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BEING WHOLE: ALIGNING PERSONHOODS TO ACHIEVE SUCCESSFUL
CHILDBIRTH WITH A HISTORY OF CHILDHOOD SEXUAL ABUSE DURING
PERINATAL SERVICES

by

Karla Kendall Richmond, R.N.C., M.S.N., C.N.S

A dissertation presented to the
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In partial fulfillment of the requirements for the degree
DOCTOR OF PHILOSOPHY IN NURSING

December 2005

Dissertation Committee

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Abstract

Being Whole: Aligning Personhoods to Achieve Successful Childbirth with a History of Childhood Sexual Abuse during Perinatal Services

Being a pregnant female is a temporary condition. A woman with a history of childhood sexual abuse aligns the personhoods of child victim and adult survivor to achieve a successful pregnancy, labor, delivery and postpartum experience. Female survivors desire to be recognized and function as whole being during the perinatal experience.

It is estimated that 15 to 32 percent of females prior to the age of eighteen have unwanted sexual contact. Female survivors carry this history of childhood sexual abuse (CSA) with them throughout their lives which may involve childbirth. There are many long term psychological consequences that can occur as a result of a history of CSA, which may include possessing a spoiled identity. Pregnancy and childbirth is a vulnerable experience for many women. The purpose of this study was to explore the meaning of having a history of childhood sexual abuse to pregnant survivors during perinatal services. This study focused on how pregnant female survivors perceived their perinatal care within the context of possessing long term psychological consequences of CSA.

Constant comparative analysis was used to develop an explanatory model of the meaning of having a history of childhood sexual abuse during perinatal services to pregnant female survivors. In-depth interviews were conducted with eleven survivors between the ages of 26 to 51 years of age. Analysis of the data yielded a basic social

process grounded in the experiences of female survivors who have experienced childbirth.

Aligning personhoods emerged as a context of the study that described how female survivors integrate the child victim, survivor and pregnant female into a whole being to achieve successful childbirth. *Discerning safety* and *managing vulnerabilities* represent major categories that depict survivors' fluid mechanisms that lead them to *focus differently to get through* perinatal services.

Discerning safety contains subcategories of gender preference, assumptions, disregarded/regarded, and attitudes and actions which denote survivor's discernment of personal safety. *Managing vulnerabilities* contains the subcategories of rectifying pregnancy and controlling actions which includes mechanisms of avoiding and delaying, enduring, presencing and changing that survivors actively employ to achieve successful childbirth integrated with a sense of personal safety and being whole.

Dedication

I dedicate this work to my family. First, my one and only true partner in life, my husband Ron, who knows better than anyone the struggles and energy it takes for doctoral study. Thank you for your editing, constructive criticism and support in all ways. Thank you, Dr. Richmond, I love you.

Thank you to my sons, my greatest gifts and pleasure, Scott and Daniel, for your continued interest and support in this project. Thanks for just saying, “How ‘ya doing, mom?” and the warm hugs. I love you both, more than words can ever express.

To all my other beloved family; Mom, Nancy, Wayne and Vicki, thanks for hanging in there with me by missing sand buggy trips, travel or other fun activities. Thanks for all of your needed support and words of encouragement.

Thanks to all of my friends who continually encouraged and supported me.

A special thank you to the female survivors who participated in this study. I am in awe of your strength and spirit as women and survivors. You are all remarkable women; it was a privilege and a blessing to get to know you, and hear your voices.

In memory of my dad, Joe Kendall, who always was interested and supported my work. Thanks for being a role model in strength and perseverance.

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To my committee members, Dr. Kathy James, Dr. Stephanie Vaughn, Dr. Marianne Hattar and Dr. Diane Hatton, thank you for sharing your expertise in women's health for completion of this research. Each of you are valued experts.

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Chapter I: Focus of the Inquiry

Childhood sexual abuse is a serious problem with far reaching negative psychological and social consequences. Estimates of prevalence rates for women who have been abused as children range from 15% to 32% within the United States (Vogeltanz, et al., 1999). One in three girls in the United States (Seng & Hassinger, 1998) have experienced unwanted sexual contact by the age of eighteen. In a national survey concerning a history of childhood sexual abuse of 2,626 participants, it was found that 27% of females acknowledged childhood sexual abuse involving physical abuse during their childhood (Finkelhor, Holtaling, Lewis, & Smith, 1990). Abuse of any kind and particularly sexual abuse of female children, is likely to expose them to vulnerabilities and possibly long-term consequences that may permeate their life. Long-term consequences that have been reported are: depression, revictimization experiences, suicidal ideas and behavior, fearfulness, sexual dysfunction, drug and alcohol abuse, powerlessness, a sense of betrayal of trust, guilt, shame, insecurity, and vulnerability (Bachman, Moeller, & Bennett, 1988; Beithchman, et al., 1992; Brown & Garrison, 1990; Draucker, 1993; Edwards & Donaldson, 1998; Rew, 1989; Rimza, Berg, & Locke, 1988). Clearly, childhood sexual abuse (CSA) statistics and consequences demonstrate this is a serious and widespread problem with long lasting health implications.

The impact of childhood sexual abuse depends on the meaning of the abuse experience to the person who has been abused (Kondora, 1993). Although some women

may experience few or no aftereffects of CSA, other women may internalize the stigma of being exposed to a condition that society generally views with disgust or disapproval. To hide the social stigma, the women end up hiding their perceived stigmatizing conditions. The stigmatizing condition of CSA may have a long-lasting impact on self-esteem and self-concept, body image, and their own perception of sexuality (Coffey, Leitenberg, Henning, Turner, & Bennet, 1996; Draucker, 1993; Felitti, 1991). Stigmatizing conditions with clear symptomatology, such as AIDS and human papillomavirus, receive health care providers' attention, whereas a history of childhood sexual abuse that has no outward signs and can more easily be kept secret from a provider. A number of individuals with stigmatizing conditions such as CSA choose not to disclose their condition, although it may have tremendous relevance to their physical and psychosocial health (Limandri, 1989).

Throughout life sexually abused women may encounter difficulties and issues that seem to be connected with the abuse. No difficulty can come close to the potentially connective memories of childhood sexual abuse than those related to pregnancies and autocratic perinatal care. During the perinatal and childbirth period, the reproductive system, which at some point has been the object of abuse, is the focus of care, provider attention, and examination. Depending on the personality make up of the woman and her ability to work through the issues of abuse, her responsiveness to the experience may vary (Doob, 1992; Limandri, 1989). Many health care practitioners during the course of perinatal care do not directly question patients about a past history of sexual abuse (Bohn & Holz, 1996). Providers often ask about any abuse under the guise of domestic violence. Not asking about CSA may impart the idea that a history of childhood sexual abuse doesn't matter, or isn't worth mentioning, and once the abuse is over it's done with, giving the impression that childhood sexual abuse has no long-term effects (Holz,

1989). For disclosure to occur, the person disclosing must feel that the benefits of disclosing outweigh the risks of exposure (Jourard, 1972). Individuals who choose to disclose a stigmatizing condition often do not regret their decision (Keller, vonSadovszdy, Pankratz, & Hermensen, 2000). If a woman chooses to relate her secret to a health care provider during pregnancy, this information is not often disclosed to any other perinatal team member (Seng & Hassinger, 1998; Seng & Petersen, 1995). Telling of a history of childhood sexual abuse may have numerous implications to the pregnant survivor, for herself and her care throughout perinatal services. There is anecdotal evidence suggesting care for survivors in a variety of perinatal settings (Bohn & Holz, 1996; Burian, 1995; Courtois & Riley, 1992; Grant, 1992; Holz, 1994; Simkin, 1992; Waymire, 1997). There is little research, qualitative or quantitative that explores and reflects the experience and meaning of a history of childhood sexual abuse to women during perinatal services and in other settings (Schacter, Stalker, & Teram, 1999). Research concerning this phenomenon has only begun to document the impact past childhood sexual abuse has for women survivors (Briere, 1992; Courtois & Riley, 1992; Draucker, 1992; & Holz, 1994). The purpose of this qualitative study is to begin exploration into the meaning delivered mother's attach to their history of childhood sexual abuse as they experienced it during perinatal services. The ultimate goal of this study is to begin to generate a formal theory surrounding this phenomenon. Grounded theory approach with an applied feminist perspective will be utilized and will begin with discovering a substantive theory concerning CSA and its meaning to pregnant women during perinatal care and services. It is hoped that data from this study will provide clinicians with a developing theory for evidenced-based practice.

Background and Significance

At present no documentation exists that health care providers customarily assess for a history of childhood sexual abuse. CSA and its impact on perinatal services often goes unnoticed and undisclosed. Therefore, it is not an integrated aspect of perinatal nursing practice. Fellitti (1991) reported evaluating participant's feelings concerning being questioned about a history of CSA. He stated that 90% of the participants who had been abused had never been questioned before and only 3% were angry about being asked. Russell (1983) interviewed 152 participants who had a history of incestuous abuse, of which sixty-four percent were *very willing* to disclose their experience, thirty-three percent were *willing*, and only three percent were *unwilling* to disclose. Being comfortable enough to disclose was also a theme reported by Russell. A majority of the participants, 78% reported they felt very comfortable or somewhat comfortable answering questions about CSA. Six percent reported feeling uncomfortable. Robom and Bottenhiem (1995) specifically researched survivor disclosure to gynecological providers. Sixty-five percent of survivors responded with an unqualified *yes* that providers should ask about a history of childhood sexual abuse. By not asking specifically about a history of CSA, the provider may unintentionally create a milieu of secrecy around the pregnant survivor.

Jameton (1984) asserts that secrecy can cause personal isolation and it is often motivated by perceived negative emotions including the sense of shame. An individual with secrets may become vulnerable while maintaining a personal illusion of power, and secrecy may help redefine the survivors' intimate boundaries. The survivor may risk ignorance, illusions, reasonable discussions, and fact-finding that could be explored. Survivors may also require an

environment during perinatal care that is not counter productive to their healing or obtaining an avenue to start healing from childhood sexual abuse.

The very nature of examinations, procedures and treatments involving reproductive systems in the course of perinatal services, may evoke memories of childhood sexual abuse and subsequent psychological issues associated with abuse (Burian, 1995; Courtois & Riley, 1992; Grant, 1992; Holz, 1994). Sources of trauma for women with a history of CSA have been identified as powerlessness, abandonment, violence, betrayal, guilt, and shame, loss of self, loss of childhood, and impact on sexual adjustment (Draucker, 1993). The foremost reported psychological symptoms of women who have been sexually abused as children are: depression, guilt, low self-esteem, poor body image, inability to trust others, flashbacks to the sexual abuse, anxiety, anger, confusion, and dissociation (Brown & Garrison, 1990; Herman, Russell, & Trocki, 1986; Hulme & Grove, 1994; Jackson, Calhoun, Amick, Maddever, & Habif, 1990). However, some survivors of CSA have few or little aftereffects (Kondura, 1993). It is likely that examinations, procedures, and treatments inherent within the scope of nursing care throughout her perinatal course will have different impacts on the survivor due to her attached meaning to the sexual abuse and own coping abilities. Reactions to examinations, procedures, and treatments may have varying degrees of negative consequences to the survivor if poorly handled. Seng and Peterson (1995) state, "Evoking a strong emotional response to the screening question might seem like the worst that could happen. But it is not. It would be worse not to ask and to proceed with an exam that itself may cause a strong response" (p. 28).

Many survivors may desire control and may search for power during the vulnerable time of pregnancy and childbirth. During the process of pregnancy and childbirth, there may be examinations, procedures, and treatments that could decrease the amount of control women have

over their bodies and the situation. Waymire (1997) stressed the importance of giving women control in all procedures including asking permission to proceed with vaginal or other body part examinations. Control was the single most important issue for women during the childbirth experience reported by Burian (1995). Victims of childhood sexual abuse who have been violated by an authority person may feel betrayed. They may try and gain a sense of control through various mechanisms. Elaborate birth plans, aggressive behavior, and /or creating chaos are some reactive strategies used to regain a sense of control and an attempt to adhere to their agendas. Some survivors describe adopting a demeanor of passivity as a means of control. It is the same demeanor the woman as a child, assumed during the abusive situation (Burian; Grant, 1992). Survivors also may feel that their bodies do not function correctly, which may lead to poor self-esteem and anxiety. They may become anxious over the environment; including the use of equipment or invasive procedures that could replicate the abuse (Burian; Kitzinger, 1992; Waymire).

Procedures and treatments in the course of pregnancy and childbirth, which are supportive and inherently determined to be of benefit for every pregnant woman, may pose adverse consequences to the pregnant survivor. Fetal/maternal electronic monitoring may be viewed by the survivor as being strapped down or restrained. Internal monitoring along with vaginal exams, being placed in a vulnerable position and being touched intimately by another person are invasive procedures necessitating exposure. The use of certain comfort measures such as touching or use of soothing words such as *relax, yield, trust your body, let your body go, or tune into your body* could cause immediate psychological dissociation or trigger flashbacks of the perpetrators words used during sexual abuse (Holz, 1994). Painful memories may also be evoked by the look or gender of a care or ancillary provider (Schachter et al., 1999).

Individualized care for pregnant survivors of childhood sexual abuse may begin with sensitive, customized care. According to Schachter et al. sensitive care includes establishing a partnership with clients which includes sharing control, obtaining consent for components of therapy, respecting the client's tolerance of treatments, giving permission to say no, and be willing to give alternatives. Schachter et al. also report survivors need choices in disrobing, clothing, alternatives in privacy, body positions, touch, and choosing the gender of the provider. They also emphasize that providers should respond sensitively to and understand attitudes about survivor's bodies, pain, triggers, dissociation, and the issue of disclosure about childhood sexual abuse.

A patient's past history, including childhood sexual abuse, should be recognized and integrated into perinatal care because it is part of the survivors' identity and of self. In the perinatal setting there are realities in present circumstances that do not preclude the past of female survivors. If in providing care in the immediacy perinatal providers disregard the past, the possibility of different, appropriate actions are limited (Liaschenko, 1995). However, survivors have the option of how much of their history of childhood sexual abuse to reveal to perinatal providers. They may want to share everything concerning the abuse to only an amount that will facilitate a less traumatic experience or a more therapeutic relationship (Teram, Schachter, & Stalker, 1999).

Pregnant survivors encounter the perinatal environment for a specific purpose and a set amount of time. However, it is an opportune time to aid these women in dealing with CSA if they have never done so, to minimize pain and traumatization within the perinatal experience, and facilitate an easier and happier transition into motherhood. Childhood sexual abuse is a gender and societal issue for men and women. Further, it is an issue for health care providers

that strive to care for survivors with little foundational knowledge or evidence on which to base nursing practice. CSA survivors are a particular group of women who have historically had little voice in the world and in nursing. Yet, as the estimated prevalence rates suggests, in every third bed in any given facility that cares for women, is a woman who has experienced childhood sexual abuse. Kondora (1995) states “It is imperative that women be allowed to speak their own truths regarding their experience of abuse. It is difficult, if not impossible, to quantify intensely personal experiences such as these” (p. 23). The personal experience of childhood sexual abuse and its meaning during perinatal care should begin with the voices of pregnant survivors. A change of practice or evidence-based nursing cannot occur until voices of the women are delineated and confirmed.

Within this framework, beginning to discover the meaning of childhood sexual abuse for pregnant survivors through their voices may lead to improve optimal care and relationships with providers. Improved physical and psychological outcomes for the CSA survivor could be achieved. Survivors and perinatal health providers may share these goals. Yet, these outcomes are supposed, and have not been grounded in theory.

The lack of research surrounding the meaning of being a pregnant CSA survivor during perinatal care suggests that additional study through the voices of pregnant survivors is needed. Estimated prevalence rates of childhood sexual abuse suggests that evidence-based nursing should be incorporated into clinical practice to benefit CSA survivors during perinatal services, perinatal nurses, and health providers. It is within this context that the proposed qualitative study will be conducted to explore the meaning of being a pregnant woman with a history of childhood sexual abuse within the scope of perinatal care and services.

Chapter II: Review of Literature

Examinations of the concepts and related care of the non-pregnant person with a history of childhood sexual abuse have yielded a plethora of anecdotal articles concerning care for CSA survivors within perinatal services (Bohn & Holz, 1996; Burian, 1995; Courtois & Riley, 1992; Grant, 1992; Holz, 1994; Simkin, 1992; Waymire, 1997) such as office, hospital, and prenatal childbirth classes. There is limited research, quantitative and qualitative, which reflects the meaning and experience of childhood sexual abuse and implications for care of survivors in perinatal and other settings (Schacter et al. 1999). To date no studies were discovered that pertained to the phenomena of the meaning being a pregnant survivor with a history of CSA during perinatal care and services. The review of literature concerning this phenomenon will be divided into three major foci; long-term psychological consequences, stigma, and disclosure of stigmatizing conditions.

Long-term Psychological Consequences

Health literature abounds with articles and research on childhood sexual abuse, its consequences and sequelae. This literature can be broadly grouped into two categories, psychological and physical. Most scholars agree that childhood sexual abuse may lead to a variety of physical and mental disorders later in life, but as yet direct causal relationships have eluded the scientific community. There are few studies that explore the phenomena of CSA, disclosure, and childbirth, particularly during the perinatal period. However, there are studies that have reported the psychological trauma of women who were sexually abused as children.

Draucker's (1993) qualitative study reported on sources of trauma of CSA in women. Eight categories emerged. They are identified as powerlessness, abandonment, violence,

betrayal, guilt and shame, loss of self, loss of childhood, and impact on sexual adjustment. The foremost reported psychological symptoms of women who have been sexually abused as children are: depression, guilt, low self-esteem, poor body image, inability to trust others, flashbacks to the sexual abuse, anxiety, anger, confusion, and dissociation (Brown & Garrison, 1990; Herman et al., 1986; Hulme & Grove, 1994; Jackson et al., 1990).

The aforementioned sequelae have been linked to possible problems and situations during the perinatal period that could cause further psychological trauma to women with a history of CSA (Burian, 1995; Courtois & Riley, 1992; Grant, 1992; Holz, 1994). During the process of labor and delivery and the postpartum period, there are treatments and procedures that can decrease the amount of control women have over their bodies and the situation. Waymire (1997) stressed the importance of giving women control in all procedures including asking permission to proceed with vaginal or other body part examinations. Control was the single most important issue for women during the childbirth experience reported by Burian. Since victims of childhood sexual abuse feel betrayed by an authority person such as a father, they try to regain a sense of control through various mechanisms. They try to gain or keep control through elaborate birth plans, aggressive behavior, or creating chaos in an attempt to adhere to their agendas. Some women describe adopting a demeanor of passivity as a means of control. It is the same demeanor the woman as a child, assumed during the abusive situation (Burian; Grant).

Women, who have been sexually abused as children, sometimes believe their bodies do not function correctly leading to poor self-image, poor self-esteem, and anxiety. They are unsure and anxious not only about whether their bodies will work right but are anxious over the environment; including the use of equipment and invasive procedures that may replicate the abuse (Burian, 1995; Kitzinger, 1992; Waymire, 1997).

Dissociation is also a coping mechanism for women who have been sexually abused as children. Dissociation is a defensive response to overwhelming psychological trauma. It is the process of going numb, staring, or blocking the bodily pain of the abuse. Victims of CSA disassociate from their bodies to help them cope and survive the abuse. This numbing process may be carried through into adulthood and used in time of a painful experience such as childbirth to cope with pain that resembles the pain experienced during the abuse (Burian, 1995; Kitzinger, 1992; Lubin, Johnson, & Southwick, 1996).

Schacter et al. (1999) studied twenty-seven adult females who had been sexually abused as children and their reactions to physical therapy and how therapists could be more sensitive in their care. Many of the survivors stated feeling safe was a crucial part for them during physical therapy. Many of the suggestions for creating a safe environment involve health practitioners and dimensions of care.

According to Schachter et al. (1999) the first suggestion for health practitioners is one of establishing and maintaining a trusting relationship with the woman that involves communicating clearly, connecting, and validating the client. Another suggestion for sensitive care included establishing a partnership with the client which includes sharing control, obtaining consent for components of therapy, respecting the clients tolerance for treatments, giving permission to say *no*, and be willing to give alternatives. Further suggestions were giving the CSA survivor the choice in choosing the gender of the therapist, give alternatives in privacy, clothing, disrobing, body positions, and touch. A few final suggestions for health practitioners were to respond sensitively to and understand attitudes about their bodies, pain, triggers, dissociation, and disclosure about childhood sexual abuse.

Life events may trigger memories of childhood sexual abuse. Pregnancy and birth can trigger memories of CSA. Flashbacks of previous childhood sexual abuse can be triggered by nakedness, a particular position, smell, touch, or the gender or look of a certain caregiver. Flashbacks can cause great anxiety, tension, rigidity, or a change in breathing patterns (Kitzinger, 1992; Simkin, 1992). All of these symptoms can interfere with the process of labor and delivery and the postpartum experience (Olds, London, & Ladewig, 2000).

Women desire safety for them and their child during the childbirth experience since it can be a vulnerable and fearful time. This is especially true for women with a history of childhood sexual abuse. A safe environment is needed for disclosure of childhood sexual abuse (Schachter et al. 1999) and disclosure is needed to create a safe environment.

Stigma

Survivors of childhood sexual abuse often do not risk disclosure because of perceptions they believe that are held by society. Goffman (1963) defined stigmatized as having a “spoiled” identity by a discrediting attribute, which leads to a person’s disqualification from full participation in society. Joachim and Acorn (2000) state “stigmatization is a process by which society bestows its own negative meaning on the behaviours, signs, or attributes of an individual” (p. 39). Survivors of childhood sexual abuse fear they will be “frowned upon” or rejected by others and the survivors will then feel self-blame and shame (Teram et al. 1999). However, Katz (1981) states the public often has a mixture of feelings toward a stigmatized person. Society may feel contempt, be shocked and dismayed, but also feels great compassion. The divergent feelings may lead to erratic, inconsistent, and uncertain behavior toward the stigmatized person.

Goffman (1963) in describing the spoiled identity person divides the individuals into two groups. One group is the *discredited*; the attributes of stigmatization are obvious as in blindness or other physical disabilities. When the stigmatizing condition is not immediately visible, as in the case of childhood sexual abuse or infertility, the person is *discreditable*. The discreditable individual must always make a choice whether to disclose or not disclose.

Tomlin (1991) studied if stigma is felt toward incest survivors, and how relationships affect the level of stigma. Incest survivors of varied ages, races, and both genders were included in this quantitative study. The results suggest four conclusions concerning this phenomenon.

The first conclusion was that an extreme level of discomfort was not seen in any relationship for either gender. The mean score was neutral at 3.07 on a Likert scale of one meaning very comfortable to five being very uncomfortable. A second conclusion was that both genders would experience less discomfort if a history of incestuous abuse was disclosed to a partner in an established relationship (1 year, composite mean of 2.24), rather than a new one (1 month, composite mean of 2.56), regardless of the gender of the friend.

A third conclusion was that women valued the nature of the relationship (friend verses dating) as an important factor. Women were more comfortable with new friends (2.53) than with dating relationships (3.19), whereas men opted for length of the relationship (2.18). A final conclusion compared marriage and parenting. Women demonstrated a greater level of discomfort in every relationship that involved children. They were more comfortable with marriage without children. The men were comfortable regardless of the relationship. They “were more comfortable sharing parenting with an incest survivor than were women” (p. 563). The length of the relationship was more important to the men, however the nature of the relationship was more important to the women in this study.

The study points to the differences between men and women survivors and stigma. Although stigma toward the incest survivor was present, it was not extreme. More importantly, it demonstrated that the nature of a relationship, regardless of the length of time was more important to women survivors. Other hidden conditions of women such as infertility and being a lesbian can be stigmatizing.

Whiteford and Gonzalez (1995) reported on the hidden burden of infertility and stigma. Infertile women are among the *discreditable* (Goffman, 1963), due to the invisibility of their condition. They display no attributes of an obvious stigmatization, “only their own knowledge of their condition distinguishes them from others” (p. 28). Involuntary childlessness becomes an abnormal condition in a pronatalist society. Women in this study expressed the stigma of childlessness manifested as being somehow different, being handicapped, ostracized indirectly and directly, and feeling isolated and violated. Infertile women feel as if they have broken an unspoken cultural rule, classify themselves as “other,” and are misunderstood and rejected. This analysis coincides with Goffman’s work on stigma where discreditable individuals have broken group norms. Another group of women who might be considered discreditable is lesbian women because of the perception by society that they have also broken group norms.

Stevens and Hall (1988) studied lesbian women, stigma, health beliefs, and experiences in the health care environment. Forty eight percent of the 27 women interviewed felt they were easily recognizable as a lesbian. They felt because of the attributes they displayed such as a more purposeful carriage, a more athletic body, open, definite body gestures, and more of a casual mode of dress and hairstyle they were more recognizable as lesbians. They included character demeanors such as self-reliance, assertiveness, confidence, persistence, strength of will, and more independent as making them identifiable as lesbians. Social factors of political

activism, feminism, and minority rights also add to their being identified as being lesbian. When lesbian women chose to conceal who they are “and avoid stigmatization, comprehensive management of that information involves vigilance about the intimate details of who they are, how they act, how they look, what they say, who they are with and where they are” (p. 71). It is a combination of physical, psychological, and social factors that lesbian women believe distinguish them from nonlesbian women.

The stigma of being lesbian may occur in any encounter with health care providers. Stevens and Hall (1988) found that many lesbian women avoided mainstream health care because the women had an overwhelming mistrust of the health care system and its ability to care adequately and safely for them. Lesbian women’s fear of the health care system was delineated by interactions with health care providers. Seventy-two percent of lesbian women had experienced negative encounters regardless if disclosure was verbally given or noted by their appearance and behavior. They described being responded to as being ostracized, shock, embarrassment, unfriendliness, pity, condescension and fear.

Because health care providers have responded to lesbian women in this manner, 96% felt it would be harmful to them if the health care provider were to know they were lesbian. However, every woman in the study thought it would be important for her providers to know about her lesbian identity so they could deliver optimal, comprehensive care. The participants noted that positive encounters with health providers were when they were treated respectfully, maintained a calm and supportive demeanor and treated them like anyone else. This supports Limandri’s (1989) study concerning disclosure of stigmatizing conditions and Whiteford and Gonzalez’s (1995) research on stigma and infertility. The participants in both studies also feared rejection, other people’s irrationality, and disclosure would make matters worse. As with lesbian women,

the subjects stated it was helpful when treated with respect, compassion, and others were non-judgmental. Disclosure would only occur when the person disclosing thought it was safe to do so (Limandri; Stevens & Hall, 1989).

Stigmatization of people may cause feelings of shock, dismay, contempt, rejection, and fear for the stigmatized and the person to whom the stigma is disclosed. Regardless of the stigma, it is important that behavior toward the discreditable and discredited be one of compassion and respect.

Disclosure of Stigmatizing Conditions

Several studies discuss disclosure of stigmatizing medical conditions such as abuse, HIV/AIDS, human papillomavirus, and herpes. Some of these studies (Gielen, O'Campo, Faden, & Eke, 1997; Keller, von Sadvoszky et al., 2000; Limandri, 1989; Schachter et al., 1999) have been from the perspective of the person disclosing and the contact, or the person to whom the secret was revealed. To date no studies were discovered that pertained to disclosure, CSA, and the childbirth experience. However, parallels can be drawn from previous empirical research on disclosure of other stigmatizing conditions and disclosure of childhood sexual abuse.

In a qualitative study by Limandri (1989) the role of disclosure in seeking help for stigmatizing conditions was discussed. All the respondents felt stigmatized or ashamed of their conditions, which were AIDS/HIV positive, herpes, or being an abused woman. The informant's rank-ordered stigmatizing conditions. "Invariably abuse of any kind (childhood, spousal, etc.) was harder to disclose and was even not disclosable" (p. 75). The respondent's explicated four reasons for non-disclosure. They were fear of rejection, fear of the secret getting out of their control, not knowing how to discuss the secret or condition, and believed that disclosing would

make matters worse or expose them to other people's irrationality. Disclosure would more likely occur when the person disclosing felt it was safe to do so. The respondents stated it was helpful when health care providers acknowledged the disclosure and treated them with compassion, respect, and were non-judgmental.

The response of the confidant was the most important factor for disclosure to occur. Positive responses from professionals were listed as reassurance, instilling of confidence, and providing information. Negative responses were rudeness, non-acceptance, rejections, and mistreatment.

Gielen et al. (1997) reported on the experience of women's disclosure of their HIV status. Four main themes emerged concerning the fear of disclosure, which support Limandri's (1989) study. The four fears were rejection, discrimination, public ignorance, and violence. The women perceived public ignorance about HIV/AIDS as the foundation for their fears prior to disclosure.

Following the women's disclosure of their HIV/AIDS status four themes emerged. They were acceptance, emotional upset, rejection, and violence. However, some of the women reported feeling a sense of relief after disclosure despite experiencing abandonment, rejection, and physical and verbal abuse (Gielen et al. 1997).

In a recent study about self-disclosure and human papillomavirus (HPV), Keller et al. (2000) focused on disclosure decisions including factors influencing disclosure decisions, results of disclosure, and the moral obligation to disclose. Individuals newly diagnosed with HPV were divided into two groups; the same relationship at point of diagnosis and new relationship since diagnosis. In the same relationship group the overriding factor for disclosure of HPV to the partner was one of moral obligation. The respondents expressed it was morally right to disclose,

that honesty in a relationship was important, and they had a concern for their partner's health (p. 292). In the new relationship group the two foremost factors for disclosure was concern for the partners health and feeling morally obligated to reveal the diagnosis. In evaluating their decision to disclose both groups (94% and 100% respectively), felt happy, relieved, and felt they had made a good decision. Knowledge of their diagnosis or disease process had little effect on their decision to disclose.

The health care literature documents the existence of long term psychological consequences, stigma, and disclosure of some stigmatizing conditions; however, little research is available concerning how pregnant women disclose the stigmatizing condition of childhood sexual abuse to perinatal care providers. Thus, a substantial need exists to begin exploration into the meaning of a history of CSA to pregnant survivors during perinatal care and services. This study is proposed as a starting place to provide the clinician with a developing theory for evidenced-based practice.

Chapter III: Methodology

Qualitative research is a nonmathematical, systematic, empirical method in which the world. It is a way to interpret data, to give meaning to individual's experience with a particular phenomenon. Qualitative research can be used to discover theoretical frameworks, variables, concepts, or theory that may be tested quantitatively or explored separately from the original research. It leads to theory building in order to give meaning to the whole (Denzin & Lincoln, 2000; Strauss & Corbin, 1990). "Qualitative methods can be used to uncover and understand what lies behind any phenomenon about which little is yet known" (Strauss & Corbin, 1990, p. 19). It is a research design that employs inductive and dialectic reasoning to generate knowledge and to perceptually put pieces together to create a whole within a particular truth and reality. Strauss and Corbin (1990) state "The purpose of grounded theory method is, of course, to build theory that is faithful to and illuminates the area under study" (p. 24).

The responsibility of the qualitative researcher in conducting a study on a particular phenomenon is to interpret the data to reflect the most accurate picture of the informants' thoughts and meanings. It attempts to give an accurate account of the reality of the informants' world and point of view (Strauss & Corbin, 1990). The account of reality must make sense to those practicing in that particular area. In an area where little is known, qualitative research is the method of choice for the researcher (Strauss & Corbin, 1990). It can give the phenomenon a foundation on which the researcher can build further theory, concepts, influence nursing practice, and continue the research process (Glaser & Strauss, 1967).

Grounded Theory

Generating theory will be the goal and outcome of the proposed study concerning the meaning of childhood sexual abuse and pregnant survivors. The scarcity of research concerning

CSA survivors within perinatal settings necessitates an empirical study that explores this phenomenon from the perspectives and voices of survivors. The type of qualitative research in this study will be grounded theory using constant comparative analysis (Glaser & Strauss, 1967).

Grounded theory is the discovery of theory from raw data. The data is “systematically obtained and analyzed and ... can be furthered” (Glaser & Strauss, p. 1). A provisional theory is generated from raw data. The development of theory involves a process of research. Concepts, statements of relationship, hypotheses, and theory are derived and emerge from the data in qualitative research (Glaser & Strauss). As data is gathered through continued substantive studies, the theory may further evolve and ultimately relate to other theories within a respective discipline (Strauss & Corbin, 1990). Grounded theory provides the researcher with relevant predictions, explanations, interpretations and applications from the particular phenomenon studied (Glaser & Strauss). Denzin and Lincoln (1998) note that there are no objective observations. There are only observations, which are socially situated in the worldview of the observer and the observed. Through grounded theory method the researcher focuses on how human beings are related to each other in their respective worlds. “The design serves as a foundation for the understanding of the participants’ worlds and the meaning of shared experience between the researcher and participants in a given social context” (Janesick, chap. 2, in Denzin & Lincoln, 1998, p. 37).

Constant Comparative Analysis

Comparative analysis is a general strategic method for generation of theory (Glaser & Strauss, 1967). Glaser and Strauss delineate five purposes of constant comparative analysis. These are, verifying accurate evidence or facts, establish the generality of a fact, to specify a unit of analysis or concept, verify emerging theory, and generating theory. The comparative analysis

method develops two types of theory, substantive and formal. This method requires the researcher to obtain many carefully selected groups for comparison. This is done so the researcher can account for much of the relevant behavior within a specific phenomenon, not so the researcher can know the whole of the phenomenon (Glaser & Strauss). The systematic method of constant comparative analysis joins explicit coding and analysis procedures to generate theory. This method helps the researcher to generate a theory that is integrated, consistent, plausible and close to the data (Glaser & Strauss, p. 103).

Constant comparative method requires through theoretical sampling, theoretical saturation of data to generate and plausibly suggest categories, properties and hypotheses about certain phenomenon. When theoretical sampling is conducted at the same time as coding and analysis, a theory will emerge from the data. This method starts with coding each incident or interview for as many categories of analysis as possible. As the data emerges, it will either fit the categories or the categories will fit the emergent data. During coding an incident, it will be compared to previous incidents and different groups coded in the same category (Glaser & Strauss, 1967). As coding and analysis continues, properties of the emergent categories will begin to appear. Through constant comparative analysis, the properties will begin to be integrated. As the process continues, categories will begin to be integrated with other categories. Through ongoing theoretical sampling, constant comparison of categories and properties, the emergent theory becomes more solid and categories can be integrated and collapsed into higher level concepts that help formulate the theory. The reduction of categories and terminology helps the theory to become more generalized (Glaser & Strauss). Through the use of all of these mechanisms and memo writing that is constantly compared for analysis, the researcher can arrive at a provisional substantive theory for this particular phenomenon. A substantive theory may be

modified in the future as further research within the same phenomenon is studied and compared to other substantive theories with the same theoretical framework.

Substantive theory involves an empirical area of sociological study whereas; formal theory is developed for a conceptual or formal area of sociological inquiry (Glaser & Strauss, 1967). Both theories, substantive and formal, must be grounded in data. This study will focus on the substantive area of the meaning of being a pregnant survivor with a history of childhood sexual abuse during perinatal care.

Comparative analysis in this study will be between groups within the same substantive area, which are pregnant survivors with a history of CSA. Initial comparative analysis will begin by analyzing data collected from pregnant survivors who encountered perinatal care and services through the experience of their first pregnancy and delivery. As the data emerges, subsequent constant comparative analysis may indicate the need to seek pregnant survivor participants who have previously encountered perinatal care through previous pregnancies and delivery. Concepts and hypotheses will emerge from the data. Substantive theory can help to develop formal theory. Constant comparison analysis moves the raw data or facts into a substantive theory and progresses to a formal grounded theory.

The design of constant comparative analysis leading to substantive and formal theory begins with the facts or raw data through participants in the research. The voiceless, marginalized group of women known as pregnant survivors of childhood sexual abuse will be given a voice.

Feminist Theory

Feminist theory has a goal of feminist knowledge. Feminist knowledge must ground its examination of a phenomenon in the experiences of women. A goal of feminist knowledge is to

see the world from the perspective any one woman or a group of women. A feminist perspective has characteristics of unity and relatedness, contextual orientation, and subjectivity on the lived experience of women (Bunting & Campbell, 1991). Thus, women have multiple explanations of reality.

Epistemological issues surrounding feminist thought are, women can be knowers, their experiences are valid sources of knowledge, informants are experts on their own lives, subjective data are valid, knowledge is contextual and relational, and personal and political boundaries are indistinct and artificial as are the boundaries between theory and practice (Bunting & Campbell, 1991). Feminist perspective in research concerns inquiry about and for women. The researchers' biases are a part of the data. Participants and researcher are partners in the study with observations and interpretations validated by participants. Feminist perspective in research requires reflexivity, which advocates a reciprocal relationship with participants to endeavor to understand the world, through their eyes and context (Wuest, 1995). Reflexivity is the opposite of constructing a viewpoint of participants' voices and social reality from the outside. It is constructing reality from the inside. "In feminist research, women's perspectives are afforded primacy" (Hall & Stevens, 1991, p. 17).

Feminist Perspective and Grounded Theory

A feminist perspective and grounded theory fit well together in the discovery of knowledge about and for women. Grounded theorists are seeking the basic social process that accounts for the majority of variation in behavior within a contextual and interactional process (Wuest, 1995). A feminist perspective in this research will be conducted seeking the basic social process about the meaning of childhood sexual abuse during perinatal care and services. It is within the context of CSA that the voices of the marginalized group of pregnant survivors will be

heard. A feminist approach in grounded theory will strengthen the emergent fit of the data into concepts of this phenomenon.

Grounded theory focuses on emerging concepts from data that yields a substantive theory. It is not a static process, but allows the researcher to deepen the core categories through divergent interviews and constant comparison. Likewise, feminist perspective seeks to illuminate the process through the diverse voices of the pregnant survivors. Through constant comparative analysis in grounded theory, participants can clarify and help interpret the data surrounding childhood sexual abuse and its meaning to pregnant survivors during perinatal care.

Research Questions

Questions in grounded theory are guided by the data. In this research study it is the voices and reality of pregnant survivors of childhood sexual abuse that will yield the data. “The research question in a grounded theory study is a statement that identifies the phenomenon to be studied” (Strauss & Corbin, 1990, p. 38). Grounded theory questions begin in a broad sense and progress to a more narrow focus during the research process. Concepts and hypotheses are discovered, and relationships in the concepts are evaluated if they are relevant or irrelevant to the phenomenon (Strauss & Corbin). One broad question and subsequent narrower questions will guide the semi-structured interviews. Listed below are the purposed questions.

Broad question:

1. What is the experience of being a pregnant survivor with a history of childhood sexual abuse and experiences during perinatal care and services?

Subsequent questions:

1. Tell me about a visit you had with your (provider) that went well while your were pregnant.

2. Tell me about a visit you had with your (provider) that did not go well while you were pregnant.
 - A. Describe how you handled treatments and procedures during your pregnancy visits to your provider.
3. Tell me about a labor and delivery experience that went well.
4. Tell me about a labor and delivery experience that did not go well.
 - A. Describe how you handled treatments and procedures during your labor and delivery experience.
5. Tell me about a postpartum experience that went well.
6. Tell me about a postpartum experience that did not go well.
 - A. Describe how you handled treatments and procedures during your postpartum experience.
7. What would you like to tell nurses in perinatal settings in caring for survivors of CSA?
8. What would you like to tell (providers) in caring for survivors of CSA?
9. Is there anything you wish to add?

As the data dictates, concepts will be discovered and questions may become more focused. This enables the researcher to stay within the boundaries of the phenomenon being studied. Researchers cannot explore all aspects of phenomenon to be studied. Research questions are meant to narrow and focus a problem into a workable size (Strauss & Corbin, 1990). By focusing back into the data, research questions, and validating meanings during interviews, the researcher can become more focused during the process to be able to discover concepts that are relevant or irrelevant to the phenomenon (Glaser & Strauss, 1967). This initial study will focus on female CSA survivors within the boundary of perinatal services. Data and refined questions

will focus only on this aspect of the reality of female childhood sexual abuse survivors.

Questions can and should be refined during the process of research to increase clarification of the phenomenon and reality of the participants.

Participants

Theoretical sampling is inherently intertwined with theoretical sensitivity in grounded theory process. Theoretical sensitivity is the awareness by the researcher of the subtleties or nuances of the meaning of the data. It is an attribute of having insight, understanding, and being able to separate what is relevant or irrelevant about and from the data (Strauss & Corbin, 1990). Theoretical sampling occurs through the process of collecting, coding, and analyzing data. It is the process by which the researcher decides what data to collect next to further develop the theory. This type of sampling is controlled by the emerging data. Through the researcher's theoretical sensitivity and initial collecting and analyzing data, further theoretical sampling is chosen. Subgroups or groups are selected to enhance the theoretical purpose and add to the density of the phenomenon under study (Glaser & Strauss, 1967). As the process develops emerging gaps in the theory can be answered by questions derived from previous answers from previous data.

For the present research study simple and general comparisons are suggested to control the effect of the scope of the population and the conceptual level of the theory. Compared groups must show enough similar features, which will enhance theoretical relevance. Thus, with similar conceptual and theoretical relevance through compared groups, categories and properties of each group will help in discovering theory. The data or facts can then be held constant. Control of the groups compared helps in excluding unwanted differences, which has no conceptual or theoretical relevance to the substantive theory under study. Simple comparisons

lead to a substantive theory of one type of group. As different types of groups are compared, a substantive theory can become more general. Comparing different groups within larger groups, and/or different regions can increase generality of a theory (Glaser & Strauss, 1967). The scope of groups proposed for this grounded theory study will begin with interviews of women with a past history of CSA over the age of 18 who have delivered within approximately one year.

Simple comparison analysis for related concepts and theoretical relevance would begin with the aforementioned women who have had their first encounter with perinatal care and services.

Constant comparison analysis will continue with simple comparisons that encompass women with a history of CSA who experienced a second or more encounters with perinatal care and services. The initial two groups were chosen to begin to form an emergent analytical framework to discover a substantive theory. Glaser and Strauss state “The scope of a substantive theory can be carefully increased and controlled by such conscious choices of groups” (p. 52). There is no *set* number in a grounded theory research project. As Glaser and Strauss emphasize, the number of groups and types of groups are cited at the completion of the project. Each researcher engaging in grounded theory collects and analyzes data until each category is saturated, in other words, until no new data is being presented from the groups or participants. In continuing research on this phenomenon it may come to be revealed that other groups or subgroups such as race, ethnicity, age, or level or therapeutic status could systematically generate theory and add depth to the initial substantive theory, thus moving the phenomenon toward formal theory.

Following approval by the University of San Diego Institutional Review Board, women for this initial research project will be recruited through contact with therapy groups, perinatal provider’s offices, and clinics through explanatory recruitment letters. Public newspapers and flyers will also be used. Written, informed consents will be obtained for participation with full

disclosure concerning the study. A resource list of psychotherapy support with names, addresses, and telephone numbers will be provided to the woman in her geographical area should the need for such support arise during the study. Participants will have the opportunity to question and contact the researcher during the research process or stop the interview at any point. All data will be kept in a locked file and only the researcher will have access to these materials. The identity of each participant will be kept confidential by assigning a pseudonym and keeping all consent forms in a location separate from the data.

Data Collection

Demographic data such as age, race, gravid, para, abortions, marital status, age at onset of sexual abuse, years/months of abuse, age at cessation of abuse and if the women currently or in the past has sought psychotherapy will be gathered. Information such as environment, where perinatal care and services occurred and gender and professional status of the perinatal provider will also be a point of inquiry. Descriptive statistics will be used to analyze demographic data.

Interviews will be tape recorded. The investigator will also take salient notes during the interviews from which to make theoretical, methodological, and observational memos. The initial interview will be unstructured, but will proceed to a more structured process as the interview continues or dictates. Each interview will be conducted in an environment that is private and acceptable to the participant and is estimated to last one hour. Tape-recorded interviews will be transcribed and the constant comparison method will be used to determine core categories. Review of audiotapes and memos will be extensive to interpret the thematic categories. It is anticipated that saturation of core categories will occur following the interviews of ten to twelve participants. Thus, a total of approximately twelve to fifteen participants are

anticipated. Results of the initial substantive grounded theory will be shared with participants if they so desire.

The Researcher

The researcher has over twenty years as a perinatal nurse in which she has handled many various situations involving women in childbirth. She has cared for women with high and low risk factors, different races, marital, life style, and socioeconomic statuses. She has cared for women who experienced vaginal and cesarean births. The researcher has been involved throughout a pregnant woman's course of care and services which includes antepartum, intrapartum, and postpartum. The researcher is currently a maternal/child assistant professor in a private university. In this current role she continues to encounter pregnant women, nurses, and students of varying ages and histories that are not aware of the potential or real problems that may arise from a history of childhood sexual abuse and the unheard voices of this group of vulnerable women.

The researcher is also a student of qualitative research, a feminist, and a woman who has not experienced childhood sexual abuse, but feels a passion to give survivors special nursing care throughout perinatal care and services. The investigator, through an incident in an acute facility, realized that much is unknown about the meaning of being a pregnant woman who has experienced childhood sexual abuse and encounters the perinatal environment for a set period of time for a specific purpose. This nurse also realizes that she may have taken care of CSA survivors antenatally, in labor and delivery, postpartally, and in childbirth classes unknowingly and could have done nursing care differently. Conducting care that could be perceived by the survivor as harmful psychologically or physically is an antithesis to her nursing practice and spiritual being. This nurse and researcher desires to know a patients' problems or history to

provide correct, safe, and optimal nursing care, albeit *different* from the norm of perinatal nursing. Nursing knows little of what CSA survivors know of their unique experience during pregnancy and perinatal care. The bias of this researcher suggests that it is time to discover the meaning of the survivors' experience; that the secrecy of childhood sexual abuse must be addressed to change not only the women's lives, but also to benefit their experience during the process of pregnancy and childbirth. Childhood sexual abuse and its meaning during pregnancy while encountering perinatal service and care needs to be investigated. Through this initial substantive grounded theory and continuing grounded theory research, changes in perinatal care for the pregnant survivor could occur.

The researcher is highly reflective and motivated to change the perspectives of nurses, perinatal health providers, and acute facilities concerning the comprehensive, individualized care that is needed for survivors. The researcher is committed to education of other survivors, women, nursing students, and practicing perinatal health practitioners about CSA survivors' special needs, feelings, and worldview.

The investigator will continue to read about the context of childhood sexual abuse and will support this research with known psychiatric experts, her dissertation committee, and meritorious resources. This research hopes to be the beginning of a foundation for theory surrounding pregnant survivors of childhood sexual abuse, which will lead to changes in perinatal services and practices.

Chapter IV: Findings

The constant comparison method of the grounded theory was used to analyze data. The method is described in detail in Chapter III. This approach to data analysis begins to conceptualize the complex and interrelated concepts of the basic social process of aligning personhoods of pregnant female survivors for successful childbirth through discerning safety and managing vulnerabilities. The analysis included identifying the circumstances and context of being a pregnant survivor of childhood sexual abuse. Positive and negative experiences of survivors during perinatal services of antenatal, labor and delivery and postpartum care were identified and analyzed.

Each transcript was read a minimum of two times and read along with the recording of each interview to verify transcript accuracy and interpret tone and inflection from the participant. Coding of the raw data was completed on each interview. Some of the themes that emerged from coding the first interview were: focusing on a healthy baby, being upset, painful to be yelled at, wanting direct communication, recalling pain, trigger points for memories of CSA, separation of birth vs. CSA trauma, disregarded, being told ahead of time, different focus, put woman in control, no trust, and not feeling safe with anyone. These themes were compared to the second interview and further themes emerged. Some of the themes that were compared and corresponded were: provider assumptions of positive sexual experience, shock, shame, embarrassment, desiring equanimity, remembering deep hurt, hurtful language, rejection of provider, minimal relationship, impact on self, disgusted with vaginal exam, disassociate, no recognition of her personhood, feeling uncomfortable, trigger, flashback, not vigilant, naïve, innocence stolen, ashamed, re-violation, survivor disdain, wrong sexual/self assumptions, safety

through presence, safety through words, instructions, no absolute trust of males, always mistrust, validating the survivor, establishing a positive connection, establishing a negative connection, extremely afraid, trauma equals birth defect, no self-confidence, excited and scared, needing self validation, external validation, overwrought with fear, flashbacks, numbing, enduring procedures, establishing safety through connection, encouraging words, desiring different care, disregarded, asking for safety, recognition as whole person, safety through presence, to be safe must be numb, depressed, determined, being alert in the world, involvement in intimate world, showing regard through teaching/telling, regard through options, regarded through control, no choices, not worthy, no rights, not regarded, ask/give choices, regard as whole person, flashbacks with males and being wary. The previous themes were compared to themes that emerged from the third participant. Some of the themes were: lack of trust, rushed, disregarded, informed prior to touching, trust, vulnerable position, uncertainty, lack of control, safety in simple differences, options, asking, choices, flexibility of practitioner, history not relevant to care, situational handling of CSA, still grieving, time allowed, concerned about the whole person, environment of trust, clear memory, uncomfortable, needing respect, disregarded, survivor vulnerable, no time allowed for person, trapped between knowing and acting, being paralyzed, numbing equals paralyzed, making choices to feel safe, feeling respected, recognized, establishing connection, respect, survivor control, scared, depersonalized, fear of pain, fear of treatment, perceiving a safe environment, impersonalization, asking/giving options, recognizing self in environment, exposed, unnatural, lack of consideration for survivor, spotlighting the abused area, vulnerable, disregarding women's personhood, crying with fear, recognizing self-trust, dismissing self, fears, reconciling self to embryo/fetus, giving permission to fetus to be there, environment violated, nightmares, confirming value of each pregnancy, valuing verses invading, woman to woman

care, reassurance, ask, fighting for self, creating normalcy, fear of pain in genitals, being exposed, connecting pain and abuse, numbing, chancing illness rather than remember pain of CSA in genitals, dreaming of alternatives to the focusing on genital area, support/presence, relief in disclosure, individualizing care, unable to voice pain, need of privacy to be safe, had to be quiet during abuse, and feeling exposed. Some concepts emerged from the data from interviews one, two and three. Concepts such as validation and whole persons were prominent. The themes from interviews one, two and three were summarized and collapsed into subcategories. The subcategories were *creating an environment of trust* and *establishing a relationship*.

Creating an environment of trust means making it safe for the survivor through different mechanisms such as trusting the provider, trusting their bodies, being allowed time, being given options, choices, being asked being informed prior to, education and providers not making assumptions about the survivors. Establishing a relationship entails making eye contact, tone of voice, listening, hearing the survivor, appropriate (motherly) physical contact, respect, making a connection through conversation, individualizing care, and recognizing the survivor as a whole person. Part of this phenomenon involves creating an environment of trust.

As the interviews of participants four, five, six and seven were coded and compared more refined themes began to emerge. Coding incidents were compared to previous coding incidents. The themes that emerged from collapsed codes were *discerning safety, making health decisions during perinatal services, innocent normalcy, presence, asking, give options/choices, focus on pregnancy, and forge ahead*.

Making it Safe emerged as a category after collapsing codes. This category included such themes as discerning gender practitioners, presencing choosing female knowing, questioning self, discerning safety, blocking, and positive connection. Another emergent category was

desiring equanimity which included the themes of no label, victim, survivor, desiring normalcy, identity, questioning stigma, rejecting stigma, desiring professional deference, and awareness. *Sorting of self* was a third category which emerged containing themes of innocent naiveté, innocent vulnerability, recognizing vulnerabilities to personhood, feeling deeper, recognizing not in control, dual identities, desiring professional deference, and sorting realities. Two other categories emerged which were, *making it safe for others* and *forging ahead*.

Making it safe for others contained themes such as protecting, being vigilant, enduring procedures, keeping the status quo, advocacy, helping, and desiring openness from other survivors. *Forging ahead* contained the themes of disregarding the disregarding, being asked, dealing with realities, it is what it is, overcoming consequences, giving control to others, feeling normal, accepting control, rejecting stigma, choosing differently for self, inner strength and rejecting shame.

Codes and themes were compared and collapsed through interview ten. Major categories which emerged were: *personhood*, *making it safe*, *feeling unsafe* and *managing vulnerabilities*. *Personhood* contained the collapsed themes of child victim, survivor and pregnant female. *Making it safe* emerged from the collapsed themes of discerning, presencing, provider gender preference, unobtrusive, and taking control. The collapsed themes of innocent vulnerability, innocent naiveté, assumptions, panic/extremely anxious, surprise, scary, power imbalance, disregarded and hidden secrets formed the category of *feeling unsafe*. The category of *managing vulnerabilities* emerged from the collapsed themes of gender preference, changing, insurance/providers, and confronting.

Coding and collapsing the data in interview eleven helped change and finalize the emergent final subcategories and categories for the basic social process. The subcategories of

presencing, being disregarded, regarded, provider gender preference, managing vulnerabilities, no labels, enduring, focusing differently and making it safe emerged.

Through continued comparison of themes, subcategories and re-reading of transcripts; final subcategories and categories were discerned. The major categories of *discerning safety* and *managing vulnerabilities* were finalized. The category of *discerning safety* contains the merged subcategories of provider gender preference, disregard/regard, assumptions, and attitudes/actions. The category of *managing vulnerabilities* contains the merged subcategories of controlling actions, avoiding/delaying, enduring, presencing, changing and rectifying pregnancy. The subcategories of *focusing differently to get through, the spoiled* and *aligning personhoods* helped to formulate the basic social process. Through constant comparison of the data it emerged that pregnant survivors align personhoods to discern safety and manage vulnerabilities through focusing differently to get through the spoiled during perinatal services.

Through constant comparison, properties of the emergent codes began to appear. Codes were grouped and integrated into themes and themes were collapsed into higher level subcategories and the subcategories were collapsed to major categories. The data formulated a basic social process. Coding memos were written with each transcript and included operational and theoretical notes which guided the researcher in the constant comparison analysis and in achieving a sense of theoretical saturation throughout the research process concerning childhood sexual abuse and pregnant survivors.

Childhood sexual abuse transcends all ethnic and socioeconomic backgrounds. This was found to be true in this sample of survivors. The participants were divergent in ethnicities and experience of CSA. Using feminist thought it was found that the participants were experts on their own lives and the researcher and participants became partners in the study. Many

observations and interpretations of the researcher were validated by participants as the research progressed. Through the process of feminist thought using constant comparative analysis in grounded theory, a model for a basic social process for pregnant survivors of childhood sexual abuse during perinatal care and services emerged. The present model is based on the data forming a substantive theory for this phenomenon. This chapter describes the model of the basic social process of the meaning of a history of childhood sexual abuse to pregnant survivors during perinatal services.

A Model of the Meaning of a History of Childhood Sexual Abuse during Perinatal Services

The model in Figure 1 depicts the substantive theory of, being whole: aligning personhoods through discerning safety and managing vulnerabilities by focusing differently to get through the spoiled for successful completion of pregnancy and childbirth during perinatal care. Each core category is interrelated and fluid with survivors. The processes are cyclical and intertwined to achieve a successful pregnancy and childbirth in a temporary circumstance for the survivor and fetus.

Being Whole: Aligning Personhoods

The process of aligning is the adjusting the parts of the triad of innocent child victim, pregnant female and adult survivor into one present personhood to accomplish a successful childbirth. The American Heritage Dictionary (3rd) edition defines aligning as “to adjust parts of a mechanism to produce a proper orientation” (p. 22). It is an interconnected, interlocked triad that is fluid. At times survivors can be the child who cannot express themselves well or function as an adult. However, they are functioning as an adult in the world. Survivors are responsible persons; going through education, obtaining and holding responsible jobs and careers, forming

Figure 1. Explanatory model of Being Whole: Aligning Personhoods to Achieve Successful Childbirth.

families and functioning within society. None of the survivors in this sample became pregnant as a result of their childhood sexual abuse. The survivors in this sample chose pregnancy as a life option. As a child victim and a survivor, an adult pregnant female is melded into one whole personhood to accomplish this chosen option.

Adult Pregnant Female

Adult pregnant female is one of the personhoods they are throughout antenatal, labor and delivery and postpartum care. At this time the survivor possesses many identities in their lives such as wife, partner, daughter, sister, employee, victim and survivor. Just as the other identities are present, so are the identities of victim and survivor. The adult pregnant female is the person making adult decisions, reflecting on the past, dealing with a past history of childhood sexual abuse and moving forward in life. Survivors speak of themselves as a *whole person*. The whole person is a combination or a melding together of the victim and survivor. It is the person they are *good, bad or indifferent*. This is the part of the triad that survivors want recognized, but not labeled. It is the part that survivors want health care providers (HCPs) acknowledge as the whole person or identity. This melded personhood is extremely attuned to discerning intentions, attitude and treatment from providers. The treatment and responses survivors receive may cause them to act or function differently during perinatal care or in the world. Survivors believe they feel *more deeply* than adult females who have not experienced childhood sexual abuse. One participant states, "...I look back on my childhood and I see all the good times and I see this has made me the person I am good, bad or indifferent." Another participant expressed this concept as, "I don't know what *normal* is, but you want to be normal ...like everybody else. One participant was explicit in explaining the concept of adult pregnant female,

...there are certain parts of me that *are* me because of that's what happened, but yet, I am a normal person. I can be a good mother, I can have relationships, I can do things and I can function. It's not going to make me go off the deep end or do this or that.

Survivors are "normal" female persons participating and functioning within society. This aligned person is the identity that seeks to accomplish a successful childbirth. The whole being is the aligned person includes the child victim.

Child Victim

Survivors are aware of their past history of childhood sexual abuse and how it has affected their lives. Survivors are aware that once they were an innocent child. When the abuse occurred then they became a victim because their innocence in being an untouched sexual being was taken from them unwillingly. However, as a child there is innocence in the knowledge of sexual matters. One participant speaks of the "six year old girl in there." Survivors are victims until they are able to be out of the circumstance of abuse or in some cases, until the adult female either remembers the abuse or becomes aware that childhood sexual abuse is abnormal or wrong and does not happen to every female child. Survivors are innocently naïve or vulnerable in their lack of knowledge at that point. As children they experience fears and are vulnerable, that makes children a target for becoming victims through no fault of their own. As the abuse occurs the child believes it is a normalcy of life. Part of the survivor's identity is the child victim.

Survivors can regress into being the victimized child during vulnerable times such as during pregnancy and perinatal care. One participant described the concept of innocent naiveté in being a child victim as "Well, I wouldn't know it wasn't ...out of the ordinary. Um, to me it was normal ...it becomes regular, I guess." Another participant states the concept of child victim in this way, "When I was a child I thought this happens to everybody. Or this is just how life is or

this is just what happens. You don't know any other life..." A third participant relates as a child would feel as she stated,

It's fear of the unknown and of being vulnerable. There is a certain amount of regressing that goes on because you're put in a situation that you're stuck in. You were eight, you were ten, you were twelve; however old your were; so you regress to that age...some of us do regress to that place where we were stuck. So, when I couldn't move off that table, I was probably eight years old.

The child victim emerges to become a survivor. Participants describe becoming a survivor at different times; yet express similar characteristics in that identity. It is the combined victim/survivor that incorporates the adult pregnant female in the whole being.

Survivor

The survivor is the person who has *lived through* the sexual abuse. A survivor is the victim that continues to grow and become the adult. It is this identity that carries the *scars or vulnerabilities* of the child victim. This is the personhood that functions as an adult and at a level for the betterment of themselves and others all the while being wary of present vulnerabilities. The survivor is "sorting" and incorporating personhoods. One participant states,

I've spent the first part of my life knowing not where I was going or why, just going through it. You don't realize that until your done and by the time I decided or I realized that I was doing that, I wanted to change directions. But, by then you have children and things and their lives and you never get to be what you want to be. You're there for other people. That really bothered me for a long time because I felt like my whole life was for other people. That I was nobody.

This same participant changes into a different personhood in survivorship. “Because there wasn’t anything I’d wanted from where I’d been. I did just really concentrate on trying to be certain things and I kind of modeled myself after other people; the qualities I had seen in other people.”

However the survivor incorporates the child victim identity into the survivor identity, the temporarily pregnant female will strive to align these two preexistent identities to achieve a whole being and a successful childbirth throughout the vulnerable circumstance of pregnancy and childbirth. In the process of aligning, the fetus becomes a focus of concern for the survivor. The added dimension of pregnancy may cause the survivor to focus differently on their body or purpose for the pregnancy.

Summary

Adult pregnant survivors are an integration of child victim, adult survivor and present pregnant female. However, survivors want to be recognized as a whole being. The temporary identity of a pregnant survivor is a cyclical and fluid process. One participant states,

I think I’m always a victim and am always a survivor because I could go into victim mode easy. It could be so easy for me...because it’s cyclical, I mean, your self worth is so low, hey, I’ll always be a victim. There’s always that bit of mentality in the back of your mind. But, I think that if you’ve lived through, you are a survivor. I think the minute it happened to you and you wake up the next day, even if it happens to you the next day, you’re still a survivor because you survived the first day. And so every day that you survive, you’re a survivor...We’ve lived with the scars on our bodies for two, three, myself seven years and you know, I’m a survivor by just living through that first day

plus, 365 days for seven years...like I said, I can sit back in the victim mode and be 'oh, poor me.' But, I just choose not to. That's just a way of looking at it.

Another participant speaks of this process of aligning personhoods as,

But as far as like moving forward I just try to deal with it in bits and pieces because I know how I want to live the rest of my life. I've tried reading on it, but when I read on it I get depressed. I've tried therapy, I couldn't do it. So, I just try to do a little bit at a time and just not let it... not let it overwhelm me. Not let it dictate what I do or the decisions that I make so much.

The aligning of personhoods may not be a smooth process for survivors. As the above quote qualifies, the aligning may be done a little at a time and in bits and pieces, much like children do to accomplish a goal or to be successful with a task at hand.

Children need to feel and be safe to develop a sense of trust. As child victims/survivors safety is a major concept of their whole personhood. It is especially important during the vulnerable time of pregnancy and childbirth. A major category that emerged from the data is one of discerning safety. The pregnant survivor spends much time in discerning safety for her to achieve a successful childbirth.

Discerning Safety

Discerning safety is a core category because participants spend much time assessing or discerning personal safety for the child victim, survivor and pregnant female. They are discerning for the whole personhood. Discerning is the process where survivors use the eye and intellect to determine safety during pregnancy and childbirth. Discerning reflects the pregnant survivors' mental workings to process not only if the provider, but the circumstance is one in which they feel is safest for them. Discerning occurred without disclosure. Disclosure in this

participant sample was at an impasse. Health care providers, including primary care physicians, nurse practitioners or nurses involved in perinatal settings, did not ask the pregnant survivor either through an admitting or questionnaire form or personally if there was a history of childhood sexual abuse. Likewise, pregnant survivors did not divulge their history of abuse to providers for a variety of reasons.

Survivors are constantly aligning their personhoods to attempt to achieve safety and consequently during pregnancy, safety for the fetus. Regardless of the circumstance, during antenatal, labor and delivery and postpartum care, survivors are evaluating safety through how comfortable or uncomfortable they feel with a provider. Being comfortable or uncomfortable is expressed either as what the survivor has evaluated about HCPs that give them a sense of trust or in the very least, *having their best interest at heart* and events that occur that promulgate a uncomfortable feeling or a wariness in the survivor. The negative of *being uncomfortable* constitutes disregard whereas the positive of *being comfortable* with providers constitutes regard within the realm of discerning safety. Survivors discern if they are disregarded or regarded to attempt to establish a trust relationship with providers. This is important for women within perinatal care, but especially important to survivors due to a continued sense of vulnerability as a child victim and now as a vulnerable pregnant female. This first step guides the triad of personhoods to achieve a successful pregnancy and childbirth experience. A concept within this category is being disregarded by primary providers. To limit the feeling of vulnerability and disregard many survivors choose female providers whether it is obstetrical physicians or midwives. Other survivors continue with male providers due to personal reasons for safety or insurance/circumstance. Regardless of circumstance or choice, survivors evaluate gender trust toward their personhood as an important concept during perinatal care.

Evaluating Gender Trust

Gender trust is a sense of trust survivors feel with providers and starts in perinatal care with discerning. For this sample of survivors discerning gender trust is one sided because participants did not disclose their history to the provider. Thus, the survivor is evaluating the provider only from their perspective and that perspective is one of being a victim and an adult pregnant survivor.

Many of the survivors chose female providers because of their own lack of trust with males. “Because I think as a survivor of abuse you don’t...you trust the male probably about 90%, not 100% ever I don’t think, ‘cause you feel uncomfortable I think at some point.” One participant did not want to have a male provider because it was male police officers that did not believe her upon report and felt she would have been “...like on defense right away.” Other survivors chose or remained with their male primary provider when they felt safe because the male provider did not ask or seem interested in a history of childhood sexual abuse.

You know it’s funny because I actually prefer a male doctor to a female doctor. And I know that probably goes against everything...because I don’t feel like I have to explain anything. That might be it right there. Because they tend, just the male species, tends to not want to know any more than they really have to. I’ve gotten to the point where I can just detach from it you know.

The participant can trust the male physician because she understands that she will not feel obligated to disclose her history of childhood sexual abuse thus making her feel safe during care. One concept within discerning safety is one of disclosure. Survivors may not disclose to increase their sense of trust or safety with a provider.

Another participant stated trusting was from her perspective. For her the trust was only for the provider to take care of her and the baby. She did not want to *feel ashamed* or make the provider think ‘why didn’t you report it’ [the CSA]?

I just really wanted him to just take care of me and the baby and not get into my head and because first of all, I was frightened. I didn’t want anyone in my head because I really had put it to rest all that happened.

Deidra, another participant prefers to have a female provider due to the power imbalance of males over females. She states,

Probably the underlying thing is a general distrust of men in a position where I am subjected to their power because of the circumstances of my abuse. I also have a feeling or belief that a male OB-GYN couldn’t possibly be empathetic to my circumstances.

They have never been pregnant, you know, the whole bit.

Deidra continues by stating “from the start I was uncomfortable. I was uncomfortable being up on the table and the man...because I was totally powerless.” Gender distrust in this case is due to a power imbalance issue. A feeling of powerlessness is also felt in having little choice in gender providers in medical insurance or geographic constraints.

Some of the participants could not choose a female provider due to constraints in medical insurance or could not find a female obstetrician in a local area. However, survivors seem to choose females because of a sense of “female knowing”, *a gender specific understanding of things*.” One participant states,

I think women understand certain things, like women connect more. They understand about motherhood, about what issues affect your children and how you feel about them.

Even with the breast exam and everything...all of that is uncomfortable for me. It's just the whole setting is uncomfortable. It's less uncomfortable when it's a woman.

Regardless of the genders of providers, discerning safety through trust of providers is a major focus for survivors. Included in the process of trust are negative and positive events that occur with providers that signal wariness in survivors making them feel unsafe. Attitudes and actions of providers do influence an over all feeling of safety or non-safety for survivors and may cause survivors to manage their perceived vulnerabilities differently. Two concepts within the category of discerning safety is being disregarded or regarded. This concept explains how survivors discern feeling unsafe or safe.

Being Disregarded/Regarded

Survivors as child victims were disregarded by the abuser and sometimes by their mothers or other family members who were aware of the abuse and chose to ignore it. The female child's innocence was disregarded by the abuser. Often child victims were disregarded by authority figures in not being believed. As adult survivors they no longer want to be disregarded by another person, which in this study focuses on health care providers (HCPs). As pregnant adult survivors it becomes more important because the focus on the baby they carry. It is the disregarding or regarding of their present personhood that is vitally important in feeling safe. A perceived disregard to survivors has an impact not only on their whole personhood, but influences how survivors choose or will choose to manage the vulnerability of disregard by providers. Instances of disregard and regard will be discussed. Discerning safety and managing vulnerabilities is often a simultaneous process by survivors. The concepts of discerning safety will be linked to survivor vulnerabilities and will be discussed under the category of managing vulnerabilities.

Faith speaks of why she chooses her practitioners for safety. She speaks of choosing a midwife in “pursuing a more natural course.” If she needs “more medical practical help” and it is more economically feasible, she chooses a medical physician. Faith states,

I’ve made particular choices that make me personally feel safer. The doctor I see now is a male, but I see him because of a lot of reasons. One, is that I know I feel respected when I go. He’s still in a rush. He’s not a hand holder, but I know that I can get his attention if I want to and talk with him about issues. I know he’ll hear me and I feel respected for the most part.

Faith had related a negative incident of disregard with a provider that makes it important to her as a survivor to feel safe and less vulnerable.

I was trying very hard to go ahead with seeing a male doctor ...there were only male doctors on our insurance plan at that time and so I thought I would try that. So, I went to this doctor and oh my gosh, I remember so clearly, I was really, really unhappy from the beginning because I had never met him and even though I brought my husband with me because I was uncomfortable with the whole situation. I...when I went in I filled out all the paperwork and the nurse came in and got me all set up and undressed and in a gown and then on the table, in the stirrups and everything before, and then the doctor came in. My husband’s sitting in his nice business suit in a chair next to me and that was how I met the doctor. That’s how he did things with all his patients for efficiency and time-wise. He had the nurse get them all set up and then he’d walk in when you’re in this totally vulnerable position covered with paper with your legs open to come and meet you and that experience alone sent me packing. I just couldn’t believe I allowed myself to go through that. It went against everything I felt in my spirit. I wanted to refuse and just

meet him in a dignified way first and then change into examination clothes, as is customary. And that experience made me never go back. It was a pretty bad experience.

I felt degraded and it felt very degrading and disrespectful.

Another aspect of disregard is one in which survivors feel that providers make assumptions about their female personhood. These assumptions usually surround the sexual aspects of femaleness and pregnancy.

Making Assumptions

A prominent concept within being disregarded is one of assumptions made by providers. Participants speak of assumptions being made about their personhood as a female and yet survivors possess an innocent naïveté and vulnerability. The survivors that remember their abuse feel as if the childhood sexual abuse was normal, it happened to every girl. However, the abuse is not relative to a sexual or *female knowing*. Terri, a participant relates an instance during pregnancy of disregard by the provider concerning her innocent naïveté because she had a vaginal infection and was unaware of how to apply the medication given to her.

He gave me some tampons that had purple at the end, some type of medication and I went home; as a young girl, I was only 18, I didn't know a lot about sex education to begin with, about any kind of contraceptive or anything like that. No one never talked to me about that and I couldn't put the tampons on because he only gave me the box and said, 'Use them, they are like tampons' and he walked out of the room. I went home. I couldn't even do them because it was too painful, so I didn't do them. I went back the following week. He said, 'How could you have not used the tampons? You're having a child for Christ sake! Well, didn't you have sex to have the baby?' I was numb. I didn't know what to say and I felt ashamed and embarrassed.

Terri states it has been eighteen years since that incident and she still remembers the comment. That incident changed her attitude toward the physician. “It had an impact on me...then I didn’t want him to deliver my baby. My attitude towards him changed after that.”

Another participant, Hank relates to being innocently naïve and the provider making assumptions. “...people just assume because you’re female and you grew up that far you know and you don’t. I didn’t know anything about being female let alone how things were supposed to happen...it was frightening to me.” Hank continues in expressing her innocent naiveté during her first pregnancy in stating,

... because of the lack of relationship with my mother, I was afraid of the unknown. I didn’t know what to expect. I didn’t know what was happening to me. I didn’t know how to function through it, you know. Basically, I was at a loss there. I do think that had a lot to do with how I grew up.

Hank later on expresses, “Because I’ve never been able to tell anybody I didn’t know what to expect out of pregnancy.”

Providers making assumptions about survivors innocent naiveté implies to survivors that they do not have a trustworthy foundation for a relationship with the provider. Child victims/pregnant survivors already possess a feeling of vulnerability and disregard when seeking perinatal care. There are personal attitudes of practitioners that can add to survivor’s sense of being disregarded or regarded.

Attitudes and Actions

Pregnant survivors relate many instances of being wary in determining disregard or regard. It is important to them when practitioners have “eye contact” with them. Samantha states,

...as soon as he walked into the room there was eye contact made and he did a salutation, “how are you doing today,” that type of thing. He didn’t come in and fidget with paper or read your chart. He came in and looked directly at me and that made a world of difference.

Survivors discern tone, time spent and how the practitioner speaks with them whether during pregnancy or labor and delivery.

Terri speaks of being disregarded in labor and delivery when the physician would come in to perform a vaginal examination. There was little recognition of her as a whole person.

Even with the delivery, you know how every so many hours the doctor comes and checks you? I thought, if this man puts his whole hand in me again, I am gonna probably kick him. I was just disgusted with that whole issue right there because he wouldn’t, you know, talk to me! He would just (raises voice) ‘I’m gonna check you now’ and just ‘Okay, you’re not ready. I’ll see you later.’ It’s very, ‘I’m just here.’ I felt violated when I left that place. I felt like, I don’t know. I felt ashamed and violated when I left that hospital.

Survivors discern being disregarded with nursing care. Participants spoke of being disregarded in personal exposure or actions by nurses in the hospital setting that reflected vulnerability for them. One participant states,

I had never been in a hospital in my whole life. I was in labor so there was a lot of things’ happening at the same time. But, I was afraid of all of it. I was very introverted at a younger age and shy. I didn’t like the positions they put you in. I didn’t like people picking up the blanket. I didn’t want people looking at me.

Another participant, Andrea relates an incident of disregard in labor and delivery.

Andrea and her husband had already decided that in delivery they would be alone; no one else would be in the room. Andrea relates,

And I'm there with my mother, my doula and my husband, a nurse and a doctor in the room when they finally decided to do the C-Section. The nurse rips my gown up goes over to get the razor and the little thing of water and comes over and starts shaving me and I'm like, oh, hi mom and hi my husband, how uncomfortable for you both to be standing here and looking at that spot. I think that was like the only part that was to me kind of amusing, oh wow, they really just don't care do they? They just whipped up my gown and just exposed me to my mom and my husband and my doula without even saying, 'Okay, now we're going to shave you.' There's never any words that make me uncomfortable because I think, god, at least ask before you throw that thing up over my head and shave my pubic area! No friends, no family, no one else gets to see down there. And so when they flipped the gown up and didn't even tell me what they were doing and I'm trying to pull it down because I don't know what she's doing....

Another disregard in attitude and actions is not listening to survivors and ignoring giving choices. Deidra was trying to express her wants to the nurse in labor and delivery and felt disregarded in many of her desires. Deidra states,

I didn't want to be strapped down. I didn't want anything in my arms during my first pregnancy. I didn't want to be on a table. I wanted to walk around. And I had this nurse from hell. She was just so tied into what you have to do and what the rules are. And, oh, she got me in that bed and she just put those needles on ...in me and you're gonna be in bed. And I just stared to panic all over again. And I kept telling her I want, I just

want, I don't want the monitors on me. I want to be up. I want to be able to get up to go to the bathroom and then they put the catheter...and you're there...it's like being a prisoner all over again. But, I was very upset. And I remember thinking, 'I'm going to have to have this woman for however long my labor is and I've already ticked her off.' She was already going to get me. But, she wouldn't listen. She just wouldn't hear my side of it. She just, 'This is what you're going to do. This is what you have to do. This is what's required.'

The labor nurse disregarded Deidra as a person through attitude and action. In not listening and ignoring Deidra's requests, her personhood was disregarded which caused Deidra to be upset and feel unsafe. Not being able to walk, receiving an intravenous infusion and being strapped down were all unsafe vulnerabilities to Deidra as a pregnant survivor. Although there are other incidents from survivors of being disregarded some participants described circumstances or incidents in which they discerned they felt personally safe.

Informing survivors of any forthcoming procedure and telling them exactly what is being done as it is being accomplished is regard for their personhood and a major safety concept. Experiencing no surprises to their person or in circumstances gives a foundation of trust, thus safety. Faith explains about her first pregnancy and how she felt safe during care even at a young age. "I appreciated that he always would tell me what he was going to do before he touched me or did anything and that helped a lot, even though it was very difficult." Another participant, Terri, speaks of feeling safe with a practitioner with breastfeeding. Terri states,

She'll tell you, 'Okay, well I am gonna touch you right here and this is what I'm going to do and this is what it's gonna feel like. If you don't feel this symptom, then we'll try it

on the other breast.’ She says if your husband wants to be present, that’s fine, but it’s up to you. So, she let’s you make that option.

Survivors can experience triggers and flashbacks. Practitioners that keep survivors fully informed of exact procedures and when touching will occur, decreases uncertainty and increases a feeling regard and safety.

Although survivors do discern safety through a variety of mechanisms they manage their vulnerabilities at the same time. This is a fluid process for survivors. Managing vulnerabilities can occur at the same time that discerning safety is occurring or later after an incident has occurred in which they feel unsafe or threatened. Survivors manage their vulnerabilities through controlling actions and the different mechanisms of rectifying pregnancy, presencing, avoiding/delaying, enduring, and changing through *focusing differently to get through the spoiled* achieve a successful pregnancy and childbirth.

Managing Vulnerabilities

Managing vulnerabilities is concerned with control to survivors. Managing vulnerabilities is the whole of their perceived unsafe issues during perinatal care. Managing vulnerabilities to survivors is an ongoing process much like discerning safety during perinatal care. Controlling is how survivors go about managing perceived vulnerabilities. Control is something that survivors feel and need. They need to feel in control of circumstances and self. Being given choices about or during perinatal care allows pregnant survivors be in control and manage vulnerabilities to achieve success in childbirth. Rectifying pregnancy, presencing, avoiding/delaying, enduring and changing are five subcategories of managing that survivors activate to control vulnerabilities during perinatal care.

Rectifying Pregnancy

Many of the participants spoke of fears concerning their fetus' health and knowing if the baby was *fine*. Some spoke of not knowing if disease could be a concern or making sure that the baby was developing normally. Participants often speak of these fears in terms of being petrified and having nightmares concerning the baby they carry. Some survivors have to come to terms with a pregnancy. This is part of managing vulnerabilities in the temporary condition of pregnancy to get through for survivors.

Melissa, a participant who has had trouble with drugs in the past, spoke about receiving ultrasounds with her first pregnancy and the benefit of those procedures in rectifying the pregnancy. She states,

He gave me an ultrasound every time I went too. That's what I liked 'cause that way I can see the baby. I could see the progression of the baby. It makes you more like to bond more, I guess. To know what's going on with the baby. Because I know when you see the ultrasound it makes you smile. You can't help but smile. It helps me...it helps me mentally, I guess. I want to take care of myself, to see the baby in there.

Another participant, Terri speaks of needing to be reassured although she had attended prenatal care and classes because she did not believe she could ever deliver a child. She believed something was wrong with her baby. Terri states,

I was traumatized. I thought something was wrong with my baby always, so I was always afraid, and I had nightmares, and was very, very petrified. I didn't think I could do that. I could deliver actually a child. I didn't think I was capable of doin' that. I just didn't think I could do that right. Constantly I would call, "are you sure everything's

okay?” I even told my girlfriend, ‘when I deliver, please count my baby’s toes. You need to check him out and make sure my baby’s okay.

Another participant, Faith, explains how she had to “give permission” in each pregnancy for the baby to be in the womb. In speaking of CSA and her pregnancy, Faith states that a history of CSA had a lot to do with *having the baby inside me at all*.

When I first found out that I was pregnant, every single time, I’d have to go through a period of just realizing that there was something inside me that wasn’t me and I knew every single time that that was really on the ‘to do list’ and it would make me sick. I was nauseous anyway with all of my pregnancies, but when I thought about that I felt guilty about it too. When I thought about the baby being inside me, I would just get sick. Like I had to come to terms in myself and allow that thing to be in there, like giving permission. It sounds really weird and convoluted, but that was something that I went through very strongly and I think that the reason I knew that they were related is that I had so many nightmares during those times....I knew inside me that the baby was a baby and mine, but just where it was habituating was the issue for me. Just being in that private area.

Time was the managing factor in Faith’s experience. She states, *time just took care of it*.

Another participant, Hank, relates being extremely scared in her first pregnancy. The pregnancy scared the daylights out of me and I was never comfortable with myself. I wasn’t advised of anything that should be happening or anything like that. I wanted to be alone. I didn’t want anybody involved... the doctors, the nurses, and so it was a struggle to get through the first one.

Hank continues to relate about the rectifying pregnancy with her second pregnancy. She was afraid of becoming like her own mother or be in a relationship with a man that was like her father.

I had gotten pregnant with my second son, I was so afraid. I never sought therapy to sort myself out, but I was so afraid I was going to end up like my mother. And, or end up with somebody like my father or whatever. But, that just terrified me and the second time I got pregnant I thought about having an abortion 'cause I thought I was doing okay with one, but I didn't want to have that added stress, you know?

Hank managed that pregnancy through therapy. She sought help to continue in the pregnancy through counseling about how to be a "good mother." Hank rectified the pregnancy by confirming that she could be a different type of a person and mother to her present and future children.

Deidra, another survivor tells of pregnancy nightmares and rectifying the pregnancy.

I had nightmares before my deliveries that were awful. I would get up just horrified from these horrible nightmares. ...nightmares of delivering a baby boy with this huge penis, I know survivors who have this whole thing with penises. And I remember waking up and being absolutely horrified that I would have this horrible nightmare. It always had to do with my child with a deformity... with this penis. And I was panicked, panicked. Things were always not normal. Or my baby didn't look like my husband or I at all. And then it was the guilt, well, whose baby is it? I thought, how horrifying! But, I did have that anxiety of these weird dreams and just this guilt and this fear that this baby...wasn't my baby.

Deidra continues with this concept after delivery in referring to the baby.

I was not prepared for the detachment that I had to my child too, because here was this...it was like I had all these nightmares...exactly like an alien. I remember the nurse coming in and saying or the nurse talking to the nurse in the outer room saying, 'Doesn't he look like E.T?' and it just got me crying because that's how I was feeling. I birthed this other person, what have I done? What have I done?

The above stories tell of pregnant survivors coming to terms with a pregnancy. Some of survivors managed their fears with therapy, others managed through time without therapy. Connected to the category of managing vulnerabilities is the phenomenon of rectifying the pregnancy through sorting out their feelings and thoughts. Pregnancy is a vulnerable time for women however; it seems it is a deeper vulnerability for survivors. Controlling are actions by survivors for managing perceived deeper vulnerabilities. It is a subcategory of managing and contains the concepts of presencing, enduring, avoiding/delaying, and changing.

Controlling

Many of the survivors describe a feeling of needing control. Being intertwined with managing vulnerabilities and discerning safety, controlling or seeking control encompasses the survivors' personhoods. To survivors the positive aspect of control is one of being given choices or options which is discerned as safety. When survivors as persons are not given the consideration of choice it is viewed as a threat to their personhood and is viewed as negative or discerned as being unsafe. Survivors strive for control for self and in circumstances.

One participant describes why control is important. She states,

'Cause I don't have control I guess. That's a big thing I guess, because for so many years I couldn't say nothing. I couldn't do anything. I just let everything happen...and since I would let everybody else have control ...well, not really let them but, since everybody

would take...just do whatever. It's like now I want control. Now I want to be in control...but since....I guess I don't really know how to do that at the same time.

Survivors may or may not know how to take control to manage their vulnerabilities but, they do know they want control in circumstances and want to be in control of themselves in circumstances. Not only do survivors rectify the pregnancy, but manage fears and safety through pregnancy and childbirth through presencing. A majority of survivors spoke of the phenomenon of needing a presence with them during antenatal and labor and delivery care.

Presencing

Presencing is an external mechanism of management for personal safety for survivors. Most of the survivors in this sample spoke of needing someone at bedside during any type of examination or during childbirth. Sometimes they require an intimate partner, mother, female friend, doula or nurse to be present. Participants stated feeling safe with another person present physically with them. Survivors speak of managing safety through this controlling action.

One pregnant survivor, Samantha, although she was very informed about pregnancy having attended prenatal care, classes, read "everything I could get my hands on" and trusted her physician states,

At the time of delivery I had to have my mother there and I expected her to be there for the whole duration. I just felt a sense of ...I felt secure and safe that she would have my best interest at heart regardless of the outcome.

Another participant, Terri, relates about presencing during antenatal care and how she would manage the absence of another person other than the provider.

I know that there's always gonna be a nurse in the room with me. I know there's gonna be a woman there that's gonna be a witness. That does make me comfortable. If we

were alone, then I would have to look for another doctor. Knowing that the nurse is always there for any kind of exam where he has to touch me that she'd be there, so I'd never be alone. If I were alone, I would be...It won't happen. I can control that. I think that no; I don't want that or this exam unless you have somebody in here. Unless there is a woman in here.

It is a managing mechanism and control action to insure personal safety, and to survivors this concept is of great importance. There was no one present during their abuse as a child except for the abuser and them. Thus, being alone in a vulnerable circumstance in which abuse could happen again or put the survivor back into that child victim role will not occur. One participant, Melissa states this concept succinctly in discussing having another person present and the relationship to trust, "It makes me more relaxed. It makes me a lot less tense. 'Cause I don't know ...even though the doctors tell me what's going on, I still have trust issues. 'Cause people can tell me one thing and do another." Melissa relates how she felt without a presence (her boyfriend) in the exam room during perinatal care with a provider that did not allow another person in the room and how she may manage that vulnerability in the future.

It just made me feel little, like I had no control over anything...which I don't like that feeling...at all. I know I had to be there for the baby, but it made me feel like I don't ever want to do this again. I didn't want to have no more kids if I was going to have to go to doctors like that.

Another control action that is reported by survivors is one of enduring. It is a self or internal managing action which corresponds directly to how survivors manage and control during difficult circumstances such as during a vaginal exam or being exposed.

Enduring

Enduring is a subcategory of controlling. It is an internal state for survivors. Enduring is a mental state that survivors do to manage their vulnerabilities during intimate or personal exposure. Participants describe enduring in a variety of ways and circumstances. There are two subcategories within enduring. These are blocking/numbing and being passive. Survivors report having flashbacks and experiencing triggers at vulnerable times, however, each survivor manages these circumstances differently. Two participants relate not having flashbacks or feeling triggers. One states it was because she has healed from the abuse and the other states she would not know to have flashbacks because her childhood sexual abuse was a state of normalcy for her. One internal mechanism of enduring is blocking or numbing.

Blocking/numbing

Blocking or numbing for survivors is *going somewhere else* mentally. It involves an internal mental exercise to manage a perceived vulnerability during circumstances that may mimic or are inherently close to their childhood abuse experience. As each survivor is a unique individual and has perceived their abuse differently, blocking or numbing is also described differently.

One participant speaks of how she handled procedures and exams through numbing during labor and delivery. She states,

Throughout that whole time I think I was more numb than anything. I just put myself on numb mode...when I would feel uncomfortable or violated, I would just think about a different scenario or just know that this, ...that I have to get this done.

Terri relates that to manage her safety in vulnerable circumstances she must be numb. "A lot of times I run on numbness, a lot of times in life I run in numbness."

Faith also speaks of a type of numbness. She describes her process as *being paralyzed*. In the scenario of Faith being disregarded by the provider by being put in a totally vulnerable circumstance during an initial prenatal exam, even as her husband was present at bedside, states that that experience *alone sent me packing*. Faith had wanted to refuse, but felt paralyzed in action. In speaking with the researcher Faith re-states the numbing this way, “Yes, I would describe that as feeling kind of paralyzed. You identify with what you’re feeling and then kind of shut it off-down to try and get through the moment instead of expressing how you feel.” Faith describes the numbing and how she managed the circumstance later on.

And that experience made me never go back. I think I knew. I knew even as I was doing it. I didn’t know why I kept going along with it and I knew I wouldn’t go back. It was a pretty bad experience.

Many of the survivors speak of blocking experiences and circumstances to accomplish procedures and treatments for the benefit of the pregnancy and childbirth. If flashbacks or triggers arise during vulnerable times, survivors mentally block or numb themselves. Some survivors such as Faith manage the circumstance later in which they had to mentally numb or manage the present by being passive.

Being passive

Being passive is a subcategory of enduring because it is a management mechanism that occurs for survivors to get through the experience. Several survivors describe this phenomenon.

Timmie, in describing her dislike of vaginal exams and feeling unsafe relates how she managed those experiences. She did not describe blocking or numbing. Timmie states, “No, I didn’t do anything [mentally]. I just knew that they have to check me so I had to go through it.”

Melissa also describes being passive at times which is derived from her history of childhood sexual abuse.

I didn't use to speak up about anything. I'd just let it be. If I had a problem I'd just keep it inside. It's only during the past year that I've learned to speak up for myself a little bit more and ask questions and like try to go about things differently if I had a problem, but during those times, I was just...whatever happens was gonna happen, and I didn't feel that I could change anything.

This same participant describes being very unhappy with a physician during pregnancy. She states how she should have managed the circumstance, but also why she manages circumstances as a survivor of CSA.

I should have changed doctors is what I should of did, but I never do. I just...I was real passive, I was real passive. I just don't want to hurt nobody's feelings and I don't want to say the wrong thing to make people mad.

Melissa feels she cannot control circumstances as an adult because she could not control circumstances as a child. Thus, passivity is her way of control and managing vulnerabilities.

Another participant describes having to *give up* her control and become passive although unwillingly. She was having difficulty in labor and trying to cooperate with the providers to accomplish birth. Hank states,

I just felt it was never gonna be over and I just gave up and went with it. I don't know how else to describe it because you get to that point were you're not in control anymore. There were problems so I had to let them do what they were doing. But, I wanted to get up and go and if I was physically able I probably would have but, I wasn't.

Hank was forced into being passive; she knew she had to give up because she could not remain in control.

Participants describe incidents of being passive and blocking or numbing during perinatal care. It may be described as feeling paralyzed, blocking, being numb, not saying anything or going somewhere else in your mind. Regardless of the words used to describe the phenomenon, it is an internal managing that survivors use to get through perceived difficult circumstances. Another controlling action that survivors activate is one of avoiding /delaying health care or procedures to get through the spoiled and achieve a successful childbirth.

Avoiding/Delaying

Many survivors describe incidents of managing vulnerabilities through the control mechanisms of avoiding and delaying. This phenomenon encompasses avoiding or delaying health care needs for themselves thus the pregnancy also, and avoiding circumstances, procedures or treatments that would possibly interfere with internal control.

One participant described an incident of refusing medications during childbirth to insure self control. The participant wanted *everyone to leave me alone* states,

I just wanted them to leave me alone. I would get through it somehow. I don't like any kind of pain pills or anything where I don't feel like I'm in control of myself. I would rather go through the pain than feel like I'm not in control of myself. I was feeling like I was losing control. That just terrified me. I didn't like the way they were always trying to give you a shot, give you a pill...take something...give you a drop or whatever. I didn't want any of that. I resented that.

Others describe various mechanisms of controlling that involve self in care in antenatal, labor and delivery and postpartum. Participants relate waiting until they were almost ready to

give birth before entering the hospital. It is directly related to a history of childhood sexual abuse and continuing vulnerabilities.

Genieve, a nurse participant relates that with her second pregnancy she knew she was in labor since morning. She wanted to walk during her labors and not be in bed because of her history of childhood sexual abuse and the possibility of triggering flashbacks. Thus, Genieve worked all day, went home to take a bath, wash her long hair and *got all of my things taken care of and came back and had the baby*. Upon entering the labor unit she wanted to control her ability to walk through labor and not be in bed.

I really made sure, I was pretty adamant, but I was kind and I said, ‘You know, doctor said I could walk, so I have to walk.’ I just wanted to let everybody know I’ll do anything you say, but I have to walk. I just knew if I laid in bed, I wouldn’t be a very good patient, I knew that. I think now that I look back, it might have brought up memories.

Genieve did not have time to walk because she delivered the baby soon after arrival in the labor unit. She was trying to control flashbacks through not being in bed and walking by avoiding being put in bed through delaying admission to the hospital. Another survivor, Melissa relates a similar example to avoid *being touched* and wanting to be *alone*. A third participant, Hank states, “Then the third time I waited until the last possible minute... to go to the hospital. So, it’s good I had the system down by then just to avoid it.”

Many survivors avoid and delay medical procedures and routine appointments to avoid going to providers. Melissa does not return to her physician after giving birth nor regularly attends prenatal care. She states, “Because I get scared. I don’t know why. But, I never go back for ‘em. Like after I have my kids they say to come back for a check up. I never go back.”

Melissa also relates that due to not being able to have a presence [her boyfriend] with her during prenatal exams she “wouldn’t go back. I quit.”

Many of the survivors in this sample describe being reluctant to attend to medical needs and care because of a history of childhood sexual abuse. Some delay and avoid physician care and put themselves and possibly the baby in medical jeopardy. It is not only due to the need for control in circumstances and of self, but due to the manner in which they discern feeling unsafe with providers. Survivors manage through avoiding or delaying medical care.

Changing

Another significant way survivors manage vulnerabilities is to take an active role to control circumstances. The active role of the survivor is externally accomplished for internal safety. As with other subcategories in managing, changing is intricately intertwined with the categories and subcategories of discerning safety.

Changing is a type of managing through control of either the type or gender of practitioner that treats them and/or medical insurance or payment for medical services that is most beneficial to survivors. In many instances, survivors change insurances, practitioners and circumstances that enhance safety and decreases perceived disregard of personhood to accomplish pregnancy and childbirth.

Survivors relate many instances of changing practitioners due to disregard for a variety of reasons. Faith speaks of changing physicians due to disregard and seeking alternative practitioners, such as a midwife. Faith also relates changing to home deliveries in lieu of hospital births. She states,

I have felt safe in situations with the midwife that has provided care, just by some simple differences, like not having to completely undress. By them just being practical and

flexible, giving me choices and options as far as ...even as far as her hands go, like simple questions like, 'Would you like to be on the exam table or on the couch with a pad? Or at the house, the exam was at home, 'Would you like to be on the bed or on the floor? It's a simple choice. It makes a big difference.

Faith views control through active choices such as switching to a midwife, delivering at home and being given choices in circumstances.

Another participant survivor, Deidra relates about fighting to change medical insurance due to disregard by a nurse practitioner. She felt that the nurse practitioner had put her in a situation of danger through assumption and disregard. Deidra took control through changing insurance mid-year. She states,

Then I have to go through a huge battle at work to get my insurance changed. I had to go to our insurance provider at the state and detail all of this and go through that humiliation and then say, I'm not going to do this. I'm just not going to do it.

Some survivors activate change when they discern disregard as adult persons. As they were disregarded as children, disregard during adulthood and vulnerable times such as pregnancy becomes a major concern for survivors.

Hank relates being disregarded by a newly assigned health care provider. The physician did not listen to her during a doctor's visit leaving her feeling unsafe. Hank felt disregarded as an adult person by the physician. She managed through control of practitioners. Hank relates,

I thought she wasn't even listening to a word I said and there wasn't another doctor that I could see in that office. So, I went home cursing and I called the medical place and I said I want to switch doctors. And I switched doctors.

Many survivors such as Hank spoke of managing through switching or changing practitioners, circumstances and insurance to obtain perceived safe care. Survivors will discern who and what circumstance is safe for them. Survivors are suspicious of providers already; disregard can cause managing actions. Survivors manage vulnerabilities through control mechanisms which includes changing. Managing vulnerabilities is part of the process for survivors who are focused differently to get through the spoiled to achieve pregnancy and childbirth.

Focused Differently to Get Through

Some of the survivors spoke of being focused differently during perinatal care because of the pregnancy. Some survivors describe an altruistic theme common among pregnant females which is doing what is best for the fetus they carry. However, participants in this study relate to putting aside any personal uncomfortable feelings, tampering down, not thinking negative, decreasing drugs and smoking, and trying to be perfect to achieve a successful pregnancy and childbirth.

It took Genieve ten years to decide to try and get pregnant and deliver a child due to childhood sexual abuse and her childhood living situation. As decided she could be a good mother because she was a responsible person, Genieve started to focus differently to get through or make the pregnancy as optimal as it could be.

I went off the pill, waited three months and I also started taking prenatal vitamins, cut out alcohol and no drugs at all and no smoking. I took parenting classes, breastfeeding class, the Harris Method. I did everything I was supposed to. I never drank, I stayed away from people who smoked, and I tried to get rest. You know, the whole thing, nutrition everything and had a healthy baby. For many years I suppressed it

[CSA]. I just wanted to carry on with my life. I didn't want this to overpower me, so I had a very wonderful pregnancy. I loved being pregnant and I breastfed...I did it all. Genieve continues with this phenomenon by stating she wanted the physician to *only take care of me and the baby*. She wanted the focus solely on achieving a pregnancy and childbirth.

Dawn also relates about being focused differently. She relates about the labor and delivery experience, the pain and preferring one doctor over another. However, she relates no one incident *sticking out* because "I guess in my mind everything was for the well-being of my baby and that's what I was concerned about." Another survivor relates the same phenomenon when relating to control and being a survivor in labor and delivery. She states, "I had no control over what was happening to my body, but you know, I realized it was for the safety of the baby. So, I think at that point I didn't *think* of anything." This survivor continues this concept stating,

I felt then when the babies were being born, that once again I had to let go of my fears in order for somebody else to be safer or to do what they needed to do...not deal with my problems or my issues for the betterment of somebody else. I think that's what I felt at that point in time. Whatever issues I was having wasn't as important as opposed to bringing a healthy baby into the world. That's what I did to not face them putting the things in me and doing the procedures that they had to do.

Survivors focus differently to get through medical procedures and achieve successful pregnancies and childbirths. Focusing differently to get through encompasses discerning safety and managing vulnerabilities. Focusing differently involves putting self aside during pregnancy and childbirth for the health and safety of the fetus. However, a final concept that was drawn from the data is one of *the spoiled*. Survivors align personhoods to discern safety and manage

vulnerabilities by focusing differently to get through the spoiled to achieve a successful pregnancy and childbirth.

The Spoiled

Many survivors spoke of the concept of being spoiled using different terms. Many spoke of having spoiled parts, feeling dirty and feeling the spoiled was focused upon. Many of survivor's feelings in discerning safety and actions in managing vulnerabilities are aimed at a feeling of being spoiled.

One participant states, "I have this sense of feeling dirty. When I say dirty, I mean dirty in the sense of unclean like dirt dirty." The survivor relates the ritual that she completed prior to each delivery. She admits to not relating this ritual to CSA prior to the interview. Samantha states,

All these different things are clicking now. With my first one, I had the doctor scheduled for me to go to the hospital that morning to be induced and I'm pretty sure when you're in your late pregnancy you're not suppose to take hot, hot baths or anything like that. That morning I took a hot, hot bath. I actually sat and soaked in bubbles and I'm wondering now if it was to get clean for the baby.

The survivor continues in explaining how she feels about the baby being born. "...like she walked through fire. That's what I kind of felt like that she walked through fire, now she's okay 'cause it's done. It's over with."

Andrea, another survivor relates of being sorry when the membranes ruptured. She kept on calling the nurses to change the sheets underneath her. She states that is when she felt most uncomfortable, but not because of the leaking bag of waters, it was because she felt guilty.

I mean I was apologizing right and left. I think that might be a survivor issue when it comes to things with the vagina, you're sorry. Because you have this guilt feeling from the abuse and I think that kind of transferred because I mean I was apologizing right and left. Those nurses have to clean that up and it's not big deal to them. But for me it was like, I'm so sorry, I'm so sorry, it's like what could I have done? I couldn't have stopped it so why am I so, so sorry about it?

Another participant speaks of getting through *the spoiled* in the context of managing her pregnancy and labor and delivery; she wanted *everything to be perfect*.

...and I never did once feel uncomfortable, but then I look back and I think, did I block it because I wanted this to be a good experience? And, I loved being a mom and I loved being pregnant. Maybe I didn't allow myself to feel negative thoughts, I just wonder now that I look back if I just didn't want anything to spoil it 'cause I had felt like my life up to that point had been spoiled, tarnished, and I didn't want anything to (voice breaks) harm my memory.

Many of the survivors speak of feeling more vulnerable when the genital area was focused on. One survivor speaks of feeling more vulnerable in being draped rather than being naked. She does not know if other women feel this way or "it is worse for survivors." Faith states,

They just cover everything and isolate and expose just the genitals. That bothered me quite a bit. It's a very vulnerable, vulnerable feeling. I think it's horrible. Because it's just all isolated and exposed. It feels more exposed to have everything covered up but that area and then all this attention on that and the bright lights on it and everything.

Other survivors relate that being exposed bothered them. Most survivors want to be very minimally exposed and would prefer to be in their own clothing. There is much significance in exposing *the spoiled* or discerning and managing *the spoiled* which encompasses the reproductive parts of female survivors. These are parts that were abused as children and to some survivors the reproductive area is *spoiled* and continues to be extremely vulnerable. The spoiled is within the personhoods of child victim, adult survivor and pregnant female which in turn make the whole of a survivor's personhood vulnerable.

Summary of Findings

Participants activate several processes to achieve successful pregnancy and childbirth. Survivors align the triad of child victim, adult survivor and pregnant female into one whole being or personhood. All participants use the whole being to discern safety and manage vulnerabilities during perinatal care. Participants begin to discern personal safety through evaluating gender trust. Discerning safety continues through how participants perceive being disregarded or regarded with a health care provider. Managing vulnerabilities and discerning safety is a fluid and cyclical process. The subcategories within managing vulnerabilities explain how the aligned whole being institutes mechanisms to achieve increased personal safety to get through the spoiled to achieve successful pregnancy and childbirth. The basic social process of *being whole: aligning personhoods to discern safety and manage vulnerabilities by focusing differently to get through the spoiled* to achieve a successful pregnancy and childbirth reflects the meaning of a history of childhood sexual abuse to pregnant survivors during perinatal services.

Chapter V: Discussion of the Findings

The problem which gave rise to this study was to begin to discover the meaning of a history of childhood sexual abuse to female survivors during perinatal services since little is known concerning this phenomenon. It was also hoped that data from this study would provide clinicians with a developing theory for evidenced based practice.

First, the developing explanatory model (Figure 1) of the basic social process of the meaning of a history of childhood sexual abuse to female survivors during perinatal services will be discussed in relation to grounded theory using a feminist perspective. Findings will be correlated to existing theory and anecdotal literature when possible. New findings will be explicated. Second, a conclusion of the substantive theory will be made concerning the findings of the research. The third section offers a critique of the study, implications for clinical practice and recommendations for future research.

Grounded Theory and Feminist Perspective

Grounded theorists seek the basic social process within a contextual and interactional process (Wuest, 1995). Grounded theorists seek to discover the basic social process from raw data as concepts, statements of relationship, hypotheses and theory emerge. To verify facts, establish the generality of a fact, to specify a unit of concept, verify an emerging theory and generate a theory; constant comparison of the data can be used as a general methodology (Glaser & Strauss, 1967). A feminist perspective in grounded theory requires the discovery of knowledge about and for women. Feminist knowledge is grounded in a phenomenon concerning experiences of women. Women are *knowers* and experts on their own lives. Hence, the data is subjective, valid and the knowledge is contextual and relational (Bunting & Campbell, 1991). The explanatory model of the basic social process (BSP) of the meaning of a history of

childhood sexual abuse describes the reflexivity and the voices of survivors of CSA in the research which is consistent with grounded theory and a feminist perspective. Participants recognized women as knowers in choosing females as practitioners. Participants expressed that female practitioners possess a deeper understanding of female bodies and minds. Thus, some participants stated they feel more comfortable or safe with female practitioners knowing she has a deeper knowledge of them as a pregnant female. Participants described aligning personhoods to discern safety and manage vulnerabilities by focusing differently to get through the spoiled as female survivors during perinatal services.

Being whole: aligning personhoods is an emergent concept discovered in the present research. Several studies have noted short and long term traumas or consequences in being a child victim of CSA (Brown & Garrison, 1990; Draucker, 1992, 1993; Herman et al.1986; Hulme & Grove, 1994; Jackson et al. 1990). It has also been suggested that some survivors have few lasting consequences of CSA (Kondura, 1995). No research was found that discusses how the adult female survivor as a pregnant person describes the consequences or vulnerabilities of this history during perinatal care. However, the emergent phenomenon of aligning personhoods encompasses the concepts of child victim, adult female survivor and pregnant woman into one personhood or whole being that contextually carries the short and long term vulnerabilities with her into the temporary state of pregnancy.

Pregnancy and a history of childhood sexual abuse is a vulnerable state for the survivor. The survivor experiences the three personhoods simultaneously and is inextricably intertwined. The triad of child victim, female survivor and adult pregnant woman aligns into one whole being to get through the stresses and vulnerabilities of pregnancy. Participants speak of being a *whole*

person. At times during perinatal care they can become the child victim unable to speak clearly or act as an adult even though recognizing their vulnerability as a pregnant female.

The adult personhoods carry the memories of the child victim. Doob (1992) and Limandri (1989) have suggested the personality of the woman and the ability to work through the issues of abuse varies. However, it was found that it is survivor's integrated personhoods that intersect into perinatal care. In this sample of survivors it was also found that regardless of the type of sexual abuse, a history of CSA affects how they function in life and at any time which their whole being may deal with the issue at hand. It is this combined, aligned whole self, not remembered or remembered and present, that discerns personal safety and manages the vulnerabilities to get through the spoiled to achieve successful childbirth.

Since the triad of personhood functions as a whole, it cannot be known by survivors in what circumstance or at a particular time that any one personhood may be exhibited. It appears that the fluidity of being a child victim, adult survivor and pregnant female actually causes discerning safety and managing efforts during perinatal services. Further research is warranted to further discover when and how the personhoods intersect into perinatal care for survivors.

Discerning Safety

Defining safety for survivors has not been studied. There is literature that suggests that sensitive care implies safety and is of major concern for survivors (Schachter et al. 1999). Pregnant survivors discern safety in a variety of ways. Safety for survivors begins with the survivor's mental and visual interpretations of the whole environment including surroundings, persons present and perceptions of being disregarded or regarded as persons. Safety for survivors and the fetus they carry is of major concern. Schachter et al. (1999) delineated components of a safe environment for survivors during physical therapy. Pregnant survivors also

delineated components of safety during perinatal care in this study. The components of safety during perinatal care coincide with the components for sensitive care during physical therapy. However, further research with increased and divergent groups of survivors continues to be a need.

Provider Gender Preference

Pregnant survivors do not totally trust providers. They seek to have a reciprocal trusting relationship and assess diligently to discern the safety of the relationship with the provider. Trust is an issue with female survivors (Bachman et al. 1988; Briere, 1992; Brown & Garrison, 1990; Draucker, 1993; Finkelhor, 1986; Herman et al. 1986; Hulme & Grove, 1994; Jackson et al. 1990). Survivors seek and chose female providers largely due to a lack of trust. Two of the survivors in this sample believe they have been re-victimized by male providers (Russell, 1986) and seek female providers exclusively. However, within the trust issue with providers, survivors have a varied of issues that have not been explored in the literature. It has not been widely explored how survivors discern safety with providers which include a sense of trust. A lack of trust may be due to perceived power imbalances and a general male disconnect from female understanding. Included in discerning safety are attitudes, actions and assumptions by providers which give an overall feeling of being disregarded or regarded to survivors.

Disregarded/Regarded

Much of the literature concerning female survivors and birth is aimed toward care during perinatal services (Bohn & Holz, 1996; Burian, 1995; Courtois & Riley, 1992; Grant, 1992; Holz, 1994; Kitzinger, 1992; Seng & Hassinger, 1998; Seng & Petersen, 1995; Simkin, 1992; Waymire, 1997). The literature addresses the desires of survivors for care in wanting consideration, giving control, and asking permission prior to procedures. Although a lack of

trust from survivors is generally acknowledged; survivor's sense of safety and what constitutes safety has not been fully explored and constitutes a new phenomenon within perinatal care. Schachter et al. (1999) did explore the phenomenon of survivor's reactions during physical therapy. It was found that safety was crucial during care and suggestions for care were explicated. Suggestions included establishing and maintaining a trusting relationship with the woman that includes communicating clearly, connecting and validating the client. This phenomenon correlates to the concepts of being disregarded and regarded, but does not establish how survivors and providers establish and maintain a trusting relationship.

The phenomenon of being disregarded or regarded by providers toward survivors is a major issue for survivors overall discernment of personal safety. Survivors as pregnant females discern safety through a sense of being regarded in their whole personhood even without disclosure. Survivors discern personal safety which involves assumptions, attitudes, and actions by providers regardless of setting; antenatal, labor and delivery and postpartum.

Assumptions

No literature was found that explored the phenomenon of provider assumptions toward survivors. This phenomenon of *being disregarded* was repeated often by survivors in this sample. It is assumptions by providers of sexual foreknowledge about survivor's female personhood. Whether or not survivors remember the abuse, assumptions about sexual knowing by providers is an issue and concern. Survivors feel disregarded as a person and survivor when assumptions are made. It is a disregard of their innocent naïveté. Being disregarded through assumptions by a provider undermines an ability of survivors to form a foundation of trust with that provider, thus there is a lack of safety for the survivor.

A lack of disclosure by CSA survivors could be a contributing factor to assumptions made by providers, but again literature has not explored disclosure of CSA within the perinatal setting. Disclosure has been advocated for routine perinatal screening (Bohn & Holz, 1996; Holz, 1989; Seng & Petersen, 1995) and other health care settings (Sharkey, 1997; Teram et al. 1999). There is a plethora of research and literature surrounding disclosure of stigmatizing conditions (Gielen et al. 1997; Keller et al. 2000; Limandri, 1989). Ten of the eleven participants answered *yes* when directly asked if providers should be asking in some manner about a history of childhood sexual abuse. One participant was equivocal stating both sides of the issue of disclosure; asking and telling is difficult. Only one participant verbalized her reason for non – disclosure was due to a fear of embarrassment. Ten of the participants stated that asking is needed to help survivors during perinatal care. Disclosure from survivors to perinatal providers and providers asking about a history of CSA needs to be a focus of research.

Through an impasse by survivors and providers, assumptions about survivors are made and the cycle of being disregarded and thus feeling unsafe is felt. If assumptions are not made by providers a sense of regard and safety is discerned. Another phenomenon which is correlated in literature, but has not been fully explored and is a cause of further research is the attitudes and actions of providers which lead to a survivor's sense of being disregarded or regarded.

Attitudes/Actions

Literature explicates care for the survivor during perinatal care (Bohn & Holz, 1996; Burian, 1995; Courtois & Riley, 1992; Grant, 1992; Holz, 1994; Kitzinger, 1992; Seng & Hassinger, 1998; Seng & Petersen, 1995; Simkin, 1992; Waymire, 1997). Literature suggests that certain actions by providers during care such as specific words used, fetal monitoring, being placed in vulnerable positions and/or intimate touching such as vaginal exams may cause

flashbacks to the abuse experience and cause further psychological trauma. It was generally found through this research that survivors feel unsafe when disregarded through attitudes and actions of providers and feel safe when given regard by the same.

Attitudes and actions such as quick dismissiveness, no eye contact, exposure, being strapped to a monitor, having an intravenous infusion, not being able to walk, not being informed of procedures prior, not addressing or speaking with survivors in a professional manner and not being listened to correlate to being disregarded and overall feeling of being unsafe. It was found that survivors generally separate medical procedures and words and realize they are necessary during perinatal care for their and the baby's health. This is not to say that survivors do not have flashbacks during perinatal care, they do; however, survivors manage their flashbacks by focusing differently to get through the spoiled to achieve successful pregnancy and childbirth.

Managing Vulnerabilities

To achieve a successful pregnancy and childbirth survivors manage vulnerabilities that are intertwined with safety issues. Being given options and control helps survivors manage vulnerabilities of CSA during perinatal care. Literature concerning control and adult survivors of childhood sexual abuse abounds. It is suggested that survivors be given choices and options in care, disrobing, permission to say *no* and providers needing to ask prior to intimate procedures to decrease a sense of powerlessness caused by childhood sexual abuse (Draucker, 1993; Finkelhor, 1986) and gain a sense of control (Burian, 1995; Grant, 1992; Kitzinger, 1992, Teram et al. 1999; Waymire, 1997). It was found that pregnant survivors desire control as a mechanism to manage vulnerabilities. Through this study how survivors manage control of vulnerabilities was explicated.

Rectifying Pregnancy

Survivors rectify the pregnancy through managing fears concerning the fetus. Survivors spoke of nightmares concerning disfigurement of their fetuses and being petrified or horrified about having the nightmares. Finkelhor (1986) documents nightmares among sexual abuse survivors as a behavioral manifestation related to a sense of powerlessness. An emergent concept within rectifying pregnancy is of nightmares concerning the fetus. Another emergent concept is the coming to terms with the pregnancy itself through granting permission for the fetus to abide in the uterus, consistently thinking something is wrong with the fetus or even contemplating abortion due to not wanting to end up like her mother or with a person like the abuser. Finkelhor supports the concept of survivors becoming an abuser as a behavioral manifestation and fear, and a sense of a lowered sense of efficacy in psychological impacts of sexual abuse. Research and literature of non-pregnant survivors support the findings of pregnant survivors in experiencing nightmares and fears. However, the emergent phenomenon of rectifying pregnancy for survivors is supported by survivors having to give permission for the fetus to abide in the uterus and working through the fears that somehow the baby appears as an alien or is altered in some manner. It seems that these are exaggerated fears during pregnancy as survivors describe this time as being petrified, horrified and disillusioned. Further research concerning nightmares of pregnant survivors is needed. Participants manage their vulnerabilities through a variety of phenomenons.

Controlling Actions

Participants in this study described ways of controlling actions to manage their vulnerabilities. It derives from survivors self knowledge concerning the need for control and safety for their whole personhood. Control is acknowledged as a crucial issue among survivors

(Burian, 1995; Finkelhor, 1986; Grant, 1992; Kitzinger, 1992, Teram et al. 1999; Waymire, 1997). Much of the literature states how providers are to give control through choices and options. There is some literature that explicates how survivors gain a sense of control during perinatal services through elaborate birth plans, aggressive behavior, creating chaos or assuming a demeanor of passivity (Burian; Kitzinger; Waymire).

Controlling actions for survivors includes the mechanism of passivity in this sample, but phenomenons of avoiding/delaying, enduring, presencing, and changing emerged from the data as part of managing vulnerabilities during perinatal services.

Avoiding/Delaying

Avoiding and/or delaying are described in literature as a mechanism that female CSA survivors evoke during routine gynecological or physical therapy care (Doob, 1992; Felitti, 1991; Robohm & Bутtenheim, 1994; Schachter et al. 1999). Survivors will avoid or delay medical examinations and treatment to prevent exposure and touching of the female genital area or reproductive parts. This phenomenon was validated in this study; participants describe avoiding and delaying attending pregnancy and postpartum exams. Participants further describe avoiding and delaying labor and delivery experiences to avoid being exposed, touched, denied control or forced to participate in medical regimes. It is unclear in the literature if creating chaos, aggressive behavior and trying to adhere to their agendas is the same mechanism of avoiding and delaying the labor and delivery experience for survivors that is described in this study (Burian, 1995; Grant, 1992). Again, as the emergent voices of survivors during perinatal care is heard continued research is warranted. Avoiding and delaying during perinatal care and services is an emergent phenomenon through this study as is presencing.

Presencing

Presencing is a mechanism that survivors enact to manage the vulnerability of safety. An emergent phenomenon from this study is that survivors need another person in attendance at the bedside regardless of circumstance. Survivors often manage the vulnerability by taking a person with them during exams, insuring that a nurse is in the room, or insisting that a doula or family member they feel most safe with is present during labor and delivery. This is an external mechanism of control for survivors. Without another's presence in perinatal circumstances represents a loss of control and may lead survivors in performing or considering different alternatives to ensure safety. Participants stated they may reject an exam, prevent another pregnancy or seek another practitioner. Presencing is a management mechanism that is intertwined into discerning safety. However, as an emergent concept in childhood sexual abuse presencing needs additional study. An additional internal control mechanism that participants describe is enduring.

Enduring

The internal control mechanism of enduring has several concepts within this phenomenon. Participants describe the concepts of blocking, numbing, disassociation and passivity to manage vulnerabilities during perinatal care and services. Anecdotal and research literature describes these psychological mechanisms survivors employ to get through exams or difficult circumstances that may trigger flashbacks to their sexual abuse situation (Bohn & Holz, 1996; Burian, 1995; Courtois & Riley, 1992; Holz, 1994; Kitzinger, 1992; Simkin, 1992; Waymire, 1997). The concept of enduring to live is within the mid-range theory of enduring and suffering discussed by Morse and Carter (1996) in which persons "find themselves in untenable life circumstances and 'shut down' psychologically" (p. 51). The persons try to avoid a

psychological stressor that is unresolved or they cannot accept. The theory of enduring and suffering as discussed by Morse and Carter can be linked conceptually to the phenomenon of enduring by the participants in this study.

Although two participants stated not experiencing flashbacks; other participants described using the mechanisms to endure exams or circumstances such as being placed on a table during perinatal care and services. However participants describe the mechanism, internal control to manage vulnerabilities occurs. Participants endure whether through blocking, numbing, disassociation or passivity to *get it done*. An external control mechanism which survivors employ to manage vulnerabilities is the emergent concept of changing.

Changing

Survivors actively seek to change circumstances to promote personal safety. As a consequence of discerning an unsafe circumstance to their personhood or in the environment, survivors will employ the mechanism of change. They will change practitioners, medical insurance or circumstances which is more beneficial for survivors. A practitioner or circumstance that is more beneficial means increased safety either for the survivor's personhood or environment during perinatal care and services. A safe environment as desirable for survivors has been noted in literature (Briere, 1992; Schachter et al. 1999; Waymire, 1997); however, a definition of a safe environment has not been explicated nor has it been explicated how survivors manage an unsafe environment during perinatal care prior to this present research.

Participants describe management of a safe environment through positive and negative events. Through providers giving options and survivors being able to make choices within an environment is the ability to control. Participants have begun to describe how they actively manage feeling unsafe through this research. Changing is an emergent phenomenon in which

survivors actively choose a perceived safer environment, practitioner or medical circumstance for a variety of reasons in which they felt unsafe.

Discerning safety and managing vulnerabilities are inextricably intertwined and fluid during the process of perinatal care and services for survivors. These two mechanisms, safety and managing combine as survivors focus differently to get through the spoiled to achieve a successful pregnancy and childbirth.

Focused Differently to Get Through

Survivors adopt a different focus during perinatal care. There is an altruistic theme for survivors to get through the pregnancy. Participants describe putting themselves or putting uncomfortable feelings aside for the benefit of the pregnancy. Through aligning personhoods, discerning safety and managing vulnerabilities survivors incorporate a focus on the fetus to get through a pregnancy, labor and delivery and postpartum.

Survivors put their feelings secondary for the well being of the fetus during pregnancy and childbirth. Participants describe taking better care of themselves through nutrition, not taking drugs, smoking or being around anyone who smoked, and attending classes to achieve an optimal pregnancy. It is an attempt during this time to be more perfect for the baby. One participant who had eliminated drug use during pregnancy illustrates the point when she stated that the day she came home from the hospital after delivery she *got high*. Survivors tamper down or dismiss their CSA issues to deliver a healthy baby. Focusing differently to get through perinatal care has not been explored in the literature. It may be generally accepted that most pregnant women have an altruistic attitude during pregnancy; however, considering the vulnerabilities and sequele of CSA, this is an important concern during pregnancy for female survivors. Draucker and Stern (2000) describe female survivors of sexual assault as *moving on*

or *working past it* in the core variable of forging ahead in a dangerous world. This core variable “reflects the women’s struggle to get on with their daily lives” (p. 389). Forging ahead correlates with the phenomenon of focusing differently to get through as this is the struggle of pregnant survivors to get on with the pregnancy and childbirth. This emergent phenomenon coincides with getting through the spoiled to achieve a successful pregnancy and childbirth.

The Spoiled

Participants describe being spoiled in different terms. They describe feelings that their reproductive parts were focused on and being sorry about occurrences connected with the abused part. Participants describe mechanisms to get through the spoiled such as taking very hot baths prior to labor or wanting everything to be perfect. Feeling spoiled or tarnished is a phenomenon reported in the literature. It involves the self or personhood of the child victim.

Goffman (1963) describes the spoiled identity person. In the case of survivors of CSA since it is an invisible stigmatizing condition, the person is discreditable. Stigmatization is a concern and in describing avoiding stigmatization in infertile women. Whiteford and Gonzales (1995) reported feelings of feeling isolated and violated. In concealing identification of being a lesbian and managing stigma, Stevens and Hall (1988) reported lesbian women not willing to disclose this identification of self. Being a discreditable person such as a survivor of CSA is not a condition that is easily disclosable to health care providers (Limandri, 1989). Participants in this sample did not disclose a history of childhood sexual abuse to their providers in a first pregnancy. Only one participant disclosed to a midwife in her second through fourth pregnancies. Thus, getting through the spoiled is a self-identified stigma kept secret during pregnancy and childbirth. Non-disclosure and feeling spoiled during perinatal care needs to be

further researched. Actions by survivors to overcome feeling spoiled or tarnished during pregnancy and birth also needs to be explored.

The spoiled identity is a part of the child victim personhood. It is awareness of this personhood that affects the actions of survivors to manage vulnerabilities during pregnancy and childbirth. It is this pre-existent identity that aligns with the pregnant female and adult survivor to discern safety and manage vulnerabilities to focus differently to get through the spoiled to achieve a successful pregnancy and childbirth.

Summary

A discussion of findings and related literature was discussed in relation a feminist perspective. Voices in this study are the marginalized women with a history of childhood sexual abuse who have experienced pregnancy and childbirth as a life option. Relevancies of the findings in this study have been correlated to existing research and literature concerning aspects of care for survivors of CSA. Research concerning the phenomenon of childhood sexual abuse is in its infancy (Finkelhor, 1986). Research concerning CSA and female survivors during perinatal care is minimal. The explanatory model and basic social process of a meaning of a history of childhood sexual abuse to female survivors during perinatal services is consistent with grounded theory and a feminist perspective.

The processes employed and activated by pregnant survivors have some correlation to existing research and literature. Emergent concepts within this present research which need further study have been explicated where minimal or no relevant findings were noted in the literature.

Development of a substantive grounded theory is important step in further research to eventually arrive at a formal theory concerning CSA and pregnant survivors. This research is a

step in helping to determine health care needs and improve care for female survivors especially during perinatal services. Continued research will further the basic social process of survivors of childhood sexual abuse who align personhoods to discern safety and manage vulnerabilities while focusing differently to get through the spoiled to achieve a successful pregnancy and childbirth.

Discussion

Critique of Study

Discovering the basic social process of the meaning of a history of childhood sexual abuse for pregnant survivors during perinatal services was the focus of this inquiry. The results of this research have provided a provisional model, a substantive theory and emergent concepts within the phenomenon of childhood sexual abuse and pregnant survivors. Strengths and weaknesses of the present study will be examined along with implications for clinical practice and directions for future research.

A feminist perspective provided a theoretical approach within grounded theory methodology for this study. This proved to be an appropriate perspective and methodology. Many new phenomenon and concepts emerged from survivor's voices. This is consistent with grounded theory methodology and feminist perspective. A substantive theory is the beginning towards a formal theory of a history of childhood sexual abuse and female survivors during perinatal services. This study needs to be replicated. Further research surrounding the phenomenon of CSA and perinatal services continues to be a need to eventually develop valid instruments to test formal concepts.

Eleven participants were interviewed for this study; all participants' voices were included in the data analysis. Another six women were contacted but were unable or chose not to

participate in the study. The process of analysis began as the data was collected. As each interview was conducted, emergent concepts were compared to generate and deepen the theory. Data was constantly compared throughout the study. Eleven participants yielded theoretical saturation. Participants in the study were open and extremely grateful their voices were being heard. One participant stated she was *so glad to be able to put in words what she has thought for so many years*. All of the participants stated female survivors need a voice concerning perinatal services. Many different ethnicities were represented in the study. All socioeconomic, therapy and birth experiences, ages, number of children, marital status and sexual abuse experiences were represented which added depth to the research (see Appendix A).

The researcher validated experiences of the participants through a non-judgmental attitude and a knowing of perinatal care and services through being an experienced perinatal nurse, clinician and educator. All interviews were conducted in a face-to-face manner between the researcher and participant in a private environment that was conducive to openness and safety for the survivor. Each participant was assured of confidentiality and that she had a right to stop the interview at any time if memories became too painful. No interviews were abrogated. Each participant was assured that her voice was valued and meaningful for other survivors and towards educating health care providers concerning a history of CSA, survivors and perinatal care. Participant's voices are reflected in the explanatory model and the basic social process. The findings have added to the body of knowledge surrounding this phenomenon and hope to generate further knowledge.

As further knowledge is generated, more considered and optimal care can be rendered to survivors with a history of childhood sexual abuse. Survivors may be able to feel safer with providers which in turn may lead to survivors disclosing to providers. If disclosure occurs,

optimal actions from providers could ensure a higher level of feeling safe for survivors during perinatal care.

Participants in this study are survivors of childhood sexual abuse who have chosen pregnancy and birth as a life option. Participants volunteered with reimbursement for the interview through different avenues of recruitment methods. This self-selected group may have contributed to a bias due to the incentive of reimbursement for the interview. Participants were geographically located in Southern California although in several different counties. Participants were ethnically diverse, however some ethnicities were under or not represented.

The researcher comes from an ethnically diverse background without the personal experience of childhood sexual abuse. As CSA research is in infancy and little was known concerning this phenomenon by the researcher prior to this study, biases were held to a minimum. This background helped the data analysis to derive from a more objective perspective and increase a deeper understanding of the experiences of pregnant female survivors of CSA from their worldview.

Data collected were from the marginalized voices of female survivors of childhood sexual abuse and their experiences during pregnancy and birth. Codes were used to identify themes, subcategories and categories on a more conceptual level until a basic social process and explanatory model was explicated. This methodology allowed the researcher to give voice to survivors and generate a substantive theory and new knowledge concerning childhood sexual abuse and antenatal, labor and delivery and postpartum care.

Implications for Clinical Practice

Generating new knowledge generates a need for improved clinical practice. There are many clinical implications which have been derived from this research. The central basic social

process that survivors align personhoods to discern safety and manage vulnerabilities has a major impact on clinical practice within perinatal care and services.

Perinatal providers should begin to include on intake or admission forms or through asking directly if females have a history of childhood sexual abuse. Providers need to explain to females why the question is being asked and relevancy to their care during antenatal, labor and delivery or postpartum. Many of the survivors did not disclose at the time of perinatal care because they did not see the relevancy of their history of CSA. It is only after experiencing pregnancy and giving birth that survivors had a better understanding of their history and care during pregnancy and childbirth.

It is this beginning of understanding of child victim, adult survivor and pregnant female that different actions and attitudes could possibly change care to a safer level for survivors. Survivors do not want sympathy, to be labeled, or be *treated special*. One participant spoke of desiring compassion and considered care similar to that of a person with diabetes. Survivors want to be treated as a whole person, which incorporates recognition of child victim, adult survivor and pregnant female.

Providers first need to be aware of the safety factor for survivors. Greeting survivors personally with eye contact and prior to disrobing is a start in regarded care. Survivors discern safety through their feelings of disregard or regard. Asking females what makes them uncomfortable, asking permission and informing them of every minuet step prior to and during exams whether or not the female has disclosed a history of CSA is an important clinical implication. Encouraging, allowing and ensuring that a trusted person or female is present during all exams and any labor or postpartum experience are vital along with speaking to

survivors with professional deference. Providers being able to demonstrate flexibility and choice in procedures or treatments imply a sense of control and safety to survivors.

Survivors do not desire large or unmanageable changes during perinatal care in labor and delivery. It is the consideration in small actions which can create a safe environment for survivors. Nurses need to be more conscience of asking permission and informing survivors of procedures. Nurses need to perform deeper assessments concerning routine treatments, positions and reactions during vulnerable situations. Symptomatology is primary and if females experience extreme tenseness or other adverse reactions; gentle, educated questioning should be included in the assessment. Exposure should be kept to a minimum regardless of persons in the room in the acute setting. Minimizing exposure could mean *not* [italics added] spotlighting the genital area during delivery, draping, or leaving survivors uncovered. Control of persons allowed in the room, and personnel and nursing activities should be controlled and minimized to insure a feeling of safety for survivors during childbirth and postpartum care.

Surprises to their person or circumstance, especially at night, are more difficult for survivors to manage. Surprises that may occur during night hours or when it is dark such as approaching survivors in bed or examinations without warning need to be handled differently. Survivors may need to be awakened prior to physical exams for health reasons, lights left on or an agreed upon method of night examination adhered too. Survivors spoke of being wary of people approaching them from behind or the surprise of being moved from one place to another without being informed.

One of the greatest needs in clinical practice is one of practitioners being informed. Practitioners, regardless of status, need education concerning a history of childhood sexual abuse during pregnancy and childbirth. Survivors want practitioners to be aware of symptomatology of

their reactions which could cause the survivor to be extremely uncomfortable or start feeling disregarded or unsafe. Each participant stated that physicians and nurses need to know how to handle the information and what to do with it. Participants do not want to be labeled as unruly or uncooperative patients when, as survivors their reactions to treatments, procedures, attitudes and actions during perinatal care could be a regression to childhood and it may be difficult reconciling child victim, adult survivor and pregnant female during a vulnerable circumstance such as pregnancy and childbirth. Survivors do not want to be negated by health practitioners. One participant feels the medical community is *dismissing you [survivors] because they can't explain you.*

There are many implications for medical clinical practice to give regarded care to survivors. Assessing deeply, giving choices and being flexible through care may enhance feelings of regard and safety. If survivors have an increased sense of regard, managing the vulnerabilities of CSA could decrease. Survivors of CSA may experience enhanced, compassionate health care for themselves and fetuses during perinatal and women's health care. Through increased knowledge practitioners may feel more powerful to understand and help survivors of childhood sexual abuse.

Directions for Future Research

This research needs to be replicated with other survivor groups of mixed ethnicities and with survivors of specific ethnic groups such as American Black, Hispanic or American Asian survivors. Cultural perspectives would enhance and add to the growing knowledge of survivors of CSA. Care during perinatal services could be culturally bound for different ethnic groups. Survivors who have recently delivered need to be researched from a phenomenological

experience to determine if there are differences in the voices of survivors who delivered in years past to survivors of a recent delivery.

Comparative studies between non-survivors and CSA survivors concerning the concepts within discerning safety and managing vulnerabilities during perinatal care should be conducted. Further research surrounding survivors and perinatal care would deepen and add to the body of knowledge concerning this phenomenon which is in its infancy. Continued substantive theories with emergent phenomena should be conducted in other geographical areas to verify consistency of survivor's voices. Continued research surrounding the phenomena and concepts of CSA may lead to a more formal theory concerning female survivors during perinatal care.

Disclosure and non-disclosure issues of female survivors should be researched to aid practitioners in discussing this sensitive issue. Further development could lead to newer intake or admission form that asks specifically about a history of childhood sexual abuse with every female patient that would give the survivor an opportunity to disclose. Instruments and sensitive valid questionnaires could be developed that aide in the process of determining help needed, not only for survivors but for practitioners also. With added avenues for open communication between survivors and practitioners, considered care could be given to female survivors.

Through replication a formal theory concerning a history of CSA and female survivors during perinatal care, a quantitative instrument could be developed to validate helpful or non helpful interventions for survivors during perinatal services and care. This future instrument could help guide survivors and practitioners through an understandably vulnerable time to prevent retraumatization. Specific nursing assessments and interventions could be developed to facilitate a safer environment for survivors. Through reliable and validated research, birth plans

for survivors could be developed that could prevent retraumatization and enhance the pregnancy and birth process.

Research concerning practitioners in all clinical settings and their care and management of female survivors of CSA needs to be conducted. It needs to be explored if practitioners, male or female, ask specifically about a history of CSA and how practitioners deal with this issue if it is disclosed. The results of this further investigation should be correlated to formal theories concerning CSA survivors and perinatal care to ascertain gaps in perspectives and care. It is certainly a need to increase education of all medical practitioners concerning this phenomenon.

Another indicated research concerns individuals who refuse to advertise or allow studies to be conducted of a sensitive nature. In disallowing the opportunity for survivors or other stigmatized groups to have a voice; “gate keepers” continue to prevent sensitive issues from being explored and keep stigmatized groups such as survivors of CSA marginalized. It also inhibits valued research to be conducted which can help survivors and practitioners to base their practice on evidence. It inhibits the opportunity to change for many individuals who desire it.

Another direction for research concerning childhood sexual abuse is one that was reported through this sample by several of the survivors. Female survivors have reported an *intuitive knowing* or having a *sense* about persons who are abusers and persons that have been abused. This new phenomenon should be explored. Research of this type could lead to survivors helping other women/men who have been abused in obtaining help and giving support.

Conclusion

This study provided a beginning opportunity to have the marginalized voices of female survivors speak about particular issues and concerns during perinatal care. All survivors in this study were willing and glad that they were finally being able to express thoughts and feelings

concerning a history of childhood sexual abuse and their experience during perinatal services. Survivors desire to have health practitioners further educated and sensitive to their needs. They desire not to be labeled as *special*, not disregarded, but regarded in their whole personhood or being. Survivors do have certain needs and issues that perinatal procedures and protocols overlook. Survivors want the same optimal care that health practitioners desire, a healthy baby and mother. The heaviest burden to fulfill survivor's voices lies with the health care community through education and evidence based practice.

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Appendix A

Consent to Participate in a Research Project: The Meaning of a History of Childhood Sexual Abuse to the Pregnant Survivor during Perinatal Services

CONSENT TO BE AN INTERVIEW PARTICIPANT

1. Purpose and Background

Karla Richmond, RNC, MSN, CNS, a doctoral student at the University of San Diego is giving you an opportunity to participate in a research study. This study will be collecting data from participants (survivors), such as you, of childhood sexual abuse who have experienced pregnancy and delivery of a child. The goal of this study is to explore the meaning of this history to women survivors during perinatal care and services from their perspectives.

It is understood that to participate you are at least 18 years old, have had a baby, and are a survivor of childhood sexual abuse and have encountered perinatal care and services.

The Institutional Review Board of the University of San Diego has approved this research study.

2. Procedures

If you agree to participate in this research study, the following will occur:

- a. You will be given a chance to ask questions about this research study before being asked to sign the consent form.
- b. The taping session will be held at a time that is convenient for you. The session will be in a neutral private location of your choice in agreement with the researcher. The tape interview will take approximately 60 – 90 minutes of your time. If you become bored, tired, uncomfortable, or for any other reason, you can ask that the session be terminated or completed on a different occasion.
- c. Karla Richmond, the investigator, will be the only one present at the session. The investigator will only prompt you to continue to verbalize your thoughts. The taped interview will be transcribed at a later time. Detailed hand-written notes also will be made of the interview conversation.

- d. Your participation is voluntary and may be terminated at any time for any reason. If you wish to withdraw from the study medical care will not be affected in any way and, Karla Richmond will destroy the interview tape and hand written notes and any transcription of it will not be included in the data analysis.
- f. You will fill out questions concerning your age, ethnicity, marital status, age at onset and end of childhood sexual abuse, how many times you have been pregnant, and the number of children you have delivered. You also may be asked the genders and professional status of the perinatal providers that have attended you during pregnancy. You understand this is for statistical purposes only.
- g. You may be re-contacted to clarify and/or confirm the data analysis.

3. Risks and Discomforts

- a. Speaking out loud and recalling the experiences during perinatal services as a woman who has been sexually abused in childhood may make you feel a little uncomfortable, but you are free to stop at any time.
- b. The tape will be transcribed and a code assigned to the transcription. You may use a pseudonym (another name) if desired to hide your identity. Neither your name nor any identifying information will appear on any written records of the session. Transcriptions will be kept in a locked file by the researcher. All audiotapes, notes, etc. will be destroyed after five years.
- c. Karla Richmond may consult with Dr. Jane Georges, professor at the University of San Diego, Dr. Diane Hatton, professor at the University of San Diego, or Dr. Marianne Hattar, professor at Azusa Pacific University for data analysis. Dr. Jane Georges serves as Karla Richmond's advisor and committee chair. Dr. Jane Georges can be reached at (619) 260 - 4566. Drs. Hatton and Hattar serve as committee members. All committee members will only have access to transcriptions that do not contain identifying information.
- d. If you experience memories and are in need of psychotherapy help at the completion of the interview or at the end of the research process, you will be given the contact information for an appropriate mental health professional in your county.
- e. You will be given a copy of this consent form.

4. Benefits

Upon completion of the interview a remuneration of \$100.00 will be offered and/or given to the participant in compensation for their time. There will be no other direct benefit to you for participating in this research project. This knowledge may be helpful to all women survivors of childhood sexual abuse. It may benefit perinatal providers and change nursing care for survivors during perinatal care and services.

5. Questions

I have read and understood this form. I have talked with Karla Richmond about this research project and I have had my questions answered. If I have further questions I can call Karla Richmond at (951) 320 – 5090 or Dr. Jane Georges at (619) 260 - 4566.

I, the undersigned, understand the above explanations and on that basis, I give my consent to my voluntary participation in this research project.

Signature of Participant

Date

Location (e.g. County, Ca.)

Signature of Person Obtaining Consent

Date

Remuneration of \$100.00 in cash has been received by me at the completion of the interview.
Participant _____

I have voluntarily refused the remuneration of \$100.00 for participation in this research study.
Participant _____

Thank you for helping me learn and share information that will result in improving the understanding and care for women survivors of childhood sexual abuse.

Sincerely,

Karla Richmond, RNC, MSN, CNS, Ph.D. ©

Appendix B

Demographic Questionnaire

Interview # _____

Pseudonym _____

Please fill in answers to the best of your recollection.

1. Current Age: _____
2. Marital Status: S - M - W - D- Living with a significant other _____
3. Present Occupation _____
4. Ethnicity: Caucasian __ African American __ Hispanic __ Asian __
Other _____
5. Number of pregnancies you have experienced (regardless of outcome of pregnancy) _____
6. Number of living children _____
7. Your age at first pregnancy _____ Your age at first delivery _____
8. Who cared for you during your pregnancy (ies)?
Did not receive any care _____
Obstetrician _____ General/Family Practice Physician _____
Nurse Practitioner _____ Licensed Midwife _____
Lay Midwife _____ Physician's Assistant _____
9. Gender of primary person who cared for you during pregnancy:
Doctor – M or F
Midwife – M or F
Nurse Practitioner – M or F
10. If you changed from one type or gender to another during a subsequent pregnancy, briefly explain why:
11. Location of deliveries: (1) Hospital __ (2) Home __ (3) Birth Center outside of hospital
____(4) Other _____
12. Type of delivery: (1) Vaginal _____ (2) Cesarean Section/Birth _____

13. If you have experienced both types of deliveries, how many of each?
Vaginal _____ C/S _____

Please circle Male (M) or Female (F)

14. Gender of primary doctor or midwife who delivered your:

1 st child - M or F	4 th child - M or F
2 nd child - M or F	5 th child - M or F
3 rd child - M or F	6 th child - M or F

15. Gender of the nurse(s) providing care in labor and delivery:

1 st delivery - M or F	4 th delivery - M or F
2 nd delivery - M or F	5 th delivery - M or F
3 rd delivery - M or F	6 th delivery - M or F

16. Age at onset of sexual abuse _____

17. Age at end of sexual abuse _____

Please circle your answer to the following questions:

18. Did the sexual abuse result in 1 or more pregnancies – Yes / No.
19. Have you ever had counseling for childhood sexual abuse? Yes / No
20. Are you currently in counseling for past childhood sexual abuse – Yes / No
19. If you had any counseling in the past for childhood sexual abuse, how many years and / or months did you have counseling?
Number of Years _____ Months _____
22. Have you ever been specifically or directly asked about a history of childhood sexual abuse? Yes / No.
23. If yes, how many times were you asked by your primary doctor, nurse practitioner, or midwife? 1 time only ___ 2-3 times ___ 4-6 times ___
over 7 times _____
24. Have you ever been asked by a nurse in labor and delivery about a history of childhood sexual abuse? Yes / No.
- If yes, did she/he ask you: 1 time only ___ 2-3 times ___ 4-6 times ___
over 7 times _____

Circle all that apply.

25. Did you decide to tell your doctor/nurse practitioner/midwife/labor and delivery nurse/ and/or postpartum nurse about your history of childhood sexual abuse?

Appendix C

Demographic Questionnaire

RESULTS – MEASURES OF CENTRAL TENDENCY

1. Current Age
Range: 26 – 51 Average: 39.6 years
2. Marital Status: S - M - W – D- Living with a significant other
Single: 3 Married: 6 Widowed: 0 Divorced: 1 LWSO: 1
3. Present Occupation

a. Case manager	b. Working at Curves for Women
c. Registered Nurse	d. Instruction Asst. for Special Education
e. Doula, Educator	f. Assist. Grommer
g. Homemaker	h. City Planner
i. Realtor	j. Homemakers (2)
4. Ethnicity: Caucasian 4 African American 3 Hispanic 3 Asian 0
 Other Mulatto - 1
5. Number of pregnancies you have experienced (regardless of outcome of pregnancy)
Range: 1-9
6. Number of living children
Range: 1-4
7. Your age at first pregnancy: Range: 14-33 yrs. Average: 22 years old.
 Your age at first delivery: Range: 18-34 yrs. Average: 24 yrs.
8. Who cared for you during your pregnancy (ies)?
 Did not receive any care: 0
 Obstetrician: 11 General/Family Practice Physician: 0
 Nurse Practitioner: 1 Licensed Midwife 1
 Lay Midwife: 2 Physician's Assistant: 0

9. Gender of primary person who cared for you during pregnancy:

Doctor – M or F: Male: 10 Female: 3

Midwife – M or F: Male: 0 Female: 1

Nurse Practitioner – M or F: 0

10. If you changed from one type or gender to another during a subsequent pregnancy, briefly explain why:

Insurance – choose for her, limited in choice

Trust in quality of care & personal involvement, respect for feelings and wishes

11. Location of deliveries: (1) Hospital: 11 (2) Home: 3
(3) Birth Center outside of hospital: 0 (4) Other: 0

12. Type of delivery: (1) Vaginal: 8 (2) Cesarean Section/Birth: 2

13. If you have experienced both types of deliveries, how many of each?

Vaginal: 2 C/S: 2 (Only 1 survivor had 2 NSVD, 2 C/S = 4 deliveries)

Please circle Male (M) or Female (F)

14. Gender of primary doctor or midwife who delivered your:

1st child - M or F - M/8 F/3

4th child - M or F - M/1 F/2

2nd child - M or F - M/5 F/3

5th child - M or F - 0

3rd child - M or F - M/4 F/1

6th child - M or F - 0

15. Gender of the nurse(s) providing care in labor and delivery:

1st delivery – M or F - M/0 F/10 (1 = both M & F in 1st delivery)

2nd delivery – M or F - M/1 F/8

3rd delivery – M or F - M/1 F/4

4th delivery – M or F - M/0 F/3

5th delivery – M or F - M/0 F/0

6th delivery – M or F - M/F/0

16. Age at onset of sexual abuse: Range: 5-12 yrs. Average: 8.45 yrs.

17. Age at end of sexual abuse: Range: 9-22 yrs. Average: 13.86 (14 yrs.)

Please circle your answer to the following questions:

18. Did the sexual abuse result in 1 or more pregnancies – Yes = 0 No = 11

19. Have you ever had counseling for childhood sexual abuse? Yes = 11 No = 0