The Impact of Childhood Sexual Abuse on Pregnancy, Labor and Birth

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Publication info: Journal of Prenatal & Perinatal Psychology & Health 18. 4 (Summer 2004): 313-325.

Abstract: None available.

Full Text: Headnote ABSTRACT: Current estimates of the incidence of childhood sexual abuse range from 12% to 40%, indicating that a significant number of women enter pregnancy, labor and birth with past experiences of trauma. Recent quantitative research results have revealed little significant difference in rates of obstetrical complications and pregnancy outcomes in women reporting histories of childhood sexual abuse and those reporting no history of childhood sexual abuse. Empirical data and anecdotal reports of women's experiences during pregnancy, labor and birth, as well as health practitioners' experiences of providing prenatal and obstetrical care, indicate that a history of childhood sexual abuse can have a psychological and behavioral impact on the woman that may be evidenced throughout the prenatal and birth process. An awareness of the individual needs of survivors of childhood sexual abuse during this critical time has implications for the care provided by prenatal and obstetrical health care practitioners. KEY WORDS: childhood sexual abuse, pregnancy, labor, childbirth, prenatal care, obstetrical care. INTRODUCTION Current estimates of the incidence of childhood sexual abuse in the United States range from 12% to 40%, but the actual prevalence is unknown due to the fact that many survivors never disclose their experiences as a result of the shame and stigma associated with the abuse (American College of Obstetricians and Gynecologists, 2001). Based on these statistics, it is likely that a significant number of women enter pregnancy, labor and birth carrying the effects of past trauma. The impact of prior trauma, particularly childhood sexual abuse, on pregnancy, labor and birth has been evaluated in both quantitative and qualitative research. H. Grimstad and B. Schei (1999) and M. I. Benedict, L. A. Paine, et al. (1999) have conducted quantitative studies examining the impact of childhood sexual abuse on pregnancy, labor and birth outcomes. These studies are contrasted with the anecdotal reports of survivors' experiences giving birth, health care providers' experiences attending them and qualitative studies. The anecdotal reports provide significant information regarding the implications of histories of abuse for prenatal and obstetrical care (Courtois, C.A. &Riley, C.C., 1992; Grant, 1992; Kitzinger, 1992; Rhodes &Hutchinson, 1994; Simkin, 1992). Although the quantitative studies do not support evidence of significant differences in obstetrical outcomes between birthing women with histories of childhood sexual abuse and those without such histories, the potential behavioral and psychological impact of labor and birth on these women, and in turn on their babies, is significant and should inform the care provided to women and their babies during this critical period. Acknowledgement of this fact is addressed in The American College of Obstetricians and Gynecologists' (ACOG) official educational bulletin (2001) entitled, "Manifestations of Childhood Sexual Abuse." Changes in prenatal and obstetrical care that respect and are sensitive to survivors' particular needs at this time, a time that can often trigger memories of past abuse experiences, will help prevent women from experiencing birth as a reenactment of the violation they experienced in the past. DEFINITION OF CHILDHOOD SEXUAL ABUSE, DISCLOSURE AND PREVALENCE As described in ACOG's educational bulletin, "Childhood sexual abuse can be defined as any exposure to sexual acts imposed on children who inherently lack the emotional, maturational, and cognitive development to understand or to consent to such acts. These acts do not always involve sexual intercourse or physical force; rather, they involve manipulation and trickery. Authority and power enable the perpetrator to coerce the child into compliance" (2000, p. 311). Finkelhor describes legal and research definitions of child sexual abuse for which two elements are required: sexual activities involving a child; and an abusive condition (1994, p. 33). Finkelhor defines sexual activities as those intended for sexual stimulation, including contact and noncontact sexual abuse. He describes abusive conditions as existing when, "the child's

partner has a large age or maturational advantage over the child; or the child's partner is in a position of authority or in a caretaking relationship with the child; or the activities are carried out against the child using force or trickery" (p. 33). According to Bohn and Holz, "all forms of abuse are known to be underreported. Survivors are often ashamed or afraid to disclose what has happened to them ... They often fear repercussion from the perpetrator as well as insensitive or punitive responses from those to whom they might otherwise disclose" (1996, p. 442). Simkin notes, "Many women have no conscious memory of abuse, and, therefore, may not disclose such a history in response to direct questioning" (1992, p. 224). As a result, it is likely as Simkin points out, that, "Those of us in maternity care knowingly or, more likely, unknowingly care for survivors of childhood sexual abuse" (Simkin, 1992, p. 224). Perry categorizes four types of memory, "cognitive, motor vestibular, emotional or affect, and state memories" (1999, p. 6). Bessel van der Kolk points out that "trauma interferes with declarative memory, i.e. conscious recall of experience, but does not inhibit implicit, or nondeclarative memory, the memory system that controls conditioned emotional responses, skills and habits, and sensorimotor sensations related to experience" (1994, p. 8). Perry and van der Kolk's descriptions of the nature and storage of memory help to explain Grant's observations that "awareness of previous abuses may surface initially during pregnancy. Women who have no recollection of abuse may begin to experience feelings, dreams, memories, or behavioral patterns that do not make much sense until the memories are recovered and dealt with in therapy" (Grant, 1992, p. 221). The psychological and physical experiences encountered in pregnancy, labor and birth, including, as Grant points out, the "concomittant body image changes, changes in lifestyle, and assumption of a parenting role, could have an impact on the incest survivor, causing previously effective coping mechanisms to fail and trigger memories that can no longer be repressed" (1992, p. 221). CHARACTERISTIC BEHAVIORS EXHIBITED BY SURVIVORS OF CHILDHOOD SEXUAL ABUSE DURING LABOR AND BIRTH Whether a woman is consciously aware of her history or not, she may be experiencing a number of physical, psychological and behavioral effects of the trauma of past sexual abuse that can be observed by care providers and may impact pregnancy, labor and birth. Survivors of childhood sexual abuse may exhibit some of the symptoms of trauma that Levine (1997) describes as generally taking a long period of time to develop including: excessive shyness; muted or diminished emotional responses; inability to make commitments; chronic fatigue or low physical energy; immune system problems and certain endocrine problems such as thyroid dysfunction; psychosomatic illnesses, particularly headaches, neck and back problems, asthma, digestive, spastic colon; depression, feelings of impending doom; feelings of detachment, alienation, and isolation; fear of dying, going crazy or having a shortened life; abrupt mood swings, including rage reactions, temper tantrums or shame; exaggerated or diminished sexual activity; feelings and behaviors of helplessness; inability to love, nurture and bond with other individuals; difficulty with sleep; reduced ability to deal with stress and to formulate plans (Levine, 1997, p. 149). Bohn and Holz describe physical and somatic health problems commonly experienced by survivors of sexual abuse which also include, "changes in health habits such as diet, exercise, and drug use initiated to cope with the psychic trauma of abuse; chronic overarousal due to PTSD; heightened focus on internal sensations ... For sexual abuse survivors, physical symptoms may result from body memories. A body memory is the body's ability to re-experience (remember) a painful/traumatic event with the original painful sensations, although no physical cause is currently in evidence" (Bohn and Holz, 1996, p. 443). Simkin describes common behaviors sexual abuse survivors may exhibit during labor and birth including: confusion and anxiety over body boundaries evidenced by fear of invasive procedures and discomfort with nakedness or exposure of sexual parts of the body; the need to maintain as much control as possible over the care she receives and her responses to pain and stress in labor; fear of pain or injury in the sexual parts of her body during labor and birth; unwillingness to trust those in authority; resistance to the language and expectations of childbirth classes; flashbacks or body memories in labor; shutting down labor progress at a level of pain where she can maintain control (Simkin, 1992, p. 224-225). However, it should be pointed out that any of these behaviors may be found in women who have not been sexually abused. What matters is the total picture,

not one or two isolated behaviors. As Bohn and Holz point out, "Many of the behavioral and interpersonal consequences of abuse stem from the violation of trust in a love or familial relationship" (Bohn &Holz, 1996, p. 443). Kitzinger observed that "Medical examinations and interventions are crisis points for many women" (1992, p. 219). Kitzinger interviewed 39 survivors of sexual abuse and found that "more than one-half of them were reminded of sexual assaults by internal examinations, cervical smears, or even visits to the dentist; childbirth was often particularly significant. Medical examinations can repeat the physical intrusions that women endured during the assaults as children, and involve loss of control over one's own body ... The experience of being helpless in the hands of another person recalls their powerlessness during abuse" (p. 219). RESEARCH ON LABOR EXPERIENCES AND SELECTED PREGNANCY OUTCOMES The impact of childhood sexual abuse on labor experiences and pregnancy outcomes has been studied using quantitative and qualitative research. Recent quantitative research studies have revealed little significant difference in rates of obstetrical complications and pregnancy outcomes in women reporting histories of childhood sexual abuse and those reporting no history of childhood sexual abuse. In one study, Grimstad and Schei (1999) conducted research on "Pregnancy and Delivery for Women with a History of Child Sexual Abuse." The authors' primary objective was to examine whether women who delivered low birth weight infants were more likely to have experienced child sexual abuse than women who delivered non-low birth weight infants. secondary objectives were to explore medical complications, urogenital infections, use of health care services, medical treatment during pregnancy, intervention during delivery, and discomfort during pregnancy among women with or without a history of child sexual abuse. During an 18-month period from 1992-1994, women were recruited for the study at the Department of Obstetrics at the University of Trondheim in Norway. Women who delivered a baby with a birth weight below 250Og, regardless of gestational age, were assigned to the study group. Following each identified case assigned to the study group, the next woman delivering a baby with a birth weight 250Og or more was selected as a control subject. Eighty-six women were interviewed in the case group and 92 women in the control group totaling 178 women. One hundred ten women recruited in the maternity ward, were interviewed at the hospital after delivery, while 68 were recruited and interviewed one year after delivery. Four women were excluded from the study group: two were not asked about a history of child sexual abuse due to the distress of fetal death or birth of a handicapped child; two others didn't want to answer the questions on abuse. One woman was excluded from the control group because she did not remember if she had experienced child sexual abuse. The final study population totaled 173 women consisting of 82 cases and 91 controls. All participants were interviewed by the first author (Grimstad) about experiences of child sexual abuse. Medical data including birth weight, gestational age, maternal age, pre-pregnancy weight, and pregnancy complications were obtained from the birth records (Grimstad &Schei, 1999, p. 82). The authors determined child sexual abuse status by asking all participants about "unpleasant sexual experiences as a child or adolescent (before 18 years of age)." Those answering affirmatively were asked about the character of the experience(s) and when the incident(s) occurred. Abusive experiences were classified according to "what had happened" (Grimstad &Schei, 1999, p. 82). Participants' reports were divided into six categories: genital touch; forced to touch the other person's genitals; attempted coitus; penile-vaginal coitus; not categorized further; not abused (p. 83). Data on medical and obstetrical complications including preeclampsia, hypertension, vaginal bleeding, premature labor, premature rupture of the membranes, infections with group B-streptococcus (GBS) and medicine consumption were obtained from the hospital records along with the level of assessment and the kind of therapy given, as was data on admission to the hospital in pregnancy (defined as admission before start of labor) (Grimstad &Schei, 1999, p. 83). Other data on interventions during delivery, including use of forceps, vacuum extraction, and cesarean section were obtained from hospital records. Gestational age at delivery was based on ultrasonography at 17-18 weeks. The following data was obtained during the interview: total pregnancy weight gain; information about urogenital infections; sociodemographic information; obstetrical history; alcohol, tobacco and illegal drug consumption; and medicine consumption (also obtained from hospital records) (Grimstad

&Schei, 1999, p. 83). Discomfort during pregnancy was measured using an interval scale. Participants were asked to answer each question on a scale from 1 (never) to 7 (very much so). The women were also asked to indicate the number on the scale that best described the degree to which they had suffered from the different kinds of discomfort. Study results revealed: a total of 34 women (19%) who disclosed information of unpleasant sexual experiences before 18 years of age, including exhibitionism, verbal sexual advances and forced non-genital touching; 25 (14%) of the women, 12 cases and 13 controls, reported experiences of child sexual abuse involving at least genital touch; 2 women who did not want to give details of the abuse experience and were categorized in a special group within the abused group. Grimstad and Schei found that birth of low birth weight infants was not associated with a history of childhood sexual abuse (1999, p. 84). In the case group (women who delivered low birth weight babies), 58% of the abused women delivered preterm compared with 66% of the nonabused women. Socio-demographic data indicated that among controls, abused women had less education than non-abused women, and were generally more likely to be unemployed, (defined as unemployment, on social welfare, long-term sick-leave, and housewives) than nonabused women (significant in controls in stratified analysis). More than half of the abused women reported cigarette smoking in pregnancy compared with one-third of the nonabused group, significant in the control group and the total sample, but not in the case group. Mean rate of weight gain was 54 grams less for the abused women than the nonabused women (Grimstad &Schei, 1999, p. 86). Study results also revealed that the proportion of women with an intervention during delivery, including forceps, vacuum extraction, or cesarean section did not differ between the abused and the nonabused. Among the abused women, 36% self reported genital infection with Candida and gardnerella as compared to 19% of the non-abused women. Self reported genitourinary infections including urinary tract infections, pelvic inflammatory disease, and sexually transmitted diseases before and during pregnancy did not differ between abused and non-abused groups, nor did group B-streptoccocus infection during pregnancy. Of the abused women, 48% reported using medicine during the pregnancy as compared to 36% of the nonabused women. 76% of abused women had at least one nonscheduled visit to the hospital's outpatient antenatal clinic or had been admitted to the hospital during pregnancy compared to 58% of the nonabused women, the abused women more often having been to a nonscheduled visit at the antenatal clinic (Grimstad &Schei, 1999, p. 86). The authors also report that abused women had in total, a higher mean score of discomfort on the discomfort scale compared to that of the non-abused women, a relationship that was significant among cases and the total sample, but not among controls. Higher values of discomfort were reported by abused women on the following items: heartburn/regurgitation, pelvic joint syndrome, and back pain. Feeling faint/fainting and uterine contractions were also significantly more often reported by the abused women (Grimstad &Schei, 1999, p. 87). The conclusions drawn by the authors from the data were the following: "women who delivered LBW infants were not more likely to have experienced childhood sexual abuse (CSA) than women who delivered non-low birth weight infants. Abused women were unemployed and daily smokers more often that non-abused women. Abused women reported more health complaints and more use of health care services during pregnancy, but did not have more obstetric complications during pregnancy and delivery compared with nonabused women" (p. 89). The authors point out that, although this study did not find more abused women among mothers of infants with low birth weight (below 2500g), smaller differences in birth weight can not be ruled out (p. 87). An important limitation in the study's methodology, pointed out by the authors themselves, is the fact that, as discussed earlier, some abused women might choose not to participate or not to disclose experiences of childhood sexual abuse because of feelings of shame and guilt, and some may not have explicit memories of these experiences and would therefore, not have been able to report them. The authors note, "If more abused women among cases compared with abused women among controls refrained from participation or from reporting CSA, it would result in a differential nonparticipation or under reporting" (Grimstad &Schei, 1999, p. 88). Although the authors acknowledge the possible impact on study results of women choosing not to participate or not to report their experiences of CSA, the most difficult limitation in getting more valid results is imposed by the fact that

some women do not remember their experiences yet may be impacted by them. They, in fact, may be incorrectly included in the non-abused groups, reducing the statistical differences between the abused and non-abused groups for the variables studied, including complications and interventions during labor and birth. This appears to be an unavoidable problem associated with the quantitative study of the effects of childhood sexual abuse. The authors note that the fact that the relationship between abuse and smoking in pregnancy, low educational level and unemployment was significant among controls, supports the conclusion that there is an association between abuse and these variables (Grimstad &Schei, 1999, p. 88). As suggested by the authors (p. 88), the higher degree of discomfort reported by abused women during pregnancy as compared to non-abused women in this study, may be supported by other studies describing reports of abnormal pain perception in abused women (Scarinci, McDonald-Haile et al., 1994). Increased use of illegal drugs, medical problems during pregnancy, teenage pregnancies, and pregnancy terminations by pregnant women who have experienced childhood sexual abuse were not supported by this study. Grimstad and Schei suggest that due to the fact that CSA can be recalled during pregnancy and birth, and can result in dissociation during delivery, it is important "to ask pregnant women about their experiences of abuse to understand their needs during pregnancy and delivery" (1999, p. 89). Simkin (1992), Kitzinger (1992), Bohn and Holz (1996), Grant (1992), and Courtois &Riley (1992) all describe additional effects of CSA on labor and birth, dissociation being only one of the potential effects observed at that time. The fact that the authors once again, are focused on obtaining a history of CSA indicates that they are not focusing on the many women who may not have explicit memories of their experiences or will not report their histories. This fact highlights the need for practitioners to become familiar with the signs of past abuse in the absence of reported histories, as well as the care and support that are helpful to women exhibiting behaviors or expressing feelings consistent with such histories in prenatal visits and during labor and birth. Another quantitative study by Benedict, L. L., Paine, L. A., et al., (1999) examined the association of childhood sexual abuse and depression during pregnancy, and selected pregnancy outcomes. Their findings support Grimstad and Shei's findings. Benedict et al., investigated labor and delivery factors, including indications for cesarean section, length of labor with indications for induction or augmentation, whether anesthesia was used, and labor complications. They found "no significant differences between abused and comparison women on any labor and delivery characteristics" (1999, p. 665). These authors did note that, although not significantly different between abused and nonabused women studied, "There was a trend indicating that abused women who had an assisted and/or cesarean delivery were more likely to have the indication listed for the delivery as fail to progress/descend whereas for non-abused women, the reasons were more likely to be baby position, dystocia, or maternal health condition ... suggestive for future investigation" (Benedict et al., 1999, p. 665). These authors go on to point out that, "although this investigation found no associations, the theoretical and empirical literature suggest that further investigations are necessary to fully understand the relationship between adverse childhood events, and current experiences as they relate to pregnancy, labor and delivery outcomes" (Benedict et al., p. 667). As discussed above, the findings of this study may also have been impacted by women not reporting or not being aware of their histories of childhood abuse. Another limitation in this study is the fact that women were interviewed in weeks 28-32 of gestation to identify those with histories of childhood sexual abuse. As discussed above, for some women, memories are not triggered until labor and birth. Interviewing them before labor and birth may incorrectly assign women to the non-abused group, possibly decreasing the apparent differences between the groups. In contrast to the quantitative studies referred to here, Rhodes and Hutchinson (1994) conducted a field study using the ethnographic method "to explore and describe the labor experiences of childhood sexual abuse survivors. The study investigated perceptions of survivors and their caregivers (nurse-midwives and nurses) in order to understand the meaning they attached to the experience of labor" (p. 214). The authors define childhood sexual abuse as "rape, incest or molestation" (Rhodes and Hutchinson, 1994, p. 213). The fifteen study participants included seven sexual abuse survivors, five nurse-midwives, and three labor and delivery nurses. Data

collection included in depth interviews and participant observation in labor and delivery over a period of six years, and anecdotal material from the literature. The authors note that data collection was extremely difficult since the study focused on intrapsychic phenomena and "an affirmative response to the question, 'Have you been sexually abused?' does not guarantee that the woman can connect her experiences in labor with her history of sexual abuse" (p. 214). The initial phase of the study focused on observations of women's behavior and body language. Participant observation data was gathered for six years in the form of field notes, kept by one author of the study (Rhodes), from work in the labor and delivery unit and from conversations with clients, nurse-midwives, and medical personnel (Rhodes &Hutchinson, 1994). Formal interviews using guiding questions with the five nurse-midwives and three labor and delivery nurses provided experiential data. Open ended questions were asked about sexual abuse survivors' behaviors during labor and delivery, the ways and reasons why nurse-midwives should discover a history of sexual abuse, and strategies a nurse-midwife can use to help a woman with a history of abuse through labor or clinical exams. Seven women who experienced childhood sexual abuse were interviewed by Rhodes. Three women heard about the study and volunteered to participate, four others were interviewed after the author observed unusual behavior during prenatal visits or labor. The interviews were tape recorded (lasting approximately one hour) and transcribed for data analysis. Open ended guiding questions were asked about the sexual abuse, memory of the abuse, pelvic and vaginal exams, labor, the description of labor feeling like being out of control, pushing, "going away" (dissociating) when things get hard to handle, preparation for labor, and the triggering of sensations or memories of abuse during labor. The authors found four recognizable labor styles that act as powerful markers for a past history of sexual abuse; fighting, taking control, surrendering, and retreating. The authors note that a woman may demonstrate different styles during the labor process, and in fact, all laboring women may exhibit some of the same behavior as sexual abuse survivors, but the survivors' behavior may appear extreme (Rhodes &Hutchinson, 1994, p. 216). The authors suggest that "The fighting style is a panic response, a self-defensive posture. The woman actively engages the labor, battling against sensations she interprets as an attack on her body's integrity" (p. 216). This observation echoes Simkin's (1992) and Kitzinger's (1992) observations discussed earlier. Rhodes and Hutchinson (1994) describe the "taking control" style of labor as being an "attitude and set of actions that the woman assumes to counter her fears of labor" (p. 216). The woman resists helplessness and fear of being out of control that was experienced during sexual abuse . . . Efforts to attain control during labor may not always be successful, but in making the effort, the sexual abuse survivor affirms her right of control" (216). The authors describe the "surrendering" style of labor as one in which the woman submits to labor without fighting. A survivor who surrenders may appear to be outgoing and uninhibited and is described as a "good patient" by caregivers. She may be eager to please caregivers and dependent on them for approval. Rhodes and Hutchinson note that surrendering may be a form of dissociating in labor (p. 218). Women who adopt the "retreating" style of labor coping are attempting to remove themselves emotionally and or mentally from sensations that replay the abuse. A woman may appear disconnected from bodily sensations and may not respond to directly asked questions. Interviewees (survivors) describe it as "going away" or "disappearing from the situation," another form of dissociating (p. 218). The authors found that "caregivers may interpret survivors' behavior as fearful, mistrusting, controlling, panic-stricken, or conversely, appearing sexually uninhibited, stoic, withdrawn, or regressed. The sexual abuse survivor may exhibit an extremely low or an extremely high pain tolerance in labor. Both reactions can be clues to uncovering a history of sexual abuse" (Rhodes and Hutchinson, 1994, p. 216). The authors suggest that, "Irrespective of whether caregivers are aware of a history of sexual abuse, they should attempt to avoid triggering traumatic memories" (p. 219). The study by Seng &Sparbel et al., (2002) which examined the perspectives of women who suffered from abuse-related posttraumatic stress on maternity care practices, provides a "Summary of Participants' Messages to Providers Framed as 'Desired Practices'" (p. 364) which includes invaluable information for maternity care providers. This information would significantly improve providers' understanding of the needs of survivors of abuse.

SUMMARY Recent quantitative research results do not yield evidence of a significant impact of a history of childhood sexual abuse on labor and delivery outcomes. Due to the fact that often survivors of childhood sexual abuse are unable to consciously recall these experiences or may be unwilling to report these experiences, researchers may inadvertently include them in non-abused cohorts, affecting the validity of their research results. This does not preclude the necessity to ensure that care given during labor and birth, as much as possible, serves to counteract, not reenact (Kitzinger, 1992, p. 220) known and unknown previous traumatic experiences of abuse. Knowledge of the signs of possible prior sexual abuse observable in pregnancy, labor and birth, and an awareness of and sensitivity to the particular needs of survivors of sexual abuse during this time can increase the possibility for a positive birth experience for these women. As acknowledged by Bohn and Holz, "A positive birth experience can go a long way in helping abuse survivors heal" (1996, p. 453). Survivors' experiences and needs during pregnancy and birth highlight the importance for reform in prenatal and obstetrical care for all women in this country. It can be argued that health practitioners should offer all women care that reflects the provider's understanding of the potential impact of their services on all aspects of a woman's health and well being. The data seem to suggest that improved obstetrical outcomes for all women would result from health care that is more attuned to a woman's individual physical, psychological and spiritual needs during pregnancy and birth. References REFERENCES American College of Obstetricians and Gynecologists. (2001). Adult manifestation of childhood sexual abuse. ACOG educational bulletin. International Journal of Gynecology and Obstetrics, 74, 311-320. Benedict, M.I., Paine, L.L., Paine, L.A., Brandt, D., &Stallings, R. (1999). The association of childhood sexual abuse with depressive symptoms during pregnancy, and selected pregnancy outcomes. Child Abuse and Neglect, 23(1), 659-670. Bohn, D.K., &Holz, K.A. (1996). Sequelae of abuse: Health effects of childhood sexual abuse, domestic battering, and rape. Journal of Nurse-Midwifery, 41(6), 442-456. Courtois, C.A., &Riley, C.C., (1992). Pregnancy and childbirth as triggers for abuse memories: Implications for care. Birth, 19(4), 222-223. Finkelhor, D. (1994). Current information on the scope and nature of child sexual abuse. The Future of Children, 4(2), 31-53. Retrieved August 25, 2003, from http://www.futureofchudren.org/pubs-info2825/pubs-info.htm?doc_id=74215 Grant, L.J. (1992). Effects of childhood sexual abuse: Issues for obstetric caregivers. Birth 19(4), 220-221. Grimstad, H., &Shei, B., (1999). Pregnancy and delivery for women with a history of child sexual abuse. Child Abuse &Neglect, 23(1), 81-90. Kitzinger, J.V. (1992). Counteracting, not reenacting, the violation of women's bodies: The challenge for perinatal caregivers. Birth 19(4), 219-220. Levine, P., &with Frederick, A. Waking the Tiger. Berkeley: North Atlantic Books, 1997. Perry, B.D., (1999). Memories of fear: How the brain stores and retrieves physiologic states, feelings, behaviors and thoughts from traumatic events. Child Trauma Academy Materials, 1-23, Retrieved August 16, 2003 from http://www.childtrauma.org/print/print.asp?REF=q/CTAMATERIALS/memories.asp Rhodes, N., &Hutchinson, S. (1994). Labor experiences of childhood sexual abuse survivors. Birth, 21(4), 213-220. Scarinci, I.C., McDonald-Haile, J., Bradley, L.A., &Richter, J.E. (1994). Altered pain perception and psychosocial features among women with gastrointestinal disorders and history of abuse: A preliminary model. The American Journal of Medicine, 97, 108-118. Seng, J.S., Sparbel, K.J.H., Low, K.L., &Killion, C. (2002). Abuse-related posttraumatic stress and desired maternity care practices: Women's perspectives. Journal of Midwifery &Women's Health, 47(5), 360-370. Simkin, P. (1992). Overcoming the legacy of childhood sexual abuse: The role of caregivers and childbirth educators. Birth, 19(4), 224-225. van der Kolk, B. (1994). The body keeps the score: Memory and the evolving psychophysiology of post traumatic stress. David Baldwin's Trauma Information Pages, Articles, 1-21, Retrieved August 16, 2003 from http://www.trauma.pages.com/vanderk4.htm. AuthorAffiliation Ann Diamond Weinstein, M.S. and Thomas R. Verny, M.D., D. Psych., FRCPC AuthorAffiliation Ann Diamond Weinstein, M.S. is a doctoral student in the Prenatal and Perinatal Psychology Program at the Santa Barbara Graduate Institute, and the Replications and Resource Development Director of The Parent-Child Home Program, Inc. in Port Washington, New York. She can be contacted via e-mail at weinsteinann@hotmail.com. Thomas R. Verny, M.D. is on the faculty of the Prenatal and Perinatal Psychology Program of the Santa Barbara Graduate

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Publication title: Journal of Prenatal&Perinatal Psychology&Health

Volume: 18

Issue: 4

Pages: 313-325

Number of pages: 13

Publication year: 2004

Publication date: Summer 2004

Year: 2004

Publisher: Association for Pre&Perinatal Psychology and Health

Place of publication: Forestville

Country of publication: United States

Journal subject: Medical Sciences--Obstetrics And Gynecology, Psychology, Birth Control

ISSN: 10978003

Source type: Scholarly Journals

Language of publication: English

Document type: General Information

ProQuest document ID: 198685797

Document URL: http://search.proquest.com/docview/198685797?accountid=36557

Last updated: 2010-06-06

Database: ProQuest Public Health
