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Lifetime sexual violence and childbirth expectations – A Norwegian population based cohort study

Lena Henriksen, RM, PhD[a,*], Berit Schei, MD, PhD (Professor, Gynecologist)[b,c], Mirjam Lukasse, RM, PhD (Professor)[d]

[a] Section of Obstetrics at the Department for Women's and Children's Health, Oslo University Hospital, Postboks 4950 Nydalen, N-0424 Oslo, Norway
[b] Department of Public Health and General Practice at the Faculty of Medicine, The Norwegian University of Science and Technology (NTNU), Håkon Jarls gate 11, N-7489 Trondheim, Norway
[c] Department of Gynecology at the Women's Clinic, St.Olavs Hospital, Trondheim University Hospital, Postbox 3250 Sluppen, N-7006 Trondheim, Norway
[d] Department of Health, Nutrition and Management, Faculty of Health Sciences, Oslo and Akershus University College of Applied Sciences, Postboks 364 Alnabru, N-0614 Oslo, Norway

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ABSTRACT

Objective: this study aimed to explore the association between lifetime sexual violence and expectations about childbirth.
Design: Norwegian population-based cohort study.
Setting: women presenting for routine ultrasound examinations were recruited to the Norwegian Mother and Child Cohort Study between 1999 and 2008.
Population: 78,660 pregnant women.
Methods: sexual violence and expectations about childbirth were self-reported during pregnancy using postal questionnaires. Risk estimations were performed using multivariable logistic regression analysis and stratified by parity.
Main outcome measures: fear of childbirth, the thoughts about pain relief, worries about the infant's health and looking forward to the arrival of the infant.
Findings: of 78,660 women, 18.4% reported a history of sexual violence and 0.9% were exposed to sexual violence within the last 12 months, including during the current pregnancy. We found that nulliparous women who reported previous or recent sexual violence had a decrease in the odds of looking forward to the arrival of the infant with an AOR of 0.8 (95% CI 0.7–0.9) and 0.4 (95% CI 0.3–0.6), respectively, compared to non-abused women. The same pattern was observed among multiparous women and they were more likely to report worries about the infant's health. Severe sexual violence (rape) was associated with concerns about childbirth, especially for nulliparous women that were more likely to express fear of birth, a hope for a pain-free birth, a desire for caesarean section and worries about the infant's health than non-exposed women.
Conclusions: women with a lifetime exposure to sexual violence, both past experiences and within the last 12 months, were less likely to look forward to the arrival of the infant than non-exposed women, and they were more likely to worry about the infant's health. Women with experiences of severe sexual violence (rape) had more concerns about childbirth than women without this experience. This finding shows that exploring women's attitudes toward childbirth may work as an approach when examining exposure to violence.

Introduction

Sexual violence against women is a major public health problem that can cause physical and psychological harm to women and lead to pregnancy complications (Campbell, 2002; Boy and Salihu, 2004; Leserman, 2005; Ellsberg el al., 2008; Sarkar, 2008), which can also affect parenting (Garcia-Moreno et al., 2013) and the well-being of the children (Rivara et al., 2007). Sexual violence is highly prevalent, and the World Health Organization (WHO) states that 35% of women worldwide have been exposed to physical and/or sexual violence during their lifetime (Garcia-Moreno et al., 2013). Studies within this field often include women that have been exposed to different types of abuse, both as a child and

* Corresponding author.
E-mail addresses: UXHELZ@ous-hf.no (L. Henriksen), Berit.Schei@ntnu.no (B. Schei), mirjam.lukasse@gmail.com (M. Lukasse).

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adult and co-occurrence of violence and re-victimisation are common (Ellsberg et al., 2008). This makes it challenging to investigate consequences of specific types of violence, for example sexual violence (Ellsberg et al., 2008; Garcia-Moreno et al., 2013). Women are also vulnerable to violence during pregnancy and the prevalence of physical and/or sexual violence during pregnancy ranges from 3.4% to 11% in high-income countries (Campbell et al., 2004). Given this high prevalence, it is likely that a considerable proportion of pregnant women have been exposed to sexual violence at some point during their lifetime.

Pregnancy is a period when past and ongoing violent experiences can affect both the woman's maternity care experiences and outcome (Seng et al., 2010). It is known that a history of sexual violence can interfere with the bonding process and have a profound effect on a woman's ability to relate to her infant and affect the quality of parenting (Buist, 1998; Lieberman et al., 2005). Memories of violence may for some women resurface during pregnancy or it may be the first time they become aware of previous exposure to sexual violence (Courtois and Courtois, 1992; Leeners et al., 2013). Studies show that women rarely disclose past or ongoing abuse (Montgomery et al., 2015; Thoresen and Kristian, 2014), and screening for violence during pregnancy has been discussed as an action to increase disclosure in order to prevent adverse consequences and help women who live in an abusive relationship (McFarlane et al., 1992; WHO, 2013). The WHO recommends screening in settings such as antenatal care where sufficient guidelines exist and accurate help may be provided for exposed women (WHO, 2013). Women do not necessarily answer direct questions about violence, and open communication and a genuine interest in women as individuals are required (E. Montgomery et al., 2015). This genuine concern should include interest in women's thoughts and hopes about childbirth. It is likely that abused women have unmet mental and psychological needs that will affect their expectations about birth. Negative feelings towards childbirth are considered important for the outcome, both during birth and post partum (Waldenstrom et al., 2006).

Studies that have examined the effect of lifetime sexual violence on women's expectations of childbirth are few, except for studies on the fear of birth in which studies have shown an association with sexual violence (Heimstad et al., 2006; Lukasse et al., 2010; Schroll et al., 2011). The main exposures have traditionally been childhood abuse (Heimstad et al., 2006; Lukasse et al., 2010) or both physical and sexual violence (Schroll et al., 2011). Among several questions in the Norwegian Mother and Child Cohort Study (MoBa), pregnant women were asked specific questions about exposure to sexual violence and also a set of questions about their expectations about childbirth. We hypothesised that women who were exposed to sexual violence would express more worries towards childbirth that the non-exposed. The aim of this study was to investigate whether women with a lifetime exposure to sexual violence have different thoughts regarding childbirth, pain relief and the arrival of the infant than non-exposed women.

Methods

Our study examined this question in the Norwegian Mother and Child Cohort Study (MoBa), a prospective population-based pregnancy cohort study conducted by the Norwegian Institute of Public Health (Magnus et al., 2006). The study was conceptualised in the 1990s, and the main aim of the study was to find causes of disease (Magnus et al., 2006). The MoBa study is a large epidemiological study designed to investigate many correlations and a large number of research questions have been and are still being examined (Magnus et al., 2006). Participants were recruited in

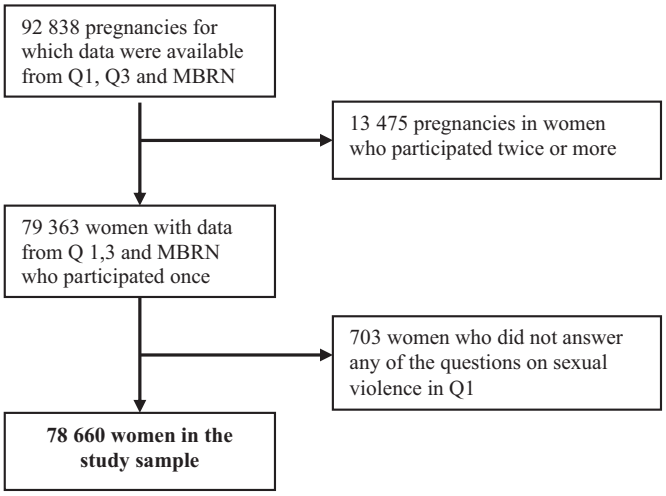

Fig. 1. Inclusion and exclusion process.

Norway from 1999 to 2008, and 40.6% of the invited women consented to participate. The participants in this study received a postal invitation with their routine ultrasound appointment. The women answered extensive questionnaires regarding demographic factors, general health, reproductive history and maternal health during pregnancy. We used questionnaire 1 (Q1), completed at approximately gestational week 17, and questionnaire 3 (Q3), completed at week 30. Data from the MoBa study were linked with data from the Medical Birth Registry of Norway (MBRN), a registry that keeps record of all deliveries in Norway with data based on a standardised form completed by midwives shortly after birth (Irgens, 2000). This study is based on version VI of the quality-assured data files released for research in 2011. The MoBa study is described in detail elsewhere (Magnus et al., 2006), and additional information about the study can be found at the following web address: http://www.fhi.no/studier/den-norske-mor-og-barn-undersokelsen.

Fig. 1 describes the inclusion and exclusion criteria and process for this study. The study sample consisted of 78,660 women.

Exposure

The exposure variable was collected from Q1. In this questionnaire, the women were asked if they had ever been pressured or forced into sexual activities. The answer options included the following: 1) No, never; 2) Yes, pressured; 3) Yes, forced with violence; and 4) Raped. A positive answer was defined as having experienced sexual violence. The answer options were recoded into mild, moderate and severe sexual violence. Women with more than one positive answer were classified according to the most severe level reported. We used this terminology because it corresponds to other studies that have used validated instruments to study the prevalence of violence (Garcia-Moreno et al., 2013) and the Norwegian wording in the MoBa questionnaire suggests an increasing severity in the answer options that we wanted to examine. We recognise that all three answer options may be considered severe by the person who experienced the violence. Women could also indicate the timing of the violence for the following time periods: 1) during this pregnancy; 2) during the six months prior to this pregnancy; or 3) earlier. Approximately 1700 women who responded to the first version of Q1 had the option to answer 'earlier' and 'during the last 12 months'. Because of this option, we created the variables 'previous' and 'recent sexual violence', with the latter including sexual violence that occurred during the last 12 months, including the current pregnancy. A