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This chapter examines the ways in which childhood sexual abuse can influence women's feelings about pregnancy, childbirth and the transition to motherhood. Drawing on in-depth interviews with adult survivors the chapter explores the links between women's experiences of sexual violence and their experiences of giving birth. It describes how such adult life-events can stir up memories of past abuse and it draws out the implications of this for midwifery practice. Finally, the chapter suggests ways in which midwives can help pregnancy and childbirth to be an empowering rather than disempowering process, which challenges rather than reinforces the feelings of violation and pollution inflicted on women by sexual violence.

The research findings

The research reported here involved in-depth, tape-recorded interviews with 40 adult female survivors of (mainly incestuous) childhood assault. My interest in the impact of sexual violence on women's lives grew out of my voluntary work in a refuge for young women needing to leave home to escape abuse. It was also fuelled by some research I was then doing into the maternity services (Green et al, 1988) as well as conversations about this issue with my mother (see Kitzinger, S, 1992). The interviews with adult survivors of childhood sexual abuse were designed to explore the process of surviving such traumatic abuse. During interviews, I was struck again and again by how women's encounters with health carers in general (from dentists to surgeons) and their encounters with the maternity services in particular, were often the source of renewed trauma. In fact, over half of the interviewees reported that such experiences had in some way reminded them of their abuse.

The impact of sexual violence on women's feelings about their bodies is now well-documented in the literature written by and for, survivors. The consequences of abuse can include hatred for and dissociation from one's own body and can affect a woman's feelings about her reproductive capacity. (Armstrong, 1987; Bass & Davis, 1988; Hall & Lloyd, 1989; Maltz & Homan, 1986). If women detest their own bodies or feel alienated from their sexual organs then the intimate intrusions of a physical examination can make them feel particularly vulnerable. Their past abuse may also have made them acutely alert to any situation in which they are vulnerable and therefore open to victimisation. The women I interviewed frequently described their reluctance to surrender to intimate manipulations of their bodies while in the powerless position of a patient. Sophie, who was abused by her grandfather, explained: "I have enormous resistance to opening my legs on demand".

Although some survivors do not find examinations difficult, others can only cope by 'switching off': 'Of course I hate them but I just detach my mind from my body, I've had years of practice doing that - with my stepfather!' Some women find that internal examinations bring memories of abuse flooding back. One woman, for instance, had a flashback after being examined, in which she felt herself to be a child again and re-experienced an assault. Another is fearful that male staff might take advantage of her vulnerability to sexually assault her, so prefers always to be treated by women. A third

talked of her unexpected terror before an internal examination when she became convinced that the doctor was going to thrust his whole hand inside her. Confronting her fear about the examination was one step in the gradual realisation that her father sexually assaulted her as a child.

For some women these fears mean that they avoid attending for internal examinations, cervical screening or ante natal care. Morag, now in her forties, managed to avoid internal examinations during 16 years on the Pill and throughout a pregnancy. Her evasion of medical care, originally a reaction to her childhood sexual abuse, was reinforced by the treatment she received when, at 20 years old, she had a smear test. In a letter she wrote to me after her interview she described her feelings:

'I can see myself walking out of the hospital gate feeling guilty, not a good wife, dirty, in pain, humiliated. They were holding me down while the doctor tried to take a smear; they were shouting at me. It was painful. I just wanted to get away. They said my marriage wouldn't last and I should be ashamed of myself for carrying on like that. When I started to struggle they should not have held me down. It does not seem a big thing but the feelings are still there.'

Such treatment is clearly abusive but sociologists have pointed out that hospital institutions can encourage such abuse and that staff are sometimes "paternalistic" and that medical institutions routinely "infantilise" patients (Cartwright, 1976; Roberts, 1985). Ironically, it is also true that some of the rituals designed to 'desexualise' encounters with health carers (such as a lack of eye-contact or the isolated focus on a woman's genitals) can make women feel 'depersonalised' and treated 'just like an object'. When women are treated in this way while painful and intrusive things are done to their bodies, this replicates their experiences of childhood abuse.

Labour and delivery and the accompanying medical treatment can be frightening and a woman may feel trapped just as she did when she was pinned down by her assailant. As one woman recalled, her labour triggered memories of abuse because: "I was on my back where I don't like to be, and I was out of control, and I was in pain". In fact, many women (whether or not they have been sexually abused) talk about unpleasant experiences of birth using the language of rape - they talk of feeling "skewered", "abused", and "treated like a lump of meat" (Kitzinger, S, 1992). For women who have been sexually assaulted in the past childbirth may feel, as one described it, "like being sexually abused all over again". One woman vividly described how her birth experience echoed her childhood victimisation: "The same indignities, lack of control, humiliation, and depersonalisations. My despair led to a total loss of self-esteem and I attempted suicide ... My horror of hospitals and doctors has increased. I find myself terrified at the thought of an examination".

Midwives may find they have to deal with the fall-out from women's past experiences or their encounters with doctors. Some incest survivors may approach childbirth as if they are totally helpless; they may be utterly subservient and unable to express their own desires. Others treat the midwife as a potential assailant. They refuse to negotiate and insist on rigid rules about what the midwife can or cannot do. They react to any deviation from pre-

agreed plans as if it is an immense betrayal of trust. This can leave midwives feeling that their own professionalism, and indeed character, is being called into question.

It is important to recognise the ways in which a woman's ability to trust anyone (and perhaps especially health carers) may have been destroyed by the abuse. Survivors have, after all, been tricked and abused by those, such as a father, who claimed to have their best interests at heart and they sometimes also feel betrayed by their mothers because they believe that she must have known what was happening. A survivor knows how trust can be abused. She has no reason to have faith in anyone until they have demonstrated just how trustworthy they can be; she is unlikely to accept promises at their face value or to trust you simply because you are a professional. After all, abusers include respected members of the community (including teachers, lawyers, psychiatrists and health professionals) who sometimes use quasi-medical justification for the abuse they inflict on their victims. Miranda's father would insist on putting his fingers in her vagina 'to check you are still a virgin', Diane's father would pull her knickers off 'to make sure you are growing properly' and Lesley's twenty-year-old brother raped her when she was eleven under the guise of 'playing doctor'.

Understanding the ways in which trust has been undermined allows the midwife to work with the woman on those issues and to respect her point of view. As Penny Simkin points out: 'What is sometimes exasperating and unreasonable to the caregivers really makes all the sense in the world when we recognise why she may have trouble giving up control [...] 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 resistance or over anxious woman. We realise that she has very good reason to feel the way she does.' [Simkin, 1992, 225]

Childbirth also may have particular significance for survivors because of the physical sensations involved. Memories may be released by the power of the contractions. Some women feel as if 'the memory of the violations during my childhood was locked in my birthing muscles' (Rose, 1992) and women may fear 'tearing wide open' during the delivery. Some practitioners suggest that women may have such deep-seated fears that they can stop labour before it goes beyond their control or may opt for elective caesareans (Simkin, 1992). Anna Rose, describes how, during her delivery, 'my mind was full of images of the rape I endured when I was 2 years old [...] Later I realised that the size of the baby coming out compares with the size of an adult penis raping my 2-year-old vagina. At the time, however, it was as much as I could do to let the midwives know what was going on for me. I was screaming that it felt like the abuser's penis in me, and 'just get it out!'. Thankfully, knowing about my past, they made a strong effort to help me through the experience. Through the haze I heard them saying to me, "You are safe now. You are not being raped. It is not a penis going into you, it is your beautiful baby trying to come out.' [Rose, 1992]

Pregnancy and childbirth also invoke feelings about one's body - how it looks and feels and whether it is "good" enough. Women often feel that they have been 'ruined' by abuse and that their bodies betrayed them by attracting the abuser or sexually responding to his touch

(Maltz, 1987; Wisechild, 1988). They can not believe that their polluted and abused flesh can contain and bring forth a perfect baby. Some girls grow up with the continual anxiety that they might become pregnant, indeed, some do become pregnant by their abuser. Such fears or experiences may colour their feelings during this pregnancy (and it must be remembered that some women in your care will be carrying the child of a rapist, including, in some case, their own fathers).

Many incest survivors also believe that their genitals have been damaged beyond repair, or 'turned inside out' by the years of abuse. The fear of long-term physical damage is, for a minority of victims, well-founded, (Cleveland, 1986) but most children experience a symbolic rather than actual physical distortion. They feel that they must have been physically altered by the abuse because of the sheer pain they suffered as children and this concern is often fed by an adult tendency to warn children that their bodies are infinitely impressionable and that physical signs will yield up secrets of any 'solitary vice'. Children know that if they masturbate they'll get hairy hands, picking their nose will make it swell up to twice its natural size and if they suck their thumb, they'll get buck teeth. Young women in the incest survivors refuge often asked questions such as 'when I get married, will my husband be able to tell' or confided worries about being 'abnormal', 'all red and swollen' or 'with bits hanging out'. Many women grow up with no access to information about what 'normal' genitals look like. This, combined with a reluctance to examine that shameful part of themselves (their private parts are 'untouchable' at least by them) means they have little recourse but to live with this fear for years.

But it is not only lack of information or the physical experiences of penetration which may influence a survivors' relationship to her body, her feelings are also influenced by the abuser's attitude toward her. He may have called her names ('slut', 'tart', 'whore') ; he may have treated her body as both dirty and as irresistible. The child thus experiences her growing body as it is refracted through the eyes of her assailant. His furtive approach to rubbing her genitals or the way he spits on his fingers before inserting them into her can increase feelings of self-disgust. Any sexual response to his touch can make her despise herself, and if he seems irresistibly attracted by her pubescent body she may have grown to loath her developing breasts and genitalia. Alison, for instance, describes her feelings:

'I can remember cutting my labia with scissors. I can remember shaving my pubic hair ... I always wanted to change my genitals. Even though I used to go through my mom's nursing books and knew this was the way they were supposed to be, somehow they never looked right. [...] I know where the feelings stem from. They stem from [the offender] who started his business as soon as he discovered I had pubic hair. Things were never the same after that [...] He would frequently make the comment 'now you're growing into a woman' as though I was supposed to share his fascination with the idea' (quoted in Jehu, 1988, 270-271).

These negative images of their genitals obviously have implications for women's feelings about ante natal care and childbirth and especially for specific procedures such as internal examinations, episiotomies and suturing. Childbirth can thus re-awaken anxieties: "What will the midwife discover when she examines me?" "Are there any scars?" "Is my vagina

wide enough to let the baby come out?" However, by the same token, this can be an opportunity for women to gain information about their bodies and begin to see their 'sexual organs' in a new light. Some women I interviewed spoke of their relief to discover that they were not 'deformed' and, for some, talking with a midwife had been their first opportunity to ask questions about 'down there'. The midwife may be able to reassure the woman that there has been no physical damage or, if there are signs of the abuse, discuss this with her too. Women who are scarred should not be treated to averted eyes, and evasion when they seek information and midwives need to think carefully about how to describe any damage to the genitals. Evasion or negative language can reinforce women's alienation or sense of freakishness. One woman, for example, was told that she was 'deformed' rather than that she had a ring of scar tissue - perhaps in an effort to deny sexual abuse and the types of injuries that might ensue (Courtois & Riley, 1992).

In addition to all the issues related to pregnancy and childbirth women may also find that memories of abuse are provoked by the fact that they are now the mother of a baby girl or boy. The transition to motherhood confronts women with questions about what it means to be a parent. It is often a time when people think about their own childhoods and it may arouse women's fears about the dangers facing their own children. Indeed, one woman's first thoughts after giving birth to her daughter were: "Oh my God! It's a girl. I can't bear it if she has to go through what I've been through". Women may not trust their male partners with the baby. As another woman explained: "My mum didn't know my dad would abuse me when she married him; how do I know my husband won't turn out like that?"

Some women also worry that they themselves are a threat to children. Survivors are repeatedly bombarded with messages that their sexuality is dangerous. The media often refer to incest survivors as "time-bombs" who are trapped in "the cycle of abuse", destined to repeat their own victimisation by assaulting their children. Such myths fail to address even the simplest flaw in that equation - that most victims of sexual abuse are female and most abusers are male. Given the ubiquitous nature of such theories, however, it is not surprising that women who were abused are sometimes wary of touching their babies. The sensuality of breast feeding may provoke anxiety, and daily care incites fears because, as one woman commented: They tell you that if you've been abused, you abuse". Referring to the difficulties she had in bathing her son, she added: "I didn't like to touch his bits because I thought if I did I'd end up like my dad and do it to him."

On the other hand, some women may find holding their own baby brings home the vulnerability and 'innocence' of the infant and makes them feel that they were less to blame for their own childhood abuse. For others this does not happen until their child reaches the same age as they were when the abuse began. As one mother of a seven year old commented: "If he wanted a cuddle you don't take it as he wants sex. I think its helped having Tim to see what a seven year old looked like!"

Some women also found that becoming a mother made them decide to 'sort themselves out'. Motherhood is, after all, supposed to be about being 'grown up', mothers ought to be sorted out for the sake of their children. As Amy explained: 'I'd think "so what, you are feeling pain, it doesn't matter; you are depressed, so what?" Before I had any children I could live

quite happily with the fact. "So, that happened, it doesn't matter, its a secret". But when I had children ... I knew I had to do something about it.'

Given all the factors discussed about it is not surprising that women often enter treatment for incest during this time (Haugaard & Repucci, 1988) and some have written about the links between such events, their childhood abuse, and postnatal depression (Fay, 1989; McNeill, 1986). But childbirth also can be an opportunity for women to relate to their bodies in new ways, to experience them as powerful, competent, and creative.

Although internal examinations can reawaken anxieties, they can also be a source of information. Although treatment from staff can make women feel powerless and humiliated, it can make them feel respected and in control. Although becoming a mother can make women feel frightened and incompetent, it can also make them more aware of their own 'childhood innocence' and look toward the future with optimism. Some women whom I interviewed spoke positively of the care with which midwives, doctors, and nurses responded to their needs. A gentle examination, a listening ear, and a respectful approach can all help women to 'reclaim' their bodies and to become angry instead of ashamed of what has been done to them in the past. Sensitivity on the part of staff who understood and validated their distress, provided information, and offered practical support was vital in helping women through such experiences. The following guidelines suggest some ways in which midwives can begin to address this issue.

Guidelines for midwives

1. It is helpful if all health care staff are informed about sexual violence. This involves reading up about the subject and trying to ensure that the topic is discussed in training courses and on the ward. [For further reading see those items which have an asterisk in the reference list.]
2. It is important to be open to the possibility that any woman who you are caring for may have been sexually assaulted. Some writers recommend routinely asking questions about sexual abuse of all 'patients' (Courtois & Riley, 1992). Although I would suggest a more cautious approach, I do think that it is appropriate to introduce the topic in ante natal discussions and to ensure that leaflets about abuse are available. Ignoring the topic only reinforces women's feelings of isolation and freakishness. Ring the local rape crisis information centre or Citizen's Advice Bureau for advice about leaflets and support groups or help-lines to which you could refer women (see Westcott, 1991).
3. Respect women's desire for confidentiality and their fears about 'telling'. Women may be reluctant to talk about their victimisation because of the stigma surrounding it or because they fear the consequences of revealing such a terrible secret (their abuser may have threatened them to ensure their silence, they may have been rejected by other people in whom they have confided or they may simply not wish to confront the truth of what has happened to them.) Do not push women to discuss this subject. Midwives can show a willingness to discuss experiences of sexual violence, but it must be up to the woman

whether she wishes to take advantage of this. Pregnancy and childbirth may stir up memories but is not necessarily the right time for a woman to confront her past (Breitenbucher, 1991).

4. Accept the woman's pain and distress. Do not try to minimise the impact of the abuse on her. Survivors are frequently subjected to hollow reassurance or told that they should have 'got over it' by now (because it was a 'long time ago' or because the abuse 'wasn't that bad').

5. Recognise that an act that is defined as medical treatment or 'health care' can still be a form of abuse. Respect a woman's subjective experience of such treatment and, if necessary, be prepared to help her to challenge abusive behaviour from other staff. It seems that some health care providers act as if abuse 'explains away' women's resistance to examinations of treatment. One midwife told me how she had heard a colleague challenge a 'difficult' woman by asking: 'What's the matter with you then? Have you been abused or something?' Experience of abuse does not mean that women's concerns are 'illegitimate' or distorted, nor should the accusation of having been abused be used against women in this way.

6. Some survivors of childhood sexual abuse seem to become classed as 'difficult patients' by their health care workers. It is important to deal with your own feelings of impatience or frustration and to respect any woman's resistance to trusting you or her insistence of trying to control every aspect of your interaction. It is vital to be open about the power dynamics that exist (within the hospital for example) and not to make false promises. Anything which the woman experiences as 'a betrayal of trust' may only reinforce her feelings of isolation and pain.

7. Think about your own reactions. You may find that you are left with feelings of distress, anger, grief, or memories of your own experiences of sexual violence. It is also very disturbing for the midwife when a woman experiences flashbacks during labour or examinations. You may find it helpful to talk through your feelings with another midwife.

8. Survivors of child sexual abuse may need extra reassurance about their ability to mother their children and may be particularly fearful for their babies' safety. It may be helpful to discuss the fact that survivors of sexual abuse are particularly aware of the dangers to young children and that this may make them more likely to take precautions and provide the information to their children which will help to protect them. Survivors of child sexual abuse may also need extra support to establish breast feeding and it is important to acknowledge the 'normality' of sensual responses to the baby.

9. Consider the language you use during ante natal classes or during labour. For example some women find that relaxation sessions or 'listening' to their body may lower their defences exposing them to horrific memories of abuse. As Penny Simkin points out: 'Using language and imagery emphasising "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' [Simkin, 1992]. If a woman is very aware of the effects of abuse then

ask her about the strategies she uses to cope with frightening recollections or how she deals with 'flashbacks' and dissociation. During labour it may be important to encourage her to 'stay in' her body, to maintain eye-contact and to remind her that she is safe. Think through each aspect of your practice from the point of view of a woman who has been sexually assaulted. For example, consider all the issues involved in an internal examination. Show your acceptance and understanding of her fears. Acknowledge that many women find the examination difficult. Explain how, why and for how long you will examine her. Knowing why you wish to examine her and what that involves directly contrast with the incomprehension and confusion she probably experienced as a child. Explicitly state that you will stop the moment she asks and discuss her preferred position for the examination. Make sure she has the opportunity to tell you what she found helpful or unhelpful about the way you examined her and to ask any questions e.g. about her own genitals. (Some women find it useful to be shown photographs demonstrating the variety of women's genitalia). Above all listen to the woman, she is the best source of information about what she would prefer and it is impossible to generalise about the best way of responding to every woman.

10. Obviously all the recommendations suggested above are influenced by the conditions of midwifery training and practice. Discussion of sexual violence should be built into midwifery courses and midwives need the working conditions and institutional support which enable them to learn about the issue and spend time with individual women. Above all midwives need the power to act as advocates for the women in their care and the freedom to provide the continuity of care which will enable them to build up trust and understanding.

Conclusion

Instead of seeing survivors of childhood sexual abuse as women with 'special needs' who can be identified and offered 'special treatment' it is perhaps better to consider sexual violence as a continuum that influences all women's experiences of their bodies. Most of us know how it feels to be sexually harassed, intimidated, pressurised into sex or physically humiliated. In North America, random population surveys have shown that between 12 and 38 per cent of adult women have suffered childhood sexual abuse, while British researchers have reported rates between 16 and 42 per cent. (Kelly, 1988; Kelly et al. 1991). One study of 535 young women who had become pregnant during adolescence found that 44 percent had been raped (Boyer & Fine, 1992). The variation between the statistics reflects variable factors, such as the definitions of 'child' and 'abuse' and the sensitivity of the research design, but the inescapable conclusion is that sexual violence in one form or another is an endemic part of women's experience. The threat or reality of rape affects us all. The women quoted in this chapter had endured childhood experiences which had long term effects on their sense of self and the quotations reflect the voices of those who had the strongest reactions to the events surrounding pregnancy and childbirth. Many of the women I interviewed experienced less dramatic reactions and most did not discuss the issue with their health carers. Thus it is important to realise that survivors of abuse can not be identified as a discrete group and that, to a greater or lesser extent, all women are affected by sexual violence. Instead of thinking of survivors as posing 'special problems' it then becomes more appropriate to think about the insights that they can bring to the maternity services. All the factors which are so often important to survivors of sexual violence -

communication, information, respect, choice and control - are important to all women. Survivors' reactions throw a spotlight on the impact of sexual violence on women's relationship with their bodies and highlight the power dynamics of the encounter between women and health care professionals. Their insights help us to explore the construction of childbirth within a world in which women are routinely subjected to a variety of abuses and within which the hospital institution and medical hierarchy can further disempower women. The challenge for midwives is to ensure that midwifery care helps to counteract rather than re-enact the violation of women's bodies.

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