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The maternity needs of women who were sexually abused in childhood

The rarely heard voices of women who were sexually abused in childhood are brought to the fore by Elsa Montgomery, Lecturer and Head of the Department of Midwifery at King's College London

Introduction

This article addresses a subject which remains taboo despite recent media attention. It presents some findings from a study on the maternity care experiences of women who were sexually abused in childhood and considers how practitioners can provide sensitive care to these women. Nine women spoke in depth about their experiences as part of the study. Their words are powerful and it is important that they are heard. The names used are pseudonyms chosen by the women.

The prevalence of childhood sexual abuse

Childhood sexual abuse (CSA) is very common. Determining prevalence is difficult and there is considerable variation across studies.¹ However, it is generally accepted that approximately one in five women have experienced CSA.^{1,2} As it is so common all practitioners will meet women with a history of abuse. A sensitive approach to these women is important in facilitating their journey through pregnancy, birth and into motherhood.

The impact of childhood sexual abuse

As few women choose to disclose abuse³⁻⁵ their history is unlikely to be known by those caring for them. The maternity care experiences of women with a history of CSA can be characterised by 'silence' and this creates challenges for practitioners

working with them.⁴ There are significant long term physical and mental health effects of CSA. These include depression, substance misuse, eating disorders, risky sexual behaviour, problems with the gastro-intestinal tract, gynaecological problems and chronic pain.⁵⁻⁷ There is also an association between the common complaints of pregnancy (e.g. heartburn, backache, tiredness and constipation) and a history of abuse.⁷ Published personal accounts reveal how being pregnant and having a baby can be traumatic for these women and how the situation may be made worse by care providers.⁸⁻¹¹ The research reported here confirmed those accounts.

Why don't women disclose?

Women who have experienced CSA can feel guilt and shame. They often grow up thinking what happened to them was their fault. Linda had believed for 30 years that she was to blame for 'encouraging' her stepfather to abuse her:

I felt that I must have been in some way provocative, encouraging, some sort of Lolita-type figure... (Linda)

Consequently it was not something she would ever have shared with her midwife even though she found her 'absolutely fantastic'. Women fear that they will be judged if people find out. Elizabeth struggled

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with flashbacks throughout her pregnancy and desperately wanted to be able to tell someone how bad it was but she didn't think anyone would support her:

I thought that everyone would just hate me and think I was a terrible person and that I didn't deserve to have this baby. (Elizabeth)

So women hide their true feelings, try to fit in and appear 'normal'. For Sue this meant curling up and being 'part of the wallpaper' but even so, like several of the other women in the study, she felt different and 'a little bit odd':

...because in antenatal class and postnatal class I, I almost felt like I had a... banner on me and although I didn't and it's perhaps a bit stupid saying it, it's how I felt... (Sue)

It is therefore not surprising that women are reluctant to divulge their abuse. But there is an even greater fear haunting many – that their babies will be taken away if anyone was to find out about it. For example, Sam's view was:

I can't afford to tell you [healthcare professionals] because you'll take my kid away; y'know, if you really knew how bad... (Sam)

There is also concern that 'the abused becomes the abuser' and it scares women. Elizabeth's mother had been implicated in her abuse and she was frightened she would be the same:

And all the way through my pregnancy with [my first son] I had, I, I, I had this image of this... a monster being in me that was gonna make me into this horrible person and make me hurt my son. (Elizabeth)

Although evidence is lacking, this view is prevalent and Linda recognised that:

...unless we can take away this awful cliché that the abused become the abusers. Then, I don't know if anybody will ever be really free of fear enough to talk. (Linda)

Pregnancy, birth and beyond for survivors of childhood sexual abuse

Becoming a mother can be challenging for any woman but for those with a history of CSA there are particular issues that can potentially heighten the challenge. These include the fear, shame and secrecy discussed above. On a physical level, having a baby involves intimate procedures and the invasion of personal space. These aspects can remind women of their abuse and are frightening as a result. But it is not only

physical aspects of care that can trigger memories of abuse. CSA is fundamentally about power and control. Any situation that leads to loss of control for women can leave them feeling very vulnerable. Women want to feel safe when they are having a baby.¹² For these women that means not being reminded of their abuse. It is not always possible for women to predict what will trigger memories. It depends on the context, how they are feeling at the time and the relationship they have with care-givers. Even sensitive care doesn't always prevent the experience from being traumatic. However with hindsight the experience can be healing.

Breastfeeding provides a useful example. For Elizabeth and Linda choosing to breastfeed was part of proving they were good mothers. Women varied in their experience of establishing breastfeeding. Sue had no problem with it but appreciated the fact that her midwife and health visitor did not insist on checking her nipples – something she would have found challenging. For Sam breastfeeding was difficult on a number of levels. Not being able to 'escape from it' reminded her of how she felt as a child:

...it's like being it's like it's happening again because you are being controlled by another person. (Sam)

Sam was very sensitive about her breasts so the 'help' she received to latch her baby was problematic:

And then all of a sudden they're trying to get you to whip it all out and stuff it in this baby's mouth. (Sam)

The brutality of the help given to breastfeeding women and lack of respect for bodily integrity is recognised elsewhere.¹³ Sam felt huge relief when she decided to give up breastfeeding. On the other hand Elizabeth was determined to do it and the time that a community midwife spent helping her to establish breastfeeding was very validating. It suggested that the midwife believed in her. Ultimately it was healing for Elizabeth:

...that made me feel so much better about myself, that my body could be actually used for some good, and could make this beautiful baby and that I could feed this beautiful baby for so long... (Elizabeth)

Meeting women's needs

The issues with breastfeeding demonstrate some of the factors that need to be considered in caring for women with histories of CSA. However, if we cannot expect to know who these women are, how can we meet their needs? As they will be hidden in apparently ordinary situations encountered daily, the answer lies in 'making

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changes for many to protect a few'.³ Control is really important in helping women to feel safe. This includes both self-control and control over what is being done to them.¹ For some women lack of control over their body during labour is difficult:

I just felt totally out of control. This was all happening to me and you can't stop your body from having contractions... (Helen)

Attempts to retain control may be seen in very detailed birth plans. For some women epidurals can be helpful, but for others they are counter-productive:

...I had asked for an epidural, which did help with the pain, but then you're just on this bed and you can't move... (Elizabeth)

The fact that sitting epidurals often requires women to have their back to the door can also be difficult. Not knowing who is about to come through the door leaves women feeling very vulnerable. These issues can be helped by the sharing of information so that they are fully informed and are prepared for what might happen. However, listening is also important. Even though they are a silent population and won't necessarily speak out, these women want to be heard:

I hoped that somebody would just ... just say one thing and make me think they actually will want to listen... (Elizabeth)

Picking up cues and responding to unspoken messages (like requests for a caesarean section or concern over male staff) become key aspects of care. Trust is also important and that can be promoted when women develop good relationships with practitioners. Getting to know a woman enables cues of distress to be noticed and a sensitive response to be given. For as Garratt says *'the most useful guide to providing appropriate care for a woman with a history of abuse is the woman herself'*.¹³

Awareness of CSA as a widespread issue, compassion during times when women appear uncomfortable, acknowledgement of their distress without attempting to name a cause, sensitivity to their body boundaries and ensuring that they are able to retain control over what happens all help to meet women's needs. If their needs are met, rather than feeling like 'it is happening all over again' more women will enter motherhood feeling 'so much better' about themselves.

Educational resource

Voicing the Silence animation reflects the words and experience of a woman who survived childhood sexual abuse.

www.kcl.ac.uk/cultural/culturalinstitute/showcase/current/kei/voicingthesilence/index.aspx

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