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

Penny Simkin, PT

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.

Abuse survivors often vividly and poignantly describe the connections between their history of abuse and their birth experiences. Their difficulties during labor may include a long painful induction, fear during second stage or refusal to push, difficulty initiating breastfeeding, and feelings of failure. Panic, “body memories,” flashbacks, and dissociations (“retreating out of my body”) during labor, can interfere with their self-confidence and tolerance of pain, and their ability to trust and work with their labor and their caregivers. If caregivers know about a client’s past abuse, they can often address 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 who 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 ultra-sound 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 depended 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 trouble giving up control. Recognizing the possibility of a history of sexual abuse may keep the caregiver from judging the woman unfairly.
When Survivors Give Birth

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 soured 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?

Child Maltreatment

Facts at a Glance

2010

Note: Some numbers have been rounded.

Child Maltreatment

- In 2008, U.S. state and local child protective services (CPS) received 3.3 million reports of children being abused or neglected.¹
  - CPS estimated that 772,000 (10.3 per 1,000) of children were victims of maltreatment. Approximately three quarters of them had no history of prior victimization.
  - Seventy-one percent of the children were classified as victims of child neglect; 16 percent as victims of physical abuse; 9 percent as victims of sexual abuse; and 7 percent as victims of emotional abuse.
- A non-CPS study estimated that 1 in 5 U.S. children experience some form of child maltreatment: approximately 1 percent were victims of sexual assault; 4 percent were victims of child neglect; 9 percent were victims of physical abuse; and 12 percent were victims of emotional abuse.²

Gender and Race Disparities among Children

- In 2008, some children had higher rates of victimization:
  - African-American (16.6 per 1,000 children).
  - American Indian or Alaska Native (13.9 per 1,000 children).
  - Multiracial (13.8 per 1,000 children).¹
- Overall, rates of victimization were slightly higher for girls (10.8 per 1,000 children) than boys (9.7 per 1,000 children).¹

Characteristics of Perpetrators

- Most children are maltreated by their parents versus other relatives or caregivers.¹
- Perpetrators are typically less than 39 years of age.¹
- Female perpetrators, mostly mothers, are typically younger than male perpetrators.¹

Nonfatal Cases of Child Maltreatment

- In 2008, CPS reported the approximate rates of child maltreatment victims:
  - 21.7 per 1,000 for infants less than 1 year old;
  - 12.9 per 1,000 for 1 year-olds;
  - 12.4 per 1,000 for 2 year-olds;
  - 11.7 per 1,000 for 3 year-olds;
  - 11.0 per 1,000 for 4 to 7 year-olds;
  - 9.2 per 1,000 for 8 to 11 year-olds;
  - 8.4 per 1,000 for 12 to 15 year-olds; and
  - 5.5 per 1,000 for 16 to 17 year-olds.¹

Deaths from Child Maltreatment

- In 2008, an estimated 1,740 children ages 0 to 17 died of abuse and neglect (rate of 2.3 per 100,000 children).¹
  - 80 percent of deaths occurred among children younger than age 4; 10 percent among 4-7 year-olds; 4 percent among 8-11 year-olds; 4 percent among 12-15 year-olds; and 2 percent among 16-17 year-olds.
  - 39% of deaths were non-Hispanic White children.
  - 30% of deaths were African-American children.
  - 16% of deaths were Hispanic children.

References


For more information, please contact:
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
1-800-CDC-INFO • www.cdc.gov/violenceprevention • cdcinfo@cdc.gov
Definition of Childhood Sexual Abuse

Childhood sexual abuse takes place between a child (anyone under 18 years of age) and someone whom the child perceives as more powerful than the child herself. It consists of any activity—physical, psychological, or verbal—that causes sexual arousal in the abuser or in someone else.

Physical sexual abuse may include intercourse, vaginal or anal penetration by fingers or objects, oral sex, fondling the child, or making the child to fondle the abuser. It may be accompanied by physical violence, or by kindness, favoritism, rewards, or flattery.

Psychological sexual abuse may include exposing the genitals, voyeurism, intrusive interest in the child's sexual development, or forcing the child to view pornographic materials or witness inappropriate sexual activities.

Verbal sexual abuse includes erotic talk or innuendo, accusations of "sexy," "loose," or "whore-like" behavior, or other explicit language.

Many of these activities leave the child victim hurt, frightened, or confused. She feels that something is wrong, that maybe she is to blame, and is not sure of how or whether to stop it. These feelings are increased when the abuser is someone she cannot avoid, whom she loves, or on whom she depends for shelter and food. While familiar adults (parents, stepparents, grandparents, or other relatives) are the most likely abusers, others include baby-sitters, mother's boyfriends, respected elders, neighbors, schoolmates, religious leaders, or strangers. Sometimes a sibling or cousin, or someone whom the girl is dating, who is close in age to the victim, is the abuser.

Ritual or cult abuse involves groups of perpetrators and victims in a closed social group. It is characterized by many extremely damaging forms of sexual, physical and psychological violence, brainwashing, enforced secrecy, and isolation from the outside world.
Adult Manifestations of Childhood Sexual Abuse

ABSTRACT: Long-term effects of childhood sexual abuse are varied, complex, and often devastating. Many obstetrician–gynecologists knowingly or unknowingly provide care to abuse survivors and should screen all women for a history of such abuse. Depression, anxiety, and anger are the most commonly reported emotional responses to childhood sexual abuse. Gynecologic problems, including chronic pelvic pain, dyspareunia, vaginismus, nonspecific vaginitis, and gastrointestinal disorders are common diagnoses among survivors. Survivors may be less likely to have regular Pap tests and may seek little or no prenatal care. Obstetrician–gynecologists can offer support to abuse survivors by giving them empowering messages, counseling referrals, and empathic care during sensitive examinations.

Women who are survivors of childhood sexual abuse often present with a wide array of symptoms. Frequently, the underlying cause of these symptoms is unrecognized by both the physician and patient. The obstetrician–gynecologist should have the knowledge to screen for childhood sexual abuse, diagnose disorders that are a result of abuse, and provide support with interventions. Adult childhood sexual abuse survivors disproportionately use health care services and incur greater health care costs compared with adults who did not experience abuse (1).

Definitions
Child sexual abuse is defined as any sexual activity with a child where consent is not or cannot be given. This includes sexual contact that is accomplished by force or threat of force, regardless of the age of the participants, and all sexual contact between an adult and a child, regardless of whether there is deception or the child understands the sexual nature of the activity. Sexual contact between an older child and a younger child also can be abusive if there is a significant disparity in age, development, or size, rendering the younger child incapable of giving informed consent. The sexually abusive acts may include sexual penetration, sexual touching, or noncontact sexual acts such as exposure or voyeurism (2). Legal definitions vary by state; however, state guidelines are available by using the Child Welfare Information Gateway (www.childwelfare.gov/systemwide/laws_policies/state).

Prevalence
Although the exact prevalence is unknown, it is estimated that 12–40% of children in the United States experience some form of childhood sexual abuse. Shame and stigma prevent many survivors from disclosing abuse. Incest, once thought to be rare, occurs with alarming frequency (3). Survivors come from all cultural, racial, and economic groups (4). Approximately one in five women has experienced childhood sexual abuse (4). From 2006 to 2008, among females aged 18–24 years who had sex for the first time before age 20 years, 7% experienced nonvoluntary first sex (5). Twelve percent of girls in grades 9–12 reported they had been sexually abused; 7% of girls in grades 5–8 reported sexual abuse. Of all girls who experienced sexual abuse, 65% reported that the abuse occurred more than once, 57% reported that the abuser was a family member, and 53% reported that the abuse occurred at home (6).

Sequelae
Symptoms or behavioral sequelae are common and varied. More extreme symptoms can be associated with abuse onset at an early age, extended or frequent abuse, incest by a parent, or use of force. Common life events,
like death, birth, marriage, or divorce may trigger the return of symptoms for a childhood sexual abuse survivor. The primary aftereffects of childhood sexual abuse include the following:

- **Emotional reactions**
  Emotions such as fear, shame, humiliation, guilt, and self-blame are common and lead to depression and anxiety.

- **Symptoms of posttraumatic stress**
  Survivors may experience intrusive or recurring thoughts of the abuse as well as nightmares or flashbacks.

- **Distorted self-perception**
  Survivors often develop a belief that they caused the sexual abuse and that they deserved it. These beliefs may result in self-destructive relationships.

**Physical Effects**

Chronic and diffuse pain, especially abdominal or pelvic pain (1), lower pain threshold (7), anxiety and depression, self-neglect, and eating disorders have been attributed to childhood sexual abuse. Adults abused as children are four to five times more likely to have abused alcohol and illicit drugs (8). They are also twice as likely to smoke, be physically inactive, and be severely obese (8).

**Sexual Effects**

Disturbances of desire, arousal, and orgasm may result from the association between sexual activity, violation, and pain. Survivors are more likely to have had 50 or more intercourse partners, have had a sexually transmitted infection, and engage in risk-taking behaviors that place them at risk of contracting human immunodeficiency virus (HIV) (8, 9). Early adolescent or unintended pregnancy and prostitution are associated with sexual abuse (10, 11). Gynecologic problems, including chronic pelvic pain, dyspareunia, vaginismus, and nonspecific vaginitis, are common diagnoses among survivors (12–14). Survivors may be less likely to have regular Pap tests and may seek little or no prenatal care (15).

**Interpersonal Effects**

Adult survivors of sexual abuse may be less skilled at self-protection. They are more apt to accept being victimized by others (15, 16). This tendency to be victimized repeatedly may be the result of general vulnerability in dangerous situations and exploitation by untrustworthy people.

**Obstetrician–Gynecologist Screening for Sexual Violence**

With recognition of the extent of family violence, it is strongly recommended that all women be screened for a history of sexual abuse (15, 17). Patients overwhelmingly favor universal inquiry about sexual assault because they report a reluctance to initiate a discussion of this subject (18). Following are some guidelines:

- Make the question "natural." When physicians routinely incorporate questions about possible sexual abuse, they will develop increased comfort (19).

- Normalize the experience. Physicians may offer explanatory statements, such as: "About one woman in five was sexually abused as a child. Because these experiences can affect health, I ask all my patients about unwanted sexual experiences in childhood" (19).

- Give the patient control over disclosure. Ask every patient about childhood abuse and rape trauma, but let her control what she says and when she says it in order to keep her emotional defenses intact (19).

- If the patient reports childhood sexual abuse, ask whether she has disclosed this in the past or sought professional help. Revelations may be traumatic for the patient. Listening attentively is important because excessive reassurance may negate the patient's pain. The obstetrician–gynecologist should consider referral to a therapist.

- The examination may be postponed until another visit. Once the patient is ready for an examination, questions about whether any parts of the breast or pelvic examination cause emotional or physical discomfort should be asked.

If the physician suspects abuse, but the patient does not disclose it, the obstetrician–gynecologist should remain open and reassuring. Patients may bring up the subject at a later visit if they have developed trust in the obstetrician–gynecologist. Not asking about sexual abuse may give tacit support to the survivor's belief that abuse does not matter or does not have medical relevance and the opportunity for intervention is lost (20).

**Obstetrician–Gynecologist Intervention for Sexual Violence**

Once identified, there are a number of ways that the obstetrician–gynecologists can offer support. These include sensitivity with the gynecologic or obstetric visit and examination in abuse survivors, the use of empowering messages, and counseling referrals.

**Obstetric and Gynecologic Visits and Examinations in Abuse Survivors**

Pelvic examinations may be associated with terror and pain for survivors. Feelings of vulnerability in the lithotomy position and being examined by relative strangers may cause the survivor to reexperience past feelings of powerlessness, violation, and fear. Many survivors may be traumatized by the visit and pelvic examination, but may not express discomfort or fear and may silently experience distress (20). All procedures should be explained in advance, and whenever possible, the patient should be...
allowed to suggest ways to lessen her fear. For example, the patient may desire the presence of friends or family during the examination and she has the right to stop the examination at any time. Techniques to increase the patient’s comfort include talking her through the steps, maintaining eye contact, allowing her to control the pace, allowing her to see more (e.g., use of a mirror in pelvic examinations), or having her assist during her examination (e.g., putting her hand over the physician’s to guide the examination) (20). It is important to ask permission to touch the patient.

Pregnancy and childbirth may be an especially difficult time for survivors. The physical pain of labor and delivery may trigger memories of past abuse (21–23). Women with no prior conscious memories of their abuse may begin to experience emotions, dreams, or partial memories. Pregnant women who are abuse survivors are significantly more likely to report suicidal ideation and depression (7, 24). There are no consistent data regarding adverse pregnancy outcomes for women with histories of childhood sexual abuse.

Positive Messages
Some positive and healing responses to the disclosure of abuse include discussing with the patient that she is the victim of abuse and is not to blame. She should be reassured that it took courage for her to disclose the abuse, and she has been heard and believed (19, 20).

Counseling Referrals
Traumatized patients generally benefit from mental health care. The obstetrician–gynecologist can be a powerful ally in the patient’s healing by offering support and referral. Efforts should be made to refer survivors to professionals with significant experience in abuse-related issues.

Physicians should compile a list of experts with experience in abuse and have a list of appropriate crisis hotlines that operate in their communities. Contacting state boards of psychology or medicine can be beneficial in locating therapists who are skilled in treating victims of such trauma. Veterans’ centers, battered women’s shelters, and rape crisis centers often are familiar with therapists and programs that treat various types of trauma, as are many university-based counseling programs. Because of the relationship between trauma histories and alcohol and drug abuse, therapists should be skilled in working with individuals who have dual diagnoses (25).

When discussing with a patient referral to a mental health professional, it is helpful to identify a specific purpose for the referral. For example, “I would like Dr. Hill to assess you to determine if your past abuse is contributing to your current health problems” is more effective than telling the survivor that her symptoms are all psychological and that she should see a therapist (26). It is important to secure the patient’s express authorization before referring her to a mental health specialist, as well as helping the patient to not feel abandoned or rejected when a counseling referral is made.

Conclusion
For some survivors of childhood sexual abuse, there is minimal compromise to their adult functioning. Others will experience psychologic, physical, and behavioral symptoms as a result of their abuse. An understanding of the magnitude and effects of childhood sexual abuse, along with knowledge about screening and intervention methods, can help obstetrician–gynecologists offer appropriate care and support to patients with such histories.

References


Possible Impact of Childhood Sexual Abuse

Suspect a history of sexual abuse without an obvious physical or psychological cause.

Human Responses to Trauma:

Note: No single person exhibits all these symptoms. Nor is every person who exhibits one or a few of these symptoms necessarily a survivor of sexual abuse.

1. **Sexual**
   - sexual dysfunction/addictions
   - prostitution
   - teen pregnancy/promiscuity

2. **Physical and Medical**
   - asthma
   - infertility
   - chronic gastro-intestinal disorders
   - migraines
   - chronic pelvic pain and other pain
   - vaginismus
   - constipation
   - musculoskeletal pain and tension
   - fibromyalgia, chronic fatigue
   - temporo-mandibular joint (TMJ)

3. **Psycho-social**
   - dysfunctional relationships
   - substance abuse
   - discomfort with touch
   - fear of medical, dental procedures
   - high achievement (never good enough)
   - trust issues with authority figures

4. **Mental health**
   - obsessive compulsive disorders
   - numerous mental illnesses
   - dissociative disorders, DID
   - phobias
   - nightmares
   - depression
   - anxiety (hyper-vigilance), panic attacks
   - low self-image
   - anorexia, bulimia, morbid obesity
   - post-traumatic stress or PTSD
Possible Impact of Childhood Sexual Abuse

Suspect a history of sexual abuse without an obvious physical or psychological cause.

Note: No single person exhibits all these symptoms. Nor is every person who exhibits one or a few of these symptoms necessarily a survivor of sexual abuse.

1. **Sexual**
   - fear of permanent damage during birth
   - focus on sexual parts of body disturbing
   - phobias of needles, vaginal exams, other invasive procedures

2. **Physical and Medical**
   - exaggerated symptoms of pregnancy
   - rejection of bodily changes of pregnancy (evidence of sexuality)
   - repeated miscarriage
   - hyperemesis gravidarum
   - pregnancy induced hypertension
   - fertility problems
   - preterm labor

3. **Psycho-social**
   - bonding failure
   - desire for abortion
   - strained relationship with father/partner
   - fetus perceived as a parasite or invader
   - difficulty with (mistrust of or overdependence on caregiver
   - fear of being out of control or dependent

4. **Mental health**
   - fear of birth pain
   - fear of not being a good mother
   - recurrence of previous sexual abuse memories
   - anxiety
   - depression
   - dreams & nightmares
   - gender preference for baby & caregiver

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Suggestions for How to Ask a Client If She Has Ever Experienced Sexual or Other Abuse:

1. On a printed intake form:
   Please answer the following questions to help us discover if there are potential problems which we should discuss together. This information is completely confidential.

   Is there anything about your sexual development that you’d like to discuss?
   Yes _________ No _________

   Have you ever been or are you now in an abusive relationship (that is, physically or emotionally threatened, insulted, beaten, injured, or made to take part in sexual activities against your will)?
   Yes _________ No _________

2. Direct questioning of the client:
   “Many women have had unpleasant sexual experiences—being touched or forced into sex—or they have been physically abused. Have you ever experienced anything like that?”

3. Question for the counselor, caregiver, or nurse to ask her/himself (when there has been no disclosure):
   “Would everything that I see, hear, and feel with this client seem more natural or understandable, and make more sense if she were in fact a victim of abuse?”
# The Power Differential between Caregiver and Client

Penny Simkin, PT  
and Phyllis Klaus, MFT, LCSW

<table>
<thead>
<tr>
<th>Caregiver:</th>
<th>Pregnant or laboring woman:</th>
</tr>
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<tbody>
<tr>
<td><strong>1. Physical</strong></td>
<td></td>
</tr>
<tr>
<td>is upright</td>
<td>is lying down</td>
</tr>
<tr>
<td>is clothed in prestigious uniform (scrubs or white coat)</td>
<td>is partly naked, wearing hospital issued gown</td>
</tr>
<tr>
<td>is strong</td>
<td>is weak</td>
</tr>
<tr>
<td>is free to come and go</td>
<td>is restricted to room or in bed with tubes and lines</td>
</tr>
<tr>
<td>does painful or stressful things to woman</td>
<td>submits</td>
</tr>
<tr>
<td><strong>2. Mental</strong></td>
<td></td>
</tr>
<tr>
<td>has knowledge</td>
<td>has less or no knowledge</td>
</tr>
<tr>
<td>is the expert</td>
<td>is not an expert</td>
</tr>
<tr>
<td>uses medical jargon</td>
<td>does not understand medical jargon</td>
</tr>
<tr>
<td>discusses impersonal risks, benefits, odds, 'science'</td>
<td>responds with unscientific, personal feelings and worries</td>
</tr>
<tr>
<td>has tools (machines, tests)</td>
<td>depends on caregiver's interpretation</td>
</tr>
<tr>
<td><strong>3. Emotional</strong></td>
<td></td>
</tr>
<tr>
<td>is not in pain</td>
<td>is in pain</td>
</tr>
<tr>
<td>is not in physical danger</td>
<td>feels in danger</td>
</tr>
<tr>
<td>is in control</td>
<td>is stressed, frightened</td>
</tr>
<tr>
<td>remains composed</td>
<td>is in a position where her public person (makeup, clothing, hairstyle) is stripped away</td>
</tr>
<tr>
<td>is independent</td>
<td>is dependent, vulnerable</td>
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</tbody>
</table>

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Possible Impact of Childhood Sexual Abuse

Suspect a history of sexual abuse without an obvious physical or psychological cause.

Note: No single person exhibits all these symptoms. Nor is every person who exhibits one or a few of these symptoms necessarily a survivor of sexual abuse.

1. **Sexual**
   - fear of male caregiver (or female)
   - vaginal exams & instruments as rape
   - nakedness, modesty issues
   - baby in vagina (body memories)

2. **Physical and Medical**
   - postdates pregnancy? (induction)
   - vomiting in labor?
   - dysfunctional labor (augmentation, cesarean section)
   - excessive pain and tension

3. **Psycho-social**
   - control issues (re: management & self control)
   - "fighting" staff & labor
   - passivity, submission, "easy, good patient"
   - abandonment, isolation issues
   - lack of cooperation with staff, pushing, positions
   - bonding difficulties
   - dependency on partner, doula, caregiver

4. **Mental health**
   - fear, repugnance of blood, secretions
   - fear of the unknown, danger
   - "body memories of abuse" & intense distress
   - ambivalence re: c/s, epidural
   - fear of invasive procedures
   - hypervigilance
   - trauma
   - panic
   - dissociation ("withdraws," "goes away")

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Potential “Triggers” That May Cause Anxiety or Body Memories for Childhood Sexual Abuse Survivors During Pregnancy, Birth, and Postpartum

by Penny Simkin, PT
and Phyllis Klaus, MFT, LCSW

Following are some specific actions, events, or factors that may occur during childbirth. Each has raised undue anxiety, fear, resistance, or tension in some survivors. Caregivers should recognize that when their clients react extremely to several of these items, it may indicate a history of sexual abuse, which may explain their apparently extreme reactions.

Match the theme to the trigger:
1. Control and loss of control
   - Self-control (crying out, struggling, being agitated)
   - Restraint (being trapped, tied down, hooked up)
   - Control over what is done to her
2. Pain, injury, and damage to her body; invasion
3. Dependency on partner, doula caregiver
4. Mistrust of strangers
5. Shame and being judged over body image, behavior, ‘weakness’, secretions
6. Exposure (modesty, people staring, looking and feeling inside)
7. Ignorance: fear of unknown

<table>
<thead>
<tr>
<th>Intrinsic to Pregnancy</th>
<th>Intrinsic to Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hormonal/bodily changes</td>
<td>1. Changed appearance (make-up, hairstyle, clothing)</td>
</tr>
<tr>
<td>2. Evidence of sexuality</td>
<td>2. Nakedness/exposure of sexual parts of the body</td>
</tr>
<tr>
<td>3. Conflicting feelings (shame, anxiety, excitement, worry, self-disgust)</td>
<td>3. Secretions (show, blood, amniotic fluid)</td>
</tr>
<tr>
<td>5. Question of disclosure and revealing history. May have history of drug, alcohol abuse, STD, abortions</td>
<td>5. The actual birth, baby bulging the perineum, emerging from your body</td>
</tr>
<tr>
<td>6. Fear/anxiety around procedures (blood draws, pelvic/vaginal exams, ultrasound, invasive events, etc.)</td>
<td>6. Holding and suckling baby</td>
</tr>
<tr>
<td>7. Skepticism about the need for tests</td>
<td></td>
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<tr>
<td>8. Difficulty with compliance with provider recommendations</td>
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<tr>
<td>9. Sensitivitlty around touch</td>
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</tr>
<tr>
<td>10. Need for long appointments (many fears and concerns)</td>
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</tr>
<tr>
<td>11. Dependency issues (many calls, questions)</td>
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<td>12. Trust in caregivers (difficulty, gender preference)</td>
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<td>13. Gender preferences for fetus. If girl, will she be safe? If boy, ‘can’t have penis inside me.’ ‘Will he do that?’ ‘Will he be safer?’</td>
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<tr>
<td>14. Worry about self/partner as parents</td>
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<tr>
<td>15. Development of birth plan</td>
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<tr>
<td>16. Symptoms of pregnancy, somatic complaints (distress, exaggerated)</td>
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<tr>
<td>17. Fears related to upcoming labor and birth</td>
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<tr>
<td>18. Postpartum and breastfeeding concerns</td>
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<tr>
<td>19. Worry about management of emotions (anger, anxiety, etc.) being triggered with flashbacks</td>
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</tr>
</tbody>
</table>
## Interventions or Procedures

1. Hospital environment (smell, machines, sounds, uniformed personnel)
2. Blood draws
3. Intravenous fluids
4. Vaginal exams/AROM
5. Connection to lines from body to machines or containers (EFM cords, IV line, continuous BP cuff, bladder catheter, epidural catheter, oxygen mask)
6. Restriction to bed
7. Episiotomy/tearing
8. Forceps or vacuum extractor delivery
9. Cesarean section
10. Postpartum (inspecting vaginal canal, stitches, fundal massage)

## People Involved in Care

1. Relationship with your doctor or midwife (gender, familiarity, trust, expectations, confidence)
2. Strangers (nurses, unfamiliar caregivers)
3. Behavior of caregiving staff toward you (respect, control, individual treatment, asking before touching)
4. Issues re partner, doula, family, friends (disapproval, abandonment, unreliability, inadequacy, disagreement, trust, dependency)

## Relating to Pain

1. Pain with labor contractions
2. Pain-related behavior, panic, loss of control
3. Expressions of pain (facial, vocal, bodily tension)
4. Pain medication ‘trade-offs’:
   - Narcotics (groggy, sleepy, less pain, more relaxation)
   - Epidural (numb, less participation, inability to do as much, possible inadequate pain relief/less pain, more relaxation)
5. Pushing effort, sounds and the pain

## Postpartum Issues

1. Postpartum events (inspecting vaginal canal, stitches, fundal massage). Unexpected pain related to afterbirth contractions, episiotomy, breasts
2. Relationship to infant (touch concerns). Fear of diaper changing, cleaning, left alone at night with baby, co-sleeping
3. Relationship to partner, family of origin. Wil partner abuse?
4. Breastfeeding comfort/discomfort. Baby at breast, sensations, demanding, intimate touch, no control
5. Negative, traumatic or unexpected events of birth relived
6. Avoid postpartum check-up
### Clinical Challenges and Possible Solutions

#### Prolonged prodromal labor (non-progressing contractions)

<table>
<thead>
<tr>
<th>Clinical Challenge</th>
<th>Psychological Causes</th>
<th>Possible Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reluctance to enter the process that results in parenthood.</td>
<td>2. Recognition that she is out of control over her body.</td>
<td>1. Talk it over. “Why do you think this is taking so long?” 2. Help her shift control from her body to her conscious responses to her contractions, which she can control. 3. Reassurance that prelabor often takes a long time, while the cervix ripens, effaces, and moves forward. 4. Patience, nourishment, sleep (bath, massage, sleeping medications).</td>
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</table>

#### Resistance to or inability to tolerate vaginal exams, blood draws, IV’s, catheters, etc. (physical struggle, tension, panic, fainting)

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<td>1. Association with rape, more so if done by same gender as her abuser.</td>
<td>2. Phobia over blood. 3. “Invasion” of body boundaries may remind her of rape, helplessness. 4. Fear of having genitals exposed, visible to strangers.</td>
<td>1. Do as few of these procedures as possible and tell her that. 2. Should have been discovered before labor and noted prominently in the chart. 3. Get the woman’s permission. 4. Proceed slowly, step by step, regulated by the woman. 5. Have a trusted, kind, familiar person with her. 6. Respect her modesty as much as possible.</td>
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#### Strong preference for one care provider or gender of care provider (“wrong” gender is on call). This may apply to doctor, midwife, nurse, anesthesiologist, or pediatrician.

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<td>1. Distrust of authority figures of that gender (associated with gender of perpetrator).</td>
<td>2. Client may believe other women are, like her or like her mother, weak, incompetent, untrustworthy or evil.</td>
<td>1. Validate her need and try very hard to honor this need (and, if impossible, tell her that you tried). 2. Should have been discovered ahead of time. 3. If possible, arrange for person of client’s desired gender to do vaginal exams and other invasive procedures. 4. Use active listening; try not to take it personally.</td>
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#### Labor progress stalls in active phase.

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<td>1. Labor pain is reaching a point where she can no longer remain “in control.” Deep fear of pain behaviors (screaming, thrashing, panicking) associated with being helpless and out-of-control during abuse. She keeps the labor at a level where she can remain in control.</td>
<td>2. Deep fear of vaginal birth, preference for a cesarean for “failure to progress.”</td>
<td>1. Talk it over: “Why do you think your progress has stalled?” 2. Pain medications or an epidural may diminish the output of catecholamines, and enable further interventions, such as oxytocin or second stage interventions.</td>
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#### Struggling during administration of epidural, even though requested.

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<tr>
<td>1. Anesthesia placed by unseen person at her back, may remind her of abuse from behind at night.</td>
<td>2. Reminders to “lie still and it will be over sooner.” This may apply to doctor, midwife, nurse, anesthesiologist, or pediatrician.</td>
<td>1. Speak to her face-to-face before beginning procedure. 2. Describe every step. 3. Ask her for feedback. 4. Have her partner or doula at her face and the nurse offering encouragement and praise. 5. If necessary, speak firmly and confidently. No coaxing or sweet-talking.</td>
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When Survivors Give Birth

Penny Simkin, PT & Phyllis Klaus, MFT, LCSW
When Survivors Give Birth

Revised 1/12

6. Woman appears “out-of-touch,” in a trance. Difficult or impossible to speak with her (dissociation, blanking out). “Coming back” may be shattering or upsetting, or merely like gradually waking up.

1. This may be a survival technique, used since childhood to “leave” during pain or terror.

2. Dissociation blocks not only the experience, but any memory of it as well.

Dissociation may delay bonding.

1. Dissociation may delay bonding.

2. Baby as perpetrator, manipulative, willful, hurtful, selfish.

3. Modesty issues around exposure of breasts.

4. Episiotomy, forceps may add to emotional trauma.

5. Delay or failure in descent in second stage.

Fear of vaginal birth: the pain, stretching, possible tearing, episiotomy.

Perception of baby as “perpetrator,” hurting and damaging her.

Reluctance to become a parent. “Holding back” — tension in perineum.

Fear of exposure or expelling feces.

1. Reassurance.

2. Associate birth more with bowel movement than rape. Sitting on the toilet for a few contractions may help relax her perineum.

3. Remind her that the pain is coming out of her body; her baby is her ally in getting rid of the pain. If abuse history has been described, tell her, “This is not the pain of rape. Push the pain out with your baby.”

4. Cover her vaginal outlet and perineum with a warm compress, which protects modesty, helps her relax, and know how or where to push.

5. Ask her why she thinks the baby is not coming. If she says she doesn’t want it to come out or the baby doesn’t want to come, tell her that holding the baby in will not take care of the problem. “Let the baby out and we’ll figure out what to do.”

6. Episiotomy, forceps may add to emotional trauma.

7. Lack of interest in the newborn:

8. "Baby as perpetrator."

9. Dissociation during birth may delay bonding.

Traumatic birth may override thoughts for baby.

Abuse in childhood may have left woman with little instinct of mothering.

1. Allow expressions of anger, lack of confidence, dislike toward baby.

2. Encourage a more positive family member to be with baby.

3. Don’t rush contact between mother and baby. Give mother time to recognize that labor is over, to “come back.” Most abuse survivors do “take in” the baby.

4. Model ways to hold child, encourage positive gestures by mother:

Prescriptive Breastfeeding: Latch and Feed the Baby. Keep in mind that bicycling the baby will not take care of the problem. Let the baby hold her

Tear, and she will heal one week to 10 days.

Rear of Composer of Composition. I was not born with this skill. Preventing cracking or peeling in prenancy.

Prescription of Baby as Perpetrator. Hunting and gathering involved.

Possible genetic factor.

Fear of vaginal birth: the pain, stretching.

Gently wash up.

Showering or washing may not be necessary of it is well.

If there is difficulty or impossible to bathe, she may be a survival technique used since childhood to “leave” during pain or terror.