study participants. All of the data will be destroyed five years after the end of the study, unless you are specifically consulted and agree to its use. Following the completion of the study, a summary report of the findings will be available upon your request.

I hope you will consider this study to be worthwhile. If you want to participate in the study, or if you want to discuss it further before making a decision, please feel free to contact me by telephone at: (604) xxx-xxxx or by e-mail: xxxxxxxxxx.

Sincerely,

Becky Palmer, RN, MN, CNM

## CHILDHOOD SEXUAL ABUSE SURVIVORS EXPERIENCES OF PREGNANCY, LABOR, AND CHILDBIRTH

**Researcher:** Becky C. Palmer, RN, MN, CNM  
Doctoral Student,  
UBC School of Nursing  
604-xxx-xxxx

**Supervisor:** Angela Henderson, RN, PhD  
Associate Professor, UBC School of Nursing  
604-822-7426

### INFORMATION LETTER FOR HEALTH CARE PROFESSIONALS WHO HAVE CARED FOR CHILDBEARING WOMEN WHO ARE CHILDHOOD SEXUAL ABUSE SURVIVORS

I am a registered nurse and a student in the PhD program in the School of Nursing at the University of British Columbia. For my dissertation, I am studying the experiences of pregnancy, labor, and childbirth for women who are childhood sexual abuse survivors. There is little research about the complex process of pregnancy, labor, birth and postpartum adjustment for women who have experienced childhood sexual abuse. By sharing your experience of being a health care provider, you will help childbearing women who have experienced sexual abuse as well as help nurses and other health care professionals to provide better care for women living with this experience. Talking about your experiences may also be difficult at times, but most people find it helpful to discuss them.

If you participate in the study, interviews will last one to two hours and between one to three interviews are anticipated. I will arrange to interview you at a time that is convenient for you and in a place of your choice. The interview will be audiotaped and then transcribed. If you wish, you may refuse to answer any questions during the interview. Open-ended questions about your experience as a caregiver to a women who is a childhood sexual abuse survivor will be asked during the first interview. The second interview, if desired, will give you an opportunity to share any further thoughts with me. I will summarize what you told me during the interviews to check that I understood you correctly. We may decide to meet a third time to validate the intended meaning of your shared experiences.

Your participation in the study is voluntary. You are free to withdraw from the study at any time, ask for any audiotaped information to be erased in your presence, and ask for any sensitive information not to be divulged. Confidentiality will be strictly maintained. You will be asked to choose a code name that can only be accessed by me. Fieldnotes, transcripts, and audiotapes will be kept in a locked filing cabinet. Selected sections of data that will not compromise confidentiality will be shared with my dissertation

committee. Only I can access the data that will be kept for future publications, presentations, and possible secondary analysis. Biographical details will be altered as

necessary in published and unpublished work to conceal identifying characteristics of study participants. All of the data will be destroyed five years after the end of the study, unless you are specifically consulted and agree to its use. Following the completion of the study, a summary report of the findings will be available upon your request.

I hope you will consider this study to be worthwhile. If you want to participate in the study, or if you want to discuss it further before making a decision, please feel free to contact me by telephone at: 604-xxx-xxxx or by e-mail: xxxxxxxxxx.

Sincerely,

Becky Palmer, RN, MN, CNM

**Appendix C**  
**Consent Forms**

## Consent Form for Survivors

**Researcher:** Becky C. Palmer, RN, MN, CNM  
Doctoral Student,  
UBC School of Nursing  
604-xxx-xxxx

**Supervisor:** Angela Henderson, RN, PhD  
Associate Professor, UBC School of Nursing  
604-822-7426

**Title: The Experience of Pregnancy, Labor, and Childbirth for Women who are Childhood Sexual Abuse Survivors**

You have been asked to participate in a research study. Participation in this study is entirely voluntary. You may decide not to participate or may withdraw from the study at any time. If you decide to participate, you may refuse to answer any questions, may ask any audiotaped information to be erased in the researcher's presence, or may ask for any sensitive information not to be divulged.

Purpose:

The purpose of this study is to enhance our understanding of the experience of pregnancy, labor, and childbirth for women who are childhood sexual abuse survivors.

Procedures:

You are being asked to participate in this study to share your experiences of pregnancy, labor and birth. Women who are eligible for this study will be asked to participate in an interview, a group discussion, or both. You will also be asked to respond to a short questionnaire that includes background information about yourself. The interview will take about one hour and will be held at a time and place convenient for you. The interviewer will ask you questions about your childbearing experience and your sexual abuse history. This interview will be audio recorded and transcribed. You may also be invited to participate in a focus group discussion. At this meeting, the preliminary results of the study will be shared so that they can be reviewed, corrected, and further developed by the group participants. The group meeting will last about 1 hour and it will be audiorecorded. The researcher will review the audiotapes of the focus group meeting and write out the main points of the discussion.

Risks:

There are no anticipated risks related to participation in this study. However, since you will be asked to talk about experiences in your life that may be painful or difficult, you may experience some feelings of sadness, anger, or hurt. Sometimes having the opportunity to talk about a stressful experience is helpful in working through such feelings. At any time you may ask that the interview be ended. The researcher's phone number will be made available to you if, at a later date, you should wish to talk about the interview.

### Potential Benefits

You will not receive any direct benefits from participating in this study. However, it is anticipated that the results of this research may provide important information for developing strategies to assist childbearing women who are survivors of sexual abuse.

### Monetary Compensation

There will be no monetary compensation.

### Confidentiality

Any information resulting from this research study will be kept strictly confidential and stored in a locked filing cabinet. The notes, audiotapes, and interview transcriptions will have all identifying information removed and your name will not be used in the research reports. Biographical data will be altered as necessary in published and unpublished work to conceal identifying characteristics of study participants. Selected sections of data that will not compromise confidentiality will be shared with the researcher's dissertation committee for the purpose of analysis and writing of the research report. Only the researcher can access the data that will be kept for future publications, presentations, and possible secondary analysis.

At the end of the study the audiotapes will be erased. However, the typed transcripts obtained in this study may also be used for educational purposes and research that involves secondary analysis of the interviews, with the understanding that any additional research projects that use the transcriptions will be approved by the appropriate university research and ethics committees. All of the data will be destroyed five years after the end of the study, unless you are specifically consulted and agree to its use.

### Contact Information

If you have any questions or concerns at any time during this study you may contact Becky Palmer at 604-xxx-xxxx. You may also contact Dr. Angela Henderson, the researcher's supervisor at 604-822-7426. If you have any concerns about your rights or treatments as a research participant, you may contact Dr. Richard Spratley, Director of the UBC Office of Research Services and Administration at 604-822-8598.

I have read the above information and I have had an opportunity to ask questions to help me understand what my participation will involve. I freely consent to participate in the study and acknowledge receipt of a copy of the consent form.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

I would like to receive the summary report of the findings. Please mail it to me at the following address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Consent Form for Health Care Professionals

**Researcher:** Becky C. Palmer, RN, MN, CNM  
Doctoral Student,  
UBC School of Nursing  
604-xxx-xxxx

**Supervisor:** Angela Henderson, RN, PhD  
Associate Professor, UBC School of Nursing  
604-822-7426

**Title: The Experience of Pregnancy, Labor, and Childbirth for Women who are Childhood Sexual Abuse Survivors**

You have been asked to participate in a research study. Participation in this study is entirely voluntary. You may decide not to participate or may withdraw from the study at any time. If you decide to participate, you may refuse to answer any questions, may ask any audiotaped information to be erased in the researcher's presence, or may ask for any sensitive information not to be divulged.

Purpose:

The purpose of this study is to enhance our understanding of the experience of pregnancy, labor and childbirth for women who are sexual abuse survivors.

Procedures:

You are being asked to participate in this study to share your experiences of caring for women who are sexual abuse survivors and their experience of pregnancy, labor and birth. Health care professionals who are eligible for this study will be asked to participate in an interview. The interview will take about one hour and will be held at a time and place convenient for you. The interviewer will ask you questions about your professional experience working with childbearing women with a history of sexual abuse. This interview will be audio recorded and transcribed.

Risks:

There are no anticipated risks related to participation in this study. However, since you will be asked to talk about experiences in your life that may be painful or difficult, you may experience some feelings of sadness, anger, or hurt. Sometimes having the opportunity to talk about a stressful experience is helpful in working through such feelings. At any time you may ask that the interview be ended. The researcher's phone number will be made available to you if, at a later date, you should wish to talk about the interview.

Potential Benefits

You will not receive any direct benefits from participating in this study. However, it is anticipated that the results of this research may provide important information for developing strategies to assist childbearing women who are survivors of sexual abuse.

### Monetary Compensation

There will be no monetary compensation.

### Confidentiality

Any information resulting from this research study will be kept strictly confidential and stored in a locked filing cabinet. The notes, audiotapes, and interview transcriptions will have all identifying information removed and your name will not be used in the research reports. Biographical data will be altered as necessary in published and unpublished work to conceal identifying characteristics of study participants. Selected sections of data that will not compromise confidentiality will be shared with the researcher's dissertation committee for the purpose of analysis and writing of the research report. Only the researcher can access the data that will be kept for future publications, presentations, and possible secondary analysis.

At the end of the study the audiotapes will be erased. However, the typed transcripts obtained in this study may also be used for educational purposes and research that involves secondary analysis of the interviews, with the understanding that any additional research projects that use the transcriptions will be approved by the appropriate university research and ethics committees. All of the data will be destroyed five years after the end of the study, unless you are specifically consulted and agree to its use.

### Contact Information

If you have any questions or concerns at any time during this study you may contact Becky Palmer at 604-xxx-xxxx. You may also contact Dr. Angela Henderson, the researcher's supervisor at 604-822-7426. If you have any concerns about your rights or treatments as a research participant, you may contact Dr. Richard Spratley, Director of the UBC Office of Research Services and Administration at 604-822-8598.

I have read the above information and I have had an opportunity to ask questions to help me understand what my participation will involve. I freely consent to participate in the study and acknowledge receipt of a copy of the consent form.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

I would like to receive the summary report of the findings. Please mail it to me at the following address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CHILDHOOD SEXUAL ABUSE SURVIVORS EXPERIENCES OF  
PREGNANCY, LABOR, AND CHILDBIRTH**

**Researcher:** Becky C. Palmer, RN, MN, CNM  
Doctoral Student,  
UBC School of Nursing  
604-xxx-xxxx

**Supervisor:** Angela Henderson, RN, PhD  
Associate Professor, UBC School of Nursing  
604-822-7426

**TRANSCRIBER'S CONSENT FORM**

I have agreed to participate in this study by transcribing fieldnotes and interview materials.

I will protect **CONFIDENTIALITY** in this study by translating any names of persons or institutions I encounter during transcription into initials. Furthermore, I will not, under any circumstances, disclose any information in fieldnotes or interviews to any persons or agencies.

All research materials for this study will be kept secured in a locked cabinet or drawer while in my possession. Once I have completed each transcription, I will return all tapes, disks, original print outs, and copies to the researcher. I will also erase all transcription materials from the hard drive of the computer that I am using.

I have had the opportunity to discuss these requirements with the researcher, Becky Palmer.

**Signed:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Receipt of Copy of Consent Form Acknowledged:** \_\_\_\_\_  
*(Please initial)*

**Appendix D**  
**Interview Guides**

## **INTERVIEW GUIDE - SURVIVORS**

### **1. Tell me about yourself...**

### **2. Tell me about your current pregnancy...**

#### **Prompts:**

- How have you been feeling?
- Would you describe it as an uneventful pregnancy?
- Tell me about some of the exams that you have had during the pregnancy (i.e.: vaginal, breast, or pelvic exams)
- Who did you choose as a care provider? Physician? Obstetrician? Midwife? Why?
- Where are you planning on giving birth?
  - Hospital/home?
  - What has influenced this decision?
- Do you have a birth plan developed? What sorts of things have you included on your plan? Why have you made these choices?
- Is your partner aware of your history of sexual abuse?
  - If yes, how did you inform them of your history?
- Is your health care provider aware of your history of sexual abuse during your pregnancy?
  - If yes, how did you inform them of your history?

### **3. Tell me about your prior pregnancies...**

#### **Prompts:**

- How would you describe the pregnancy?
- Is/was your health care provider aware of your history of sexual abuse during your pregnancy? During your birth?
  - If yes, how did you inform them of your history?

### **4. Tell me about your labor and birth...**

#### **Prompts:**

- How did you feel at this time?
- How would you describe your labor and birth?
- What type of birth did you have?
  - Vaginal, forceps, vacuum extraction, cesarean section
- Some people have told me that it is painful and like being out of control. Was this your experience?

- Tell me more about how you were feeling...what were some of the body feelings you were having?
- Tell me about your experience of pushing?
- Did you have any pain medications in labor or during the birth?
- Did you have an episiotomy?
- Did you have External Fetal Monitoring?
- Did you have Internal Fetal Monitoring?
- Is/was your health care provider aware of your history of sexual abuse during your pregnancy? During your birth?
  - If yes, how did you inform them of your history?

**5. Tell me about after the baby was born...**

**Prompts:**

- How did you feel at this time?
- How would you describe this period?
- Tell me about your experience of breastfeeding...
- Were your nurses aware of your history of sexual abuse?
  - If yes, how did you inform them of your history?
  - Did anyone ask you about your history or the potential impact/influence this may have had on your experience?
    - If yes, what did they say?
    - How did you respond?
      - If no, would you have liked them to ask about it?
      - What would you have wanted them to say?

**6. When you were pregnant/in labor/following birth...**

**Prompts:**

- Did you feel that your health care provider treated you with respect and compassion during your labor and birth?
- Did you have similar feelings as those during the abuse?
- Did you have different feelings than those during the abuse?
- How were they similar or different?

**7. Please describe your pattern of feeding for your baby?**

- Did you breastfeed?
- Did you bottlefeed?
- What feelings did you experience during this time?
- Do you believe that your history of CSA has had any affect on your ability or willingness to breastfeed your baby?

8. Do you believe that the sexual abuse you suffered in any way affected the birth of this child? Other children? How so?
9. Do you think that your history of sexual abuse in any way affected your bonding with your child?
10. Some women have said that labor triggered sensations or memories of the sexual abuse. Can you tell me about this?
11. How did your history of childhood sexual abuse impact your thinking about becoming pregnant?
12. Tell me, as much as you are comfortable sharing with me right now, what happened when you were sexually abused...

**Prompts:**

- When did it begin that you can remember?
  - How did you feel at this time?
  - How would you describe the abuse?
  - How would you describe this time in your life?
  - What were the primary ways in which you survived?
  - How would you describe your family dynamics at that time?
  - Did you have any support?
  - Did you receive any counseling or therapy after the abuse?
13. How was the care provided to you during your childbearing cycle? How could it have been improved? What specific things worked well for you? What wasn't helpful?
  14. Some women have shared with me their thoughts about health care professionals screening for a history of sexual abuse during pregnancy, labor, or the postpartum period. If you are comfortable sharing, what are your thoughts about screening?
  15. Do you believe that your history of sexual abuse has had any negative effect on your ability to be the kind of mother you want to be?
  16. Do you see any positive effects that your surviving, recovery and perhaps eventual healing in the face of your sexual abuse have had on your ability to be the kind of mother you want to be?
  17. Is there anything else you would like to share with me about your experience?

**INTERVIEW GUIDE - HEALTH CARE PROFESSIONALS**

1. Tell me about yourself...
2. How many deliveries have you attended with women who are childhood sexual abuse survivors?
3. How did you know that they were survivors of childhood sexual abuse?
  - How did they tell you?
  - Would you have suspected? Why?
  - What did you ask them about their history?
  - How did they respond?
  - Did you alter how you provided care to this woman? In what way?
  - Has your practice changed since having this experience?
  - Did you have knowledge about the impact of CSA on women's experience of childbearing?
    - What did this knowledge entail?
4. Tell me about the pregnancies/labors/births of sexual abuse survivors...
5. Tell me about some of the specific stages of labor and birth...

**Prompts:**

- What was the pushing stage like for women?
  - Was there anything in particular you remember about the sounds she made during delivery? Actions? Vocalizations? Expressions?
  - How did the woman respond to the exposure of parts of the body?
  - What sort of body positions did the woman assume?
  - How did the women react to vaginal exams or pelvic exams?
  - How did she respond to body secretions (show, blood, amniotic fluid)
  - How did the women react to other interventions, like catheters or IV therapy, bedrest, fetal monitors, assisted delivery,
6. Tell me about the postpartum period...

**Prompts:**

- How did the woman respond to postpartum assessments?  
Fundus? Flow? Breasts? Stitches?

7. Tell me about breastfeeding...

**Prompts:**

- Was the woman comfortable with holding and suckling the baby?
8. What was your experience of partners? Were they included in the dialogue re: CSA?
9. Do you think that the history of CSA in any way affected the Pregnancy? Labor? Birth? Postpartum period? Breastfeeding?
10. Do you think that the history of CSA in any way affected bonding? In what way?
11. Do you think a history of CSA has any impact on a woman's ability to be a mother? In what way?
12. What kinds of behavior makes you suspect a history of childhood sexual abuse?
13. What strategies might a health care provider use to help a woman with a history of childhood sexual abuse through their childbearing experiences?
14. Do you think you provided care that was compassionate and respectful? How so? Can you be specific about the care you provided?
- Examples?
15. Is there anything else you would like to share with me about your experience?

## FOCUS GROUP BRAINSTORMING QUESTIONS

1. In your professional opinion, what are the major issues faced by women who are mothers and childhood sexual abuse survivors?
  - What are these issues related to? For example: maternal age, number of pregnancies, gestational age, type or degree of childhood trauma
  - How might these “issues” change throughout the childbearing experience? For example, how would your role as a health care provider change depending on the stage of pregnancy?
2. What questions are the most important to ask women survivors? What would be important to include in the interview guide for women and health care providers?
3. How did you know that your clients were survivors of childhood sexual abuse?
  - How did they tell you?
  - Would you have suspected? Why? What kinds of behavior makes you suspect a history of childhood sexual abuse?
  - What did you ask them about their history?
  - How did they respond?
  - Did you alter how you provided care to this woman? In what way?
  - Has your practiced changed since having this experience?
  - Did you have knowledge about the impact of CSA on women's experience of childbearing? What did this knowledge entail?
4. Tell me about the pregnancies/labors/births of sexual abuse survivors...
  - Do you think that a history of CSA affects pregnancy...etc....In what ways specifically?
  - Do you think that the history of CSA in any way affected bonding? In what way?
  - Do you think a history of CSA has any impact on a woman's ability to be a mother? In what way?

5. Tell me about some of the specific stages of labor and birth...

Example:

- What was the pushing stage like for women?
  - Was there anything in particular you remember about the sounds she made during delivery? Actions? Vocalizations? Expressions?
  - How did the woman respond to the exposure of parts of the body?
  - What sort of body positions did the woman assume?
  - How did the women react to vaginal exams or pelvic exams?
  - How did she respond to body secretions (show, blood, amniotic fluid)
  - How did the women react to other interventions, like catheters or IV therapy, bedrest, fetal monitors, assisted delivery
  - Tell me about the postpartum period...
    - How did the woman respond to postpartum assessments?  
Fundus? Flow? Breasts? Stitches?
  - Tell me about breastfeeding...
  - Was the woman comfortable with holding and suckling the baby?
6. What was your experience of partners? Were they included in the dialogue re: CSA?
7. What strategies might a health care provider use to help a woman with a history of childhood sexual abuse through their childbearing experiences?
8. What are the challenges and barriers experienced by women survivors?
9. What are the challenges and barriers experienced by health care providers?
10. What do you foresee are the major “red flags” in this research study?  
Suggestions?
11. How do you feel about screening practices for childhood sexual abuse survivors?  
Should the “question” be asked as part of the assessment process? What should be asked? Who should ask it? What would need to be in place to support an answer of “yes—I am a survivor”?
12. Who are the key stakeholders in this research study?
13. Reciprocity—what would you like to see in this research study that would assist in the work that you do with childhood sexual abuse survivors?
14. Any suggestions regarding recruitment strategies? Who can/should I talk to?
15. Any other comments/questions/feedback.....

**Appendix E**  
**Participant Profiles**

**PARTICIPANT PROFILE: SURVIVORS**

**IDENTIFIER:** \_\_\_\_\_ (ie: A.1.1)

**Code Name:** \_\_\_\_\_

**Date of Interview:** \_\_\_\_\_

**Interview Number: (circle) 1 2 3**

**Date of Birth (Y/M/D)** \_\_\_\_\_ **Age:** \_\_\_\_\_

\*\*\*\*\*

1. G \_\_\_\_\_ T \_\_\_\_\_ P \_\_\_\_\_ A \_\_\_\_\_ L \_\_\_\_\_

2. Self Description of Sexual Abuse:

\_\_\_\_\_

3. Age of Onset of Abuse: \_\_\_\_\_ (years old)

4. Was the perpetrator familial or extra familial? \_\_\_\_\_

5. Was the perpetrator male or female? (M/F) \_\_\_\_\_

▪ When did you remember the abuse?

▪ Within the last two years? \_\_\_\_\_

Many years ago? \_\_\_\_\_

I have always remembered? \_\_\_\_\_

Other: \_\_\_\_\_

▪ Would you describe the abuse as one time, or on-going? \_\_\_\_\_

▪ Did you receive or seek out counseling? If so, what kind of counseling did you receive?

\_\_\_\_\_

▪ How many years have you been in some kind of therapy? \_\_\_\_\_ years

▪ What type(s) of therapy or recovery techniques have you been involved with?

▪ Individual therapy

▪ Group therapy

▪ 12 Step Programs

▪ No formal therapy techniques

▪ Self therapy (describe)

▪ Other (please describe)

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- Have you found the therapies helpful? (describe)

- Yes \_\_\_\_\_
- No \_\_\_\_\_

---

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- Have you found the therapies hurtful? (describe)

- Yes \_\_\_\_\_
- No \_\_\_\_\_

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- Have you experienced any health challenges as an adult? (please describe)

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- If currently pregnant, how would you describe your pregnancy?

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- Gestational Age at Date of Interview: \_\_\_\_\_ (weeks)

- For all prior pregnancies and births, how would you describe them?

Pregnancy/Birth #1: \_\_\_\_\_

---

Pregnancy/Birth #2: \_\_\_\_\_

---

Pregnancy/Birth #3: \_\_\_\_\_

---

Pregnancy/Birth #4: \_\_\_\_\_

---

Pregnancy/Birth #5: \_\_\_\_\_

---

Pregnancy/Birth #6: \_\_\_\_\_

---

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- Did you breastfeed or bottlefeed for each of your pregnancies? If so, for how long did you breastfeed?

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- Who was your primary care provider during your pregnancy?

1. Midwife \_\_\_\_\_
2. Physician \_\_\_\_\_
3. Obstetrician \_\_\_\_\_

- Was your choice of health care provider a significant one in relation to your CSA history? Yes No

- Please briefly describe your support system. For example, are you married? Are you in a supportive relationship? Do you have family or friends you can talk with?

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- Do you have any suggestions for good resources (books, tapes, videos, support groups, etc...) for women healing from sexual abuse?

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---



---

- What has helped you heal and cope?

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- How did you hear about this research study? \_\_\_\_\_

**PARTICIPANT PROFILE: HEALTH CARE PROFESSIONALS**

**Code Name:** \_\_\_\_\_

Date of Interview: \_\_\_\_\_

Interview Number: (circle) 1    2    3

Age: \_\_\_\_\_

\*\*\*\*\*

1. What is your Occupation?

- A. Nurse
- B. Midwife
- C. Social Worker
- D. Physician: \_\_\_\_\_ (GP, OBS, PEADS, NEO, PSYCH)
- E. Psychologist
- F. Counsellor
- G. Other: \_\_\_\_\_

2. Estimated number of childhood sexual abuse survivors whom you have cared for?

\_\_\_\_\_

3. How are these women referred to you?

- A. Self Referral
- B. Other: \_\_\_\_\_

4. At what stage do you predominantly have contact with survivors? (circle all that apply)

- A. Preconception
- B. Pregnancy
- C. Labor & Delivery
- D. Postpartum (first 6 weeks post delivery)
- E. > 6 weeks (please describe)

\_\_\_\_\_

5. Years of experience working with CSA Survivors? \_\_\_\_\_ years

6. Is working with CSA Survivors your primary area of expertise?

- Yes \_\_\_\_\_
- No \_\_\_\_\_

If no, what is your primary area of expertise?

\_\_\_\_\_

7. Did you receive any additional education/training in order to work with CSA survivors? If yes, please describe:

- Yes \_\_\_\_\_
- No \_\_\_\_\_

8. Do you have any suggestions for good resources (books, tapes, videos, support groups, etc...) for women healing from childhood sexual abuse?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Additional Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Appendix F**  
**Characteristics of Sample**

## CHARACTERISTICS OF SAMPLE

**Table F 1: Childhood Sexual Abuse Survivors (N=46)**

CHARACTERISTIC	N	NOTES
<b>Age (Years)</b> 18-25 26-30 31-35 36-40 41-45 46-50 51-55 55 + Mean = 37 Years Range = 19 to 56 Years	1 5 12 18 6 2 1 1	
<b>Ethnicity</b> Caucasian Aboriginal East Indian	33 11 2	
<b>Education (Highest Level)</b> Some High School High School Diploma Some College Baccalaureate Degree Graduate Degree	11 13 8 11 3	
<b>Employment</b> Not Employed Part-Time Full-Time	21* 13 12	*This included women who were homemakers
<b>Gross Annual Income</b> Low Income Moderate Income High Income	24 19 3	

<p><b>Occupation</b></p> <p>Nurse 9</p> <p>Sex Trade 4</p> <p>University Student 4</p> <p>Therapist 3</p> <p>Artist 3</p> <p>Social Worker 1</p> <p>Day Care Worker 1</p>		
<p><b>Number of Interviews</b></p> <p>One 46</p> <p>Two 27</p> <p>Three 5</p>		
<p><b>Length of Interviews (Hours)</b></p> <p>First Interview 4</p> <p>Second Interview 1</p> <p>Third Interview 1</p>		
<p><b>Childbearing Stage at First Interview</b></p> <p>Preconception 2</p> <p>During Pregnancy 2</p> <p>Postpartum (&lt; 3 months) 4</p> <p>3 months – 1 year 4</p> <p>1 -5 years 9</p> <p>6-10 years 10</p> <p>10 + years 15</p>		
<p><b>Number of Pregnancies For Participants</b></p> <p>No Pregnancies 4</p> <p>Primiparous 8</p> <p>Multiparous</p> <p>2-4 25</p> <p>5-7 5</p> <p>8-10 2</p> <p>10 + 2</p>		

<b>Total Number of Children Born To Participants</b>	69	
<b>Number of Children Placed for Adoption</b>	3	
<b>Number of Participants whose Children were Apprehended</b>	8	
<b>Number of Children Apprehended</b>	18	
<b>Partner Status</b> No Partner Married/Common-Law	25 21*	* seven women shared they were in same sex relationships
<b>Age of Onset of Abuse</b> Birth to 3 years 3-4years 4-5 years 5-6 years 6-7 years 7-8 years 8-9 years 9-10 years 11 + years Mean: 6 years old Range: Birth to 11 years old	3 3 5 8 12 9 4 1 1	
<b>Length of Abuse</b> One Time Ongoing	0 46	One participant experienced ritual abuse over prolonged periods of time. This participant also has multiple personalities.

<p><b>Length of Time Abuse Occurred</b></p> <p>&lt; 1 year  1-3 years  4-6 years  7-9 years  10 + years  Mean: 7 years</p>	<p>3  6  17  16  4</p>	
<p><b>Treatment Received</b></p> <p>No Treatment  Individual Therapy  Group Therapy  Self-Help Groups</p>	<p>4  36  3  15</p>	
<p><b>Awareness of Abuse History</b></p> <p>Always Remembered  Recall Later In Life</p>	<p>41  5*</p>	<p>*These memories were triggered by childbearing</p>
<p><b>Abuser Characteristics</b></p> <p>Male  Female  Familial  Extra Familial (Close Acquaintance or Known Individual)  Other Trusted Individuals</p>	<p>46*  5**  22  47  3</p>	<p>*All participants were abused by males, however, many participants were abused by more than one perpetrator (n=27).  **These five women abusers were involved in the abuse of two of the participants in this study</p>

**Table F 2: Health Care Professionals (N = 22)**

CHARACTERISTIC	N	NOTES
<b>Type of Interview</b> Focus Group Individual	16 6*	*All participants were nurses who have worked with mothers who are survivors of childhood sexual abuse. Four of these nurses also disclosed their own histories of childhood sexual abuse. Three of these four were non-mothers.