What educators and doulas need to know about the impact of childhood sexual abuse on women's childbearing experiences

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As childbirth educators and doulas, our classes and clientele include people with unique personalities, belief systems, learning styles, and attitudes toward birth. They bring to childbirth a lifetime of experiences that have shaped them. At one end of the spectrum are those who are excited, confident and optimistic about their upcoming childbirth and life transition. At the other end are those who feel self-doubt, dread, incompetence, and fear. Why is there such a broad spectrum of attitudes toward birth and parenthood? One largely overlooked contributor is childhood trauma, specifically (for the purposes of this paper) childhood sexual abuse (CSA). CSA has been experienced by at least one woman in five and is a major negative influence on women's self image and their perceptions of pregnancy and birth. Childbearing survivors of sexual abuse face many challenges, which are described here, along with suggestions for sensitive, respectful childbirth education and care. Our goal is to facilitate healing and confidence at this vulnerable time in women's lives.
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Early childhood experiences, whether remembered or not, are the foundation for later development. They affect how people will function - the kinds of relationships they form, how they handle adversity, whether they find success and joy in their lives. They may promote or obstruct healthy growth and maturation.

The Adverse Childhood Experiences Study (Felitti et al., 1998) involved over 17,000 adults in a Health Maintenance Organization (HMO) in California in the mid-1990s regarding their experiences during childhood of any of these types of childhood trauma:

- physical or emotional abuse or neglect
- sexual abuse
- violent treatment of the mother
- parental substance abuse
- mental illness in the household
- parental separation or divorce
- incarcerated household member

Among other things, the researchers found that 28% of participants had been physically abused and 21% had been sexually abused. Many participants reported experiencing two or more forms of abuse. The more types of abuse suffered, the greater the negative impact on mental and physical health in adulthood. This was the first major study to shed light on the serious long-term harms and health problems, such as obesity, chronic pain, heart disease, diabetes and cancer, suffered by people who are abused during childhood. Serious psychological and behavioral disorders in later life, such as depression, posttraumatic stress disorder, substance abuse, eating disorders and incarceration, can also result from child abuse (Centers for Disease Control, 2016).

Definition of childhood sexual abuse
The Council of Europe (2012)

a) engaging in sexual activities with a child who, according to the relevant provisions of national law, has not reached the legal age for sexual activities

b) engaging in sexual activities with a child where use is made of coercion, force or threats; or abuse is made of a recognised position of trust, authority or influence over the child, including within the family; or abuse is made of a particularly vulnerable situation of the child, notably because of a mental or physical disability or a situation of dependence.

Definition of childhood sexual abuse
Simpkin & Klaus (2004)
Childhood sexual abuse takes place between a child (under the legal age for sexual activity) and an adult or someone close in age, whom the child perceives as more powerful. It consists of any activity (physical, psychological, or verbal) that the abuser expects to cause sexual arousal in the abuser or someone else

PREVALENCE OF CHILDHOOD SEXUAL ABUSE

Estimates of prevalence vary and are unlikely to give a true picture. Some estimates are based on cases that are reported to child welfare or law enforcement agencies or on school nurses' reports; others are based on recall of people who are contacted in phone or online surveys; others come from admission records of hospitals or clinics.

The American College of Obstetrics and Gynecology (2015; 2011) states that, 'Although the exact prevalence is unknown, it is estimated that 12-40% in the United States experience some form of childhood sexual abuse'. In the UK, the Ministry of Justice (2013) reported the following statistics on sexual violence in England and Wales: '1 in 5 women aged 16 - 59 has experienced some form of sexual violence since the age of 16, and 31% of young women aged 18-24 report having experienced sexual abuse in childhood'.

> The childbearing year is a common time for memories of childhood abuse to be recovered

We know that children are usually sworn to secrecy and threatened with further harm if they disclose their abuse. We also know that many choose not to disclose their abuse out of shame or sense of hopelessness that it will stop. Furthermore, we know that victims often have no memory of their abuse (even if there are court records confirming it), possibly because they dissociated ('checked out' or 'left their bodies'), a common psychological defense against reliving the horror of the trauma. Those memories, however, do not stay buried forever.

HOW PREGNANCY AND BIRTH TRIGGER ABUSE MEMORIES

The physical experience of pregnancy – the growing body, fetal movements, morning sickness, etc. and the pain and effort of birth may trigger 'body memories', that is, extreme pain and tension or psychological reactions of fear, panic, dissociation, withdrawal and flashbacks. Clinical care also includes numerous potential triggers, such as vaginal exams, breast exams, blood draws, intravenous fluids, injections, bladder catheters, epidural numbness and immobility, episiotomy, forceps or vacuum extractor, restriction to bed (with or without 'restraints' in the form of tubes, belts, monitors, blood pressure cuffs, oxygen masks). To survivors, these may seem like re-enactments of the abuse—invasion of body boundaries, exposure of sexual body parts, physical restraint in the 'victim' position (lying down while others stand) and powerlessness.

THE MEANING OF 'CONTROL' TO THE SURVIVOR

Control issues also arise. When survivors were vulnerable in the past and not in control, they were victimized. Many become extremely vigilant and guarded, so as never to be caught by surprise. Laboring while 'on guard' increases production of adrenaline and other stress hormones. These may slow labor by reducing oxytocin and increasing beta-endorphin production (Buckley, 2015:8). The survivor's effort to keep herself from losing control may slow her labor and thereby reinforce the old message that her body is inadequate. Then come the procedures to control pain and to speed the labor. These may make her feel like a victim all over again. In such situations, the caregiver's trustworthiness and respect, kindness, flexibility and understanding in communicating and caring for the woman will determine whether she feels satisfied with her birth, or angry and re-traumatized.

> Laboring 'on guard' increases production of stress hormones

The desire to remain in control may also translate into actions on the part of the survivor to keep control when she is in pain. For some, that means having an epidural before the pain reaches a point where she can no longer behave normally. The epidural enables her to control her facial expressions, speech, thoughts, and responses to others. The trade-offs involved with an epidural — a degree of helplessness in both physical movement and in self-care — bother some more than others. The desire to remain in control motivates some survivors to 'over-prepare', reading numerous books and/or taking classes with many different approaches to birth. Yet a wide variety of approaches can lead to more confusion, frustration and lack of focus as opposed to mastering and personalizing a single approach.

Doulas are often a useful guide for the woman who is overwhelmed by too many choices. They can help the woman focus on a few comfort measures that appeal to her.

SUPPORTING SURVIVORS

The educator should advise on choices of care provider and birthplace that are likely to match the woman's needs, and encourage her to disclose any fears or concerns; in some cases, revealing her history of sexual abuse may help the caregiver

understand and be more willing to tailor care to her individual needs.

The fear of losing control leads some laboring women to struggle against their contractions. Relaxation may be impossible and suggestions from well-meaning childbirth educators, doulas or staff to 'relax', 'surrender', 'yield', 'open up', 'don't fight it', may make pain worse by reminding the survivor of other times when she was told these things and was hurt.

Other suggestions, meant to reassure, such as, 'Trust your body', 'Do what your body tells you to do', are incomprehensible to the survivor whose body has been a source of anguish and betrayal. Instead, say something positive, 'That's so good! All you need to do is keep a rhythm with your breathing, moaning, movements, etc.' If she is fighting against pushing, she may need some modeling of how to push (be sure to show physiologic bearing down, not prolonged Valsalva pushing), and praise for her efforts. Criticism, such as, 'You're breathing too fast', or, 'We can hear you yelling all the way down the hall!' evokes shame and feelings of doing a bad job. Instead, use constructive suggestions, 'Follow my hand; I'm going to give you a steady rhythm. Stay with it. That's the way'. 'Let's count your breaths; keep them steady'.

If the woman is fighting against pushing, she may need modeling of how to push

During abuse situations, survivors sometimes dissociate – 'blank out', 'split off', 'check out'. They suppress thoughts, pain and memory. They may do the same thing during labor. If they perceive their ability to dissociate as valuable in helpless situations, they will welcome dissociation during labor. If they connect dissociation with victimization, they will want to remain present and aware. There are times in labor when the caregiver needs the woman to be aware, to be able to help the process. He or she should speak firmly but kindly: 'Jane, you're having your baby now. She needs you and we all need you to be alert and to help your baby come. Will you look at me and let me show you what to do? That's right'.

AFTER BIRTH

Survivors are sometimes unprepared for the new baby's demands. Being always available at the baby's beck and call may feel like abuse. Giving the baby total access to their breasts, especially if their breasts were a major target of previous abuse, may trigger resentment, guilt, and memories of childhood when they could not say no. On the other hand, they may become fiercely protective of their tiny baby, identifying with the baby's helplessness. Some fear that they or their partner might abuse their child, just as they themselves were abused.

GUIDELINES FOR THE CHILDBIRTH EDUCATOR

Childbirth educators are not therapists, but within our limits, we can be helpful to survivors of sexual abuse, mostly by treating them with the acceptance, respect, and empathy that we should extend to any class member. Here are some suggestions:

- First and foremost, recognize that in all our classes there are probably some survivors, and that their history of sexual abuse will almost surely affect them during childbearing.
- If a class member seems hostile, non-participatory, or challenging, try not to become defensive, or to take it personally. Remember—they have very good reason for the lack of trust and seemingly negative attitude that they are displaying. You may in some way remind them of other authority figures in their lives who misused their power.
- Recognize that some women may have preferences for their birth that you disagree with. Your job is to inform, not to indoctrinate. Once informed, the woman considers the information, along with her needs, fears, and priorities and comes up with the approach to birth that best suits her.
- Become familiar with resources and therapists in your community who can help sexual abuse survivors. Not all therapists are competent in this area. The best choice is a trauma therapist who understands pregnancy and birth. Because the impact of sexual abuse on childbearing is not widely understood by even experienced psychotherapists, the next best option would be a therapist who is open-minded and willing to learn about the unique challenges of birth for abuse survivors.
- Once you have resources for referral, mention sexual abuse in class when you are comfortable to do so, along with other situations that can interfere with labor. I bring it up when describing the emotions of labor by saying, 'Sometimes a history of sexual abuse affects pregnancy, labor, the birth, or breastfeeding. If you have been sexually abused, or if you feel quite afraid of labor or birth, I'd be glad to discuss this privately with you'. Usually, one or two women or couples in each class ask me about it. There are probably other survivors in class who choose not to talk to me for various reasons, including an absence of memory, or a desire not to deal with their experiences at the moment. They know best. Some teachers do not mention sexual abuse, but put out literature on the subject and resource lists.
- Be ready to listen respectfully and empathically if a woman discloses past sexual abuse to you.
- Present a variety of coping techniques for the contractions, without a value judgment on which

is 'best'. Say, 'Some people cope best by moving around rhythmically, vocalizing, with eyes open. Others are more internal; they become still, deeply relaxed, and very quiet. If 'tuning in', slow breathing and total relaxation are not suitable for you, physical movement, patterned breathing, an outward focus, or distracting visualizations may work better during painful contractions. Which way seems best for you? Some women use both at different times during labor'.

- Encourage class members to choose those comfort measures that seem most suitable, and to adapt them if necessary. Offer to help them develop a personally acceptable style for labor, based on the woman's knowledge of what helps her and what does not.
- Lastly, it is comforting to know that respectful, considerate, individualized childbirth education and clinical care can contribute to a healing and empowering birth experience that will remain with the woman as a lifelong positive memory.

Truly, this is no more than every woman deserves.

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If the educator or doula is an abuse survivor...

Many dedicated and capable educators, doulas and birth practitioners are themselves abuse survivors. Some have done much therapeutic work to resolve the effects of their abuse and are stronger and more confident than ever. This is called Post-Traumatic Growth (Rendon, 2016).They use the understanding they have gained to become effective and empathic teachers and doulas. if you are a survivor and have unresolved issues, I encourage you to use self-reflection to recognize interactions and other aspects of your work that trigger old feelings of anxiety or knee-jerk reactions that are not helpful. You can use self-help healing techniques (Rendon, 2016; Shapiro, 2012; Simkin & Klaus, 2004), or work with a counselor or psychotherapist. Learning new ways to prevent, react to and interpret triggering events leads to greater peace of mind, more joy, and posttraumatic growth.