PERINATAL CARE OF CHILDHOOD SEXUAL ABUSE SURVIVORS: SCOPING REVIEW

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Abstract

Background: An estimated one in nine women seeking perinatal care is a survivor of childhood sexual abuse (CSA), yet CSA may be unknown to nurses and other health care providers. Childhood sexual abuse can have adverse physical and psychological effects for survivors, and the intimacy of perinatal care can trigger distress like intrusive thoughts.

Purpose: To explore available literature about CSA survivors and perinatal care. Specific aims were to 1) identify nursing actions that ease undesirable feelings during perinatal care for CSA survivors and 2) identify gaps in the literature on perinatal care for CSA survivors.

Study Design and Methods: Following the PRISMA-ScR Checklist, MEDLINE and CINAHL databases were searched using: "Child Abuse, Sexual," "Perinatal Care," and "Parturition." Initial yield was 109 records.

Results: Applying inclusion and exclusion criteria produced 14 full-text articles. Findings suggest that obtaining consent, promoting safety, trust, and control, fostering a healthy nurse–patient relationship, and inquiring about abuse may improve how CSA survivors experience perinatal care. Gaps in literature include nursing assessments for history of CSA with nonverbal cues.

Clinical Implications: For all patients, nurses should foster security and trust. It is critical that CSA survivors be in control of their care. Procedures should be thoroughly explained, and most importantly, consent should be obtained prior to every physical touch. Nurses must ask about history of CSA because it is part of patient-centered care, which is central to nursing.

Key words: Adult survivors of adverse childhood experiences; Adverse childhood experiences; Child abuse; Perinatal care; Sexual.

Childhood sexual abuse (CSA) occurs when a child cannot grasp the activity, is not developmentally prepared for the act, is unable to consent, or the act violates societal laws (Centers for Disease Control and Prevention, 2021; Roller, 2011). Perinatal care entails prenatal through postpartum care (The Joint Commission, 2021). An estimated one in nine perinatal patients has endured CSA (Roller, 2012; van der Hulst et al., 2006). Given its intimate nature, perinatal care may be complicated for CSA survivors (Leeners et al., 2006). People from all types of backgrounds are affected (Roller, 2011). Childhood sexual abuse can lead to multiple short- and long-term consequences on mental and physical health (Roller, 2011; Sigurdardottir & Halldorsdottir, 2018; van der Hulst et al.).

Mental health effects include posttraumatic stress disorder, substance misuse, mood and anxiety disorders, and others (Roller, 2011; Sigurdardottir & Halldorsdottir, 2018; van der Hulst et al., 2006). It can cause somatic symptoms and serious physical ailments (Hobbins, 2004; Sigurdardottir & Halldorsdottir). Compared with women without CSA, survivors have more risky behavior like unprotected sex, sex with multiple partners, and late prenatal care (Roller, 2011; Roller, 2012) and are at increased risk for pregnancy complications such as infection and preterm labor and birth (Leeners et al., 2006). Physical changes of pregnancy can be mentally stressful for CSA survivors (Leeners et al.). Survivors have more risk of postpartum depression, breastfeeding difficulties, and mother–child relationship issues (Leeners et al.). The mother–child bond is critical for the child's adequate growth and development and attachment style in future relationships. Postpartum depression can adversely affect an infant's social and emotional functioning (Young, 2013).

The purpose of this scoping review was to explore available literature about CSA survivors and perinatal care. Specific aims were to 1) identify nursing actions that ease undesirable feelings during perinatal care for CSA survivors and 2) identify gaps in the literature on perinatal care for CSA survivors.

Methods

Using the PRISMA-ScR checklist (Tricco et al., 2018), the search strategy included all research types from MEDLINE and CINAHL databases using: "Child Abuse, Sexual"; "Perinatal Care"; and "Parturition." Duplicate, non-English, and irrelevant reports (other populations than CSA survivors or contexts outside perinatal care) were excluded. Level of evidence and quality were assessed using the Johns Hopkins Nursing Evidence Based-Practice Rating Hierarchy for Level of Research Evidence and Johns Hopkins Nursing Evidence-Based Practice Quality Ratings, respectively (Dang & Dearholt, 2018).

Results

Fourteen articles were identified based on our inclusion and exclusion criteria (Figure 1). Findings (Table 1) were

FIGURE 1. SEARCH STRATEGY FOR PERINATAL CARE OF CHILDHOOD SEXUAL ABUSE SURVIVORS

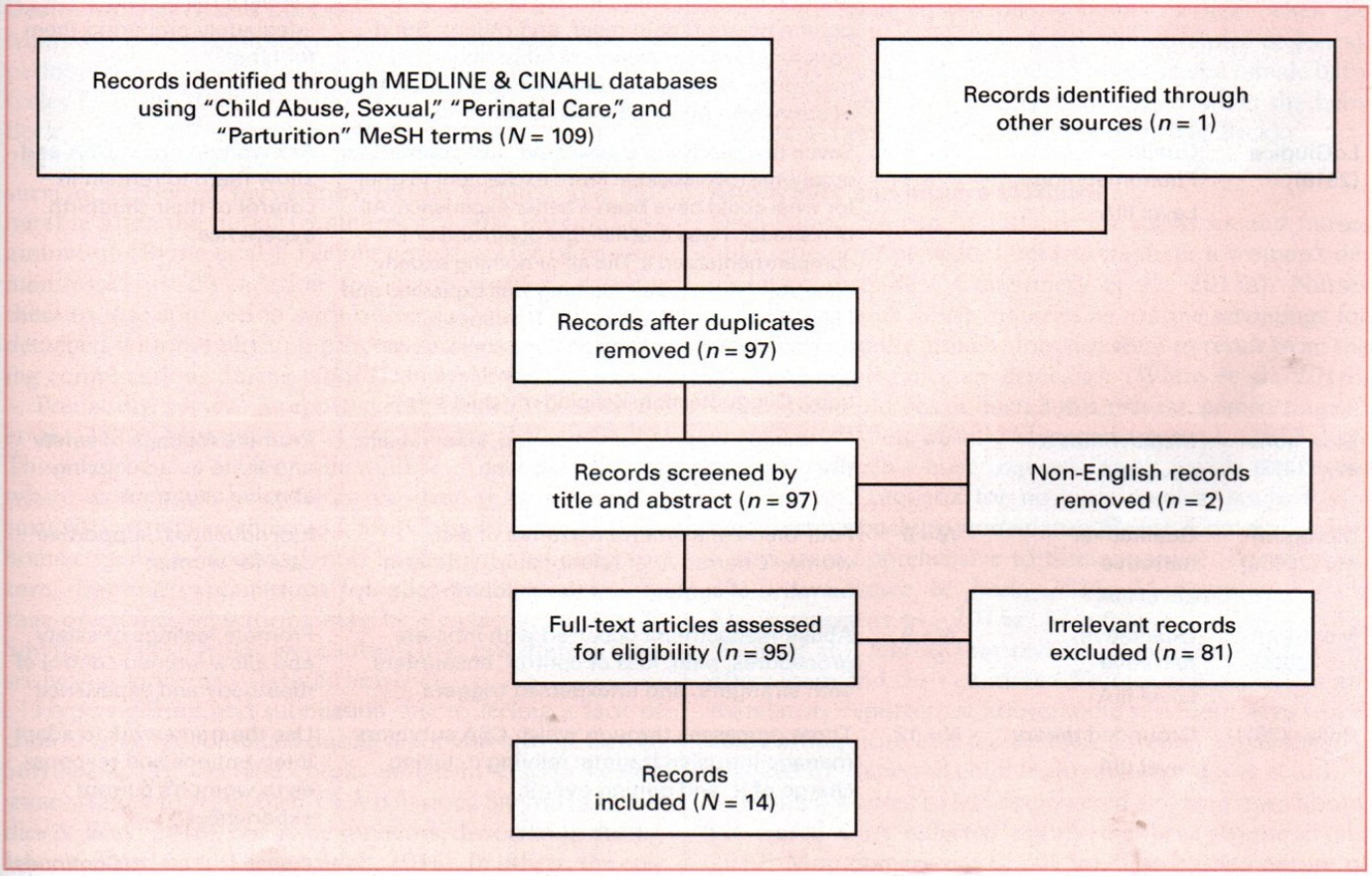

TABLE 1. SUMMARY OF STUDIES ($N = 14$) FOR PERINATAL CARE OF CHILDHOOD SEXUAL ABUSE (CSA) SURVIVORS

First Author (Year)	Design and Level of Evidence and Quality	Sample	Findings	Nursing Actions That Ease Undesirable Feelings during Perinatal Care for CSA Survivors
Byrne (2017)	Qualitative, narrative Level IIIA	$N = 3$	Three overarching dimensions of experience: identity, embodiment, and parenting. Underpinned by dimensions of disempowerment and empowerment.	N/A
Clark (2011)	Case study Level IIIA	$N = 2$	Providers are responsible for awareness of women's physical and psychological needs. At-risk women benefit from multidisciplinary approaches.	Sensitive and appropriate intrapartum care
Coles (2009)	Qualitative Level IIIA	$N = 18$	Survivors may face guilt, blame, fear, dissociation, pain, and helplessness in provider encounters. Two themes important in improving service: safety issues for survivors and their babies in the encounter, and ways of making service provision safer.	Universal precautions: consent, continuing consent, consent for baby exams, explanations, no procedure or exam should be "routine"
Leeners (2006)	Cohort Level IIIA	$N = 228$	CSA prevalence ranged from 11.5% to 14.6%. Lifetime sexual abuse prevalence was 12.8% to 15.9%. In 42.3% of women, abuse was ongoing.	N/A
Leeners (2010)	Cohort Level IIA	$N = 255$	Pregnant survivors were hospitalized with preterm contractions, cervical insufficiency, and preterm labor and birth more than women without CSA.	CSA should be identified perinatally so care can be tailored.
Leeners (2016)	Cohort Level IIA	$N = 255$	Childbirth was more highly frightening and negative for CSA survivors than nonsurvivors. Some mediation with birthing classes, support person present, pain relief, and others. Survivors had longer duration of labor. Intrusive memories of trauma arose during birth for 41% of survivors. About 58% had dissociation.	Build a trusting environment by meeting the patient's needs and adequately preparing them for labor.
LoGiudice (2016)	Qualitative, Phenomenology Level IIIA	$N = 8$	Seven themes: No one asked me. Just ask me!; An emotional rollercoaster: From excitement to grief for what could have been a better experience; All of a sudden I was that little girl again and/or I compartmentalized it: The all-or-nothing experience; Am I even here?: Nothing was explained and I had no voice; All too familiar: No support, nowhere to turn; Holding onto the choices I can make: Who my provider is and how I feed my baby; Overprotection: Keeping my child safe	Ask women about CSA and allow them to remain in control of their childbirth experience.
Montgomery (2013)	Metasynthesis Level IIIA	$N = 8$	Six themes: control, remembering, vulnerability, dissociation, disclosure, and healing	Promote feelings of safety and try to avoid copying abusive situations
Montgomery (2015a)	Qualitative, narrative Level IIIA	$N = 9$	Four themes: women's narrative of self, women's narrative of relationship, women's narrative of context, and the childbirth journey	Individualized, supportive care for women
Montgomery (2015b)	Qualitative, narrative Level IIIA	$N = 9$	Abuse reenactment occurred with intimate procedures, pain, loss of control, encounters with strangers, and unexpected triggers	Promote feelings of safety and allow women control of their body and experience
Roller (2011)	Grounded theory Level IIIA	$N = 12$	Three processes through which CSA survivors manage intrusive trauma: reliving it, taking charge of it, and getting over it.	Use the framework to adapt interventions and responses to women's current experiences.

(Continues)

TABLE 1. SUMMARY OF STUDIES ($N = 14$) FOR PERINATAL CARE OF CHILDHOOD SEXUAL ABUSE (CSA) SURVIVORS (*CONTINUED*)

First Author (Year)	Design and Level of Evidence and Quality	Sample	Findings	Nursing Actions That Ease Undesirable Feelings during Perinatal Care for CSA Survivors
Roller (2012)	Secondary analysis Level IIA	$N = 1,049$	The PSCI is sensitive to differences in mental health status and predictive of adverse perinatal outcomes. It explained 6.5% variance in birthweight.	N/A
White (2016)	Qualitative, focus group Level IIIA	$N = 6$	Five themes: a clear trauma definition; clear purpose for inquiry; reassurance that inquiry is routine; confidentiality; and helpful resources other than psychiatric therapy	Have a clear definition of trauma; explain reason for abuse inquiry which is confidential and promotes maternal and fetal wellbeing.
van der Hulst (2006)	Cohort Level IIA	$N = 625$	Sexual abuse prevalence was 11.2%. Survivors were more likely than nonsurvivors to: be younger, smokers, and low income; and have conflicted feelings about sex. They were less likely to have episiotomies.	N/A

Key: Level of evidence and quality were assessed using the Johns Hopkins Nursing Evidence Based-Practice Rating Hierarchy for Level of Research Evidence and Johns Hopkins Nursing Evidence-Based Practice Quality Ratings (Dang & Dearholt, 2018).

categorized by major concepts related to perinatal nursing care for CSA survivors: desire for safety and control, anonymity and inquiry of abuse, consent, and the nurse–patient relationship.

Desire for Safety and Control

Many CSA survivors preferred safety and control during perinatal care (Byrne et al., 2017; Clark & Smythe, 2011; Coles & Jones, 2009; Leeners et al., 2016; LoGiudice & Beck, 2016; Montgomery, 2013; Montgomery et al., 2015a; Montgomery et al., 2015b; Roller, 2011). Some survivors reported persistently feeling violated and vulnerable after the initial trauma of the first prenatal examination (Byrne et al.). Feeling unsafe or out of control manifested as dissociation for some women, causing them to lose connection with obstetrical staff, becoming detached with the birthing process and potentially ignoring complications during labor (Leeners et al., 2016).

Prenatally, survivors reported retraumatization (Byrne et al., 2017; Montgomery et al., 2015b; Roller, 2011). This may be due to the vulnerability of physical exams where women are lying flat, a position that likens how survivors may have endured CSA (Coles & Jones, 2009). Some coped via hypervigilance: having detailed plans for care, wanting explanations for all actions, and feeling that pregnancy sensations may be dangerous (Clark & Smythe, 2011). Others were submissive, not sharing their wishes or concerns (Clark & Smythe).

Hypervigilance and submission due to feeling a lack of control or safety continued during labor and birth (Clark & Smythe, 2011). Cervical checks and fetal descent caused some women to relive their CSA (Clark & Smythe; LoGiudice & Beck, 2016). For some survivors, dissociation during labor reduced pain (Leeners et al., 2016). In others, the epidural procedure evoked flashbacks, as women felt trapped and unaware of what was going on (LoGiudice & Beck).

After birth, women felt out of control in caring for their baby (Coles & Jones, 2009; Leeners et al., 2006; LoGiudice & Beck, 2016). Some found it hard to entrust their baby's exam to a stranger, and one woman was upset when the provider was the same sex as her abuser (Coles & Jones). Some survivors feared they could not protect a female baby and others were reminded of their abuser when the baby was male (Leeners et al., 2006; LoGiudice & Beck).

Anonymity and Inquiry of Abuse

Discussing CSA can be difficult for survivors and nurses alike, and prior provider interactions shape a woman's decision to disclose (Montgomery et al., 2015a). Nurses should approach abuse inquiries as routine screenings for all patients, so the inquiry does not seem to result from the woman's appearance or demeanor (White et al., 2016). Inquiries should be conducted in a private, comforting environment (White et al.). Montgomery et al. (2015a) recounted women whose requests for all female staff were ignored, and requests for no male medical students denied, further pushing women into silence. Commonly, survivors were apprehensive to disclose abuse (Byrne et al., 2017; LoGiudice & Beck, 2016; Montgomery, 2013; Montgomery et al., 2015a; Montgomery et al., 2015b; White et al.), fearing that revealing CSA would adversely affect them and their children (White et al.). As nurses are mandatory reporters of abuse, some survivors were suspicious of inquiries and feared their parental rights may be revoked for expected child maltreatment (White et al.).

Women wanted to feel empowered and heal from abuse, yet feared CSA reflected poorly on them (Byrne et al., 2017; Montgomery et al., 2015a). The hushed nature of

Approximately one out of every nine women receiving prenatal care is a survivor of childhood sexual abuse.

CSA drove some women into silence, even when their abuser was prosecuted (Montgomery et al., 2015a). Some feared society's judgment or doubt, which caused feelings of inadequacy in pregnancy and parenting (Byrne et al.; LoGiudice & Beck, 2016). Some survivors desired to be "normal" and not labeled a victim, but they used maladaptive coping mechanisms like silence (Montgomery et al., 2015a). Most women wanted nurses or other providers to ask about CSA so birthing outcomes could be discussed (LoGiudice & Beck). Some women wanted to disclose abuse after it was clear that when they did, the nurse offered resources to promote healing, like peer groups (White et al., 2016).

Four articles reported memory repression or memory resurfacing (Coles & Jones, 2009; Leeners et al., 2016; Montgomery, 2013; Montgomery et al., 2015a). Some women did not disclose CSA deliberately and some were unaware of the abuse due to memory repression (Montgomery; Montgomery et al., 2015a). With the trigger like the baby crowning or positioning during exams and labor, memories resurfaced (Coles & Jones; Leeners et al., 2016; Montgomery et al., 2015a).

When women disclose CSA, the Perinatal Self-Care Index (PSCI) can be used to assess self-care and predict negative perinatal outcomes (Roller, 2012). The PSCI is a seven-item clinical index that guides patient-centered interventions based on any deficiencies in self-care (Roller, 2012). It has been a predictor of unfavorable perinatal outcomes, but further research is needed to explore psychometrics with different populations (Roller, 2012).

Consent

Nurses may be unaware of CSA so it is vital to be sensitive to the intimacy of perinatal care (Clark & Smythe, 2011; Coles & Jones, 2009). The majority of findings related to consent involve the notion of "universal precautions" for perinatal nurses caring for CSA survivors and their children (Coles & Jones). These universal precautions were developed out of a qualitative exploration of CSA survivors' responses to perinatal professional touch, and include: consent, continuing consent, consent for baby exams, explanations, and no "routine" procedures or exams (Coles & Jones). Nurses should avoid reminding women of their abuse (Montgomery, 2013) by placing consent at the forefront of interventions to promote feeling safe (Clark & Smythe; Coles & Jones; Montgomery).

Consent to touch during perinatal care is ongoing and should never be assumed (Clark & Smythe, 2011; Coles & Jones, 2009). Nurses should explain what is being done, who is doing it, why it is necessary, and offer alternatives if applicable (Coles & Jones). Nurses should check in often with patients during procedures to ensure they are comfortable and want to continue (Coles & Jones). It is crucial to note body language, as verbal communication may contradict nonverbal communication (Clark & Smythe). If the nurse notes distress, the exam should be slowed or stopped to discuss the woman's needs (Coles & Jones). Perinatal care can become routine for nurses, so it is important they remember it is not routine for patients (Coles & Jones).

Nurse–Patient Relationship

Four studies reported on the nurse–patient relationship: it should be trusting, empathetic, supportive, and sensitive to emotional cues (Coles & Jones, 2009; LoGiudice & Beck, 2016; Montgomery et al., 2015a; Montgomery et al., 2015b). It is integral for nurses to give care that meets these characteristics (Coles & Jones; Montgomery et al., 2015b). Communication should be sensitive to potential trauma, recognizing when the patient is distressed (Montgomery et al., 2015a; Montgomery et al., 2015b). Listening is essential in all relationships; failing to listen can cause revictimization for CSA survivors (LoGiudice & Beck).

Most studies uncovered in this scoping review were qualitative (n = 8), indicating a need for more quantitative research in this area. Of the six quantitative studies, four were cohort studies. Gaps in literature identified include how nurses can assess for abuse using nonverbal cues, and what barriers keep nurses from having an open discussion about past abuse.

The small sample of studies in this review shows the dearth of evidence on this topic. It is possible that excluding non-English articles excluded evidence. Level of evidence for the majority of articles in this review was at or below level II (Dang & Dearholt, 2018). More research is needed to determine effectiveness of nursing actions identified: obtaining consent, forming a therapeutic nurse–patient relationship, and inquiring about abuse.

Clinical Implications

Our findings align with those of an earlier review (Roussillon, 1998) that described CSA implications during pregnancy, birth, and breastfeeding. Uniquely, Roussillon (1998) argued the importance of identifying a CSA survivor's progress with recovery and anticipatory guidance for perinatal care. Anticipatory guidance involves explaining potential effects of being a CSA survivor during perinatal care and can help the patient develop a trusting relationship with nurses, aid in positive maternal identity, and have a positive experience with labor and birth (Roussillon). This is an important implication not found in this review.

Nurses and other health care providers have professional, ethical, and moral duties to tailor care to women's unique needs. Perinatal care should be sensitive to women's life experiences and include tenets of trauma-informed care: physical and psychological safety, trustworthiness, collaboration, peer support, empowerment, and cultural sensitivity (Hall et al., 2021). This is consistent with our

SUGGESTED CLINICAL NURSING IMPLICATIONS

- Advocate for the routine inquiry of CSA, just as intimate partner violence screening is established as standard of care.
- Individualize perinatal care for CSA survivor patients, beginning with initial and ongoing consent to touch.
- Establish a therapeutic, supportive relationship with all patients receiving perinatal care, and especially for patients who are CSA survivors.
- Respond to disclosure of abuse in a supportive, nonjudgmental, empathetic manner.
- Ensure that patients feel listened to and have a voice in their care.

results, yet some survivor reactions imply that it was not used.

An important clinical implication is that all abuse inquiries should be treated as routine. Nurses' reactions when abuse is disclosed influence women's perinatal experiences, and ideally validate their experiences (Coles & Jones, 2009; Montgomery et al., 2015a). Women's varied reactions reflect varied CSA encounters. No single experience exists for women with CSA; each has unique complexities and challenges. As providers who are frequently at the patient's bedside, establishing trust and rapport with patients is often quicker and easier for nurses. Recognizing cues of potential CSA can help nurses gain specific insight into patients' needs, thereby individualizing patient care.

Leaders in hospitals and health care systems need to establish and implement clear and effective policies and procedures related to the routine inquiry or screening for CSA. One facet of this implementation is providing adequate and ongoing education for all care givers who may encounter CSA survivors as patients or peers. Education should include trauma-informed care and debriefing.

Future research should explore nurses' self-assessment of CSA or other types of abuse, because a history of abuse may influence how nurses respond to and care for CSA survivors as patients. Additional projects should be aimed at raising awareness of CSA or other types of abuse as a way to combat the surrounding stigma and taboo. This may be the first step toward lifting survivors out of their silence. ✣

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