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Perinatal interventions for mothers and fathers who are survivors of childhood sexual abuse

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ABSTRACT

Childhood sexual abuse (CSA) is a worldwide problem with severe long-term consequences. A history of CSA can impact the childbearing experience of mothers and fathers; affecting their mental health, parenting skills and compromising infant development. Nonetheless, the perinatal period offers huge opportunity for intervention and hope. This literature review collates evidence for perinatal psychosocial interventions targeting both mothers and fathers who are survivors of CSA. Publications dating from 1970 to June 2016 were searched using Medline, Maternity and Infant Health, PsychINFO, PsychArticles, PubMed and the International Bibliography of the Social Sciences (IBSS). There were no perinatal interventions that considered the needs of survivor fathers. Sixteen publications on 9 psychosocial perinatal interventions for CSA survivors were identified. However, no sub-analyses specific to CSA survivors were reported. Trauma-specific perinatal interventions drew from a range of theoretical models and varied widely in format. Generally interventions were associated with improvements in maternal mental health, parenting competence, infant attachment security and positive public health outcomes. They were safe and feasible to implement, acceptable to parents and therapist, and therapists were able to implement protocols with adequate fidelity. Yet current data is hampered by small sample size, inconsistent reporting of CSA rates and outcome measures, scarcity of observational data and longer-term follow-up. Intervention modifications are proposed for CSA survivors in view of their unique childbearing experiences.

1. Introduction

Childhood sexual abuse (CSA) is a worldwide problem with widely varying prevalence estimates. Meta-analytic evidence from 55 studies conducted in 24 countries, indicates prevalence estimates of CSA to range from 8 to 31% for girls and 3 to 17% for boys (Barth et al., 2013). CSA can be distinguished from other forms of abuse by specific sequelae that survivors experience. For instance,

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compared to women who have been exposed to non-sexual abuse, women with a history of CSA, are at increased risk of antenatal depression (Romano et al., 2006) and hypothalamic-pituitary-adrenal (HPA) dysregulation in pregnancy (Bublitz & Stroud, 2012). CSA has also been linked with parenting competence above and beyond the impact of other forms of childhood abuse (Bailey et al., 2012). Furthermore, compared to female survivors of CSA there is less research on male survivors who later become fathers (for example, Sandberg et al., 2012; Wark & Vis, 2016). Yet the long-term impact of CSA in males can be as severe as in females (Banyard et al., 2004; Dube et al., 2005; Young et al., 2007).

None the less, for both genders, the consequences of CSA may not manifest until salient triggers are experienced during periods of stress and transition (Noll, 2008). Pregnancy represents a vulnerable time for both parents with a considerable number of women and men reporting depression and distress (Howard et al., 2018; Philpott et al., 2017; Ramchandani et al., 2008; Van den Bergh et al., 2005). Evidence from our work suggests that childhood maltreatment increases the risk of antenatal depression by approximately 10-fold (Plant et al., 2013) – a much higher risk compared with the overall 2-3-fold increase in psychopathology throughout adult life. Similarly, the risk of posttraumatic stress disorder (PTSD) is increased by 12-fold during pregnancy in the context of childhood maltreatment (Seng et al., 2009). As a result pregnant women with PTSD present with a higher number of complications during pregnancy (Mohler et al., 2008), including severe anxiety about labour and childbirth (Soet et al., 2003). In addition to experiencing increased rates of psychiatric disorders and psychological distress, CSA survivors tend to become pregnant at a younger age (Garwood et al., 2015; Noll et al., 2009), experience higher risk of substance misuse, find it more complicated to establish supportive relationships with family and professionals (Leeners, Richter-Appelt, Imthurn, & Rath, 2006) and are more likely to re-experience interpersonal violence (Whitfield et al., 2003). Given the extent of influence, it may be crucial to recognize multi-model trauma informed interventions which can address the diverse mental health and social functioning needs of abused survivors.

Past trauma tends to resurface during the perinatal period – consequently, the childbearing experience of both mothers and fathers is influenced due to physical and psychological salience of triggers (Byrne et al., 2017; LoGiudice & Beck, 2016; Price-Robertson, 2012). In women, physical triggers may include procedures associated with pregnancy, labour and birth – for instance vaginal examinations. Emotional triggers may include the sense of a loss of control (for instance, being asked to stay still during an epidural placement), interpersonal difficulties and reminders of painful experiences in childhood. Female CSA survivors may also experience higher levels of perinatal dissociation (i.e. the occurrence of detachment and emotional distancing symptoms) (Lev-Wiesel & Daphna-Tekoah, 2010) and flashbacks – particularly during intrusive physical examinations and vaginal birth (Coles & Jones, 2009; Roller, 2011). Dissociation during pregnancy may in turn prevent women from getting appropriate obstetric care (Van Der Leder & Raskin, 1993). On the other hand, some women may become more alert to each sensation, leading to an increase in psychological distress (Heritage, 1998). As a result, many women may avoid protective routine maternity care or additional specialist services (Goodman & Tyer-Viola, 2010). Thus, the heterogeneity of presentation of abuse, the tendency to avoid reminders of trauma, and the subsequent challenges in treatment uptake, all suggest that existing long-term programmes (for example, Olds, 2006) or those that specifically require engagement with past trauma (Foa et al., 2008; McDonagh et al., 2005) may not be that helpful to CSA survivors during the perinatal period.

Similarly, for male survivors of CSA, fatherhood may be a trigger for the resurfacing of past trauma. Though less well-studied, in comparison to women, survivor fathers may also experience significant fears and anxiety. Key themes reported are distress during physical contact and displays of affection towards their child, as well as overprotection and anxious parenting behaviours (Price-Robertson, 2012). Insecurity surrounding masculinity and personal identity, as well as the inability to trust others are also significant issues (Turmel & Liles, 2015). Of note, however, is the concept of posttraumatic growth which may have important implications for survivor fathers. Accordingly, fatherhood may also drive the process of healing and provide male CSA survivors an opportunity to build trusting relationships (Easton et al., 2015; Wark & Vis, 2016). Similarly, childbearing may help empower women to experience control and competence (Heritage, 1998).

Thus far, provision of both medical and psychological interventions in the perinatal period for trauma survivors, is indeed complex due to perinatal physiological and psychological factors. As a result, trials often exclude pregnant women meaning that fewer interventions have proven efficacy and safety in the perinatal period. In the case of psychological therapies there may be concerns about the impact of exposure therapy (as in, for example, trauma focussed CBT) on intrauterine cortisol levels and provoking psychological instability (Arch et al., 2012; Cook et al., 2004). Likewise, the use of medications to treat PTSD may carry risks for foetal and neonatal development – hence decreasing their acceptability during pregnancy (Einarson & Einarson, 2005). Moreover, many high-risk families do not engage with services for several reasons, including practical aspects (lack of transport/child-care), disorganized life circumstances, stigma around mental health, lack of knowledge about available help and prior experiences with services offered. CSA survivors are also less trustful of service providers and also themselves when it comes to confidence about delivery (Leeners, Gorres et al., 2006). Despite these challenges women have indicated the need for non-pharmaceutical treatments (Muzik et al., 2013) – accessible, time-limited interventions which do not require painful exposure to childhood trauma and address several areas of family functioning, including mental health, the parent-child relationship and child development.

Taken together, the prevalence of sexual abuse in both mothers and fathers, combined with the far-reaching consequences on pregnancy, labour, and the early postnatal period (Leeners, Richter-Appelt et al., 2006), illustrates the need for research to identify effective perinatal trauma informed programmes. It is also vital that interventions are provided at the earliest time-points – i.e. across pregnancy and in early infancy. Recent evidence linking maternal childhood maltreatment and new-born brain structure highlights the intrauterine period of development as a crucial phase for the intergenerational transmission of the effects of exposure to childhood trauma (Moog et al., 2018). Furthermore, the benefits of intervening early have been reported in high-risk, trauma-exposed families (Maher et al., 2011). By disrupting the intergenerational transmission of risk and positively impacting on children's life trajectories, they are cost-effective.