Overcoming the Legacy of Childhood Sexual Abuse: The Role of Caregivers and Childbirth Educators

by Penny Simkin, PT

The legacy of Anna Rose's parents, uncle, cousin, and others lives on. The severe abuse committed by those who had authority and power over her left her frightened, angry, confused, and wary. Her body is a source of pain and illness, locked against the traumatic memories. But, ironically, Rose is one of the lucky ones. She is a survivor, and she has the courage and spirit to face and overcome the problems heaped on her by her cruel family.

One in four, one in three, one in five? Who knows the actual frequency of childhood sexual abuse in our society? All we really know is that it is shockingly common, meaning that many women in a midwifery or obstetric practice or in a childbirth education class are burdened with the psychosocial aftereffects of victimization. Those of us in maternity care knowingly or, more likely, unknowingly care for survivors of childhood sexual abuse.

Surprisingly, with all the sexual connotations of pregnancy, birth, and breastfeeding, virtually nothing is published in the social science or medical literature on the possible effects of childhood sexual abuse on later childbearing. Even mental health publications have failed to address this grave issue. Eating disorders, chronic pelvic pain, severe premenstrual syndrome, sexual dysfunction, various phobias, and other psychosomatic disorders are known to be associated with childhood sexual abuse, but what about disorders in childbearing? With the recent increase in public awareness of this subject, some magazines for the public, for childbirth educators, and for midwives or nurses have recently addressed this subject with personal accounts, as have consciousness-raising discussions for maternity care professionals.

Rose vividly and poignantly describes the connections she perceives between her history of abuse and her birth experiences. Her difficulties during labor are familiar: the long painful induction, fear during second stage or refusal to push, difficulty initiating breastfeeding, and feelings of failure. She describes panic, "body memories," flashbacks, and dissociation ("retreating out of my body" during labor, which interfered with her self-confidence and tolerance of pain, and her ability to trust and work with her labor and her caregivers. With her second birth, the midwives knew about her past abuse and addressed her fears appropriately.

How many women have had traumatic birth experiences? What role has childhood sexual abuse played? I suspect the answer to these questions is, "More than we ever imagined." As a childbirth educator, I provide counseling for pregnant women who are anxious about birth, and also for new mothers whose birth experiences were disappointing. From them I have learned much about early experiences such as sexual abuse, and how these can sometimes unexpectedly come to light during the childbearing year.

Many women have no conscious memory of abuse, and therefore may not disclose such a history in response to direct questioning. Others who remember may choose not to disclose it. Nevertheless, caregivers and childbirth educators should suspect it whenever a woman exhibits particular characteristics.

Confusion and anxiety over body "boundaries": If, as a child, her body boundaries were both not respected and violated, it is not surprising if she now fears invasive procedures, such as pelvic examinations, the vaginal ultrasound probe, drawing blood, intravenous lines, and injections. Nakedness and exposure of the sexual parts of her body may also trouble her.

Control issues: She may try to maintain as much control as possible — over the care she receives, her care during labor, and her responses to the pain and stress of labor. The prospect of losing control over her care or behavior, and the thought of being vulnerable and dependent are frightening. When she has been vulnerable, out of control, or dependent in the past, she has been hurt. Sometimes the most demanding, skeptical patients, those with long, detailed, seemingly inflexible birth plans, are not "difficult patients." Rather, they are going to great lengths to try to gain control over an inevitable and frightening experience. Long appointments and time for lots of questions may seem necessary. What is sometimes exasperating and unreasonable to the caregiver really makes all the sense in the world when we recognize why she may have

---

Penny Simkin is a physical therapist who, since 1968, has specialized in childbirth education, labor support, and counseling on issues related to childbearing in Seattle, Washington.

trouble giving up control. Recognizing the possibility of a history of sexual abuse may keep the caregiver from judging the woman unfairly.

Fear of pain or injury in sexual body parts during labor and birth: This may lead her either to perfect elaborate techniques to control her behavior and her thought processes, and thus control the pain, or to try to avoid experiencing labor (e.g., elective cesarean, early epidural block).

Unwillingness to trust those in authority: This includes those who have power over her, such as childbirth educators, nurses, prenatal care providers, doctors, or midwives. It may be hard for her to believe they have her best interests at heart, because when she trusted authority figures in the past, her trust was violated and she was tricked. If the perpetrator was a male, she may choose a woman doctor or midwife, expecting her to be "safer." She may also ask many questions that may imply a distrust of the caregiver, in reality, testing him or her to see if she really can trust. On the other hand, if she blames herself rather than the perpetrator(s) for her abuse, she may see herself as somehow unworthy, evil, or deserving of abuse, and may select a caregiver who is authoritarian and paternalistic. She may appear as a meek, passive, unquestioning patient with no personal needs or wishes.

Resistance to the language and expectations of childbirth classes: Lying down among strangers to practice relaxation may be completely unacceptable or impossible. Rather than helping her relax, it may make her feel more tense and vulnerable. If educators prepare the partner to "coach," control, or regulate the woman's behavior in labor, it may evoke memories of dominance by a male. Using language and imagery emphasizing "tuning in," "yielding," or "surrendering" to the contractions, or "listening to your body," may distress the woman whose body has been a source of anguish. Films of birth and breastfeeding sometimes trigger revulsion or panic. Instinctual spontaneous behavior, frequently encouraged in childbirth classes, may feel less safe than intellectual, rational, or planned behavior.

Flashbacks or body memories in labor: Even though they may be unavoidable, the painful and invasive routine procedures, usually performed by strangers, along with labor pain, nakedness, and possible injury of the genitals, may remind a survivor of her abuse. These memories may be conscious or unconscious, and they may make her react in the same way she reacted to her abuse (e.g., with dissociation, panic, resistance, or regressive behavior).

Shutting down labor progress at a level of pain where she can maintain control: We all have witnessed labors that stop for no apparent reason, and birth takes place only when progress is forced, as with oxytocin, episiotomy, forceps, vacuum extraction, or cesarean section. I believe that some women's deep-seated fears are so powerful that they can stop labor before it goes beyond their control. The interventions used to overcome the problem and the people who perform the interventions may be unconsciously perceived as reenactors of the abuse, especially if disrespect, coercion, deceit, or force is used. Women often feel degraded, violated, embarrassed, depressed, or angry after such a birth experience. These reactions can last for months or years.

Do all sexually abused women have the difficulties described here? Surely not. Factors that determine who will be spared must lie to a great extent within the woman herself, and with other factors (people and events) in her life that gave her relief from the horror of sexual abuse, and a sense of worth and personal power. But also, sensitive, respectful interactions with understanding caregivers and educators may lessen the likelihood of a repeat of the abuse during pregnancy and childbirth. Caregivers should learn about community resources, so they can make appropriate referrals to support groups and psychotherapists who specialize in childhood sexual abuse.

The first step for caregivers is to be aware that recollections of sexual abuse can come up unexpectedly and unconsciously during pregnancy and childbirth and can exert powerful effects on the woman. With this awareness comes a different perception of the "difficult" or "demanding" or resistant or overanxious woman. We realize that she has very good reason to feel the way she does. We become less judgmental, more patient, and more empathic. We are more ready to accept her needs as valid. And after all, isn't that what good care is all about?

Reprinted with permission from BIRTH, *Vol. 19 No. 4, December 1992.*