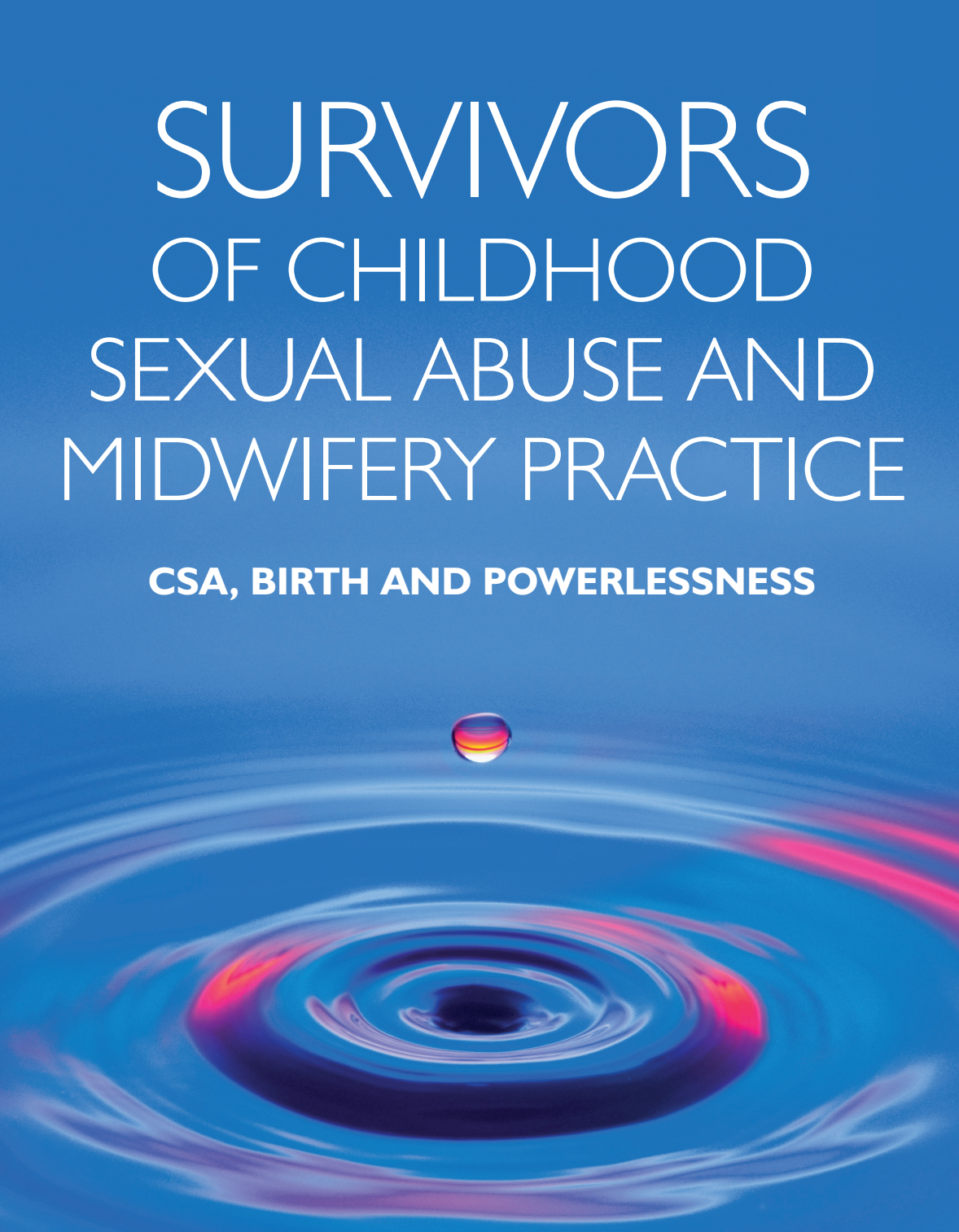
SURVIVORS OF CHILDHOOD SEXUAL ABUSE AND MIDWIFERY PRACTICE

CSA, BIRTH AND POWERLESSNESS



Lis Garratt

Foreword by Mavis Kirkham

Survivors of Childhood Sexual Abuse and Midwifery Practice

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CSA, BIRTH AND POWERLESSNESS

LIS GARRATT

RM BSc (Hons) PhD
Independent Midwife and Researcher

Foreword by

MAVIS KIRKHAM

Emeritus Professor of Midwifery,
Sheffield Hallam University

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Contents

This book is dedicated to the memory of Maggie Smith who died in 2001 but whose humanity, compassion and humour live on in the hearts of the many mothers, fathers and midwives she indelibly touched. It was through her passionate concern for vulnerable women and love for midwifery that this project was first conceived. I have been privileged to bring it to birth.

Foreword

The stories told here make me very sad as a midwife. Yet the way this research presents the stories and their insightful analysis offers great hope for midwifery.

All midwives will care for adult survivors of childhood sexual abuse, although women may not choose to tell their midwife of their abuse. We also all have colleagues who are survivors. The insights shared here can help us to develop relationships with these women which can help all concerned to feel that they are respected, cared for and safe. As the subtitle so rightly suggests, it's all about power. Reflection on this research can help us to learn to share power, rather than cling to the relatively little power we often feel we have as midwives. The significance of this book is therefore far wider than its immediate subject, for it offers us the opportunity to rethink our professional coping strategies. If we seek to make all our professional relationships ones of equality and opportunities for growth, as would benefit someone who has suffered abuse, then we can all grow and flourish.

This book is important because it brings together the childbearing experiences of mothers and midwives who have survived childhood sexual abuse. These midwives' experiences of National Health Service (NHS) maternity care are also very telling. Again, power, or lack of it, is very much in evidence.

Beyond telling the stories of the women interviewed, Lis Garratt has given us a new conceptual tool for looking at ourselves as midwives. It was brave to draw the parallel between the dissociation practised during abuse as a way of separating oneself from trauma and the professional dissociation practised by midwives in situations where they and mothers experience powerlessness. The parallel fits my experience as a midwife and gives us an important concept with which to analyse our own practice and to plan change.

As well as being important for practice, this work is important for midwifery research as an example of good practice in researching a sensitive subject. The interviews were conducted with great sensitivity and power-sharing: attributes which are as important in qualitative research as they are in clinical practice. The emotional impact of such work can be hard, as it is in clinical practice, and

this was handled here with skill and sensitivity so as to improve the quality of the work

I have watched the often painful growth of this work for a long time. It was certainly worth the time, effort and great emotional labour that went into it.

Maggie Smith would be so proud of this book, which she conceived. Lis Garratt is to be congratulated upon its birth.

I strongly recommend this book to midwives in all areas of practice.

Professor Mavis Kirkham
Emeritus Professor of Midwifery, Sheffield Hallam University
July 2010

About the author

Lis Garratt first had a career in music, which she taught for 15 years as a woodwind peripatetic. Having retrained as a midwife she qualified in 1997 and spent approximately four years working in the National Health Service, first as a hospital midwife and then in the community. In 2001, on her 50th birthday, she gave up her job in the NHS and became independent. She has wide experience of supporting women who choose to birth at home. She is married with two daughters and two grandchildren.

Acknowledgements

I would like to thank Professor Mavis Kirkham for her support and supervision while I was researching and writing up my PhD thesis and for her encouragement in bringing this book to birth. Also I would like to say a special thank you to my husband Fred and daughter Emma for their patience and help during the writing of this book. My thanks go also to Scott for helping me with the technicalities of word processing and to Vron for proofreading the manuscript.

Finally, I would like to thank all the amazing women who contributed to this book. I hope their stories will prove to be a challenge and inspiration to all who work with childbearing women.

Introduction

This project was first conceived by Maggie Smith, who, as a student midwife, was working on the delivery suite of a large consultant unit. A woman was admitted and assigned to Maggie's care. Part of the admission routine included a vaginal examination (VE), but despite giving her consent to the procedure, each time Maggie tried to examine her, she closed her legs tightly and wriggled up the bed, repeating, 'You'll go through me . . . you'll go through me!' She was clearly very distressed. Maggie fetched her mentor who also tried to examine her. When she did not succeed, a number of other staff members tried to persuade the woman to comply. Their approaches, says Maggie in her account, ranged from 'kindly reassurance' to 'cajoling' and 'reproaching'.[1] Despite having given her consent, the woman was unable to allow the procedure to take place. Eventually, the midwife in charge of labour ward became impatient and told her that she would have to notify the medical staff. A male doctor duly arrived and made another attempt, but also failed. By this time the client was so distressed that the examination had to be abandoned. Later that day, the scenario was being discussed by a group of midwives in the staff coffee room. Maggie's suggestion that the woman's behaviour could have been indicative of a history of childhood sexual abuse (CSA) met with many different reactions. Some gave accounts of women they had cared for whom they suspected might also have such a history, while others appeared unaware that certain behaviours might be symptomatic of previous sexual abuse. One midwife appeared to find the whole idea distasteful and dismissed it by suggesting that the woman was just being awkward, probably because she was an 'NCT [National Childbirth Trust] type', and therefore likely to be uncooperative.

From this, and other experiences, Maggie came to the conclusion that most midwives and other maternity carers rarely, if ever, considered the possibility that they would come into contact with women who had closely guarded secrets that could have an immense impact on their perception of pregnancy and birth. Women who find VEs or intimate procedures difficult are often perceived as being awkward and many times I have been witness to the 'coffee room post-mortem', in which they are dismissed with comments like 'Well, if

that's how she behaves for VEs [vaginal examinations], I don't know how she got pregnant!'

Maggie decided that she would like to study the subject in greater depth with a view to examining how childbirth affects women with a history of sexual abuse in order to identify ways in which midwifery practice could be improved to meet their needs. In order to do this, she undertook a case study of a woman who was a survivor of incest and the mother of two children. The report of her findings formed her BSc in Midwifery dissertation, a précis of which was eventually published in *The Practising Midwife*.[1–3] Later, having qualified as a midwife in 1997, she decided to take her interest in the subject further and enrol at The University of Sheffield for a masters degree with a view to converting to a PhD. She envisaged a small-scale qualitative study involving in-depth interviews with survivors of CSA who had given birth. Her method of recruitment was to contact survivors' support groups throughout England with a letter giving details of the research, requesting that women who wanted to be involved should contact her. She also forged links with a consultant clinical psychologist with a particular interest in the area of sexual abuse, who could provide her with advice and guidance.

However, having interviewed only two women, she was diagnosed with cancer. It was then that she invited me to join her in the project, as her prognosis was uncertain and her health steadily deteriorating. Maggie and I had trained together as student midwives and shared the same philosophies on birth, and in many ways life in general. We did our first (and last) interview together at Maggie's home, as she was too ill to travel, and the respondent just happened to be visiting the area. After this, I undertook the interviews alone, as most entailed travelling significant distances, reporting back to her and discussing the emerging themes on my return. Maggie died in February 2001, five months after the initial interview.

AIMS OF THE STUDY

The project was set up in order to identify and examine the experiences of survivors who had used the maternity services, in order to gain a more thorough understanding of the problems they encounter during pregnancy, birth and beyond. As Maggie discovered, knowledge concerning the difficulties that these women face is scarce, and there is a dearth of relevant research, particularly from a feminist standpoint. Pregnant women regularly speak of their bodies becoming 'public property', having their bellies patted or their size and shape commented upon by relative strangers.[4,5] In addition, during the course of pregnancy, they are subjected to many 'routine' medical procedures such as VEs, abdominal palpation, foetal heart monitoring and many others. This may be particularly difficult for survivors of CSA who have suffered the loss of ownership over their bodies as small children and may perceive this as further loss of control.

MAGGIE'S MOTIVATION

In order to describe the motivation and the ideology which underpinned the project, I feel it is necessary to understand Maggie's approach to midwifery. She described herself as a 'born midwife' but trained later in life, having raised her family first. Apart from the family, midwifery was her '*raison d'être*'. She was always truly 'with woman', regardless of background or status, but was particularly committed to improving the lot of marginalised or disadvantaged women. She was the type of midwife who had the ability to make everyone she cared for feel special, and would always strive to honour women's wishes. It was this 'woman-centredness' that sometimes brought her into conflict with the prevailing medical ethos.[6] However, she was undeterred; the women's needs were paramount. My own clinical practice has been profoundly influenced by her example and I have often asked myself 'How would Maggie handle this situation?' when confronted by a problem in practice. I have consequently endeavoured to continue the project in the spirit in which it was conceived and in a way of which, I think, she would have approved.

TAKING THE BATON: MY INFLUENCE

Clearly, I will have brought my own ideas and influences to bear on the research, so it would be helpful to explain something of my background. Moreover, who I am as a person, a woman and a midwife has had a profound influence on how I went about the project. Like Maggie, I came to midwifery later on in life, having first had a career as a peripatetic music teacher and a life dedicated to making music. Being a musician is something that forms part of my identity and has played a huge role in my life. Music is both highly structured and, at the same time, interpretative. Although normally written with detailed instructions concerning tempo, dynamics and style, it also requires intuition and sensitivity on the part of the individual player. It is both humanistic, in that it has the ability to portray the depths of human emotion, yet also spiritual, having the potential to take us beyond ourselves.

In my position as a teacher I had a good deal of autonomy and was generally left to make my own decisions, plan my teaching, enter pupils for examinations and festivals as I thought appropriate. I was trusted to perform the task for which I was employed and was treated very much as a responsible adult. Despite feeling very unconfident initially, with affirmation from colleagues and encouragement from increasingly good examination results, my confidence grew. I know that the positive feedback given to me by others was crucial in the development of my competence and confidence.

ANOTHER CULTURE, ANOTHER WORLD: HOW ARE THE MIGHTY FALLEN!

My initiation into clinical midwifery came as a total culture shock. I now realise that my expectations of midwifery were hopelessly naïve. I had envisaged kindly midwives and doctors working together with women to enable them to birth their babies in an atmosphere of warmth and encouragement. In the academic environment of the university, as new students, we were taught that pregnancy was a normal, healthy life event, that midwives were 'practitioners in their own right' and of the great benefits to be gained from supportive, woman-centred care. The reality, I found, was deeply shocking. That I am not alone in this is reflected in the comments of many others including Davies[7] who describes newly qualified student midwives being 'terrified of practising midwifery', especially on labour ward. Because 'normality' is the foundation of the midwife's identity, their exposure to this environment caused many to experience an identity crisis. However, I should point out that what these students (and I) feared was not practising true midwifery but obstetric nursing, a job for which they felt unqualified. The situation could be compared to being expected to drive a car, with an extremely demanding back-seat driver, having been only taught the art of equestrianism!

Although a good number of the births I witnessed in hospital were fairly non-interventionist, on looking back, my definition of normality has changed dramatically since becoming independent. When I was working in the NHS, interventions such as the use of syntometrine and controlled cord traction to deliver the placenta, and the routine administration of vitamin K to infants were invisible to me. I had no other experience or expectations. However, it was the 'deliveries' in which women were pulled down the bed by doctors using excessive force with forceps; in which blood was spattered up the walls and the delivery room resembled a slaughterhouse rather than a place of birth; in which women were subjected to repeated VEs by numerous different people, which made me reluctant to work on labour ward, and to ask myself if this was really what giving birth should be about. Sadly, these experiences are not isolated incidents, as witnessed by some of my interviewees' accounts and also by other literature.[8–10]

HEGEMONY AND HIERARCHY

Not only was there a huge discrepancy between reality and the theoretical definitions of 'normality', but I found that my knowledge, my previous life and professional experience counted for nothing in this environment. Bosanquet,[11] who was a student midwife at the time, wrote a very powerful article about her initiation into midwifery, having had a previous profession. Her experience so accurately mirrors mine that her words might be my own. She describes how she went from being a confident professional woman to a blushing student in the hospital environment. Once she put on her student uniform, she became a novice at the bottom of the hierarchy, referred to as 'this girl' and 'told off' by

junior doctors half her age. She speaks of being publicly humiliated by seniors and keeping silent despite witnessing poor standards of care.

I found, like Bosanquet, that I too shared the women's position at the bottom of the hierarchy; we were invisible and powerless. The musical concepts of interpretation, intuition and creativity had no place in this environment dominated by technology, rigid policy and rationality. Kirkham[12] describes the culture within the NHS as being 'separating, controlling, competitive, masterful and hierarchy-orientated' reflecting its solid basis in the masculine worldview. Within this culture, not only are female values such as caring and nurturing undervalued but also attributes such as intuition or interpretation are positively discouraged.

When I first began the research I initially thought that I would be identifying a list of 'do's' and 'don'ts' to help inform midwives and carers dealing with women they knew to be survivors of sexual abuse. However, the expected accounts, of how the physical sensations of giving birth mimicked those of sexual abuse and the words of caregivers mirrored those of abusers, largely failed to materialise. As time went on, it gradually dawned on me that, for these particular women, much of the problem lay with the way in which maternity care is delivered, rather than with the purely physical attributes of giving birth. It appeared that what the women struggled to cope with was the dehumanising 'production-line' ethos of the large consultant unit. I therefore found myself increasingly questioning much of what is considered to be routine maternity care. In the majority of cases, the women appeared to have had realistic expectations of the birth process and, for some, it was only after experiencing a traumatic first birth in hospital that the idea of giving birth became problematic. Of the 40 births represented in the data, 29 were hospital births. Of these, 17 women perceived some aspect of their maternity care to have been either traumatic or deeply distressing. Eleven births occurred at home, five of which were planned as a direct result of a negative first birth experience in hospital.

From the women's stories of traumatic birth, three common factors clearly emerged: powerlessness, betrayal and humiliation. All three were linked with 'routine' care in the hospital environment. Powerlessness was associated, to a large extent, with the technocratic model of birth[13] with its technology, routines and rituals, as well as the constraints placed upon them by the organisation, which deprived them of social support. Betrayal resulted when the women's expectations of caring and empathy from their attendants were met with coldness and a lack of concern. Humiliation arose from carers' lack of respect for the women's dignity and privacy and, I would suggest, resulted from a combination of maternity workers' single-minded focus on the needs of the organisation rather than those of the women, coupled with unsympathetic attitudes.

This study was designed with the aim of (as much as is possible) entering into the world of pregnant and birthing survivors in order to gain an in-depth understanding of their perceptions of pregnancy and maternity care. My use of actual names as pseudonyms (rather than referring to them as 'Woman 2' or

'Mrs X') was a conscious decision and an attempt to personalise their stories and portray these women as the real people that they are.

I hope that bringing to light these women's stories will help to inform professionals working within the maternity services, in order that they may be confident that the care they provide is appropriate for the needs of all women, including survivors.

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CHAPTER 1

What is childhood sexual abuse?

Before embarking on a book examining the impact of childhood sexual abuse on birth it would be useful to discuss various definitions of it and look at the frequency with which it occurs. It is only relatively recently that CSA has been recognised as a widespread problem affecting many individuals regardless of race, social class or culture. Obviously, it is not a new phenomenon, and in the late 19th century Sigmund Freud published a paper in which he linked 'hysteria' with early childhood sexual experiences. This arose out of his clinical practice and observations of his female patients. However, only one year later he reinterpreted his findings, stating that these reported scenarios of seduction were merely sexual fantasies, which had never actually taken place. Tragically, because the work of Freud was so widely respected, the existence of CSA was consequently dismissed for a large part of the 20th century.

During the latter half of the century, however, with the rise of the feminist movement, society's changing attitudes towards women and new understanding about the impact of trauma on individuals, Freud's assertions began to be challenged. At last, CSA was acknowledged as a reality and sexual trauma was finally recognised as having long-term psychological consequences comparable to those caused by other horrific events. There are some variations in the definitions of what constitutes CSA, but it is generally agreed that it is any kind of sexual activity which takes place between a child, who is not in a position to resist, consent to or understand the significance of the act, and a sexually more mature individual. A 'child' is usually defined as someone under the age of 18,[1,2] although an 'abuser' is also understood to be someone who is in a position of power over the child by dint of maturity or role, and is fully aware of what is taking place. Thus, an older 'child' could be described as an abuser if his/her victim is significantly younger and less sexually aware. It does not necessarily have to involve sexual intercourse or physical force, but the child may be tricked or manipulated into compliance.[3] CSA also encompasses activities such as voyeurism, forcing the child to watch pornography or sexual acts, exposure of genitals and verbal abuse such as erotic talk or accusations of sexualised behaviours.[4]

Sexual abuse of children can be perpetrated by a family member, a blood

relative or someone the child believes to be a relative, or by someone outside the family who is often in a position of trust or authority, such as a family friend, a member of the clergy or a teacher.[5] Sexual abuse by strangers is less common.[6–8]

What is clear from the literature is that sexual abuse is largely concerned with the misuse of power and the betrayal of trust and does not necessarily have to involve physical force in order to have a damaging effect. A child's essential dependence is the basis upon which an abuser is able to coerce and maintain power over his victim. Cooperation may be gained through manipulation using promises, threats, gifts or 'special' treatment.[4,9] The victim may not understand the significance of what s/he is experiencing, but may feel uncomfortable, frightened or confused about it. Children will often be reluctant to disclose, particularly if their abusers are people whom they look to for care and protection,[10,11] and sadly disclosure may be met with disbelief and dismissal.[9,10,12] Summit[13] suggests a paradigm to describe the process in which abused children may become trapped which he refers to as 'The child abuse accommodation syndrome'. He argues that an abused child's normal coping behaviour may contradict the entrenched beliefs and expectations typically held by adults, laying him/her open to accusations of lying, manipulation and fantasising by the very people who are, theoretically, in a position to help. As a consequence, s/he descends even deeper into self-blame, self-hatred and re-victimisation. Furthermore, some children who do disclose may feel unable to cope with the resultant furore and consequently may recant or minimise what has happened. Some remain silent because of threats (such as physical punishment or removal from the family) made by their abuser.[9–11,14] It is known that many cope by suppressing their memories of abuse (*see* Chapter 8), thus being enabled to continue with everyday life as if nothing were amiss.[10,15,16] As a result, children may become trapped helplessly in abusive situations not only by their abusers but also by the expectations and beliefs of a society, which, until relatively recently, has tended to look upon child sexual abuse as a rarity.

PREVALENCE

It is impossible to arrive at a definitive answer as to the incidence of CSA because this largely depends on how it is defined. If abuse consisted merely of physical contact then it would be relatively easy to define. As we have seen earlier, there are non-physical forms of sexual contact that are widely accepted as abusive; however, there are others which lie on the periphery and are therefore open to question and interpretation. To some extent, the idea of what constitutes CSA is socially and culturally constructed.[17] Conflicting opinions about exactly how to define CSA results in a wide range of prevalence being quoted. For example, drawing on current research evidence, Community Health Sheffield[18] cites a range of 12–51% of females reporting CSA, while the American College of Obstetrics and Gynecology (ACOG)[3] puts the figure at approximately 20%. Other authorities suggest numbers may be as high as 54%,[6] but studies undertaken in Sweden[8] and

Germany[2] found incidences of 8.1% and 15.9% respectively. It is highly likely, however, that for multiple reasons, CSA is under-reported.[5,19–21] Not only are survivors kept silent by their own sense of shame, but, as I previously pointed out, some fail to speak out because of threats made by perpetrators against them or their family.[10] In addition, some individuals are affected by long-term amnesia resulting from the trauma of their early experiences.[15,22] It is possible, then, that up to half of the women passing through the maternity services may have experienced some form of CSA. Given the probable scale of the problem, it is inevitable that midwives, obstetricians and other maternity workers will come into contact with a significant number of survivors during their careers.[23] It is, therefore, disturbing that so little apparent emphasis is placed upon raising professional awareness of the implications of caring for these women.

THE POTENTIAL SEQUELAE OF CSA

Research shows that CSA results in a multitude of adverse short- and long-term effects in those who have been subjected to it. There is no single syndrome or cluster of symptoms that are universally present in survivors, but this kind of abuse has the potential to have an impact on every area of an individual's life. The work of Finkelhor and Browne[24] has contributed significantly to our understanding of the effects of CSA. Their 'traumagenic model' suggests a conceptual framework of how and why CSA might have a damaging effect not only on a person's self-perception but also on how s/he views others and the world in general. Clearly, the impact of sexual abuse will differ from person to person and not everyone appears to experience long-term psychological problems.[10,25] However, this model is particularly relevant to the data generated by my research and provides a useful insight into the problematic behaviours and psychosocial difficulties experienced by these women. It is defined by four categories: betrayal, stigmatisation, powerlessness and traumatic sexualisation.

Betrayal

Sexual abuse is characterised by a betrayal of trust particularly if it is perpetrated by someone whom the child loves and depends upon, such as a parent or guardian. Consequently, most survivors will experience difficulties with trusting others, particularly someone who is perceived as being in a position of authority.[12,26–28]

Stigmatisation

The entire issue of CSA is surrounded by a sense of shame. Many survivors are led to believe by their abusers that they are somehow to blame for what has happened to them,[3,9,13,29,30] and are consequently burdened with guilt. This not only ensures their silence but can lead to feelings of stigmatisation, alienation and social isolation.

Powerlessness

CSA is, by definition, the exploitation of a weaker, dependent person, who is not in a position to resist, by a more powerful person. The child's natural vulnerability is exploited for the gratification of the abuser, resulting in feelings of powerlessness and helplessness in the victim.[4,29] These feelings are exacerbated by whatever means the perpetrator imposes as part of the abuse process, i.e. coercion, threats, manipulation. The child's perceived (and actual) powerlessness is then reinforced when his/her attempts to halt the abuse are frustrated.[13]

Traumatic sexualisation

Victims of CSA are coerced or forced into premature sexual awareness and activity, which is inappropriate for their stage of physical and psychological development. This can result in a host of sexually related problems later in life. The most common of these, according to the ACOG, are issues such as fear of intimate relationships, dysfunctions of desire and arousal, flashbacks to abuse during sexual activity and feelings of repulsion.[3] Other problems include high-risk behaviours such as dangerous sexual practices, promiscuity and prostitution.[5,11,19,31–34]

THE FAR-REACHING IMPACT OF CSA

As CSA occurs at a time when a person's psychological, social and emotional development is at an early stage, a survivor often grows up with an image of her/himself and the world which is profoundly influenced by those experiences.[24,35,36] Research has shown that adults who were sexually abused as children are also more likely to suffer from a whole host of interrelated emotional difficulties including depression, anxiety and excessive anger.[1,3,37] Among survivors of CSA there is also a higher incidence of mental illness, psychological and behavioural problems, such as post-traumatic stress disorder (PTSD), dissociation, eating disorders, self-harm, addictions, substance misuse, low self-esteem and phobias.[1,5,17,20,38,39] In addition to the huge influence on emotional and psychological functions, sexual abuse may also lead to somatisation, the development of physical conditions in association with psychological trauma. There is evidence that women who have been subjected to sexual abuse in childhood are much more likely to experience chronic physical conditions than those who have not. These include genitourinary disorders, pelvic pain, gastrointestinal disorders, respiratory problems, frequent headaches, chronic fatigue, back pain, musculoskeletal pain, morbid obesity, insomnia and many others.[3,22,27,39,40–42]

ISSUES SURVIVORS BRING WITH THEM TO PREGNANCY

All women entering the experience of childbearing carry with them the impact of past events that have shaped their opinions, worldview and self-image. These factors will have a profound impact on their expectations, their subsequent perceptions of childbearing and adaptation to motherhood. However, women

who have been affected by CSA will be approaching pregnancy with numerous antecedent factors which leave them with a predisposition for re-traumatisation.[43] Most will have experienced feeling powerless at the time of their abuse, and for many this will have been exacerbated by being 'trapped' in abusive relationships they were helpless to put a stop to. They may perceive themselves as having been betrayed not only by their abuser (often in the role of nurturer or carer), but also by others who failed to protect them.[35,44] A significant number will have experienced psychosexual problems and many will have conflicting emotions around pregnancy. Some may have experienced chronic mental health problems or engaged in various 'destructive' behaviours such as alcohol and drug misuse, eating disorders and self-harm. CSA is also known to be causally linked to PTSD and many survivors will have experienced at least some of the symptoms.[3,36,45] Furthermore, a substantial number will have suffered long-term somatic disorders.

There is no doubt that CSA has a profound and long-term effect on the lives of survivors. It brings with it a vulnerability that can remain for a lifetime, having a significant impact not only on psychological but also on physical well-being. Although it is uncertain what percentage of women have experienced CSA, maternity carers will be faced with caring for survivors, although they may never disclose. Giving birth and all that it entails in our medicalised system has the potential to mimic many of the scenarios involved with sexual abuse, thus arousing memories and extreme emotions in those who have endured CSA.

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CHAPTER 2

How the research was conducted: the problems and dilemmas of dealing with such a topic

In the previous chapter we saw that CSA has a huge bearing on how women perceive themselves and others, leaving them predisposed to traumatisation. It is therefore reasonable to expect that interviewing women with such histories would be a delicate and difficult task, requiring great sensitivity and tact. From the beginning, I was aware that retelling their stories would be emotionally costly for them and potentially traumatic. As the project continued, I gradually came to realise exactly how costly it was, and developed a sense of the depth of responsibility it laid on me as a researcher. I could have been seen as just another abuser, someone in a position of power, taking their personal stories and using them for my own ends. I feel, therefore, that it is relevant to devote a chapter to discussing the dilemmas and difficulties I found in undertaking such a project.

LIFE STORIES OR LIFE SENTENCES

In a study of this nature, stories are especially significant as a woman's outlook and expectations are determined by her inner narrative (her own private interpretation of what has happened to her) and also by the telling of the story, which affects not only her but also her listeners and their opinion of her. Not only are the women's accounts of what happened to them as children brought to light, and the relevance of that to their childbirth experiences examined, but also the ongoing impact of both inevitably crops up. A network of stories from our life experience and earliest childhood, our understanding of the world, our self-image and ability to cope with life are determined by what has already happened to us.[1] The importance of infant–mother attachment has long been acknowledged as central to the psychological and emotional development of children.[2] It is during these early years that children develop an 'inner map of the world', which determines the way in which they see themselves, their

caregivers and the outside world.[3] This 'personal narrative' is being continually assembled, added to and interpreted in the light of past experiences. This has a profound impact on the subsequent socialisation, behaviour and psychological health of an individual. Van der Kolk[4] asserts that previous experiences of being comforted, feeling safe and soothed, provide people with what he describes as 'a reservoir of pleasurable and safe memories' (p. 79) so that they are able to evoke and apply those feelings when under threat or stressed, providing, at least, temporary respite. A child who has received adequate parenting and early care is thereby equipped to cope with future stressful life events. The 'reservoir' of a child whose early experiences are of abusive, neglectful, violent or excessively unreliable carers will be either empty or unpalatable, leaving him/her vulnerable to traumatisation in the face of overwhelming circumstances.

The consequences of telling their stories may be particularly costly for survivors of CSA, because individuals who have suffered overwhelming experiences such as this may go on to develop post-traumatic stress disorder if they are unable to transform and integrate acutely vivid memories associated with a trauma.[4] This was highlighted by the research of Lee *et al.*,[5] who undertook a longitudinal study on the psychological and physical health of 200 World War II veterans. Forty-five years after their initial interview, it was discovered that those who had not developed PTSD were those whose accounts had changed significantly, softening the impact of the horror. Those who had developed it had been unable to modify their memories, which remained unchanged throughout the intervening years. Traumatic memories are often retained as acute sensory experiences, which can be re-triggered when the individual is confronted by reminders of the original trauma. Unless, or until, traumatic memories become 'defused' by being processed or softened into an acceptable form, which then becomes assimilated into the individual's 'story', they continue to act as a threat, somewhat akin to emotional landmines. Several of the women interviewed described their personal minefields in which they could suddenly be hurled into reliving their abuse by some seemingly insignificant 'trigger'. Retelling their stories for me therefore represented a potential minefield to many of them.

A PARTNERSHIP OF EQUALS

I therefore chose to approach the research from a feminist standpoint. Feminist research is typically characterised by a non-hierarchical relationship between researcher and informant and a rejection of the positivist notion that those undertaking it should or are able to do so in an objective and disinterested manner. This is particularly pertinent in the context of interviewing survivors because an authoritarian, paternalistic or disinterested approach could be perceived to mirror that of their abusers. Oakley's example of the masculine 'textbook' model of interviewing drawing on the work of many of the hitherto 'authorities' makes for uncomfortable reading particularly when viewed in the light of the dynamics of CSA. She speaks of the 'manipulation of interviewees as objects of study/

sources of data', by achieving a balance between warmth to create a rapport, and the detachment necessary to see the individual as a object under scrutiny.[6] It is obvious that, this calculating approach would be totally inappropriate for survivors of sexual abuse, several of whom spoke of being manipulated to submit to their abusers through 'kindness' or 'love'. Furthermore, when interviewees are regarded merely as data-producing objects, there is a danger that when they do express honest opinions their evidence may be discounted if their comments cut across the beliefs of the researchers. For example, Dyson and Brown[7] recount that, in one project examining the opinions of mental health patients on their treatment, one of the interviewees had described her consultant psychiatrist as a 'paid poisoner'. This, and other ensuing comments, had been edited by the transcriber as 'rambles on endlessly with largely delusional content' (p. 166). Thus this woman had been effectively silenced, presumably in favour of those who gave the 'correct' responses. As these authors point out, researchers, despite believing themselves to be disinterested, can, and do, unconsciously bring their own bias into their findings.

UNDERSTANDING, NOT PROOF

The feminist standpoint, with its emphasis on reflexivity, parity between interviewer and interviewee, and acknowledgement of the place of the researcher within the research, not only provided a more honest approach to the project but, I believe, a more responsible one given the nature of CSA. I would compare it with the concept of 'connected knowing' described by Belenky *et al.*[8] which they describe as requiring intimacy and equality rather than distance and disparity. 'Its goal is understanding, not proof' they state (p. 183). It is this emphasis on understanding rather than proof which characterises feminist and postmodernist methodology and which formed the bedrock of this research. The spotlight, rather than focusing on the researcher and his/her ability to support a hypothesis, is trained on the respondents in an attempt to understand their lives and experiences. For this reason, I would argue, this approach is less exploitative and, consequently, more acceptable to women who have been disadvantaged and disempowered by abuse. Research dealing with childbirth and pregnancy among sexual abuse survivors has been done from a somewhat positivist stance,[9,10] both using control groups and questionnaires, but the findings appear somewhat two-dimensional and far removed from the reality of the lives of survivors. Looking at complexities such as women's lives and circumstances and eliciting opinions only from within the researcher's frame of reference may result in researchers getting 'round answers to their square questions'.[7] Although these studies provide evidence to suggest that survivors of sexual abuse do experience specific problems, they tell us nothing of how these women feel and what is important to them. The real women remain invisible.

THE ETHICS OF INTERVIEWING: POWER, EXPLOITATION AND ABUSE

There has been much debate around the exploitative potential of this type of research.[11,12] Finch[13] speaks at length about her concerns for the vulnerability of her female informants because of the easily established trust between herself and them. She puts this down to her identity as a woman and her 'trading' on that, describing herself coming away from interviews feeling that the respondents needed to know how to protect themselves from people like her. The possibility that I could have been perceived as yet another abuser was very much in the forefront of my mind, particularly in view of my not being a fellow survivor of sexual abuse. The scenario of a complete stranger coming into a woman's home, taking her intimate and painful story to use for her own ends, resounds with echoes of abuse. The thought that, ultimately, my research might make these women and their experiences known and subsequently improve maternity care for them helped me not only to avoid seeing myself as an abuser but provided me with the spur to continue with the project when the subject matter threatened to overwhelm me. Moreover, I felt huge admiration for and a sense of responsibility towards those who had generously entrusted me with such intimate details of their lives.

RECRUITMENT

Women were initially recruited by Maggie via Survivors' Support Groups, found in the Survivors' Directory.[15] This publication, which covers Great Britain and Ireland, is aimed at providing sexual abuse survivors with details of support groups which exist in their localities. These organisations were sent letters giving a small amount of information about the researcher, details of the background and aims of the research and asking that women who felt they would like to take part should contact her. Between 25 and 30 women responded and each was subsequently contacted by post informing her of what to expect. It was from this group of women that the first seven interviewees were taken. The first interview was undertaken jointly by Maggie and me but thereafter she was prevented from participating owing to her illness. Of these women, however, five were in their 50s and, although their stories were an incredibly rich source of data, I felt it essential to also interview women with more recent experience of birth and, therefore, the maternity services as they are at present. In addition, several of these interviewees had no memory of their abuse at the time when they had given birth, their recollections only returning in later life. I was interested to hear from women who had recall of their childhood experiences when giving birth in order to see how, or if, they viewed their births differently. With this end in mind, I surmised that midwives who were themselves survivors of CSA might have a unique insight into the way in which sexually abused women are affected by it. Furthermore, to my knowledge, research on midwives who were survivors of CSA had not been done before. I duly wrote to the correspondence sections of the *British Journal of Midwifery*, *Midwives* (journal of the Royal College

of Midwives) and the *Practising Midwife*, setting out the aims of the research and asking for volunteers. Ten women came forward, all of whom were midwives or student midwives, although not all were practising at that time. Two of them were interviewed via email for reasons of inaccessibility – one was Australian and the other lived in Canada. One other interview took place by email because this woman presented herself very late in the process, when all the other interviews had been completed and transcribed. As it happened, her short birth story yielded some very useful data, although, as with the other email interviews, it was lacking the depth and thickness of the personal interviews. Of the two remaining respondents, one was recruited as the result of 'snowballing' and the other, a non-midwife but with very recent childbirth experience, was referred to me by her health visitor who had been present at a study day on sexual abuse at which I had spoken.

THE INTERVIEWS

Location

The locations of the interviewees represented a wide area, ranging from the south to the north of England. Although findings of this type (and size) of research cannot be generalised, I felt that this diversity was helpful as women's comments about their contact with the maternity services were not limited to the kind of care offered in one particular geographical area. The interviewees were all given the choice of where their interviews should take place and the majority opted for their own homes. Interviewing people in their own environments appeared to me to provide a much fuller impression of their lives, relationships and ways of being, which helped to contextualise them and their stories. Home was often spoken of as the place in which they had control, and a relatively high percentage had experienced (or had wanted) home birth. The issue of the power disparity between researcher and researched has provoked much discussion[14,16–18] but in examining the lives of sexual abuse survivors it is compounded. These are women who are not only disadvantaged and powerless because of gender but, owing to their childhood experiences, avoid deliberately placing themselves in a position of powerlessness. One of the interviewees commented that giving birth at home had empowered her because her carers were obliged to ask her permission in order to meet their own bodily needs, whereas in the hospital, the position would be reversed. I extrapolated that this, and similar comments from other women, would also include researchers and concluded that from the point of view of minimising the power discrepancy between us,[19] home was the ideal place. In addition, although I only began to realise this as the phenomenon of dissociation emerged, the security and familiarity of the home environment seemed to offer some degree of protection to women whose traumatic experiences still had a considerable and unpredictable impact on their lives.

The importance of time

The issues of powerlessness and control formed the leitmotif of the entire study. The power of the researcher over the researched can, and often has, been used exploitatively, mirroring the relationship between abuser and abused. I was acutely aware of trying to avoid what Scott refers to succinctly as the 'smash and grab' of data collection.[20] This seemed uncomfortably reminiscent of Amanda's (one of the respondents) description of sexual encounters she had experienced during her teenage years: '. . . it was literally a case of "wham bam thank you ma'am". It was very much like that, and then like "You can piss off now, I've had what I want!"' With this in mind, I approached each interview with the thought that there were no set time limits and, if necessary, I could spend the whole day with one woman. I also ensured that they had my contact numbers with an invitation to telephone me if they felt they would like to discuss things further or had any concerns following the interview. Furthermore, aware of the potential to cause psychological distress, Maggie had made links with a consultant psychologist to advise us on the problems we might encounter, to provide ongoing guidance and to whom we could refer women if necessary.

Most of the interviews were completed in two hours; the longest being three hours and the shortest around 90 minutes. However, the time I spent on each meeting was much longer, often taking an entire morning or afternoon. In the vast majority of cases the first part of the meeting took place over a cup of tea while we chatted informally. This had the advantage of establishing a dialogue and a rapport before turning on the tape recorder. The meeting often concluded in the same way; I felt it essential that there should be time after the official interview in which the woman could 'wind down'. I initially had thought that it might take a good deal of time for the women to feel comfortable enough with me to be able to talk openly of their abuse. In the event, this was not usually a problem.

The importance of giving the women apparently unlimited time was soon demonstrated by the data. Some of their birth stories were shot through with instances of 'professionals' who did not have time for them, of feeling pressurised to perform or of being processed by a system whose focus was on efficiency and speed. Offering these women time and my undivided attention was the least I could do.

Avoiding the clinical 'gaze'

In a similar vein, I determined that the interviews should be as unstructured as possible. This was particularly so in the earlier interviews, because I was taking a grounded theory approach and, consequently, deliberately came to the subject with little foreknowledge. I aimed for a largely self-structured format[11] associated with research using storytelling. Later, as the themes began to take shape, I realised that it was important to avoid becoming too 'directional' because being overly focused on their experiences of abuse could be seen as reminiscent of their accounts of the medical 'gaze' which fixed exclusively on their reproductive systems or genitalia, denying their humanity.

Soft focus

As the interviews progressed, I began to include questions which I hoped would elicit information around the emerging themes. For example, early on in the research I had little knowledge of dissociation and its various manifestations in the lives of survivors of sexual abuse. My first reaction on interviewing a woman who said she had had no memory of her abuse at the time when she gave birth was surprise tinged with disappointment. One of the main aims of the research was to explore the experiences of sexually abused women around giving birth. I had expected to hear accounts in which the physical sensations of labour and birth echoed those of abuse. If the women had been unaware of their history at the time, would their experiences differ significantly from those of any other woman?

As further interviews were completed, it became clear that dissociation was becoming a major theme. Therefore, if a woman did not mention it during the course of her interview I would ask her directly if she had ever dissociated. Many women were aware of the term 'dissociation' and understood what was meant by it, but others used phrases such as 'blanking out' or 'leaving my body'.

HOW THE INTERVIEWEES RESPONDED

Telling stories

All the respondents appeared to be keen to talk about their experiences and did so in various ways. One woman in particular told her story almost in one continuous narrative, hardly pausing to take a breath. It was clear that her abusive memories had ossified into a narrative and that she had given this account many times before. Telling her story in this way distanced her from the original emotional content and protected her from further psychological damage. Another woman read extensively from diary accounts concerning the birth of her first child and her subsequent decline into psychiatric illness. This may have been a similar strategy, designed to protect her from the strong emotions associated with her experiences. This particular woman was much younger, however, had recent birth experience and was in the early stages of her second pregnancy. Many of her abusive memories had emerged following the birth of her son. Her emotions were generally nearer the surface and much in evidence during the interview. I felt that she found it necessary to keep our encounter tightly under control, unlike most of the other interviewees, who appeared to be more reciprocal and relaxed. At first I tried to gently steer the conversation in order to elicit certain information but she firmly resisted my attempts, taking the story in her direction, with frequent references to her diary. I quickly realised that I had to abandon any agenda I may have had, as the only information she was going to allow me to take away was that which she had predetermined. It is possible that she considered the account of the woman in the diary to be that of a separate entity, a person who had set down her story and as long as it remained in that form she was immune from its power to traumatise. It may have been the only way she

could 'allow' me to have the information, through this 'other woman'. It is also interesting to note that this respondent was the only one of the interviewees who admitted to having had, at one time, an 'alter ego' (*see* Chapter 8).

Blanking out

Two of the interviewees described themselves as 'blanking out' (referring to dissociation) during their interviews. During the telling of their stories they became increasingly hesitant and were clearly finding difficulty articulating. Both these women had described how large a part dissociation had played in their lives, and that when they felt emotionally overwhelmed or threatened their automatic reaction was to dissociate. When this occurred during their interviews, the tape recorder was turned off and we engaged in 'everyday' conversation and activities such as tea-making to encourage them back into 'reality'. These experiences I found disturbing from the point of view of the immense responsibility it placed upon me as a researcher. Furthermore, these two respondents were both in their 50s and this served as a potent reminder of the long-term impact of CSA.

THE IMPACT OF THE RESEARCH ON ME

What I was not prepared for, however, was the impact the research was to have upon me. Wise[21] and Scott,[20] who separately researched both ritual and non-ritual child abuse, both speak of the overwhelming emotional and physical effects this had on them. According to Wise it is not unusual for female academics working on physical and sexual violence against women and children to experience emotional and physical distress. For the first time in my life I experienced recurrent digestive problems and my mind was dominated by thoughts of sexual abuse. As I transcribed each interview, like Scott, it was as if I was reliving each encounter and account in slow motion. These women and their stories became my constant companions. I felt I had suddenly entered a parallel universe in which different social and physical laws operated and my previous existence now seemed to me somewhat superficial.

Etherington,[22] an experienced counsellor, refers to this phenomenon as 'vicarious traumatisation' which was first described by McCann and Pearlman.[23] She describes how, while undertaking a research study into the experiences of men who had been sexually abused in childhood, she was deeply affected by vivid dreams, intrusive thoughts and images. For three months she listened to men telling their graphic stories of violence, neglect and physical, sexual and emotional abuse. As a researcher she felt like a passive bystander. As a counsellor, she was unable to use her skills to help the individuals and, consequently, felt powerless. Despite being aware that she needed to talk about her experiences and receive support, she became socially isolated and withdrawn from family, friends and colleagues, and so 'bogged down' that she was unable to think for herself or seek out the help she needed. This state of mind she recognised as mirroring the symptoms of post-traumatic stress.

During the interviews I felt there was a huge onus on me not to react to anything that was said in a shocked or judgemental manner. Several of the interviewees described their distress when therapists or counsellors had appeared to react negatively to their disclosures, thereby reinforcing their already keen sense of shame and guilt. Some of the information imparted to me I found extremely shocking but I was also aware of the danger of my succumbing to 'compassion fatigue' which is said to occur when, having been exposed repeatedly to horrific images of suffering by the media, people cease to respond to its impact. The temptation to dissociate myself was great. How does one expose oneself on a regular basis to such an outpouring of pain and suffering, remain 'present' with the women and yet protect oneself from the potentially crippling emotional consequences?

USING GROUNDED THEORY

Clearly, the objectives of this project, i.e. to discover what the women in question felt about what happened to them, required a qualitative approach. As this is a subject that has received little previous research attention, I considered grounded theory, an approach that is designed to generate new data, to be appropriate.[24] Grounded theory does not start from a hypothesis and then search for corroborating evidence, it starts from a position of 'ignorance' and its theories grow out of the data on an ongoing basis.

In order to gain insight and understanding into the lives and experiences of my interviewees, I felt it was necessary to engage with them, not only at the time of interviewing, but on an ongoing basis, which meant maintaining the integrity of their stories. In addition, a project such as this, in which the issues of power relationships, dominant discourses and mutedness are examined, requires a deconstructive approach. To an extent, grounded theory methods would provide the means to listen to the women's voices, but in order to make true sense of what they were saying, I felt it was the mechanisms of oppression that had to be 'stripped down', questioned and evaluated, not the women. Grounded theory alone, I felt, would not provide me with the bigger picture in that it would be, to a degree, blind to pre-existing structures and taken-for-granted social beliefs. Furthermore, I wished to place myself within the data, honestly acknowledging my part and subjecting it to scrutiny; a dimension lacking in the traditional grounded theory approach. Therefore, I determined that grounded theory would provide me with an 'internal' framework; that is, it would act somewhat similar to the skeleton, which provides structure for the body and enables movement, but is also clothed with flesh having its own very individual characteristics. What I did not want was for the framework to be 'external', i.e. a prison, which would confine both the women and me. I was particularly conscious that grounded theory had arisen out of the quantitative paradigm and does contain elements which are both interpretative and 'positivist'.[25,26] I questioned what the marriage between this and postmodernist feminism would look like and whether the

match would bring forth fruit. I decided (to continue the analogy of the skeleton) that as long as postmodernist feminism acted as the 'will', or the 'spirit', which provides the impetus and motivation for the actions of the body (and thereby the skeleton), then the partnership would be successful.

As grounded theory provided the general structure for the research, I did not undertake a detailed review of the relevant literature before embarking on the interviews as I wanted to approach the subject without too many preconceived ideas.[24,27] Literature was reviewed as it became relevant to the emerging themes. Nevertheless, I felt it necessary to combine the use of grounded theory with an additional approach in order to examine the data from as many different perspectives and angles as possible. Acknowledging my own deep involvement with the women and my close identification with them required that I should take an approach in which I could honestly examine my own preconceptions and reactions to the women's stories in greater depth, as well as extracting the more subtle meanings from the accounts by systematically reading them with different intent. Using grounded theory alone, I felt, would be like peering closely at a work of art, focusing on the means of execution and its technical excellence while remaining oblivious to the whole composition, its meaning, its message, its relationship to other works and its context.

THE 'VOICE-CENTRED RELATIONAL APPROACH'

The voice-centred relational approach of doing psychological research arose from the work done by Gilligan, Brown and colleagues at the Harvard Graduate School of Education[28,29] and was further developed by Mauthner and Doucet.[17] This provided the means by which I could 'keep sight' of the women as whole individuals while gaining a more thorough appreciation of their lives, what was important to them, how they felt and what constituted their separate ways of being. It was this approach that provided me with the 'overview' or 'the bigger picture' but also allowed me to extract the riches from each stratum of data, which, coupled with some of the elements of grounded theory, made for a more cohesive 'whole'. It consists of several different readings of each transcript, looking first at the overall plot and subplots, along with a reading in which the researcher places herself in the text. This I felt to be particularly helpful as I was identifying my own position in the research at an early stage. My initial response to many of the accounts was one of anger: towards the perpetrators of abuse, but equally towards those who had caused the women to re-experience their abuse. The acknowledgement of my personal feelings, I believe, enabled me to more clearly recognise and distinguish the women's voices from my own.

The next reading examines the voice of the 'I', which focuses on how the respondent perceives, speaks about and presents herself. This was useful in identifying not only the impact of CSA on these particular women, but also how their experiences of birth had affected them. The third reading looks at the informant's interpersonal relationships in order to examine the woman's

social context. The purpose of the fourth reading is to place the woman within a broader context: political, structural and cultural. It was particularly relevant in examining their contact with the maternity services, from the perspective of both users and midwives. It brought into relief issues such as the impact of authoritative knowledge in discrediting both women and midwives, the discrepancies between women's concept of choice and that of the maternity services and the effect of the industrialisation of birth on women and midwives.

I feel that interviewing these respondents was analogous to providing midwifery care for labouring women. I attempted to enable them to 'birth' their stories in an atmosphere of equity and respect. I tried to ensure that their 'birthing' environment was one based on the principles of good maternity care – allowing time, treating them as individuals, listening, offering choice and being prepared to stop if requested. I approached the respondents as collaborators in the research rather than subjects to be observed, and was prepared to reveal myself if that was what the woman wanted. These women have now become a part of me. In retelling their stories I have tried to present them as accurately as possible and to treat their confidences responsibly and sensitively.

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CHAPTER 3

What we already know about the impact of CSA on childbearing

THE BODY IS THE BATTLEFIELD

In her preface to Simkin and Klaus's book *When Survivors Give Birth*, Blume describes the abused woman's body, and in particular its sexual parts, as 'the battlefield on which incest is played out'[1] (p. xxii). Like any other theatre of war, the resulting devastation of abuse lingers on long after hostilities cease, causing long-term suffering and hardship. The survivor of sexual abuse carries within her body, mind and emotions the consequences of the conflict and is unable to escape her personal war zone. Research in the area of post-traumatic stress disorder indicates that when an individual is confronted with reminders of their original trauma psychophysiological and neuroendocrine responses occur, indicating that they have been conditioned to respond as if they were re-experiencing the event.[2] In other words, the body continues to act as if it were being traumatised even though the original trauma may have occurred many years previously.[3] This phenomenon is evident in the birth story of Rose, who found herself, while giving birth, experiencing vivid flashbacks to her horrific abuse.[4] She described the memories of her abuse as being '*locked*' into her birthing muscles.

Survivors of sexual abuse may have difficult relationships with their bodies.[1,5] Simkin suggests that some women may experience confusion and anxiety over body 'boundaries' owing to repeated boundary violation suffered in childhood.[6] Some survivors are dissociated from their bodies or feel alienated from their sexual functions.[7] Hanan writes about her teenage lifestyle of heavy drinking and promiscuity, which came about as the result of her feelings of self-loathing.[8] The expression of her emotional and psychological pain was continually being replayed through her body: 'I was just letting myself be abused again and again'. Similarly, the survivor interviewed by Smith[9] became sexually active at the age of 12 and had had a number of sexual relationships by the time she was 15.

BARRIERS TO BECOMING PREGNANT

Many women who have experienced CSA approach pregnancy with pre-existing problems concerning their physical and sexual selves.[10] Although many non-survivors will have concerns and conflicting emotions about childbearing, even the issue of becoming pregnant may have profoundly disturbing implications for a woman who has suffered sexual abuse. During the time of their abuse, women may learn to view the idea of pregnancy with fear and dread and, in some cases, the pregnancy itself may be a result of abuse.[7,11,12] Lipp, herself an incest survivor, describes most of the women with whom she has contact through self-help and support groups as 'terrified of becoming mothers'.[13] Some find their changing body image problematic.[14] Seng *et al.* quote one woman who felt as if her body had been 'taken over by aliens'.[11] It is also well documented that momentous life events such as pregnancy and birth can act as 'triggers' causing submerged memories of abuse to surface.[4,15–21]

A study by Hofberg and Brockington reported that of 26 women suffering from tocophobia (fear of labour) five had been subject to CSA and three had been raped.[22] Two respondents actually underwent terminations of planned and wanted pregnancies because they were unable to face giving birth, although the authors do not specify whether or not these particular women were survivors. A high proportion of survivors will have experienced some kind of sexual dysfunction even if they are in stable, loving relationships, which may have made it difficult for them to conceive.

Encouragingly, many survivors welcome pregnancy, however, and enjoy the changes occurring in their bodies. One woman quoted by Simkin and Klaus felt relief on becoming pregnant because at last her body was 'doing something right', helping her to feel normal.[1] Heritage also writes that she so loved feeling her baby's movements and enjoyed the intimate 'middle of the night talks' with him that she wanted to remain pregnant forever.[23] Hanan found that she too loved pregnancy because, as she explained, this was the purpose of her body.[8]

SURVIVORS, CHILDBIRTH AND CONTROL

It appears that the need for 'control' is of primary importance to all women, whether they are survivors of sexual abuse or not. Parratt concluded from her research investigating the experience of childbirth for survivors of sexual abuse that the one need which appeared to underlie all others was that of control.[16] Certainly, a review of the relevant literature supports this assessment. Burian, in her study of seven CSA survivors' birth experiences, also identifies the subject of control as 'the single most important issue revealed in the interviews'.[17] It is impossible to isolate the various issues concerning pregnancy and birth for survivors into clear, discreet categories as many are interconnected and overlap, but the element of control is present in the majority. Rhodes and Hutchinson in their ethnographical field study identify four 'labour styles' displayed by survivors of sexual abuse: fighting, taking control, surrendering and retreating.[24] However, the

authors fail to make the important differentiation between women's response to obstetric or midwifery procedures during labour and the 'normal' physiological sensations of labour. I would suggest that that the women's labour styles arose mainly in response to what was, or might have been, done to them by caregivers; for example, one of the scenarios they describe is of a survivor who, despite being given reassurance, continues to resist carers' request that she relaxes her legs open.[24] Obviously, this is a response to being in a situation which resembles sexual abuse and not to labour itself. Gutteridge suggests that phrases such as these, intended to calm and soothe, appearing so innocuous to carers, may, in fact, provide 'cognitive cues' that will trigger flashbacks to abusive situations.[25]

Seng *et al*.[26] who examined 15 women's perceptions of maternity care practices for survivors of abuse-related post-traumatic stress, identify three categories of women: those who were far along in their recovery from trauma; those who were 'not safe' (i.e. those whose trauma was ongoing); and those who were not ready to know. Women in the first group, they assert, exhibited 'taking control' strategies first by seeking knowledgeable providers but also (like the women observed by Rhodes and Hutchinson[24]) by striving to maintain control over care issues that could constitute memory triggers such as: keeping males away from the delivery room; advising the midwife how to avoid painful scar tissue caused by a rape; trying to prevent people doing things to their bodies without their consent. Predictably, it was only the women who were well on the road to recovery in Seng *et al.*'s study who were able to manage their circumstances in order to achieve their ends. These were the women who were already empowered to some extent and therefore had the confidence to take the initiative. I would suggest that the other women, who had not yet achieved that degree of healing, were obliged to rely on intrinsic strategies to avoid loss of control, such as dissociation.

LOSS OF CONTROL OVER THE BODY

As I pointed out previously, women may feel that they have lost control over their bodies as a result of sexual abuse.[14,27,28] However, this perception may be heightened during pregnancy. It seems that society in general views itself as temporarily immune from the normal social taboos governing touch and the passing of personal remarks when encountering a pregnant woman. On becoming pregnant, women often report that their bodies become the object of interest to relative strangers who may comment about their size or shape and even feel no qualms about patting their bellies.[5,8,28] Hanan, despite 'loving' her pregnancy was prompted to ask why her body had now become 'public property'?[8] The perception of becoming public property may be strengthened further by the women's contact with the maternity services. Once they become involved with the maternity care system women have little or no control over the extent to which they and their pregnancies are scrutinised; they and their babies become the property of the 'system'. The choice is often between submitting to a degree

of scrutiny and surveillance they may never have previously encountered,[25] or opting out altogether and avoiding contact with the maternity services, which is the route taken by some survivors.[17,29–31]

THE SIGNIFICANCE OF TOUCH

Pregnancy and birth are 'loaded' with potential for women to experience loss of control and to have their abusive memories triggered. Clearly, there is the issue of 'routine' care, with its focus on the reproductive function of the woman and the very prominent role that invasive and intimate examinations play. Many women (both survivors and non-survivors) are extremely anxious as to how they will cope with this aspect of pregnancy.[7,32] Survivors who do commit themselves to the maternity care 'system' often discover that they are faced with a series of 'hurdles' which they must negotiate on their journey into motherhood. First, by virtue of becoming pregnant, a woman is submitting herself to a whole range of different 'touches'. As I pointed out previously, she may find herself the subject of unwanted attention from complete strangers, but during the course of her pregnancy and birth, she will also be touched by a host of professionals: midwives, doctors, phlebotomists, ultrasonographers and so on. Some survivors of sexual abuse may have already developed an aversion to being touched in any way, but the majority find invasive and intimate procedures problematic.[5,7,23] Heritage recalls crying unexpectedly at each antenatal visit. At the time she had no memory of her abuse and could not understand 'the sudden terror, the shame and confusion'.[23]

Maternity carers often do not recognise the significance of their actions; a vaginal examination is seen as a routine procedure and one which is particularly integral to obstetric and hospital midwifery practice. Caregivers often fail to recognise that such an 'everyday' occurrence could be perceived very differently by their clients.[33] Moreover, the VE and its conduct has been described as demonstrative of the power differential between caregiver and the woman.[34,35] Burian, a midwife, describes providing labour care for a woman who was displaying many of the behaviours indicative of a history of CSA.[17] She had worked hard to gain her trust and the woman had allowed her to perform a VE when she requested an epidural. However, a doctor, whom the woman had never met, came into the room and insisted on repeating the procedure. Burian explained to him that the only way this woman could tolerate an examination was with one finger and her hand guiding his. During the process, however, he suddenly grabbed her hand and completed the examination forcefully. She (Burian) immediately tried to comfort and reassure the woman, but it was futile. She had 'lost her' and the relationship that she had tried so hard to establish between them had been destroyed. It may be that here the doctor is using touch punitively, in order to assert his power over the women (client and midwife) who have tried to control his actions. Robinson, commenting on the issues of consent in the context of intimate examinations, writes that she had gradually realised that the problem

was not rooted in doctors' defective hearing or intellect but in their ego. Women who refuse them or try to control the intervention present a challenge that cannot be tolerated.[36] Touch does not necessarily have to be harsh or punitive, however, in order to trigger memories of abuse. Some healthcare workers believe that touch is admissible as long as it is 'kind'.[17] However, this fails to take account of the fact that some abusers are neither violent nor brutal but gain children's cooperation by exploiting their need to feel loved and special.[13,37] Consequently, many survivors will have been touched or fondled in a 'loving' and gentle way by their abusers. One woman quoted in Parratt's research stressed how unacceptable she found this kind of contact from maternity caregivers even though it was well intentioned.[16] She described midwives trying to make her feel better by rubbing her back during labour, as making her 'want to spew up'. Another, quoted by Heritage, commented succinctly that during labour she had been 'pestered by loving hands'.[20]

The way in which people touch in the clinical setting also reveals much about their perception of their relative status. It is not unusual to see a consultant patting a woman's leg or sitting on a bed next to her prone body resting his/her arm upon her leg while addressing her. At first glance this might appear to be a means of putting someone at ease or reassuring her until one tries to imagine the situation being reversed!

'IT FELT LIKE RAPE'

As I previously stated, many survivors find that labour and birth can trigger vivid memories or flashbacks to abusive situations.[4,9,16,38] The evidence points to multiple causes for this. In some cases, it may appear to be rooted in the physical sensations of the experience. Rose describes how the pain of pushing her baby out during the second stage of labour caused her to flashback to childhood memories in which her mother's relative had torn her 'wide open' from her clitoris to her urethra.[4]

The woman interviewed by Smith reflected that, despite the fact that she had what she felt was an 'easy birth', she was left feeling that she had been raped.[9] She attributed this to having 'relived' the sensation of penetration. For one of the women in Parratt's study it was the lack of control over her body that reminded her of rape.[16]

However, in many other instances, the perception of violation appears to be more complex and has its origin in many negative emotions related to the original traumatic events. Survivors may experience powerlessness, helplessness, depersonalisation, as well as physical pain, each of which is reminiscent of their abuse. Rose describes how a particularly rough and insensitive speculum examination by a midwife triggered traumatic memories of her childhood when the cold metal felt exactly like the gun that her cousin had used to rape her with when she was only 10 years old.[4]

Many accounts of traumatic experiences are peppered with metaphors of rape

and sexual violence – 'skewered', 'treated like a lump of meat' 'like a carcass to be dealt with'.[30,39] Robohm and Buttenheim's questionnaire-based study comparing the experiences of 44 survivors with 30 non-survivors undergoing gynaecological procedures found that almost half of the survivor group reported being 'overwhelmed' by emotions such as panic, terror, helplessness, grief, rage and fear.[31] Some reported crying uncontrollably and others said they felt violated, raped or tortured. Forty-three per cent recalled having had body memories triggered by the procedures. Of the 39 survivors interviewed by Kitzinger, over half reported being reminded of sexual assaults by internal examinations, cervical smears or even dental treatment.[40] One survivor described how being 'spread-eagled' on the bed, her arms tied down by intravenous lines, with someone 'fiddling around down there' triggered memories of being tied up and abused by her father.[24]

Smith's interviewee described a very similar scenario in her labour account in which being immobilised on the bed and being 'messed about with down there' reminded her of being unable to escape her abuser as a helpless child.[9]

In each of these cases, apparently, we can see that it is the panoply of medicalised birth that is problematic, not the labour itself. The delivery of care for birthing women in an environment that is highly routinised and task-focused may create a sense of depersonalisation and alienation. Kitzinger describes the birthing woman's body as 'fragmented', with all the attention focused on her genitals as if she herself does not exist.[40] The comparison with rape and abuse is inescapable.

PAIN IN LABOUR

The issue of how survivors cope with the physical sensations of labour is a complicated one and the majority of the literature suggests that there is no one single approach appropriate for all women. This places the onus on the relationship between the individual woman and her caregiver.[20,21,41,42] The perception of not losing control over their birth experience is of paramount importance but clearly, the definition of control varies from person to person. One woman may feel that an epidural is essential, while another may need an unmedicalised, active birth, depending on her locus of control, previous life experiences and expectations of the event. Some survivors find that the immobility produced by epidural anaesthesia causes them to feel they have lost control, such as the woman quoted by Kitzinger, who, for many of her childhood years, had been repeatedly raped by her stepfather. For her, the problem was not the pain but being 'trapped' with her legs splayed out and her carers 'doing things' to her.[37]

On the other hand, an epidural, if it is her choice, can be hugely helpful. Hobbins cites two contrasting cases in her paper: one, a woman who requested anaesthesia that would facilitate a 'painless' birth, and another who wanted labour and birth to be as natural as possible, including no pain medications. Both had successful outcomes and were happy with their experiences.[21] She advocates a feminist model of care that assumes that women do indeed know

what their needs are, as the most appropriate approach to providing care for survivors of sexual abuse.

Caregivers frequently have their own opinions on what form of pain relief women need, based on their own personal philosophies and experiences of birth. Without a doubt, the satisfaction these women reported was based on the fact that they had been enabled to make their own choices and had then been supported in them by their caregivers. This is in stark contrast to the belief in some medical quarters that maternal satisfaction is largely linked with receiving adequate pain relief.[45,37]

DISSOCIATION

The literature on survivors giving birth and traumatic birth is full of references to dissociation. Consequently, I have devoted an entire chapter to the subject (*see* Chapter 8). Anecdotal evidence shows that dissociation is viewed positively by some survivors as a means of escaping profoundly distressing circumstances and coping with intensely painful psychological or physical experiences which may be reminiscent of abuse. Many women considered the ability to dissociate to be protective and had developed this coping strategy during childhood.[9,11,16,17,24,44] The women's accounts of the mechanism of dissociation were very similar and often consisted of focusing on a particular spot and disappearing into it, or removing their mind or spirit from their bodies, some even reporting that they were able to view the scene from outside their bodies.[4,9,17,24] This response to labour may go unnoticed by carers who are likely to consider these women to be excellent 'patients', to be admired for their ability to endure labour silently without demanding too much of their time and attention.[7,24] One of the midwives interviewed by Rhodes and Hutchinson described this type of client as someone staff perceived as wonderful in labour, 'except they weren't there'.[24]

There is little research evidence on how dissociation affects the duration of labour. Parratt suggests that it may serve to shorten the process but adds that a woman in a state of dissociation may only perceive her labour to be shorter because she may not be aware of her bodily sensations until it is well advanced.[16] Benedict *et al.*[45] found no significant difference in the length of labour between survivors and non-survivors, while Tallman and Hering postulate that survivors of sexual abuse are more likely to experience 'stalled labour', which they attribute, partially, to dissociation.[46] On the other hand, Rhodes and Hutchinson suggest that survivors who display what they describe as the 'fighting' style of labour (as opposed to those who surrender or retreat – behaviours encompassing dissociation) are more likely to experience longer labours and, consequently, higher levels of intervention, instrumental or operative delivery.[24] A partial explanation for this may be that the body's response to stress, raising plasma levels of adrenaline and cortisol, interferes with uterine contractility.[47]

One of Parratt's respondents felt that her being dissociated during labour was responsible for her baby becoming distressed.[16] She described how, in an

attempt to escape the overwhelming pain of labour, she caused her body to 'shut down', which resulted in a prolonged deceleration in the foetal heart rate. On realising the negative impact this was having on her baby, she 'started to come round again', at which time the heart rate returned to normal. Rose describes how, during her second birth, the physical sensations she experienced during second stage caused her to have flashbacks to her abuse.[4] She recalls dissociating and viewing the scenario from outside her body, near the ceiling. Unlike some other accounts of dissociation in which the women felt it had given them some measure of control, Rose's account is of a woman out of control and unable to function effectively in the birth process. It was only by patient encouragement and reassurance from her midwives that she was enabled to be present for and involved in birthing her baby.

POSTNATAL ISSUES

Relationship with baby

It is known that a history of sexual abuse can interfere with the bonding process and have a profound effect on women's ability to relate to their offspring.[1,48] Some survivors of sexual abuse have an extreme response to the gender of their infant.[9,16,20,21,30] One woman may be anxious that she will be powerless to protect her daughter from sexual abuse, while another, feeling that all men are potential abusers, may find it difficult to accept that her baby is male. The interviewee in Smith's case study expressed relief that her children were boys because she could not bear to watch herself grow up again.[9]

One woman quoted by Kitzinger, on first realising that her child was female, exclaimed, 'Oh my God! It's a girl. I can't bear it if she has to go through what I've been through.'[7] On the other hand, one of Parratt's interviewees felt that she related better to her daughter because she did not feel the barrier that existed between herself and her sons.[16]

Some survivors find touching their infants problematic. For some women the reluctance to touch their babies appears to be linked with their personal aversion to touch. One woman interviewed by Parratt refused to touch her newborn baby until she had showered and was back on the postnatal ward because that was when she felt she had reached the 'mother stage'.[16] Others, having been subjected to inappropriate and unwanted touch during their own childhood, are unsure as to what constitutes abuse.[1,7] Lipp experienced this dilemma and described her feeling of unease on touching her baby's penis while changing his nappy: 'I am doing what I know a mother should. Then I think, "Is this all right?"'[13]

Breastfeeding

Research on the issue of breastfeeding and past sexual abuse is scarce but the evidence indicates that it can be problematic for some survivors, particularly if the abuse involved the breasts.[7,20,21,42,49,50,51] An interesting preliminary report on a study by Halliday-Sumner and Kozlick provides some useful information

on exactly what difficulties survivors of sexual abuse may experience when breastfeeding.[52] As the authors point out, the group of 42 women had a high incidence of operative and instrumental birth and nearly half developed serious postpartum depression, all of which could be expected to have an impact on breastfeeding. However, the most commonly cited perceptions of first breastfeeding experiences appeared to be predominantly associated with CSA. They were:

- fear that breastfeeding might constitute inappropriate sexual behaviour
- shame or embarrassment about body – 'felt dirty'
- stress due to the triggering of sexual abuse memories.

These perceptions are borne out by other literature.[7,20,50,51,53] Heritage describes a woman whose submerged memories of abuse were triggered for the first time by trying to breastfeed her baby.[20] One woman interviewed by Seng *et al.* found herself experiencing 'physical and affective memories' which were particularly distressing when breastfeeding.[11] Every time the child would latch on to the breast to feed, she would be hit with flashbacks, causing her to feel nauseous and uncomfortable.

One of the women described by Klingelhafer was averse to breastfeeding, perceiving it as abusive because her baby had no choice and was unable to give his consent.[53] Survivors' problems with breastfeeding, however, may be exacerbated by the inappropriate actions of caregivers.[53] Simkin and Klaus point out that women's first experience of breastfeeding in hospital usually consists of a maternity worker holding her breast and pushing the baby towards it in an attempt to induce him/her to latch on.[1] 'I have seen many a breast grappled with in the name of what is natural and best', observes Tilley, a midwife and survivor of sexual assault.[54]

Kitzinger also highlights the difficulty survivors have with the 'sensuality' of breastfeeding and their subsequent confusion over whether or not this constitutes abusive behaviour.[7] Furthermore Simkin and Klaus[1] and Hobbins[21] suggest that their baby's frequent feeding demands may cause survivors to feel 'abused' or manipulated and, consequently out of control.

THE IMPACT OF CAREGIVERS

The importance of women's relationship with their maternity caregivers has long been underestimated, but it is clear from the evidence that women's perception of the manner in which they are cared for is highly significant. Robinson, who, as research officer for the Association for Improvements in the Maternity Services (AIMS), was privy to the accounts of many women who had contacted the organisation after a traumatic birth, states that she had never come across a case involving extreme pain and anxiety 'that did not also have a strong element of staff involvement'.[55]

Arguably, the organisation charged with providing maternity care has repeatedly failed to acknowledge that childbearing women may require more than

clinical competence from carers and a healthy baby from their experience of birth. However, recent evidence suggests that women want genuine relationships with their midwives and that being supported by known and trusted carers helps them to perceive their birth experiences positively.[56–59] Conversely, when these needs are not met, women are more likely to have negative perceptions of birth and up to a third may emerge with some of the symptoms of PTSD.

Trust and betrayal

Arguably, one of the major traumagenic factors concerning contact with maternity care providers arises from women's expectations of care, which are partly informed by literature which creates the impression that they will enter into a collaborative relationship in which they will able to discuss their needs, participate in decision-making and make free choices. However, the reality is often very different. A woman will undoubtedly be offered choices (many of them concerned with the various screening tests available), but they will be to a great extent determined (and strictly limited) by the medical or institutional agenda. The choices she might wish to make and the decision-making she may want to be involved in may be considered not appropriate. She may also find that the collaborative partnership exists only while she makes the 'right' decisions. Consequently, she may experience feelings of betrayal, similar to those she felt as a child when her expectations of care and nurture were met with abuse.[7,14,15,21,29,44]

Birthing women need to feel safe enough to let go of conscious control in order to allow their bodies to give birth.[54,60,61] This depends to a large extent on whether or not they are able to trust their carers and on the quality of emotional care they provide. Relinquishing mind control entails putting one's complete trust in another, believing that they will act protectively and kindly. If women's trust in health professionals is shattered, they may subsequently avoid all contact with the health services.[17,31] An example of this was given by one of the survivors interviewed by Kitzinger.[7] She had avoided VEs during 16 years on the contraceptive pill and for the duration of a pregnancy because of a traumatic smear test she had experienced in her 20s. The way in which clinicians handled the procedure triggered memories and emotions associated with her abuse. She described being held down and 'shouted at' while a doctor tried to perform the procedure. She came away from the hospital feeling dirty and humiliated, vowing never to put herself in such a situation again.

Emotional warmth

It appears that for all women the importance of warmth, kindness and emotional 'availability' in their caregivers is central to their long-term perceptions of birth.[17,56–58,62] For survivors of sexual abuse, with their propensity for psychological trauma, the consequences of insensitive, non-relational care (often reminiscent of their abuser's attitude) can lead to traumatisation. One of Seng *et al.*'s interviewees described how the emotional coldness of her doctor aroused memories of her

abuser, which led her to change maternity carers in late pregnancy.[26] Similarly, one woman interviewed by Parratt found her childhood memories triggered by the cold and unkind attitude of a doctor who was suturing her perineum.[16]

In a milieu in which strangers may be involved in extremely intimate contact with a woman, in order to de-sexualise the event, interactions may be highly ritualised and approached from an objective point of view.[34] Caregivers may avoid making eye contact or focus solely on the woman's genitals which may cause survivors to feel depersonalised and objectified, replicating their childhood experiences.[7]

Being listened to

The importance of two-way communication and being 'heard' is well documented as important to all birthing women[63–65] but particularly so to those who have suffered abusive childhood experiences.[5,17,26] One of Burian's interviewees described her frustration with her gynaecologist whom she felt was not listening to her when she consulted her repeatedly because of chronic pelvic pain.[17] It appears that this woman felt reticent about disclosing her history of abuse but wanted her doctor to 'read between the lines' and enter into discussion as to the reasons for her physical discomfort. Similarly, another woman cited in her study described her willingness to disclose, given the opportunity. However, the opportunity never arose because her caregivers did not create a dialogue in which this would have been possible. Conversely, Rouf's personal account demonstrates how a midwife with excellent communication and listening skills can enable a survivor to have a positive birth experience.[5] She recalled her midwife being an 'ally' who cared about what happened to her as well as her baby, being sensitive to her needs, facilitating discussion about her concerns and listening to her feedback. As a result, when labour started, she felt well prepared, supported and consequently in control. As this illustrates, the issue of being 'heard' lies at the heart of good relationships and encourages woman to feel valued and empowered. Loss of control and powerlessness during the childbearing process are instrumental in traumatising any woman. The issues of being listened to and having the option of stopping any procedure are paramount in sparing women the far-reaching impact of traumatic birth.

Leading on from Chapter 1, we have seen, in more detail, the impact of CSA, childbearing and maternity care on individuals. Survivors may find difficulty physically or emotionally with the idea of conceiving, and once they are pregnant experience a loss of control over their bodies with the perception of becoming public property. This may be exacerbated by the expectation that they will be obliged to submit themselves to a variety of different 'touches' by healthcare professionals. Indeed, they may experience extreme feelings of violation when in situations in which they perceive themselves to have lost control. CSA can also have a profound impact on breastfeeding and on the mother–infant bonding process.

Survivors may experience dissociation, a phenomenon in which some describe leaving their bodies or even viewing the scene from elsewhere in the room. These women may be perceived as 'ideal patients' by their carers as they appear to cope very well with the physical sensations of labour. Some women see it as a coping strategy, which they had employed as children to protect themselves while their abuse was taking place, but to some it is an involuntary response to overwhelming feelings of helplessness or terror.

Labouring women need to feel safe and secure in order to allow their bodies to give birth successfully. This may be problematic for survivors whose ability to trust will have been shattered by abuse. It is important, therefore, that maternity workers are aware of this and endeavour to create an environment in which women feel protected and in which trust can be rebuilt.

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CHAPTER 4

A life sentence: the effect of CSA on the interviewees' daily lives

During the course of the project it became obvious to me just how relevant women's previous history was to their perceptions of pregnancy, birth and parenting. Much of this supported the findings of previous research on the impact of CSA and its long-term psychosocial effects.

Several of the interviewees reported that they had engaged in diverse forms of self-harm at some time during their lives. This included self-biting, cutting, headbutting, ironing arms and deliberately breaking limbs. Some women reported having made suicide attempts, which mostly consisted of overdosing. One woman described this as a cry for help, whereas another explained that it was an attempt to numb the severe emotional pain she was feeling. One interviewee had even tried to hang herself when the painful memories of abuse threatened to overwhelm her during a period in which she was receiving counselling. Four of the women described struggling with various eating disorders such as anorexia nervosa, bulimia and compulsive eating. These are all behaviours recognised as sequelae of past traumatic events and are commonly reported by survivors of CSA.[1–6] Several of the women had suffered from mental health problems such as severe, chronic depression and some of those whose abusive memories had previously been submerged reported having experienced psychological crises around the time that they surfaced. From their experience of working with survivors of CSA Simkin and Klaus[7] suggest that this is not uncommon. CSA has been strongly linked with depression in adult life[1,8–10] and the work of Buist and Barnett[12] and Buist[13] suggests that women who have experienced CSA are at higher risk of developing postnatal depression. Two of the women reported suffering from profound depression following the birth of their children, but both felt that this was partly a result of their traumatic birth experiences. Several interviewees suffered from chronic ill health such as genitourinary, gynaecological and bowel problems, all complaints which have been associated with CSA.[14–16] What struck me most forcefully from their accounts was, that for most of these women, CSA was not just a distant memory, an unpleasant

episode in the past, but something which had an ongoing impact on their daily lives:

> There isn't a day goes by when I don't think about it. And I do blame a lot of things on the things that happened when I was a child. There's a lot of, the ways I think about things, and I think, 'Well, if I hadn't been abused, I wouldn't be thinking this way.'
>
> Jo

> I don't think a lot of people realise the damage that abuse leaves you with, because it colours every aspect of your life.
>
> Wanda

TRAUMA AND MEMORY

Trauma of any kind is known to have a profound impact on memory[17] and this emerged as a major theme in the research. Not only did some women report having had amnesia surrounding traumatic events from childhood but also that life events could unexpectedly trigger memories to return or cause flashbacks to situations within their conscious memories, as if they were actually experiencing the trauma.

At this point it is useful to examine the role that this had in contributing to the general and wide-ranging sense of vulnerability in the interviewees. As I discussed in Chapter 2, people who suffer from post-traumatic stress disorder are unable to assimilate and integrate their memories, causing them to relive the trauma when faced with certain triggers and, subsequently, to behave in a manner out of all proportion to their current situation.[17] This is caused by a neurobiological response to the sensation, emotions or feelings that were present during their original traumatic experience. This in turn activates a motor response to threat which would have been appropriate to the original trauma but which fails to relieve the distressing emotions. This may serve to encourage and perpetuate a sense of powerlessness and helplessness. These 'foundations' have a permanent and lasting impact on abuse victims and will deeply affect the way in which they react to and perceive things throughout their lives.

It was clear that the women were all at different stages in the process of dealing with what had happened to them. Some had only fragmentary or limited sensory memories of what had occurred. For others, abusive memories were still surfacing in response to seemingly insignificant triggers. Many continued to experience dissociation in situations that were reminiscent of their abuse or in which they felt emotionally overwhelmed. Some, like the women in Seng *et al.*'s research[4] who were well on in their healing, were able to take the initiative and manage circumstances better in order to ensure that their needs were met.

AMNESIA AND THE RECOVERY OF 'LOST' MEMORIES

Several of the interviewees reported having had long-term amnesia concerning the events of their childhood, with memories only surfacing in adult life, some as late as middle age. Amnesia or 'delayed recall' is a phenomenon which is well supported by research in the area of CSA.[18–22] It has also been suggested that the trauma of CSA is more likely to result in complete memory loss than any other type of trauma.[21] It is believed that traumatic memories differ from non-traumatic memories in that they cannot be processed in the normal way and are initially stored as sensory fragments with no semantic or linguistic components. They are therefore not assimilated into an individual's personal narrative and, consequently, remain in their 'undigested' state.[23] As a result, memories do not return in complete narrative form but are usually experienced as sensory or emotional fragments. Participants in van der Kolk and Fisler's study[23] all reported that their traumatic memories had initially surfaced in the form of somatosensory or emotional flashbacks, which is supported by other research findings.[24]

Some of the women reported that their memories had begun to return in response to momentous life events such as birth or bereavement. In several cases, memories were triggered by the death of the perpetrator. This was so in Judith's case, as the death of her mother prompted her memories to surface in the form of vivid flashbacks in which she would lose touch with reality. This had a profound impact on her psychosocial functioning, but it also had physical repercussions:

> When I first started getting the flashbacks and memories, I wouldn't talk to anybody. I found it very difficult, to sort of go out or be with anybody. I used to make myself go out but I would go . . . The time that I lived at [town], I would go to [smaller town nearby] and I would make myself go and have a cup of coffee, but more often than not I couldn't drink it because I couldn't get it up to my mouth.
>
> Judith

Lynne's memories of childhood abuse also began to surface after the death of her abusive father, prompting a psychological crisis:

> My father died . . . about 14 years ago now . . . and it wasn't until he died that I could release the memories and that's when I just went to pieces.
>
> Lynne

It is interesting that she describes herself as 'releasing' the memories. This appears to support the idea that memories may return when the survivor feels she has reached a stage in life when it is safe for her to do so.[7,25,26] Although Kerry had retained memories of her abuse, she dealt with them by blocking them or, as she described it, 'putting the dirty washing in the bottom drawer'. Like Lynne, shortly after the death of her father she suffered an emotional collapse that appeared to be linked with the release of abusive memories:

> And my father died six years ago, so the year after was when my life, if you like, collapsed in a sense about what I'd been carrying around with me.
>
> Kerry

Claire's memories suddenly started to return in the form of vivid flashbacks two days after her niece gave birth to twins, one of whom died.

Some of these women reported experiencing intrusive memories of their CSA on an ongoing basis. This took the form of flashbacks to abusive scenarios and could be triggered unexpectedly by situations which contained elements associated with the original event. Memories are often triggered by events which bear a resemblance to the original trauma or have a trauma-specific significance to the individual.[27] For example, Ehlers *et al.* describe a woman who had been attacked by a bull experiencing a flashback on seeing a car number plate displaying the letters 'MOO'.[28] Several of my interviewees described events and occurrences in their daily lives which would trigger traumatic memories, often quite unexpectedly. Some lived from day to day never knowing when they were going to be propelled into a flashback by some apparently insignificant trigger. These could be almost anything: smells, colours, touch, words or phrases, certain days or time of year. For instance, Judith reported having had flashbacks triggered by bluebells:

> The bluebells was another thing to do with another part of the abuse, that somebody took me where there were bluebells. And I had one incident where . . . I wanted to stamp on them. I thought I'd got sandals on, like a, you know, like a child – the sort that I would have had at the time. It took me about 10 minutes to sort of – 'What the hell's going on?'
>
> Judith

It seems that since her memories of abuse had begun to surface, many seemingly ordinary things had the potential to induce vivid flashbacks, all of which made for an extremely frightening and anxiety-invoking existence:

> . . . the sort of early flashbacks were quite a shock because it was as if . . . I couldn't separate what was here and now and what was then. I would get . . . the slightest little thing could hook me into being in that place [. . .] But the slightest thing could move me back into that space of time and I wasn't as aware then that I am now, sort of thing. It was as if I was whichever child part, and I have, I still do, when I have new flashbacks. I have the physical sort of pain. It can be associated with smell as well and it's – it is – very much as if . . . you know, whatever happened then is actually happening now.
>
> Judith

Kerry was also aware that certain triggers could crop up unexpectedly and, like Judith, she found that smells were particularly potent:

> I do still have moments when I'm caught unawares, smells I'm particularly sensitive to, if I smell something that reminds me of being back there.
>
> Kerry

Similarly, Sharon described herself as often taken by surprise by certain triggers which cropped up in her everyday life, while Wanda recalled repeatedly waking in the night convinced that her father was pulling the bedclothes off her.

Many of the interviewees were aware of the situations or events that constituted memory triggers for them. Familiarity, however, did not confer protection against their impact. Kerry said:

> Saturdays are bad days and my sister will say that too – Saturdays are bad days for her because my mum used to go out and do the shopping on a Saturday, so it was a long time of being left on my own and he would abuse me more than once on a Saturday, so that was quite . . . Saturdays used to be very difficult for us.
>
> Kerry

Many of the women found that invasive or intimate medical procedures, especially when carried out by men, could cause them to have flashbacks or to dissociate in response. Claire found that intimate medical examinations had the potential to cause her to relive events related to her abuse by a paedophile ring, just as if it were happening again:

> You go off, like I said when Dr C or A, my urologist, is examining me, if I'm having a bad time, it's suddenly not them. I'm in the same room, but I'm not there. It's not them; it's all the other people; I'm in a circle exactly . . . and I'm four or five.
>
> Claire

Lynne also found that certain procedures had the ability to cause her to flashback or dissociate. She described how her sense of dehumanisation at a routine mammogram examination triggered distressing memories:

> I feel like I'm being treated like an object again, like I was as a child. Ummm. . . where people are wanting to look at me and stare at me, that'll shoot me back into childhood as well.
>
> Lynne

Several of the interviewees found going to the dentist problematic as a result of their childhood experiences, partly because of the connotations with oral sex, but also because of the feelings of vulnerability it created. Arguably, most people without a history of abuse find it uncomfortable to lie back while allowing abnormally close physical contact by a relative stranger. Survivors undergoing this kind of procedure are obliged to place themselves in a position of extreme

vulnerability requiring a degree of trust they simply may not have. Judith explained how a recent trip to the dentist found her struggling with flashbacks to an event that occurred during her abuse:

> . . . at that particular time she had to put swabs into the back of my throat and at one stage somebody stuffed a handkerchief into my mouth and that, it was like the sensation of having all the moisture taken out of your throat and having to, with the dentist, because she doesn't know anything of the situation . . . She doesn't know anything at all of . . . I was sort of shaking like a leaf and her not knowing what's going on.
>
> Judith

Rosie, whose memories had surfaced relatively recently and consisted entirely of sensory fragments suggesting oral sex, recalled having a very similar reaction to a dental procedure:

> At one point when I was – this was obviously before I knew [about the abuse] when I was a young teenager, I was supposed to have a brace fitted and um . . . they sort of make a cast of your mouth, obviously, and it involves putting a sort of hard plastic thing in your mouth with some gooey stuff in so you can make a cast of your mouth. I just remember him just sort of pushing it into my mouth and not being able to breathe and gagging on it and just feeling just like really frightened. I mean I guess it probably would have been frightening anyway, but it was . . . there was something more than just fear, and that was pretty dreadful.
>
> Rosie

The link between abuse involving oral sex and fear of dental treatment is not unexpected and has been demonstrated by the work of Willumsen, who found that women reporting sexual abuse in the form of oral penetration experienced significantly higher levels of dental fear than women who had been subject to other forms of sexual abuse.[29] Furthermore, a study by the same researcher some years later linked feelings of loss of control with dental fear in CSA survivors.[30] Significantly, the data suggested that women with a history of CSA find interpersonal factors such as communication, trust, fear of negative information and lack of control more fear evoking than women with dental fear but without a CSA history.

THE MEDIA

Interestingly, several of the women mentioned that watching television had the potential to trigger flashbacks or provoke extreme emotional reactions. Judith described having an extreme reaction to merely seeing the word 'sex' and experiencing flashbacks 'quite randomly' when watching television:

J: At one stage, early on, I couldn't – just to see the word 'sex' written down was like, you know . . . and television was an absolute nightmare . . .
L: What sort of things on the television? Programmes about sex or sex-scenes or . . .?
J: Anything. It was . . . it was really quite random.
L: Would that flip you back into a scenario thing?
J: Yes. It would flip me back into a scenario or it would flip me back into what I used to call the 'black hole' because it was like everything in there was black except for this tiny chink. That would be just sort of focused on what was in my immediate view then. I would cut everything else out.

Judith

Claire explained that her husband would have to change the channel on the television when certain things came on. Unlike Judith's experience of the 'black hole' her reaction was extreme anger. An example she gave was of an National Society for the Prevention of Cruelty to Children (NSPCC) advertisement that was being aired around the time of her interview:

> I mean the advert on the telly from the NSPCC which says, you know, five or ten pounds a week will help the children forget their nightmares – when I was . . . I can't watch them . . . we turn them off, because I just can't watch them! I was talking to A, my urologist, and I said to him, 'It's a load of balls!' And he said, 'Why?' and I said, 'A, you never forget them!' They might be able to change the child's environment, but they won't send the nightmares away . . . because they're still there.
>
> Claire

Ruth recounted feeling utterly devastated when she felt compelled to watch a television programme on paedophilia; arguably, an example of a traumatised individual feeling compelled to repeat the trauma:[31]

> I started watching the first one and I don't know why, because I knew that I would get upset, but I was just – I just felt, perhaps I might understand why, why . . . these people do this, why . . . And it was awful. It left me absolutely heartbroken.
>
> Ruth

It is interesting to note that Elliott reports that the most commonly cited trigger to trauma recall among her 724 traumatised respondents was some form of media presentation.[21] However, van der Kolk, Hopper and Osterman report that a colleague attempted to simulate a traumatic stressor by showing college students a film which consisted of actual footage of human and animal deaths and mutilations. Despite its horrific nature, it failed to produce post-traumatic symptoms in these non-traumatised individuals.[32] Clearly, the students had no history which

would predispose them to trauma, and presumably were in a situation in which they had a) volunteered for and consented to the experiment; and b) would have had the ability to opt out during the film if it had proved overwhelming. In other words they had choice and control over the event. The nature of trauma is the fact that it is overwhelming, uncontrollable and unavoidable.

THE UNIQUENESS OF TRAUMA RESULTING FROM CSA

Unlike most other traumas, CSA occurs at a time when an individual's emotional and psychological development is incomplete. Parental abuse has a profoundly negative impact on the child–parent attachment bonds, which in turn affects an individual's ability to integrate sensory, emotional and cognitive information into a cohesive whole. Carter refers to the long-term impact of CSA in terms of 'role-locked' relationships; i.e. those which are formed in unfavourable environments (such as abusive ones), demanding a certain type of response, consequently causing roles to become fixed in a particular pattern.[33]

Through listening to their stories I saw how the interviewees' childhood experiences had shaped their personal perception of control, their ways of being and self-images, particularly so in those who had been incestuously abused from a young age. From early on in their lives they had known themselves to be powerless as their physical and emotional integrity were repeatedly violated. Consequently, it seems that distorted images and skewed emotional processes were built into their psyches like faulty foundations. No matter how expert subsequent building work was, the foundations had been laid and would continue to influence the structure as long as it stood. That is not to say that these women saw themselves as victims – far from it. All of them had overcome the legacy of their past to some extent and had gone on to lead relatively normal lives, held responsible jobs, formed meaningful relationships, had children and found varying degrees of healing. Undeniably for some, however, their abusers still influenced their thought patterns, their beliefs and actions, as if they viewed life through a distorting lens.

Finkelhor and Browne suggest that the conjunction of the four traumagenic dynamics described in their 'traumagenic model' (betrayal, stigmatisation, traumatic sexualisation, and powerlessness) is what makes sexual abuse unique as opposed to other kinds of childhood trauma such as parental divorce or physical violence.[34] Their traumagenic model provides a useful framework within which to discuss the impact of sexual trauma.

Betrayal

As we have seen, betrayal of trust lies at the heart of sexual abuse. A child's natural ability and need to trust is abused and manipulated by those who are in the position of caretaker or guardian. The enormity of this will have an ongoing impact on the child's capacity to trust. Trust in others over whom we have no control is a prerequisite in almost every area of life – we trust that other road users will

obey the rules of the road, that our doctors will act for our good, that the food we buy will not poison us – but survivors may find themselves unable to function in situations which demand their trust and involve loss of personal control. The issues of trust and betrayal were recurring themes in the interviews, influencing lives in subtle and diverse ways, including personal relationships, social interactions, and contact with health professionals and organisations. A deep sense of betrayal was evident in Claire's interview. Her father not only abused her himself but also hired her 'services' to a paedophile ring, and the feeling of betrayal at his hands screams relentlessly out of her words. She described him passively watching, casually smoking a cigarette while the abuse was taking place, apparently unconcerned by her suffering. During her interview she referred to this scenario three times in almost identical words:

> But he also used to take me and we used to go into the house and there would be 10 or 11 other men and he would lounge up a wall, smoking a cigarette.
>
> Claire

Despite the fact that he had been dead for many years, he and her other abusers still influenced her beliefs about herself and, to a great extent, her actions. Unsurprisingly, not only did it affect her own self-image but also her ability to trust others, even in non-threatening situations:

> . . . if somebody's being nice to you, even now, I wonder what they want . . .
>
> Claire

Both Amanda and Veronica described how their experience of betrayal by fathers (stepfather in Amanda's case) later impacted on their ability to trust other males, which proved to be a common problem among the interviewees. Lynne grew up in an abusive environment, abused by both parents and her elder brother, and had been subject to sexual attacks by strangers. Consequently, she felt there was no one she could trust and that love would ultimately lead to betrayal:

> Through being abused by people that loved me I didn't want to feel that [love] because it would mean I'd get abused.
>
> Lynne

In adult life, after reacting in an uncharacteristically violent manner towards her partner, she felt obliged to end the relationship because she did not want to risk losing control of herself in this way again. Not only had her abuse affected her ability to trust others but this unexpected reaction profoundly influenced her ability to trust herself.

Kerry's father continuously abused her from before the age of 3 until she was 17 years old, but her sense of betrayal was exacerbated by the fact that, ironically, after she eventually disclosed, they were both expected to attend the same

location for counselling. As she explained, this incongruous situation made it difficult for her to trust the therapy and receive any benefit from it:

> . . . for me that was like saying 'Well, we're both the same.' Even though he'd done the wrongdoing, and I was the victim, we were in the same establishment at the same time having therapy.
>
> Kerry

The women's sense of betrayal was compounded in some cases by the perception that the other parent or guardian was aware of the abuse but unsympathetic and/or unwilling to act protectively:

> I think my mother was aware of what was happening but didn't want to know about it.
>
> Lynne

Veronica was the second-youngest child in a family of eight children and remembers her mother appearing 'defeated' and tired, with little time for her. She felt that, almost certainly, her mother was aware of what was happening, but poverty and hopelessness made her reluctant to acknowledge the situation:

> She knew what was going on but she chose not to acknowledge it because there was no help then. I mean, what would we have done? Where would we have lived? What would she have done for money?
>
> Veronica

Some of the survivors felt that they had been betrayed by individuals or organisations whom they saw as having the ability to put a stop to their abuse. Claire revealed that the men in the paedophile ring held respected, professional positions in the community. She remembered being examined by a doctor at the house where her abuse took place. Instead of rescuing her, he merely advised her abusers to 'leave her alone for one or two weeks' in order for her injuries to heal. This continued to have repercussions later in life, as she explained:

> If I have to see a new specialist or something like that, my GP always says, 'He's a very nice man.' *Those* men were very nice men. I have no doubt that they were JPs, dentists, doctors . . .
>
> Claire

In Stacey's case, the police undertook an investigation into her stepfather's abuse of her younger sister. However, he was not given a custodial sentence, while, ironically, her sister was placed in residential care – one of the very fears that had ensured Stacey's silence. She expressed an entirely understandable sense of betrayal towards those whose role it was to protect them.

Some of the women felt frustrated and bewildered by what they saw as missed opportunities to get the help and support they desperately needed. Most of the interviewees in this study did not disclose their abuse at the time when it was ongoing. However, like the interviewee with pelvic pain in Burian's study[35] who wanted her doctor to 'read between the lines' (*see* Chapter 3), they felt that they displayed certain symptoms which ought to have alerted the appropriate bodies to suspect abuse. When, as a teenager, Amanda found herself subject to abuse by her stepfather, she quickly went from being a model student to a poor achiever who regularly truanted from school. Unfortunately, her dramatic decline went uninvestigated and unquestioned, depriving her of the opportunity to find help:

> . . . when I look back, I think, 'Why did no one pick that up? Why didn't anyone . . .?'
>
> Amanda

From a young age Wanda remembers being taken regularly to Great Ormond Street Children's Hospital by her father because she suffered from Hirschsprung's disease. She thinks that staff there may have suspected that she was an abused child, but it was never followed up.

Arguably, because of their feelings of stigmatisation, some of the women may have believed that they were displaying clear signals, when, in fact, it was not as obvious as they imagined. Moreover, at the time when most of the interviewees' abuse occurred, the frequency and indicators of sexual abuse had yet to be widely recognised and therefore it was not usually suspected as a possible cause. On the other hand, anecdotally, there was, and may still be, a general reluctance by society to acknowledge the possibility that sexual abuse is taking place.

Kerry was one of the few interviewees who did attempt disclosure at the time when the abuse was ongoing. She tried to confide in her teacher who, unfortunately, appeared unwilling to follow it up, although her response suggests that she did, to some extent, recognise the implication of what was said:

> When I was eight at school, I did say once on the dinner table that my dad did things to me that I didn't like, and I was told by one of the teachers, 'We don't talk about those things at dinner.'
>
> Kerry

She explained that her teacher's reaction left her with the conviction that she was at fault, thereby strengthening her feelings of culpability and shame which are often responsible for survivors' reluctance to disclose in the first place.[5,36]

Until recently, the sexual abuse of children has been considered an almost exclusively male behaviour and there has been a general reluctance to recognise the possibility that abusers may be female.[37] However, Longdon reports that children may indeed be subject to brutal sexual abuse by women, contrary to the popular belief that female abuse tends to be an extension of maternal activities

such as fondling or kissing.[38] Most of the interviewees in this study had been abused by men, but three had suffered abuse by mothers. Lynne describes her mother as a bully who had an obsession with her daughter's bowel movements, inserting soap into her rectum if she failed to open her bowels on a daily basis. Wanda's story is in some ways similar. Abused by her father from the age of five, her vulnerability was heightened by chronic ill health. She feels that this provided her mother with a legitimate pretext on which to abuse her:

> It [the pain of Hirschprung's disease] was every bit as bad as labour. I used to roll around the floor for hours on end with it and they'd take me into hospital . . . enemas, wash-outs, send me home and . . . they hit on the brilliant idea of having enemas at home to stop me going into hospital. My mother was a cow about those! She enjoyed every minute of those, when I look back.
>
> Wanda

Judith had been abused by her mother; although she did not go into the details her account strongly suggests that it was far from the stereotypical view of female sexual abuse. Arguably, the general expectation that mothers should be nurturing and protective served to heighten the acute sense of betrayal in these women.

Stigmatisation

As I previously pointed out, because CSA occurs at an age when the child's emotional and psychological development is at an early stage, her perception of herself and the world around her are shaped by her experiences. Finkelhor and Browne describe stigmatisation as the negative beliefs, such as shame and guilt, that become part of the child's self-image through what happens to her.[34] Some of the women saw themselves as stigmatised in the original sense of the word, marked out because of their experiences. Even though many did not verbalise this belief per se, it was very much in evidence as a theme running through their stories. Two of the women described experiencing a particularly acute sense of stigmatisation around the time that their memories surfaced:

> . . . I suddenly felt, 'I can't go outside, everybody knows about me, they're all talking about me'. If I saw people grouped together they were talking about me. They knew it! But I didn't know what they knew, but I knew they knew it.
>
> Wanda

> I was very aware in the early stages that there was no way I would look at anybody. It was like . . . I just couldn't handle that because I thought that they could see inside to what was going on in my mind.
>
> Judith

Veronica describes similarly feeling that others could see what was going on inside her head when, during sex education classes at school, she finally realised

the significance of what her father was doing to her. She had kept silent about her abuse for most of her life, never even revealing her secret to her husband, who had died 25 years previously. The impression I gained throughout the interview was of someone who had an acute sense of 'otherness' because of her 'cold dark dungeon of secrets' as she described it.

Lynne also felt this sense of isolation:

> Also, I had this feeling of being very isolated, very separate from other people. Other people seemed to possess something that I'd never really learnt or grasped hold of. They knew how to socialise, they knew how to be at ease with one another and I just didn't have that ability. So I felt very separate.
>
> Lynne

Furthermore, two of the interviewees expressed their feelings of stigmatisation when receiving psychiatric treatment for mental health problems resulting from CSA:

> . . . having to go to a mental hospital to see your community psychiatric nurse, to me felt like a punishment. I hadn't done anything, I haven't done anything wrong – why have I got to go to a mental hospital to see my community psychiatric nurse? Makes me out as if I'm mad!
>
> Ruth

Although it may be argued that the stigma attached to psychiatric illness is less nowadays than previously, it continues to be viewed with suspicion and a general lack of understanding. Ruth (a midwife) described her mother's concern that she should not disclose her psychiatric history to her work colleagues because of the connotations with Beverley Allitt, (an English serial killer of children), which is typical of the anxiety surrounding mental illness. As Ruth's assertion, that having to go to her psychiatric nurse seemed like a punishment, suggests, survivors of sexual abuse who seek psychiatric help for their symptoms may find this increases their sense of shame and stigmatisation.

Low self-esteem is common among survivors of CSA and women's anecdotal accounts clearly highlight this. Many feel that they are to blame for what happened to them, that somehow there was something they might have done to prevent it. Hanan speaks of her feelings of self-loathing and lack of self-respect resulting from her anger at 'allowing' the abuse to take place.[6] Similarly, Heritage describes herself as feeling to blame for her childhood experiences.[39] Tilley, a victim of a violent sex attack in adulthood, recounts her feelings of culpability and shame at what happened to her.[40]

Poor self-esteem was much in evidence in the majority of the interviewees and had an impact on many areas of their lives. As Kitzinger points out, survivors often reflect the attitude their abusers have towards them.[41] Stacey, whose stepfather had taunted her with being 'fat', 'ugly' and unlovable, described how she

'always felt dirty and disgusted, [. . .] meaningless and no self-esteem . . .' which she disguised with anger over the death of her biological parents.

Claire felt her self-esteem was profoundly and irrevocably shaped by her father, whom she described as sexually, physically and mentally abusive:

> . . . he used to make you feel so useless. [. . .] and I now don't feel that we'll ever amount to anything because of everything that he said. He used to put you down . . .
>
> Claire

In addition, her opinion of herself had been indelibly coloured by the organiser of the paedophile ring, who had told her that she was to blame for their actions. Despite the fact that she was only a small child when the abuse occurred, she had been unable to free herself from the belief that she was responsible, and his words continued to have a huge impact on her self-esteem:

> C: . . . he [the organiser of the paedophile ring] was always very nice . . . very quietly spoken, very gentle, and if I wasn't being very compliant with them in the circle, he would always come into the middle and talk me round. But by saying he knew it was what I wanted to do, that I enjoyed it.
> L: Oh, right. So it was your fault?
> C: Oh yes. Always my fault. If I wasn't as pretty as I was, they wouldn't want to touch me – I hate myself! I utterly and completely hate myself!
> L: Still?
> C: Oh yes. Sometimes I'm a bit better, but most of the time I absolutely hate myself and you get counsellors saying 'Stand in front of the mirror every morning and say, "I'm alright. I'm good, I'm nice", and I can't do that. When I get up in the morning I stand in front of the mirror, I brush my hair and I go away . . .
>
> Claire

Wanda described herself as always knowing that she was 'wicked', although before the memories returned, she had no idea why:

> My mother had told me that I had been wicked and dirty and bad. She blamed me. He [father] managed to convince her that it was my fault.
>
> Wanda

When her memories of what had happened did eventually surface, her initial reaction was one of disbelief, prompting her to demand that her psychiatrist should have her 'locked up'.

Lynne explained her inability to engage in loving sexual relationships as resulting from her sense of being unlovable and unworthy of love because of her childhood experiences:

> . . . love wasn't open to me. I didn't think I could be loved. I wasn't worthy of being loved . . .
>
> Lynne

Furthermore, children may feel deep shame at their own natural sexual responses they experienced during the abuse. Wanda explained that her self-esteem and psychological well-being in later life were profoundly influenced by the knowledge that she had experienced a pleasurable physical response to her abuse. Having finally admitted this, she felt her rehabilitation could begin.

Traumatic sexualisation

Children who have suffered traumatic sexualisation may subsequently develop inappropriate repertoires of sexual behaviour, confusion about their sexual selves, and unusual emotional responses to sexual activities.[34] Not surprisingly, many of the women interviewed reported experiencing severe long-term sexual problems which revealed themselves in diverse ways and behaviours ranging from aversion to sex to promiscuity. It was obviously an area in which their abuse still had a considerable impact. Even when they were in good supportive relationships, it seemed that a silent, but immensely powerful, third party was present. Several of the interviewees used strikingly similar phraseology when describing their surprise on achieving a pregnancy, given their reluctance to have sexual contact:

> . . . it's a miracle I ever got pregnant because sex was the last thing on my agenda.
>
> Veronica

> . . . how I ever conceived K [daughter] was a miracle anyway.
>
> Amanda

> . . . it was amazing I got pregnant in the first place . . .
>
> Jo

For many survivors, the feelings of shame and guilt, associated with unwanted sexual activity in childhood, continue unchanged into adulthood:

> . . . it [sex] feels so completely wrong. Totally and utterly wrong . . .
>
> Jo

Chloe explained that she found it easier to go through in vitro fertilisation (IVF) treatment than to have sex with her husband. Judith described how, before her memories of abuse emerged, she would avoid having sex with her husband by delaying going to bed. As the memories of her abuse began to surface in the form of flashbacks, she developed a severe aversion to being touched in any way,

which made any kind of sexual contact impossible, placing further strain on their already shaky relationship.

Wanda's description of her first experience of sex with the man who later became her husband clearly resonated with her CSA, although it occurred at a time before her memories had surfaced:

> . . . and he had sex with me and I remember thinking, 'Oh not again!' [. . .] There was no emotion attached to it whatsoever, I found it a strange sensation, it was just 'Get it over with and go away!'
>
> Wanda

It is significant that she chose the phrase 'he had sex with me' and not 'we made love', or even 'we had sex'. She felt that sex was something that was 'done to her' rather than an activity in which both partners participate equally.

Jane described how during psychosexual counselling she had to reveal to her husband for the first time that sex, to her, was like being raped every time and that she had always just been 'making the right noises and going through the motions'. She recounted that during love-making she would often have terrifying flashbacks to her childhood abuse which would cause her to dissociate to such an extent that she felt she had left her body and was 'floating about on the ceiling'. She also reported behaving violently towards her husband on occasions when engaged in sexual activity. Significantly, Lynne's unexpectedly violent reaction towards her partner also occurred in a sexual context. Kerry described how the revelation of the extent of her father's sexual abuse nearly caused her marriage to fail because of the huge impact it had on her husband. Although she had travelled a long way down the road to healing, she could not see her attitude to sex changing and her words reflect a deep sense of powerlessness:

> It's [sex] not a valued part of my marriage, which is sad, but I don't see how I can change that.
>
> Kerry

Similarly, Jo's account portrays her sadness at her inability to have a normal sexual relationship with her husband, whom she described as her best friend. Despite having engaged in marriage counselling, her feelings about sex remained unchanged and, like Kerry, she had no hopes for any future improvement. Her words are heavy with a sense of desperation and hopelessness:

> I know it should feel right and I still, even now, can't . . . can't get to grips with that side of our relationship at all. You know, I'd sooner just not bother, and we don't very often. Poor thing, he [husband] puts up with it, really, and I don't know why, sometimes . . . why he doesn't just clear off . . . I've tried to get help but it's not been the right kind of help and I don't think I ever will, to be honest.

> I don't think I'll ever come to terms completely with what's gone on.
>
> Jo

As I previously stated, engaging in high-risk sexual activities has also been observed in survivors of CSA. Hanan described herself in her teenage years as drinking heavily to numb the pain and having 'one night stands' while in a spiral of self-loathing.[6] Smith's interviewee recalled becoming promiscuous in her early teens, perceiving sex as a means of having some control over a relationship.[42] Some of my interviewees explained that they had been promiscuous earlier in their lives as a result of their beliefs and feelings about themselves. Lynne had been able to engage in purely sexual relationships, but love was never part of the equation:

> So my idea with sex was it was just sex – there wasn't anything, there wasn't the loving and the caring and the depth of affection. I didn't know any of that at all. It was something you did with somebody when you met them and I was often left wondering, 'What else is there?'
>
> Lynne

Like Lynne, Amanda described herself as confused about sex and love and having engaged in promiscuous sexual activity in the belief that this would satisfy her need to be loved:

> I thought that sex was love, that's what I thought. That's the only way I can look at it is that I thought that if you wanted someone to love you, you had to have sex with them, so I was very wild in my early days. I used to drink an awful lot, have sex. I was probably one of those people who put myself through an awful lot of risk. But I never enjoyed sex, I was *so* frigid. (Is that the right word?) I would have sex, but I was like a cardboard block.
>
> Amanda

Most of the women interviewed had experienced some degree of traumatic sexualisation, which manifested itself in various ways. It was clear that their beliefs and feelings about sex had grown out of their childhood experiences and were associated with a multiplicity of emotions and self-perceptions such as low self-esteem, shame, guilt, fear and anger. Although they exhibited a variety of different sexual behaviours, the beliefs underpinning their actions were similar.

Powerlessness

CSA relies on the fact that children are vulnerable, dependent and therefore not in a position to resist. The interviewees' stories confirmed the literature on sexual abuse, that abusers use many different means to control their victims including threats, physical violence, coercion and promises of special treatment.[5,7,25,42–44]

Many of the women interviewed recalled being powerless against their abusers owing to their physical size and young age. For example, Claire described how she would try to run away from her father each time he took her to the house where the paedophiles met:

> I started seeing them when I was about four, because I can remember the coat that I wore, and after the first couple of visits, I used to try, when we walked down this particular road, I used to try and run away . . . unsuccessfully, because I mean, children of four can't really outpace their parents and if you'd got a great big pixie hood up the back, and Dad just used to hold on and pull me back.
>
> Claire

Lynne's abuse started very early on in her life, probably at around the age of 18 months when, clearly, she was helpless to resist, and in an abusive household such as hers, there was little hope of anyone else putting a stop to it.

Some abusers used threats against their victims, not only to gain their compliance but also to silence them. As well as being physically unable to resist, Claire's cooperation was secured by her father's threats to separate her from her much-loved twin. Similarly, Amanda was silenced by her older brothers who abused her from the age of 6:

> . . . my older brother S said to me, 'Don't tell mum, 'cause if you tell mum, she'll leave you.'
>
> Amanda

Kerry's abusive father threatened her with being consigned to a psychiatric hospital if she disclosed. Not only did this have the effect of silencing her at the time but the long-term impact delayed her seeking help for chronic depression in later life.

Stacey's story demonstrates several different means by which her stepfather controlled her and her siblings. Her biological father had died when she was young and her mother later remarried. Soon after her stepfather started abusing her, her mother also died. Having previously secured custody of the children by adoption, he then had complete control over their lives and the abuse continued unchecked despite the fact that other family members had their suspicions. Stacey, suspecting that he may have had a hand in her mother's death, was convinced that her own life was in jeopardy. In addition to the physical threat he posed to her, he set about subjugating and isolating her psychologically and emotionally.

> . . . I didn't have friends really, was a very overweight child, believe it or not . . . I was a very overweight child, and it was, you know, there were lots of comments like 'Nobody will ever like you', 'you're too fat', 'you're too ugly', 'you'll never meet anybody', you know, 'the only person you'll ever have is me' . . . you know, 'nobody will ever care about you . . . if they cared about you they'd want you'

> you know, there was lots of psychological crap.
>
> Stacey

On the other hand, Veronica's abuse provided her with an opportunity to feel special in a large family in which parental attention was in short supply. Her account reveals how her father took advantage of her natural desire to be special and loved at an age before she had developed a sense of what was appropriate or not. She recalled him saying:

> 'This is special. I only do this to special people. You're very special', and of course, I wanted to be special and I knew . . . I didn't know any different . . .
>
> Veronica

Wanda remembers 'worshipping' her father, whom she described as a charming but violent man who gained her cooperation by 'spoiling her rotten':

> This was 'Daddy loves you' and 'special', and all that crap!
>
> Wanda

Sally's stepfather used the pretext of his paternal responsibility to initiate her into having sex:

> With me it was 'Seeing as your uncles aren't really trustworthy, I'll teach you.'
>
> Sally

Although some of the women were kept silent by various threats made by their abusers, others failed to disclose because of the expectation that it would have caused the breakdown of highly valued relationships and/or the possible disintegration of their families. Amanda chose not to confide in her mother when being abused by her stepfather in order to protect her and their relationship. Sally's close relationship with her mother was also her reason for non-disclosure despite becoming pregnant with her stepfather's child:

> . . . the last thing I wanted to do was upset my mum and let her know at that time.
>
> Sally

The opportunity to disclose presented itself to Stacey when her elder sister revealed to their stepfather's new partner that he was abusing her. However, having been isolated by him from the rest of her family, the one relationship that remained to her was with this woman. Stacey, faced with the possible loss of this relationship, denied that abuse was taking place, because, she explained:

> She's all I've got' . . . 'cause by this time my own family, my nan and granddad

> and my aunt and uncle, we had no contact with . . . I mean I should never have denied it . . . looking back with hindsight now, but at the time I did, because I thought well . . . 'They'll put me in a home . . . it'll happen to me with somebody else', 'cause this is all the things he told me . . . he'll kill me . . .
>
> Stacey

It seems that most of the perpetrators of abuse relied on the fact that their victims would not disclose, even to their siblings. Some of the interviewees said they suspected that their siblings were also being abused, but few had actually discussed it.

Most of the women had eventually disclosed their abuse, some much later in life when their memories had surfaced. For some, the cost of disclosure was huge in terms of the impact it had on other members of their family. Kerry was always aware that her father had abused her as a child but later discovered that he had also abused two of her sisters and, even more disturbingly, her own daughter. Her story demonstrates the effect that disclosure of sexual abuse can have on a family both from the perspective of a survivor and the mother of an abused child. It also illustrates the resultant sense of impotence and betrayal when care agencies fail to act appropriately:

> . . . when it came out that he'd abused her, I was so terrified that I'd been a bad mother and not protected her um . . . and so we didn't do probably what people might class the right thing to do, which was get the police, talk to them. Eventually, the police were made aware and interviewed him in a very casual way, because Social Services had to provide him with a – somewhere to live and um . . . He again never really addressed it with them, they did nothing, because in the early '80s even 'Childline' wasn't really established and people didn't believe that . . . you know, you were making it up. They just didn't believe it.
>
> Kerry

In Ruth's case, the police did bring charges against her abuser following her disclosure, but she paid a high price in terms of the devastating effect it had upon her mother:

> . . . in '94 I told my stepfather first and he broke it to my mum. I didn't tell them until I was 24 that I had been abused and it had a terrible, terrible knock-on effect. For years I wished I'd never done it. My mum, mental health, she contemplated suicide; she thought she'd let me down . . .
>
> Ruth

Wanda explained that, as an adult, she wanted to see her father prosecuted but was prevented from taking action by the thought of the impact it might have on her own children and because of her perception that the justice system would be weighted in his favour.

Dirty bodies

As discussed in Chapter 3, the body could be described as the 'battlefield' of abuse, and consequently many survivors of CSA have distorted ideas about their bodies. Wanda's feelings about her body, particularly her genitals and reproductive functions, were profoundly influenced by her abuse. She explained that her father (abuser) had been treated for a sexually transmitted disease and described how, when her memories surfaced, she had felt compelled to cut out her genitals to stop the feelings of being infected and dirty. The action of cutting genitals was also described by one of the interviewees in Kitzinger's study, who cut her labia with scissors because they 'never looked right'.[41] She recalled this perception as stemming from her abuser's fascination with her genitals, which started as soon as she grew pubic hair.

Some survivors of sexual abuse perceive themselves and their bodies to be 'dirty' as a result of what has happened. Tilley recalled showering until the water ran out because she felt so dirty after being sexually attacked.[40] Phoenix described herself as 'too dirty to defend myself, like I've been caught doing something wrong' on becoming pregnant.[45] Similarly, Kerry perceived her body to be dirty as a result of the many years of CSA she had suffered. When she experienced vomiting and bleeding in early pregnancy, she interpreted this as her dirty body rejecting the baby:

> . . . I perceived the vomiting as my way, if you like, or my body not clean enough to carry this baby, as purging. And I also bled, I spot bled throughout the pregnancy and again that to me was my body rejecting this baby – it wasn't clean enough to carry this baby.
>
> Kerry

Jane too felt that her body was ruined, not only because of the abuse but also as a result of the bulimia she had suffered from since the age of 11. The perception that the body is ruined, dirty or evil is not uncommon in sexual abuse survivors and is a recurring theme in anecdotal literature.[41,44–46]

VULNERABILITY: THE END RESULT

Trauma, of any nature, brings with it vulnerability and, consequently, the women's lives and daily activities were profoundly influenced by their need to avoid situations in which they would feel out of control or powerless, and thereby risk re-experiencing their trauma. The impact of this was evident even in the apparently mundane areas of daily existence.

For some of the interviewees, there were issues of vulnerability associated with sleep. The prerequisites of sleep are a sense of security and protection from threat, as it involves relinquishing control and vigilance. Both Jane and Kerry described the impact this had on the position in which they slept:

> I always have to sleep with the quilt in between my legs like that even now; and it's like a protection thing . . . I'd always slept on my tummy and I realise now that that's a safety thing, because nobody can screw you, frontwards anyway, when you're lying on your tummy (to be blunt).
>
> Jane

> I used to always sleep in a foetal position in bed – arms crossed like that, and I've got quite a lot of back problems simply because of that rigid position that I take . . .
>
> Kerry

Kerry also explained that any physical contact, when she was in a vulnerable position such as this, was very likely to be misconstrued as abusive. She described how she would react to her husband as if he were her abuser if he woke her when she was sleeping.

Similarly, Judith recalled her sense of vulnerability when in bed with her husband. She described lying tensely on the edge of the bed waiting for him to go to sleep before settling to sleep herself:

> I used to put a dressing gown on and I'd be sleeping on the edge of the bed, and you know, he only had to make the slightest move and I would react . . .
>
> Judith

Jane also described her reluctance to allow herself to sleep in hospital, because that required her to relinquish control. She explained that the idea of being checked on by the nurses during the night would have been perceived as threatening and caused her to scream uncontrollably.

Nightmares and sleep disturbances are commonly reported by people who have suffered traumas such as CSA,[3,15,37] and these women were no exceptions. Both Claire and Jo continued to suffer from nightmares concerning their abusive experiences as children. Wanda's sleep was often disturbed by terrifying dreams and Ruth recalled having had nightmares during her first pregnancy about breastfeeding because her abuse had focused mainly on her breasts. Sadly, since the birth of her first child, 15 years previously, one of Jo's recurring nightmares was that of having her perineum sutured.

Some of the women described how their sense of vulnerability had an impact on seemingly insignificant areas of their lives. For instance, Sally and Ruth explained that their need for security meant that they always wore trousers with a belt:

> It's to do with security. [. . .] I can't even stand pull-up trousers because they're too easy to get down and that, so I'm always in trousers with button and zip and it used to be always with a belt, which I found very hard when I was pregnant

> with my son, to find a belt that would do up . . . So I had to stop wearing a belt which made me feel very insecure . . .
>
> Sally

> I used to think 'Well, I'll put a belt on with me trousers so he can't get down me trousers and he can't get . . . I'll put tights on' and, you know, all sorts of things to try and deter him but nothing really ever [. . .] nothing did really.
>
> Ruth

Stacey described how her sense of vulnerability affected even the most mundane activities in her daily life:

> I really couldn't abide anybody walking behind me, and still don't now. I have to say if anybody gets too close . . . in queues and things like that . . . and my biggest fear with this . . . not being able to feel this left buttock . . . is that somebody may touch me and I won't know. The worst of it is queues . . . queuing up for . . . at the Post Office and things like that . . . and I tend to queue sideways . . .
>
> Stacey

One of the major areas in which the women felt vulnerable was that of contact with authority, whether individuals or organisations. This is not unexpected, given the fact that the majority will have been abused by someone who was, or whom they perceived to be, in a position of authority over them. Abusers often hold highly respected positions in their community as this provides them with the opportunity and power to carry on their activities. Some of the interviewees described their continuing struggles with the issue of authority. This encompassed having contact with professions and organisations ranging from healthcare workers to the police, and many felt that, certainly in the earlier stages of their lives, they would have found it impossible to withstand anyone in authority. Kerry explained that she continued to find some authority figures problematic because their 'bullying' behaviour reminded her of her father who was a well-respected, churchgoing member of the community:

> But I do have difficulty with authority um . . . I have difficulty with my manager because I only came to realise in fact this year that a lot of what she does and a lot of her ways and behaviours are ways that remind me of my father [. . .] because there is this perception that if someone is being authoritative or someone is being, sometimes bullying you, it's the same things that he used to do.
>
> Kerry

Lynne described how in the presence of authority, she would 'become' the abused and defenceless three-year-old child again:

> And yes, it's people in authority that – not so much now – but it used to be I was immediately three years old with no defences at all and had to do whatever was asked of me.
>
> Lynne

Throughout her life, she had felt helpless and unable to protect herself. As an example, she recounted an episode from her 20s when she had been sexually abused by a dentist while under the influence of a general anaesthetic:

> . . . I was powerless; I just let that happen [. . .] I was completely unable to protect myself . . . I just had to go along with what the stronger person was wanting at the time.
>
> Lynne

At the time of her interview she was in her 50s, had just moved house to a rural area to live alone for the first time, and continued to struggle with feelings of vulnerability. She gave a vivid account of a recent incident in which an encounter with authority was so similar to her abusive experiences that she was left devastated:

> I was stopped in the winter by the police just near my house here, because my lights had gone out on the car and they said to me would I get out of my car and sit in their police car, and I just freaked. I just went hysterical and I said, 'No, I can't do it!' and I'm really pleased that I was able to say that, and they realised what was happening, that I was distressed, and they said, 'Well, we can do it in your car', and I said, 'Well, I can't have you both sitting in my car!' I was just getting more and more wound up and in the end, I sat back in my car, wound down the window and he breathalysed me – and that – that just finished me off because I'd got this policeman standing, my face facing his trousers, and him saying 'Put this in your mouth, blow and hold it there until I tell you to stop.' Well, I was just a wreck when I got home.
>
> Lynne

This scenario, which would probably have caused a certain amount of anxiety in most people, had a devastating impact on a survivor of CSA not only because it resembled an abusive encounter, but it also replicated the power disparity that exists in an act of abuse.

Some women described their reluctance to become involved with large authoritative and paternalistic institutions such as the health and welfare services, because it aroused in them feelings associated with abuse. Veronica was particularly vociferous in her anger towards what she felt was the intrusive and threatening nature of authority represented by these organisations:

> Because the least attention I get the better it is for me. That's why I won't have Social Services involved or anything. I don't need them . . . And I suppose part

> of it is because I want to be in control of what happens to me . . . and I said to them even if I find things difficult, I wouldn't tell them, 'cos I don't want them interfering. I just tell them. I just say they are nosey-parkering busybodies.
>
> Veronica

Her aversion extended to refusing to fill in forms requiring personal details to any organisation including medical forms, guarantee forms and loyalty cards. When she did come into contact with the routines and rituals of the health service conveyor belt, her natural reaction was to become defensive and non-compliant:

> V: . . . the last time when I went to [hospital] it sort of got up my nose a bit, I arrived and the receptionist said to me, 'Have you brought a urine sample?' I said, 'No, I wasn't asked for one', which I wasn't. 'What's that got to do with it anyway?' and she said, 'Can you go and do one?' I said, 'No, I can't' . . . 'Well alright then', and she gave me this card, told me where to go, I got to this desk, these two nurses sat there – 'Brought a urine sample?' I said, 'No, I wasn't asked for one. There's my referral letter to the neurologist.' I said, 'Anyway, what do you want one for?' 'Well, it helps the doctor.' I said, 'How?' 'Well, it helps him.' Then she said, 'I'll take your blood pressure.' I said, 'It's [blood pressure] all right you know.' So I let her do that. Then she said, 'Now we want to weigh and measure you.' I said – 'Look, what's all this in aid of?' I said, 'Here I am, stuck out in public here' (because they were actually in the waiting room).
>
> L: Oh dear. No privacy then?
>
> V: So they said, 'Well, we don't have to do it.' I said – 'Look – I'm not too fat and I'm not too thin, and you can see how tall I am. Will that do?' [. . .] It makes me so angry . . . that they do these things and they don't really know why they do them, do they? It's red tape.
>
> Veronica

Most people passing through the health services do so with little or no questioning of the rationale behind the routines to which they are subjected and individuals who react in this way are usually labelled 'difficult' and can therefore be dismissed, thus avoiding the need to evaluate or consider their comments. This is similar to the censorship employed by the person transcribing the account of the patient who referred to her psychiatrist as a 'paid poisoner' (*see* Chapter 2). As a result, the system continues unchallenged and unchanged. Often the only alternative for those who do not 'fit', both employees and users, is that of avoidance. Veronica's experience of being 'processed' in this way finally resulted in her absenting herself altogether, which she felt was the only option available to her. As a self-confessed obsessively private person, she clearly felt that it presented too much of a violation of her privacy and of her personal integrity. She was powerless to change the system but could protect herself from it by avoidance:

> So we left it and then I got another appointment sent through to me, something to do with neuro-physical tests or something and it said on it – 'Please be aware that you may be required to give a urine sample'. I never kept the appointment, so it doesn't matter. I rang them up and cancelled it. It's all this 'Big Brother' business. 'We know what we're doing.' And I don't think they do.
>
> Veronica

Unlike Veronica, Judith did persist with hospital treatment, but used various strategies to minimise her feelings of vulnerability and powerlessness. Around the time of her interview she had attended a hospital appointment that involved an intimate examination by her consultant. Her coping strategy involved disclosing her history to the attending nurse and taking a friend to talk to her throughout the examination, 'to keep me calm and to remind me all the time that I was in the present and not in the past. I wouldn't get into that situation of getting hooked'. But she also had to set definite limits on where she could be touched:

> J: . . . he [consultant] sent me round the curtain and I thought, 'I'm not getting on that bed.' So I was standing there and he said, 'Come on, you're going to have to get up there for me to examine you!'
> L: Oh dear! How did you do it in the end? You obviously managed to do it.
> J: I allowed him about that much actual contact area [gestures to a very small area of her body] and that was it.
>
> Judith

Her consultant enabled her to cope with the examination because he wisely kept to the limits she had set, not abusing his position of power, therefore giving her more control over the procedure.

Claire and her urologist had developed a coping strategy in which she would hold his arm while he was performing intimate examinations. This gave her a perception of being more in control as she was able to move his hand away if the procedure became overwhelming. It also provided her with a link to reality, which helped to prevent her slipping into a flashback. They obviously had a good rapport as she felt listened to and respected by him, which enabled her to cope with consultations. This doctor was obviously willing to spend time with his patient and engage in an equitable relationship.

Unfortunately, however, healthcare workers are often 'blind' to the potential impact their apparently 'routine' procedures might have. During her interview, Stacey described a recent appointment in an outpatients' clinic in which she was expected to perform a bodily function in the presence of a male consultant and two female members of the care team who appeared to be totally oblivious to her need for privacy.

> He said, 'Do you want me to leave the room?' I said, 'Well, I'm not doing it in

> front of you!'. [. . .] and he went, 'Okay, point taken. I'm going.'
>
> Stacey

Despite this, the two female staff members, who clearly expected to stay, had to be asked to leave.

> And I had to do it very jovial because I could feel the anger rising, and I thought I'm going to lose it, I'm just going to walk out and I knew I needed this problem sorted.
>
> Stacey

Fortunately, on this occasion, Stacey felt confident enough to challenge the status quo. However, most women, and in particular survivors of CSA, would not have found the courage to resist and, consequently would have been exposed to the risk of re-traumatisation. I find it disturbing that even after she had tackled the consultant, the women had to be asked to leave. Arguably, most people would not have defended their right to privacy as tenaciously as Stacey, and would have either subjected themselves to (at the least) a highly embarrassing experience, or walked out, as she was tempted to do.

When I asked Lynne how she felt intimate procedures and examinations could be handled more appropriately, she cited a recent visit she had made to the practice nurse for a cervical smear test:

> I think the nature of the person, like the nurse I saw last week before my scan. She was talking to me and asking me how did I like living here and interesting herself in me as a person before she did any of the examination and explaining what she was going to do and why she did it. So, I suppose, being acknowledged that I'm a person there, rather than an object on a conveyor belt of vaginas that she's looking at.
>
> Lynne

As her comment suggests, and the experiences of Judith and Claire demonstrate, a significant factor in either triggering or avoiding flashbacks is the manner in which a procedure is undertaken. The women described coping well, or adequately, with potentially distressing procedures when they were treated with kindness, respect and consideration. It appears that feelings of powerlessness, loss of control or objectification had a far greater potential to cause flashbacks and re-traumatisation than the procedures in themselves. However, when asked if Claire's strategy (holding the clinician's arm when performing an intimate examination) would be useful to her, another interviewee reacted very negatively:

> Not for me at all, no. No, that would be really weird and my first reaction to that is that it would be sexual. [. . .] I think any touch is an immediate um . . . acceptance that I'm going to have sex, when I'm feeling that vulnerable, that

> touching would be followed by sex . . . so that would be scary.
>
> Lynne

One woman felt that the presence of a chaperone for an intimate examination was essential whereas another found the idea of another person being present totally unacceptable. What emerged from the women's accounts of what was helpful is that there is no single formula or 'magic bullet' that can be applied to each situation for all survivors. Each person must be treated as an individual on an individual basis.

These women's stories demonstrated the far-reaching and long-lasting consequences of CSA and their resultant vulnerability. Because it occurs at an early stage in an individual's development it has the power to significantly influence their perceptions of themselves and the world around them. Its impact is very much in evidence in the building blocks that form personality and in a survivor's response to stressful events throughout life, because it interferes with the child–parent bonds, which are central to the child's subsequent sense of security and ability to trust. Many of these women's accounts reflected the way in which their sense of vulnerability and powerlessness deeply affected their lives, from the position in which they slept, to what they chose to wear, and how they related to others.

Particularly relevant to this study was their contact with individuals or bodies in authority because the power disparity present in the interaction is highly reminiscent of that which exists in the abuser–victim relationship. Situations in which the women felt out of control or helpless had the power to cause flashbacks to abusive scenarios and re-traumatisation. Many of the interviewees found ways in which they could minimise the possibility of this occurring, some avoiding contact with authority as far as they could, while others formed coping strategies which would enable them to retain some sense of control. In the arena of healthcare, the women found the impersonal, dehumanising effect of the 'assembly line' unacceptable and expressed the need to be treated as people and as individuals. When practitioners took a collaborative, respectful approach, the women were enabled to cope adequately with procedures having the potential to traumatise.

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CHAPTER 5

The psychological needs of birthing women, post-traumatic stress disorder and traumatic childbirth

First, in order to understand more fully the needs of survivors of CSA giving birth, let us take a look at what research says about the needs of birthing women in general. No woman approaches birth without a history of some kind, and it is very likely that some will have previously suffered traumatic experiences not necessarily associated with CSA. Halldorsdottir and Karlsdottir undertook some very useful phenomenological research into the experiences of mothers who gave birth in Iceland, with particular reference to their perceptions of midwifery care.[1,2] Both studies reveal the huge impact that carers can have upon women's lived experience and lasting perceptions of childbirth. Their interviewees' accounts highlight three main areas of need as they journeyed through to motherhood: 1) caring and understanding from their attendants; 2) security, which involved being kept informed of what was happening; and 3) a sense of control of self and circumstances.

CARING AND UNDERSTANDING

All the respondents in both Halldorsdottir and Karlsdottir's studies agreed that caring and understanding from staff were essential components of their birth experiences. This included the valuing of human qualities such as kindness, connection, companionship, assistance and support. One of their interviewees spoke of her midwife looking straight into her eyes and touching her warmly, which she found hugely helpful.[1] These findings were supported by the work of Berg *et al.* who identified qualities such as friendliness, openness, interpersonal congruity, intuition and availability in midwives as important to women.[3] Lazarus, in her studies of the needs of 98 poor and middle class American women, reports that while control was more important to middle class women, the issues of caring, respect, warmth and emotional support were paramount to all the interviewees

regardless of their background.[4] In their survey of 2686 Swedish women examining maternal satisfaction with intrapartum and postpartum care, Waldenstrom *et al.* report that taking all the factors involved in intrapartum care into account, those related to the emotional aspects of care appeared to influence women's overall assessment the most.[5] This also emerged from the findings of Tarkka and Paunonen, who report from their questionnaire-based study of 200 mothers that those who were provided with good emotional support from their midwives described labour in more positive terms than those who did not.[6] Furthermore, women scoring the highest long-term satisfaction ratings in Berg and Dahlberg's study had 'positive memories of the caregivers' words and actions' and felt their birth experience had enhanced their self-esteem.[7]

SECURITY AND TRUST

According to Halldorsdottir and Karlsdottir, the desire to feel safe and secure was met by the presence of a competent, caring midwife who would guide the women through the course of labour with reassurance and information.[1] They wanted their midwives to be competent and to know what to do in an emergency but stressed their need to have a trusting relationship with them. The issue of being able to trust the competence and knowledge of caregivers was also a theme highlighted by the women interviewed by Berg and Dahlberg.[7] The importance of a sense of security was mentioned by many of the women in Tarkka and Paunonen's research, which, similarly, they attributed to professional competence coupled with warm, supportive care.[6] One described her midwife as being very professional, giving her explanations and information while taking account of all her needs. This midwife's calm and composed manner and warmth helped to give her a sense of security which she described as like having a friend with her. Conversely, failure on the part of midwives to provide a secure and caring atmosphere for the birthing woman could have disastrous consequences; one of Halldorsdottir and Karlsdottir's interviewees reported feeling very insecure and that she was 'stuck with all the responsibility' during labour.[2] This woman was apparently so deeply affected by her birth experience that she vowed never to go through birth again. Clearly, trust, both in the competence and character of the midwife, is an important component in women's satisfaction with childbirth.

Parratt and Fahy's small pilot study contrasts the medical with the midwifery models of childbirth care and their impact on women's sense of self following birth. They suggest that the midwifery model, i.e. a woman-centred way of practising that promotes continuity, individualised care, informed choice and consent, and shared responsibility, enables labouring women to: 'trust enough to let go of mind control and release their bodies'.[8]

The relinquishment of the rational mind and the entering of a state of altered consciousness is a well-documented phenomenon, observed in women undergoing normal, un-medicated labours. Anderson describes it as an: 'instinctive primal survival technique' which occurs in response to the intensity of the

experience of labour.[9] The interviewees in her study also emphasised the importance of trusting their carers in this context, one referring to the midwife as 'the anchor' that facilitates women finding that altered state.

CONTROL OF SELF AND CIRCUMSTANCES

There is a good deal of evidence that one of the major determinants as to how women perceive their birthing experience is that of feeling in control.[10–14] Green *et al.* in their 'Great Expectations' study investigated the psychological outcomes of birthing women, with regard to six 'conceptualisations' of control.[12] Three were identified as '*internal*': 1) control of own behaviour, 2) control during contractions, 3) making a noise; and three were '*external*': 4) feeling in control of what was done to them, 5) involvement in non-emergency decision-making, 6) involvement in emergency decision-making. With the exception of 'making a noise', feeling in control in any of these areas was associated with positive psychological outcomes.[15] The women in Halldorsdottir and Karlsdottir's study also expressed the need for control over their birthing environment.[1] Some of the interviewees spoke of being in their own private world where time did not exist and felt it essential that this 'inner space' be protected and respected.

The issue of the birthing environment was also the subject of a survey by the National Childbirth Trust.[16] Of nearly 2000 responses, 94% strongly agreed that their surroundings could positively or adversely affect the ease with which they gave birth. Interestingly, the comments about the hospital environment reflected the findings of Halldorsdottir and Karlsdottir, highlighting the women's need to have some control over who and how many came into the delivery room.[1] Green *et al.* also report that many people coming in and out of the labour room was significantly associated with women being dissatisfied with their birth experience.[12]

However, as Edwards points out, the birthing environment should not be perceived merely in terms of décor and the number of people in the room. She asserts that the 'material and ideological' environments should combine to 'free women's minds, bodies, spirituality and sensuality'.[17]

Creating an environment in which birth can take place is obviously the responsibility of carers and the appropriateness (or not) of that environment is, to a large extent, dependent on their ideologies and beliefs about birth. Significantly, in the Icelandic studies, the women's perception of control and mastery appeared to be rooted in the emotional quality of the care and support they were given and the focus of their midwives. One woman recounted how she was finding the pain of labour overwhelming until she had a change of midwife. Suddenly, she felt in control and started to work with her body instead of being overpowered by the experience. She put the difference down to being cared for by a midwife who was woman-centred rather than task-orientated. 'Her attention was first and foremost on me.'[1]

Berg and Dahlberg in their phenomenological study of women who

experienced complicated birth also highlight the impact of positive carer support on the perception of control and consequently their ability to cope.[7] They speak of the power of 'affirmation' to give women a feeling of control over labour and their own bodies, helping them to access their inner strengths in coping with the pain. In one of their research projects, Halldorsdottir and Karlsdottir looked specifically at the effect caring and uncaring encounters with midwives had on birthing women.[2] They refer to the importance women placed upon carers demonstrating 'genuine' concern for them and their partners. Part of being genuinely concerned, they argue, entails respect; taking the initiative when appropriate but also giving the woman space to choose for herself. The researchers coined the phrase 'professional intimacy' to describe this approach. An important aspect of professional intimacy, they maintain, is not trying to control or gain power over the woman but empowering her. The women who had experienced caring encounters with their midwives spoke about their ability to maintain this delicate balance. Encounters in which women's needs for 'compassionate competence' were met resulted in their perceiving themselves to have had a 'successful birth', which is also supported by the work of Simkin.[18,19]

Green *et al.*,[12] however, report that women in their study who were the least satisfied were those who had the highest number of obstetrical interventions, which at first glance appears to somewhat contradict findings on the importance of relational care. However, they state that having interventions does not result in women feeling dissatisfied with how they are treated by staff, but that the quality of care they receive is assessed separately. This suggests that other factors such as 'how' interventions are carried out may be more important than the procedures themselves. It could be argued that the scenarios in which the interventions occurred provided those women with more opportunities to experience substandard emotional care than those who had little intervention. Indeed, the researchers go on to say that issues such as control over what was done to them, information giving and communication were seen as key ingredients in the women's satisfaction.

THE CONCEPT OF 'MASTERY' AND ITS RELATIONSHIP TO CONTROL

Humenick, in her review, identifies 'mastery' as a recurring theme running through the childbirth literature and stresses the important role that control or mastery over their birth experiences has in relation to women's satisfaction.[10] The importance of a sense of mastery over labour and birth is also highlighted by Seiden, who emphasises the role of carers in either facilitating or hindering this.[20] She points out that women cannot achieve a sense of mastery when faced with severe pain or possible death, or when treated as if they are sick or incompetent. She refers to childbirth as an 'aggressive and libidinal task', the mastery of which is essential for confident, effective parenting. This is reflected in the comments of one of Edwards' home birthing interviewees who described birth as 'sexualising' and 'animal', the power of which she found very helpful.[17]

Niven, whose study focused specifically on coping with pain in labour, acknowledges that although it is desirable that midwives should be able to skilfully administer pharmaceutical pain relief, the midwife–mother relationship is more important because it allows the woman to fully utilise her own coping skills.[22] Anderson gives the account of Daniella, a woman who experienced a profound loss of control during the second stage of labour through severe pain, lack of trust in her body and also in her midwife. She described a second midwife, who came in and took charge of the situation, giving her a sudden surge of energy and confidence, as an 'angel'.[9]

Although some might argue that this midwife was being controlling or too directive, her actions were entirely appropriate for this woman who, at the time, needed to feel that someone was in control. Her motivation was not to control the woman, but to help her to regain a sense of control and thereby achieve mastery over the experience. The worst possible scenario, suggests Anderson, is that women perceive that no one is in control over their labour.[9] This observation may, in part, provide an answer to why some women feel a loss of control in childbirth. Inevitably, they enter labour with expectations or ideas of how events will unfold and how they would like to be cared for. When their expectations are met with coldness and indifference, the resultant feelings of betrayal, bewilderment or shock may make them vulnerable to traumatisation. This is demonstrated in Halldorsdottir and Karlsdottir's study, when women who reported uncaring encounters with midwives reacted with 'puzzlement and disbelief'.[2]

Helping a woman to achieve mastery over the rigours of labour could be likened to guiding and supporting someone sailing single-handed through tumultuous seas. The sea remains uncontrollable, but the sailor can gain an immense sense of mastery on reaching her destination having plumbed the depths of her own inner resources and emerged triumphant through the ordeal. It seems that most women do not expect to control labour per se, but they do look to their carers to 'get into the boat with them', to provide the support and encouragement they need, whatever that entails.

THE LINK BETWEEN CARERS AND CONTROL

Halldorsdottir and Karlsdottir conclude from their findings that high quality, emotionally supportive midwifery care appears to be a key element in women achieving successful birth experiences, consequently minimising the risk of psychological trauma.[1] They assert that, contrary to the belief that a long and difficult birth will cause a woman to lose her sense of control, the situation may actually be the reverse. Their findings, they maintain, suggest that women lose their sense of control through a perceived lack of caring, control and security which leaves them with feelings of helplessness, causing them to perceive the event as long and traumatic.

It would appear, then, that a woman's sense of control during labour and birth may be as much, if not more, dependent on the attitude and actions of her

attendants as on the physical characteristics of the experience alone. In fact, as we have seen, being cared for and supported appropriately can alter a woman's perception of pain and help her to cope more effectively.

The desire of labouring women to be treated with 'genuineness' on the part of their carers is also important, in that they need to feel that their labour attendants have more than a 'professional' interest in them.[1,2,7,21,24] One of the women interviewed by El-Nemer *et al.* described the desire for genuineness in their relationships with carers as being helped 'from the heart'.[23] This sentiment is also much in evidence in the work of Wilkins who examined the 'special' relationship between women and their community midwives.[24]

Significantly, all the respondents in both the Icelandic studies had problem free pregnancies and normal births in hospital, so none of their dissatisfaction could be attributed to high levels of medical intervention, instrumental or operative deliveries.[1,2] 'Uncaring', state Halldorsdottir and Karlsdottir, has been 'strangely neglected' in nursing and midwifery research, but if the impact can be such that a woman may be deterred from ever giving birth again, the profundity of the issue must be acknowledged. They conclude that 'uncaring' should be considered malpractice and treated as such.[2]

WHAT CONSTITUTES CONTROL?

Clearly, control can mean many different things to each individual. Women generally acknowledge that they cannot be in control of the physical manifestations of labour but need warm emotional support to cope with a highly challenging and intense experience, thus achieving mastery. It seems that, rather than having a desire to be in overall control, what women fear most is suffering a loss of control and the resultant feelings of helplessness. In some circumstances 'having control' may mean a midwife coming into a birth scenario and being directive; in others, it may be a midwife who unobtrusively enables the woman to access her own inner strength. More often than not, 'control', or lack of it, is concerned with the actions and attitudes of carers. Of the three major themes (caring, security and control) identified by Halldorsdottir and Karlsdottir,[2] I would argue that, in fact, women's perception of control is a result of, and dependent on, the existence of the first two.

Having identified control as a major determinant of women's satisfaction with childbirth, it is, however, impossible to arrive at one single definition of control because the perception and experience of it is seated within the individual and may change according to circumstances. Rotter[25] suggested a 'Locus of Control Scale', a continuum, with individuals who perceive that life is primarily a consequence of their own actions (internal locus) at one extreme, and at the other, people who believe that their lives are primarily influenced by external factors (external locus). Those at the 'internal' extreme, he postulates, tend to be more assertive while those with a prevalently 'external' locus are more susceptible to depression or aggression associated with feelings of powerlessness. Raphael-Leff

likewise suggests that there are two divergent types of birthing women at opposite ends of a continuum, the 'facilitator' and the 'regulator'.[26] The facilitator, she asserts, is focused on the process of pregnancy and birth taking their 'natural' course and 'gives in to the emotional upheaval of pregnancy' while the regulator may feel 'invaded' by pregnancy and resists it. Consequently, the regulator is keen to use any means to avoid discomfort and maintain her self-control. However, I would suggest that one individual may react differently in diverse circumstances depending on what options are available. Thus a woman who could be described as assertive and articulate in her employment situation can become helpless and muted in a hostile birth environment. Waymire cites the case of a survivor of sexual abuse who 'screamed for an epidural' during her first birth (appearing to be a 'regulator') but opted for a natural, unmedicated birth for her second child.[27] Her choice of pain relief during the first experience, however, was made as a result of the non-supportive attitude of her carers. When, for her second birth, she was supported by a sympathetic nurse-midwife, she was enabled to make a genuine choice, to have a natural birth. The woman's behaviour was determined by the degree of support given by her carers. From this we can also see that control is strongly linked with the existence of true choice.

LOSS OF CONTROL: THE IMPACT ON CHILDBEARING WOMEN

Without a doubt, women's perceptions of, and need for, control are diverse and influenced to some extent by their own personalities, life experiences and subsequent expectations. The fact that control and mastery are of great importance to the majority of birthing women is undeniable. Conversely, lack of control and resultant feelings of powerlessness during the birth experience is one of the major traumagenic factors associated with psychological morbidity following childbirth. In recent years it has been recognised that a disturbingly substantial number of women are emerging from 'normal' birth suffering from PTSD, experiencing some of the symptoms or describing it as traumatic.[28–40]

Just as I was embarking on writing this book in 2009, I was contacted by a couple who were struggling to come to terms with their traumatic hospital birth experience almost 18 months previously. She had apparently had a 'normal' delivery and their distress was grounded totally on the attitude of the midwife 'caring' for her during labour. Their story revealed a lack of respect, information giving, communication and emotional support:

> . . . my wife asked if she could see the monitor. X's [Midwife] response was 'Err, that would be a *no*!' as if her request were outrageous. [. . .] My wife later heard X discussing this with another member of staff in the corner of the room in a way that totally disrespected her.
>
> My wife expressed concern about her body not dilating properly as very little had happened in spite of strong contractions. This was met with a brusque comment

> like 'some people never dilate, they need surgery, it's the drip or nothing'.

These incidents were only two among many others in which the woman was treated with distain and a complete lack of humanity by her midwife. Such was the impact of this that she developed some PTSD symptoms and, despite wanting to add to her family at a later date, was left feeling that she could never consider having more children:

> I have thought about being sterilised as I'm so afraid of becoming pregnant again. I want to do everything in my power to prevent anyone else experiencing the inhumane treatment I received which resulted in a very traumatic birth.

Sadly, she is not alone. I regularly hear similar stories from women who are contemplating a second pregnancy following a first traumatic birth experience. The most prominent feature of all their stories is how they were left feeling out of control and humiliated by uncaring 'carers'.

POST-TRAUMATIC STRESS DISORDER

'Post-traumatic stress disorder' was first described among Vietnam War veterans and was initially associated with the psychological symptoms of men who had suffered horrific combat experiences.[31,41] There are strict criteria governing the diagnosis of the condition; the client must have:

1 experienced an event outside the normal range of human experience which would be markedly distressing to almost anyone
2 repeatedly re-experienced the event in some way
3 persistently avoided stimuli associated with the event or experienced emotional 'numbing'
4 experienced persistent symptoms of hyper-arousal
5 experienced symptoms for at least a month.[42]

Since that definition appeared, the first criterion has been expanded to include 'direct personal experience' of an event that involves actual or threatened death or serious injury, or a threat to the 'physical integrity of self *or others*' to which the individual's response is of 'extreme fear, helplessness or horror'[43] (my emphasis).

Traumatic childbirth

It is only since the last decade of the 20th century that childbirth has become recognised as a potential trigger for the development of actual or partial PTSD.[44] The exact number of women emerging from childbirth with symptoms that fulfil all the criteria for the diagnosis of PTSD remains uncertain, but research reveals that the number of women who are at least partially symptomatic may be substantial. Menage, one of the earlier researchers on the subject, in her practice as

a GP, encountered women who were fearful of future pregnancies and gynaecological procedures and appeared to have suffered long-term psychological harm as a result of previous experiences.[30] She hypothesised that trauma sustained during obstetric or gynaecological events might cause PTSD and that there might be similarities between these events and sexual assault, particularly where the woman perceived herself to be powerless. Five hundred self-referred volunteers, who had undergone obstetric or gynaecological procedures, took part in her study, recruited via advertisements in local and national press, and in women's magazines. Six per cent met the criteria for the diagnosis of PTSD, whereas 20% described the event as 'very distressing' or 'terrifying'.

Later, Soet *et al.*, examining the prevalence and predictors of psychological trauma following childbirth, used questionnaires administered to women in late pregnancy and approximately four weeks after the birth.[37] They found only 1.9% of their 103 respondents (recruited through childbirth education classes) met the criteria for PTSD, but 34% reported their childbirth experience as traumatic, while 30.1% were partially symptomatic. Olde *et al.* collected data on psychological predictors of childbirth PTSD from women who gave birth in a suburban region of the Netherlands as part of a larger study looking into the effects of thyroid hormones on birth.[40] They reported that 2.1% of their 140 participants were diagnosable with PTSD, while 21.4% described their birth experience as traumatic. Similar results were obtained by Ayers and Pickering in their prospective study on incidence of PTSD after childbirth, which surveyed 499 women contacted through the antenatal clinics of four hospitals.[34] They identified 2.8% of their respondents as suffering from PTSD. Although the percentage of women meeting all the criteria for the diagnosis of PTSD is relatively small, the numbers being partially symptomatic or describing their birth experience as traumatic are disturbingly high. In 2005, *Mother and Baby Magazine* conducted a survey of 3000 British mothers in which 78% said they found their birth experience 'frightening', with more than half of them saying it was 'far more shocking than they thought'.[45] None of these projects set out with the stated intention of examining the impact on women with a predisposition for trauma. It is reasonable to assume that although some of the respondents will have been predisposed to PTSD, the majority will not. Research suggests, then, that as many as one in three women perceives her birth as traumatic and may suffer long-term psychological morbidity as a result.[33,37,40]

What causes birth trauma?

There are many diverse factors involved in women developing PTSD following childbirth. First, certain women may have predisposing antecedent factors such as a history of sexual violence, lack of social support, previous miscarriage or a higher trait anxiety (tendency to experience anxiety).[31,37,46,47] Indeed, Soet *et al.* found that women who had been sexually abused were 12 times more likely to suffer PTSD than women who had not, although they do warn that the small numbers involved in their research means that their findings must be treated with

caution. Other traumagenic factors that have been associated with the event of childbirth include high levels of obstetric intervention, extreme pain, emergency caesarean section, instrumental assisted delivery, fear for their baby's or their own life and the birth of a sick or stillborn baby.[12,31,33,37] However, what is universally agreed upon is that women who experience loss of control, or who feel powerless or helpless for any reason during the birth of their baby are much more likely to perceive it as traumatic and develop long-term psychological problems.[32,35,37] This is highlighted by Ballard *et al.* who examined the case histories of four women who suffered PTSD as a result of their birth experiences.[48] The first had undergone an elective caesarean section under epidural anaesthesia for transverse lie. Unfortunately, the anaesthetic was not fully effective and the woman experienced excruciating pain. Despite 'screaming, shouting, and struggling to get off the operating table', she was held down by attendants who continued with the operation. The second had what the authors describe as a 'problem free' delivery, but pain relief was 'not optimal'. However, she had been left alone for long periods during labour and, as a consequence, felt unsupported and uncared for. The third woman's birth was complicated by a shoulder dystocia and her baby suffered a cardiac arrest but was successfully resuscitated. The fourth had planned to labour under epidural anaesthesia but had been denied this by her non-communicative midwife. She 'went into shock' on realising that she was expected to deliver without her chosen method of pain relief. After delivery, her 'off-hand' midwife went on to ignore her request to leave her perineum unsutured. The researchers speculate as to a possible cause for these women developing PTSD and highlight the fact that, in each case, a feeling of 'lack of control' was described. Clearly, the issue of PTSD in the context of birth is a complicated one, but feelings of powerlessness and lack of control appear to be almost universal.

Many of the investigations into this topic were undertaken in a predominantly positivist manner, using written or telephone questionnaires, and although they are useful in identifying '*what*' may cause a woman to perceive her birth as traumatic, they are inadequate to answer the questions, '*why*?' and *'how do women feel about it*?' It is to qualitative and/or feminist research and to women's own accounts that we must turn to understand this.

The accounts of women who have perceived their birth as traumatic are shot through with references to cold and unsympathetic carers, staff who are task-focused and/or fail to provide sufficient information or explanations. One of the Icelandic women described her distress at her midwife's apparent lack of concern and interest in her as she was labouring, describing her as 'completely indifferent' and 'careless'.[2] Reflecting somewhat the findings of Green *et al.*[12] all the respondents in Moyzakitis' study of six women who reported their births as traumatic had been subject to a high level of medical intervention in labour.[39] However, her data gives a valuable insight into exactly *why* women found these situations traumatic. The interviewees spoke of 'carers' who did not listen to them, excluded them from any decision-making and who misused their position of power. One recounted that she was screaming at the midwife suturing

her perineum to stop, but that her pleas were ignored as she continued with the procedure unmoved. This caused her to 'blank out completely', which was almost certainly a dissociative response.

Church and Scanlon describe the experiences of a young mother ('Sally') who was referred to the Community Mental Health Team suffering from post-traumatic symptoms following birth.[35] It took several weekly 'sessions' before Sally was even able to recall the details, but eventually she explained that she had wanted a 'natural' birth. However, as her labour became complicated and increasingly medicalised, she felt a complete loss of control and became convinced that she and her baby were going to die. However, many of her subsequent nightmares and flashbacks involved the behaviour of a doctor who, during the episode, had 'pushed his face towards her and shouted at her'. This, she found abusive and predatory, but it also had a deep impact on her husband, who had witnessed the event, leaving him feeling 'emasculated and ashamed'.

The first volume of the *AIMS Journal* in 2007, devoted to birth trauma, is also testimony to the lasting emotional wounds sustained by women who have experienced this kind of treatment:

> I was deceived, neglected, insulted, assaulted and ignored by hospital staff.[49]

> It is hard to explain the emotional assault of being cut open by people whom you know have no respect for you or your wishes, the feeling of utter powerlessness.[50]

It is striking how, in all these stories, comparatively little is said about the purely physical process of birth. The vast majority of traumatic childbirth accounts are concerned with the human element and the denial of women's psychological and emotional needs.

Birth trauma and the betrayal of trust

Women appear to experience a sense of betrayal when those responsible for their care treat them coldly and callously. One woman, interviewed by Moyzakitis, recalled her midwife telling her sternly not to be silly and to pull herself together when she was screaming in pain.[39] She had expected the midwife to react with kindness and comfort but was shocked by her response: 'All I wanted was some reassurance,' she said. One of the women in the case report paper by Ballard *et al.*, referred to previously, portrays a sense of betrayal towards her attendants.[48] She had been referred to the hospital in question specifically because it was able to offer a 24 hour epidural service, and, felt that delivering without this means of pain relief was not an option for her. Having been denied her request by her 'offhand' and 'authoritarian' midwives, she felt she had been forced to endure unbearable pain. Long after the event she continued to have repetitive and intrusive thoughts about the punitive attitudes of the midwives and described herself as wanting to beat this midwife to a pulp.

According to Williams, whose article gives an account of her experience of giving birth to a stillborn baby, the event was rendered all the more traumatic by her attendants' lack of empathy and communication.[51] She felt that if these needs had been met, she might have been spared the profound psychological trauma that ensued. This sense of betrayal also emerges in the research conducted by Beck.[38] She undertook a project which involved mainly internet interviews with 38 women who had experienced birth trauma in several different English speaking countries. Many of her interviewees continued to experience deep anger at the treatment they had received at the hands of hospital staff: 'Why did I trust the doctors? How could I have been so stupid?' The depth of emotional distress experienced by these mothers is heart-rending. Some described 'reliving' the experience time and time again, like a movie continually playing in their heads, while others reported feeling 'dead' or numb. One described waking up each morning unable to feel a thing and then dragging herself through the day.[38]

The vast majority of trauma-inducing factors in these women's experiences were concerned with the manner in which they and their births were 'managed' by others. Their needs for control and mastery, human warmth, encouragement and information went unacknowledged and unmet. Beck concludes that the best intervention to prevent PTSD occurring in the first place is for practitioners to take responsibility for providing more than 'safe care', to treat each and every mother caringly and to communicate effectively.

Birth trauma and sexual violence

Disturbingly, women's accounts of birth trauma frequently resemble those of women who have been subjected to rape and sexual violence.[30,38,52]

> I cried and shouted but was held down and told to stop making a noise . . .[30]

> I felt like an animal being slaughtered[53]

Kitzinger describes how she and her daughters (who were working with female rape victims) compared the language used by 345 mothers who had experienced birth trauma with that of rape victims describing their experience of sexual violence.[52] It was remarkably similar. Some spoke of being stripped of their sense of personal identity: 'I was merely a vessel with my contents to be offloaded.' The common thread, states Kitzinger, was that of complete powerlessness. She also compares the various mechanisms at play in a rape scenario with that of the traumatic childbirth situation. Both groups of women may suffer acute pain and genital mutilation, both may be coerced into compliance by emotional blackmail or threats and both suffer forcible exposure of their genitals before strangers.

Birth trauma and sexual dysfunction

Not surprisingly, as a consequence of traumatic birth experiences, women may suffer from long-term sexual dysfunction.[36,38,54,55] This may be founded on the fear of becoming pregnant again, or, in some cases, because the sexual act triggers memories of the birth. One of Beck's respondents reported having nightmares of her delivery doctor as a rapist, another, having refrained from sex for six months following the birth of her child because the 'moment of penetration' caused her to have flashbacks to being pulled down the bed during an unsuccessful forceps delivery.[38] Another, quoted by Kitzinger, described how sex with her partner caused her to have 'shooting pain' and 'a vision' of the doctor who sutured her perineum.[56] In addition, partners are also susceptible to traumatisation which can have a profound impact on their subsequent relationship.[35,57]

Birth trauma and its impact on the mother–baby dyad

The experience of birth trauma may also have a negative impact on a mother's relationship with her baby. Reynolds, Professor in the department of family medicine, University of Western Ontario, describes having contact with women whose chronic distress following traumatic birth not only affected their own sense of self-worth but also their ability to breastfeed and bond with their children.[31] They remembered their births only with 'pain, anger, fear or sadness', or, in some cases, they were unable to recall anything, which, Reynolds suggests, is indicative of trauma-related amnesia. Moyzakitis reports that all six of her interviewees identified difficulties in their relationship with their babies which they attributed to their birth.[39] One woman recalled not wanting her baby near her for a couple of days after the birth and that, during that time, she would not have minded if she had never seen him again.

Although this woman reported having difficulty relating to her infant for a short time, for others it may take much longer to develop a satisfactory bond. Three out of the four women described by Ballard *et al.* had ongoing difficulties relating to their infants following traumatic birth.[48] One (before giving birth) was described as outgoing and confident, happily married and welcoming of her pregnancy. Antenatally she had regularly sung and talked to her unborn child. Following her birth experience, however, she became clinically depressed, felt the baby was not hers and avoided all contact with him because of the 'intrusive recollections' he triggered in her. It took almost two years for her to recover, during which time her husband was obliged to take over caring for their baby and her parents moved house in order to be near enough to provide help and support.

Discussion in the Midwifery Matters 'nettalk' pages in 2004 also gives a moving illustration of the enduring problems and emotions that women may experience in relating to their children after traumatic birth.[58] One reports feeling resentment towards her child, another that her relationship with her child (who was at that time 10 years old) had been 'spoilt'. A third describes feeling that she had not given birth to her daughter but 'had her taken out instead . . .'

The work of Beck provides one of the most useful insights into the world of

women traumatised by birth.[38] Her phenomenological study is a rich source of data on the lived experience of these women and is striking in its impact. Some of her respondents describe the well-documented 'numbing' and dissociation sequelae (*see* Chapter 8) associated with trauma[59,60] which interfere with the task of mothering. Women felt themselves to be 'dead', their 'souls having left their bodies' and their existence continuing as a mere 'shell'. One described her inability to feel and embrace motherhood as her 'Gethsemane'.[8]

Emanating from many of these accounts is not only a profound disappointment and regret for what might have been, but a deep sense of isolation and shame. Beck also describes how women traumatised by birth often isolate themselves from other mothers and babies to the extent that one woman arranged to schedule her baby's clinic appointments 15 minutes before the clinic opened in order to avoid meeting other mothers.

Birth trauma and its impact on subsequent pregnancies

Recently, the issue of women requesting elective caesarean section in order to avoid labour has been hotly debated,[61,62] resulting in the popular stereotype of the woman who is 'too posh to push'. Although there may be some who eschew vaginal birth for relatively superficial reasons, it appears that some women feel unable to face normal labour for reasons more to do with their fear of losing control or of not placing themselves in situations which might be reminiscent of previous traumatic experiences.[62] Significantly, a study carried out in Stockholm into reasons for women's anxiety about childbirth reported that of the 100 respondents, 73% gave their main reason for fear as 'lack of trust in obstetric staff during delivery'.[63] Hofberg and Brockington examined the experiences of 26 women suffering from tocophobia, 13 of whom suffered from secondary tocophobia (fear of childbirth resulting from a previous distressing or traumatic delivery).[64] Of these, 11 arranged elective caesarean sections in order to avoid going through labour. It is also noteworthy that of the 26 interviewees, eight had experienced either CSA or rape. Their study also revealed that women who were refused their choice of delivery suffered higher rates of psychological morbidity than those who achieved their desired mode of birth. Of the three women who were forced to undergo vaginal birth against their wishes, all suffered from postnatal depression, two had symptoms of PTSD and two experienced delayed bonding with their babies. From this longitudinal study (the women were seen over a two year period) it emerges that elective caesarean section may constitute an avoidance strategy employed by women who are unable to face their fear, avoidance being one of the diagnostic criteria for PTSD.

Women are able to accurately remember the events surrounding their births for many years[18] and, as a result of a traumatic experience, may suffer long-term mental health consequences which interfere with the activities of normal daily life. Kitzinger quotes one woman who could not drive past the hospital where she had given birth without breaking out into a sweat.[57] Other women have been known to avoid people who remind them of the 'perpetrator' or take detours in

order to avoid going near the hospital building.[65] Consequently, a substantial number of women who have had traumatic birth experiences may choose to give birth at home for subsequent births. Arguably, opting for a home birth may be described as an 'avoidance' behaviour in that it minimises the possibility of loss of control which is associated with exposure to 'the system'. One woman quoted in research by Rhodes and Hutchinson explained her refusal to put herself in the situation again where anyone would have that kind of control over her, giving birth to her baby at home with a midwife.[66] Rose, who had been subjected to extreme and violent sexual abuse as a child, opted to give birth to her second child at home, a decision which was strongly influenced by a lack of trust in medical staff.[67] Furthermore, of the 19 births experienced by the incest survivors involved with Parratt's study, over a third of them took place at home.[68] Although it could be argued that this was predictable because she is a home birth midwife, in fact only one of her interviewees was an ex-client, the remainder having been recruited via incest survivors' support groups.

Clearly, the act of giving birth has a far greater significance to women than merely producing a healthy baby and is strongly associated with their subsequent psychological well-being, self-esteem, sense of mastery, relationships with their partners and the ability to parent their children. In order to successfully navigate the rigours of the birth process, they need to be provided with appropriate emotional care and support. The type of care women value is embodied in good, genuine relationships in which they feel valued, listened to and in which they can trust the character and competence of their carers. The issue of who is in control during the process is highly indicative as to whether the event will be perceived as traumatic or not. It is, however, impossible to define the concept of 'control' as it obviously holds different meanings for different women, but the evidence that the attitude and behaviour of carers have a crucial role to play in the prevention of birth-related PTSD is undeniable.

As we have seen, research into birth trauma suggests that, although the percentage of women fulfilling the criteria for the diagnosis of PTSD is relatively low (between 1.9 and 6%), up to a third of all women may be experiencing their births as 'traumatic'. It is very disturbing that women should be emerging from their birth experiences with symptoms identical to those suffered by individuals who have been sexually violated, involved in serious accidents, victims of crime, affected by natural disasters, abducted, involved in armed combat and imprisoned in concentration camps.

The accounts of women who have experienced traumatic birth are characterised by loss of control and feelings of helplessness, often linked with the perception that caregivers are unsympathetic, emotionally cold and uncaring. Shockingly, their accounts of birth trauma may strongly resemble those of victims of sexual violence and rape.[52] It would appear, then, that PTSD as a result of childbirth is, to a large extent, iatrogenic.[69] Survivors of sexual abuse have a predisposition for PTSD, but it is equally a cause for grave concern that women who have no known predisposing factors are also being diagnosed with birth-related PTSD.

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CHAPTER 6

Re-enactment? The women's experiences of giving birth

To all women, becoming pregnant requires a leap of faith into the unknown, but to survivors of CSA, the long journey into motherhood can be fraught with unexpected pitfalls. The majority of the interviewees described their pregnancies as planned, although some recalled having had mixed feelings about pregnancy and birth. As we saw in Chapter 4, several of them expressed surprise that they had been able to conceive at all given their unwillingness to engage in sexual contact, or because they were convinced that their bodies must have been ruined. Despite having planned their pregnancies, some women perceive pregnancy itself as an invasion of their bodies over which they have no control.[1,2] Jo described her unease on becoming pregnant with her first child:

> I knew there were things going on inside and I didn't . . . I didn't like it at all really. [. . .] I just felt that I shouldn't have done it . . . really, I shouldn't have got pregnant either.
>
> Jo

Kerry described her pregnancy as 'permeated with fear'. Apart from her doubts about her body being 'clean enough' to carry a baby, she also expressed fears about being 'invaded', not only by other people but also by her unborn child. Other women were not only frightened by the prospect of giving birth but equally terrified by their expectations of what would be done to them by maternity carers:

> I was very frightened. I was very, very frightened and the thought of going through childbirth terrified me. The thought of having people examining me terrified me. Nobody asks you whether it's all right.
>
> Amanda

Jo expressed very similar sentiments about her expectations of a hospital birth:

> . . . I knew I was going to have to deliver this baby . . . and I knew there were going to be more examinations and things being taken out of my control again, because I didn't feel strong enough to say 'No, I don't' (you know) 'I want you to do this', or explain the reasons why I would be behaving in certain ways.
>
> Jo

Their fears often went unspoken because they were unable, or unwilling, to disclose their anxieties to others. Jane questioned whether she was 'normal' or if other mothers also felt terrified of being examined:

> The other bit that's difficult with abuse is you don't know whether – well in life, really – whether you're a normal person experiencing pregnancy and every mother feels this, or you're just more bonkers than everybody else because you've been abused as well. Like getting your knickers off and things and being examined. Is everybody that terrified?
>
> Jane

The women perceived that in hospital they would be offered no choice about what was done to them and that they would be powerless to refuse. Lynne explained that, to her, the hospital environment was one in which control would be taken away and she would be unable to make her needs known. It appears that most of the women's fears centred on the loss of control involved in placing themselves in situations of dependence which would mimic their experiences of abuse. As we have seen, women with a history of CSA come to childbearing with much 'baggage', making them vulnerable to re-traumatisation. Their early experiences of betrayal, violation and powerlessness have a huge impact on their anticipation of the event and on their expectations of carers. Some women may perceive their bodies as dirty and view themselves with shame or self-loathing all of which make them particularly vulnerable to birth trauma.[3]

These interviewees had relatively little to say about the purely physical process of giving birth. Their accounts were full, however, of the impact that maternity care had upon their perceptions of birth and, in some cases, how this went on to affect their relationships with their babies. The experiences of the older women revealed the assembly line ethos at its zenith, particularly in the area of antenatal care. They described being processed in environments that were unfriendly, uncomfortable and impersonal:

> It was in a Nissen hut. You were given a grotty old dressing gown to put on. I waited four and a half hours. The place was packed with other pregnant women and loads of kids.
>
> Wanda

> You started at the back and you sort of moved round on the row of chairs like that and when you got to the front, you went in and it was just pot-luck who you saw!
>
> Claire

> . . . you had to wait and then they'd call your name over the . . . speaker system and they'd say, 'cubicle such-and-such', so you'd have to go in there and undress; you never knew how long you'd got to wait there . . .
>
> Veronica

On occasions, the stress of this environment proved too much for some of them and both Wanda and Veronica described themselves running out of the clinic and going home – Veronica often leaving her underwear behind in her haste to escape. The younger women had mainly received their antenatal care in the community from their community midwives or GPs. Consequently, there were no comments regarding the physical environment in which antenatal care was provided. In this respect, it appears that antenatal care has improved since the time of the older women's pregnancies. In some ways, the medical and midwifery staff described by the older women were more overtly dictatorial. Following her flight from the antenatal clinic, Wanda recalled her GP turning up on her doorstep an hour later and 'going bananas'. Veronica described being treated 'like a criminal' by hospital midwives because she wanted to bottle-feed her baby, and then being 'made' to breastfeed. Lynne reported being denied a home birth by her GP during her first pregnancy on the grounds that she was 'too old' (aged 29!). This is in contrast to the accounts of Rosie and Rhoda (referring to births which had occurred nine and two years previously) who, on requesting home births, were confronted with the concept of risk rather than an outright refusal. The accounts of the older women contained more reports of staff being openly rude, unkind or unpleasant. For example, Claire's labour attendants told her to 'shut up and get on with it' and the female doctor suturing Wanda's perineum snapped: 'Oh, don't start that off!' when she started to cry. Veronica also recalls maternity staff 'bullying' her and telling her it was ridiculous when her labour was not progressing well. However, despite the outward changes in care provision over the years, the accounts of the younger women revealed that maternity care could still be dehumanising, disempowering and inhumane, but usually in more subtle ways such as providers focusing exclusively on their genitals, lack of respect for their privacy or dignity, staff walking in and out of rooms or bed-spaces uninvited, or, in one case, being treated like a naughty child.

Both Sally and Stacey's first pregnancies occurred when they were teenagers. Stacey's firstborn was 18 years old at the time of her interview and Sally's son was six years. The judgemental attitude of some staff towards teenage mothers appeared to have changed little in the intervening years:

> Sister C, bless her, sitting at the desk [. . .] a big old dragon, didn't like unmarried mothers . . . didn't like young pregnant girls [. . .] you know, notes were slammed down on the desk, um, 'Have you got your urine sample?"
>
> Stacey

> . . . it's like the people trat [treated] me like I'd gone out and done it deliberately and they just sort of snubbed me at times [. . .] mainly because of my age I felt, with my first. It was just like, 'It's your fault, you've got to put up with it!' sort of attitude.
>
> Sally

Rosie, who was also a teenager during her first pregnancy, recounted her first birth in which she experienced loss of control through her labour being taken over by medicalisation, in which her birth plan was all but ignored. Others recalled being given pain relief without their consent, sutured by unknown male doctors who pressed on regardless of their obvious distress or being attended by staff who appeared intent on following protocols rather than interacting with them. Their trauma often stemmed from a lack of communication on the part of carers, or attendants who were focused on hospital routines, rather than the overt rudeness or dictatorial attitudes seen in the older women's caregivers. The traumatising factors seen in the interviewees' birth stories are very similar to those at work in sexual abuse. Powerlessness and betrayal, two of the components of Finkelhor and Browne's traumagenic model, featured prominently.[4] However, another important theme emerged: that of 'humiliation', and it is in the context of these three themes (powerlessness, betrayal and humiliation) that I will discuss the women's experiences.

POWERLESSNESS

One of the striking features about some of the women's accounts of hospital maternity care was the impression that, to a large extent, they were absent. Their stories were full of what was done to them, but contained little about what they did. The routines, rituals and procedures that form such an integral part of maternity care today overshadowed and obscured their role in birthing. Despite their fears about giving birth, none of the women in this study opted for an elective caesarean section as some tocophobic women are reported to do.[5,6] It appears that most wanted to be actively involved in giving birth.

Jo's account of her first labour (in hospital) reflects the findings of Soet *et al.*,[3] whose interviewees described being unable to mobilise and use their own pain management strategies being confined to bed by electronic foetal heart monitors, sacrificing their expectations of active birth for the requirements of the system:

> . . . I can remember trying to at one point, trying to get on all fours and rocking, because that seemed to help, but the leads wouldn't stretch and they were

> wrapped round me and things were . . . because I had got one round my leg and that was coming off, and then, there was no contact. It was just horrible, really horrible.
>
> Jo

Lynne described her distress when attached to a foetal heart monitor that was not registering her contractions:

> . . . and they wired me up to the machine that registers the contractions [. . .] and they said, 'Oh, nothing's happening . . .', you know, 'it'll be a long time yet – more of this'. And I was in absolute agony and I thought, 'Well, if it gets worse than this I'm just not going to be able to cope with it!' Then they found out the machine wasn't working!
>
> Lynne

This scenario provides an example of how maternity care has come to rely on the 'authority' of technology, which excludes women's knowledge. Lynne's opinion was not sought but she was informed by the 'experts', on the basis of their 'scientific knowledge', that she was not in labour. This situation is a vivid reflection of the dissonance of her childhood, when, she explained:

> . . . my father was abusing me but he was denying it. It wasn't spoken about, so that warped my sense of reality. Something is happening, but it's not happening.
>
> Lynne

As we have seen, survivors of CSA have a pre-existing vulnerability and may perceive themselves to be helpless, particularly in circumstances in which they encounter authority. This makes it difficult for them to withhold consent or make their needs known:

> I couldn't speak, I couldn't ask for any help. I just didn't want to be there at all . . .
>
> Lynne

This was also very much in evidence in Kerry's account as she describes how the hospital labour environment resonated stridently with her experiences of CSA; when, as a helpless child, she had been prevented from calling for help and comfort:

> . . . I was scared. I could hear other women screaming, obviously they were screaming because they were labouring too. But I didn't scream, I just swallowed all the sobs and cries because that was the way . . . I . . . did, as a child, swallowed all the sobs, the cries, when I was being abused. I was afraid, I was in pain, um

> . . . I had a mask over my face and my husband kept trying to put it on to my face which was again, you know, hands over your mouth, when you were being abused as a child to stop you shouting for help. So the whole experience was like being thrust back as an adult but still feeling like that helpless child in the dark and being so afraid and alone.
>
> Kerry

This account demonstrates how easily survivors can be precipitated into flashbacks of abusive scenarios when faced with situations that remind them of their abuse. Kerry's description of her daughter's birth by forceps is interesting in the way in which it is worded:

> . . . finally I was delivered of my little girl . . .
>
> Kerry

Kerry is a very articulate woman who chooses her words carefully. Arguably, most people would have said 'my little girl was born' or 'I gave birth'. Her choice of words paints a vivid picture of birth in which the birth-giver is absent as an active participant. This has a certain resonance with Wanda's comment about her future husband – 'he had sex with me' (*see* Chapter 4). The wordage is more descriptive of surgery or the removal of a body part than of a woman giving birth.

Jenny, who had planned a water birth in a low-risk unit within a large hospital, described how her labour became increasingly medicalised as she failed to make sufficient progress. Having been transferred to delivery suite, her identity as an active participant became that of a dependent patient:

> . . . a drip was put in my arm to re-hydrate me as my urine was showing large ketones [. . .] My contractions became more powerful after the fluid, yet a Syntocinon drip was still put up. This made me very angry and I yelled at the midwife to turn it off. This request was ignored. I was beginning to feel that I was totally powerless. I was no longer in control of this situation. Everyone around me was now in control and I felt like I had to do what they said.
>
> Jenny

Psychological morbidity following birth has been linked with high levels of obstetrical intervention[7,8,9] and this scenario may provide an insight into what lies behind this. Jenny's problems with the medicalisation of her labour stem from a loss of control over what was done to her and not being consulted or listened to. She became invisible. Interestingly, Jenny was the only woman to directly link the physical sensations of giving birth with those of sexual abuse. However, she explained that it was her sense of powerlessness that played the largest part in reminding her of CSA.

Jo described a scenario that occurred during the early stages of her first

pregnancy, in which she was vaginally examined by a consultant with several medical students in attendance:

> . . . it bothered me a lot, obviously, but I didn't say anything, as you don't, because that is what they do . . .
>
> Jo

Clearly, Jo felt that because this constituted part of what she perceived as 'routine' care and, therefore, what was expected of pregnant women, she had no grounds on which to object. The majority of women who have a history of CSA will find it difficult to question authority and for Jo, who had a deep fear of authority, this was particularly problematic.

As well as finding themselves absent through the medical and institutional management of their births, many of the women absented themselves by dissociating when they felt overwhelmed or out of control. Several of them spoke of this as a well-used coping strategy they had developed during childhood in order to endure their abuse. Dissociation, however, did not confer power but merely served to minimise the negative impact of being powerless. When asked how she dealt with intimate procedures Kerry said:

> I would cope as I always did, and completely dissociate with the situation.
>
> Kerry

> In hospitals on the occasions when I've gone to hospitals – and that's mostly to have the babies – and . . . all the examinations that you have to have [. . .] I'm not in my body – I'm not there.
>
> Lynne

Dissociation, then, was a means of coping with circumstances in which the women perceived themselves to be powerless. It was more often than not mentioned in the context of what was done to them by health professionals. This response is also very much in evidence in other qualitative research and survivors' accounts.[1,2,10–13]

ABSENT FATHERS

Several of the interviewees described how they were denied the support of husbands or partners when they were not allowed to remain with them during early labour. Apart from the known benefits of continuous labour support,[14,15] this deprived them, in some cases, of the only person whom they could trust and who might be expected to act as advocate on their behalf:

> They were telling me what to do, and what I couldn't do and . . . I can remember saying that I felt (you know, the pains were really bad because I went to the hospital

> and they sent my husband home because I was obviously in early labour) and um . . . and I was completely on my own through the night, wandering around corridors . . . trying to keep quiet because people were trying to sleep . . .
>
> Jo

Lynne's husband was sent home on her admission to hospital after being told by a doctor that labour was only in the early stages. Her husband complied and, as a consequence, missed the birth of their son. Claire recalls being angry with her husband for missing the birth of their baby after he was dispatched home by the sister in charge of labour ward. Jane described her feelings of vulnerability when deserted by her husband whom she needed to advocate for her. He, however, probably felt unable to challenge the midwife's authority, causing Jane to react angrily:

> I got really bad pain about nine o'clock and I wanted G to stay, so I asked the midwife and she examined me and said, no, nothing was happening, so he should go home till the morning, and I was really mad at him because I wanted him to say, 'No, I want to stay', but I just couldn't be assertive then. So he went and I hated him . . . for going . . .
>
> Jane

Antenatal wards are not set up to accommodate overnight stays by birth partners and neither can labour wards be populated by women who are not yet in active labour as this creates a bottleneck and threatens efficiency. Ironically, having sent the women's supporters away, maternity carers were in no position to provide adequate support for them. Thereby, the organisation effectively deprives women of a potential source of empowerment, separating them from those who could provide support and comfort.

VAGINAL EXAMINATIONS AND INTIMATE PROCEDURES

Intimate or invasive procedures could be predicted to cause problems for women whose bodily integrity had been violated as children. However, as I concluded in Chapter 4, the data showed that *how* a procedure was undertaken was far more significant in terms of the women's perception of it than the procedure itself. Procedures such as vaginal examinations and abdominal palpations, which are an integral part of routine maternity care, tend to reinforce the message that caregivers have power over women.[16] As Bergstrom *et al.*[16] point out, in an attempt to make it into a socially acceptable act, the VE has become highly ritualised and, consequently, dehumanising. Stewart also suggests that the ritual washing which aims to sanitise the procedure, may communicate to women a sense of dirtiness or pollution and this may strengthen survivors' pre-existing belief that their bodies are dirty or ruined.[17] Stacey's account of a VE that took place during her first pregnancy contains many of these elements:

> . . . and then in walks the doctor, who was all of about twenty-two, looking more nervous than me, which made me more nervous, and I just, when I got home I was physically sick [. . .] I couldn't say, 'Please don't touch me, please don't do that' . . . and it was that complete loss of control. And that . . . you know . . . that utter sort of disgust . . . and I felt dirty . . . I went home and scrubbed myself and was physically sick.
>
> Stacey

Arguably, because the doctor was of a junior rank and apparently unsure of himself, resistance or refusal might have been easier in these particular circumstances. However, she clearly felt this was not an option in an environment in which the power of medical and institutional authority set the agenda. I would suggest that both she and the young doctor were engaged in playing out a ritual over which neither had control.

From their observations, Bergstrom *et al.*[16] argue that practitioners develop strategies such as 'personal disembodiment' in order to cope with intimate contact with clients in the clinical area. This, as the authors suggest, acts to protect the professional from empathising with the client, an emotion which would seriously impede their ability to function in an environment in which such procedures are routine. However, this 'dehumanisation' may, to some women, be uncomfortably reminiscent of abuse:

> . . . it was when doctors sutured you up [. . .] it was an SHO [senior house officer] who'd obviously been dragged out of bed. [. . .] He didn't look at me once, didn't, didn't sort of get eye contact whatsoever [. . .] and I felt every single stitch he put in, every single, and I cried all the way through . . .
>
> Jo

> . . . and I had to be stitched up and I guess the birth itself in comparison was nothing. [. . .] They then put my legs up in stirrups to stitch me up and it all got very, very painful from then on. I was stitched up by a male . . . registrar, whoever it was, with my legs way up in stirrups, as close as they can get to your vagina basically . . . and I just felt like I was being assaulted and I was crying, and I just remember crying and when he'd finished, he said to the midwife, 'I'm not very happy with that. Can you get the senior registrar?', whoever it is they called in, and the senior registrar, another man, said, 'Oh no, that just won't do, I'll have to unstitch it and do it all over again.' And that's what I remember about my hospital birth. I just remember sitting in there sobbing, and them saying, 'Calm down – we've got to stitch you up.'
>
> Amanda

This scenario also contains several different elements which could be predicted to be problematic from a survivor's point of view and were obviously significant to Amanda; the restraint of her legs in stirrups, exposure of her genital area, pain

and a male who had close physical contact with and was focused on her genitals but who failed to communicate with her.

As I mentioned previously, one of Sheila Kitzinger's birth-traumatised respondents recalled feeling depersonalised by a doctor who 'never even looked at the top half' of her, reducing her to a vessel whose contents were to be offloaded.[18] Some of the women in this research expressed their feelings in remarkably similar terms:

> I feel that with both children I was just a machine producing a child and once the child was born I was cast aside.
>
> Veronica

> I was just a body that was carrying this baby and was going to have it, and that's how I felt all along.
>
> Sally

Human beings are 'programmed' to seek out others for the comfort and regulation that they cannot provide for themselves'.[19] Both Amanda and Jo report that they were crying, and expected their carers to respond sympathetically and sensitively. The fact that their distress went unheeded and unacknowledged merely emphasised their powerlessness.

The accounts of Amanda, Stacey and Kerry all contain references to the stirrups that are used to hold the women's legs in the lithotomy position for procedures such as suturing. It is obvious that these items of medical equipment, which seem so innocuous to clinicians, can have huge significance for survivors of CSA:

> . . . the fact that my legs were strapped into stirrups – that was a biggy, because, um . . . completely out of control [. . .] 'cos you can't move your legs if you want to, can you?
>
> Stacey

This reflects comments made by women in other qualitative research who were reminded of their abuse when confined and immobilised by medical equipment, while being subjected to intimate procedures.[11,20,21] Sadly, the women's expectations that birth in hospital would mean loss of control were realised in many cases. Sometimes, even when women did express their wishes to caregivers, they were largely ignored. Louise explained that she had devised a birth plan stating that VEs should be kept to a minimum, but found that:

> . . . the doctors' reluctance to follow this contributed to my feeling unable to control the way the IOL [induction of labour] proceeded. The midwives were following hospital procedures and unfortunately I was unable to find the voice to say no.
>
> Louise

Rosie had also formulated an 'extensive birth plan' during her first pregnancy in order to maintain some control over what happened to her in labour, but commented:

> You could have gone down and ticked off everything that didn't happen . . . apart from the episiotomy. I didn't get the episiotomy, which was good.
>
> Rosie

It appears that the women's strategies to avoid loss of control were invalidated because the demands of the institution took precedence. It has been suggested that birth plans may be perceived as a threat to the organisation's authority and therefore elicit a negative and defensive response from some caregivers.[22]

CONTROLLING PAIN: CONTROLLING WOMEN?

The issue of pain and its management in labour was also linked with perceptions of powerlessness and loss of control in the minds of some of the interviewees. This went far deeper than merely disliking the physical sensations of drowsiness and disorientation caused by narcotics. The connotations of being passive recipients of care rather than active participants in labour were strongly suggestive of sexual abuse. In some cases, it seems that a power struggle took place between the women and their carers:

> In the hospital I was fighting the medical staff off to prevent having the epidural they so desperately wanted me to have. I managed without it! But they coerced me into taking Nubain. A derivative of Demerol.
>
> Brenda

Clearly, Brenda's strategy to maintain a sense of control during labour was the avoidance of pharmaceutical pain relief, but losing the battle threw up issues linked with her CSA:

> I was angry I took the drug. Part of not taking the epidural and not wanting any drugs was the sense of control I needed. I know that is common in survivors of sexual abuse and it certainly was true for me. I felt like I had lost control again. That my power was taken, stolen by the nurses and doctor. I can still feel the anger!!!!!
>
> Brenda

Sally reported that during her first labour she was coerced into having an epidural against her wishes. At the time, she was a very troubled 15 year old, pregnant as the result of her stepfather's abuse. She felt that her being underage determined the way in which staff handled her labour and saw the midwives' promotion of the epidural as for their own convenience rather than for her benefit:

> . . . I wasn't asked. I was told with me epidural with me son and that – if I was in that sort of pain already, I'd need the epidural – it was just like: 'You need it', and, 'Do you consent to it?' and of course, at the time, I was in a lot of pain . . .
>
> Sally

To her mind, the epidural was responsible for causing the subsequent sharp rise in her blood pressure, which resulted in her being readmitted to hospital postnatally.

Rosie described how lack of suitable support and effective communication by her carers during her first birth resulted in her feeling she had lost control, which, in turn, led to her requesting an epidural which was not what she had planned:

> I couldn't remember anything about it [the birth]. It was . . . apart from feeling completely out of control, not knowing . . . what was going on . . . people coming in. I had a memory of somebody coming in and breaking my waters and it wasn't the person who was looking after me [. . .] so that was the whole experience. I didn't know quite what was happening . . . ended up sort of asking for an epidural because I just thought I need to sleep, you know, a long drawn out labour, very long latent phase – a typical first labour.
>
> Rosie

Some other interviewees reported being given pethidine without their consent. Jo described this happening during her first birth:

> . . . and then this awful midwife came on with a student. I don't remember their names, that's how out of it I was . . . and they were all . . . she gave me some pethidine. I don't remember them asking me if I wanted it because I know from being a nurse that I didn't want – I don't want anything like that because I've seen what it's like . . . and that was . . . I can't remember what happened then for about two hours, it was just . . . It completely knocked me out.
>
> Jo

Kerry also explained that the issue of being given pain relief without her consent was one of the major factors in causing her to experience loss of control. Amanda described herself as 'fighting the contractions' and being given pethidine in order for staff to examine her. It appears that, in some of these cases, 'woman control', as opposed to pain control, provided the motivation for giving pain relief. Truly supporting a woman through the process of labour is costly, not only in terms of staffing and resources but, on a personal level, it is exhausting and emotionally draining for the individual midwife. In an environment where numerous demands and pressures are constantly tugging at the sleeves of carers, pharmaceutical pain relief may act as 'midwife relief', a coping strategy for hard-pressed

staff. Additionally, it represents a means by which women can be made more acquiescent to medical and institutional demands.

Powerlessness, then, proved to be a highly prominent theme in the women's accounts of their contact with the maternity services. As Wanda observed. '. . . abuse is all about control'. Women who had suffered loss of control through repeated violation as small children again found themselves in situations that replicated this. Of course, VEs and intimate procedures could be expected to be problematic, but there are many other facets of maternity care that mirror the power disparity present in an abusive relationship. The immense power of the medical profession coupled with that of the organisation represent an authority that is intrinsically disempowering to users and to those working in its lower echelons. Furthermore, health professionals are often unaware of the significance of their actions and of the impact of medical equipment (such as stirrups) on individuals with a history of abuse. In addition, the need for the routines and rituals, which form such a prominent part of maternity care, is rarely questioned.

BETRAYAL

As we have seen, one of the major determinants of women's perception of control and mastery in childbirth is their perception of their birth attendants' attitudes.[14,23–26] Halldorsdottir and Karlsdottir identified three main categories of need in birthing women: caring and understanding; security and trust; and control of self and circumstances.[23] At the heart of good supportive relationships, and implicit within all these categories, is trust. In order to abandon mind control, give themselves over to the process of labour and to access their inner resources, women need to trust their carers. They need to feel that their attendants will act in their interests and protect them and that inner space. Many survivors of CSA, having been betrayed as children, will have a pre-existing propensity to distrust, particularly people in positions of authority. Many of the women in this study spoke of their difficulties with trust stemming from their childhood experiences of betrayal. Sadly, they also had much to say about their feelings of betrayal by maternity carers.

Most, if not all, women approach childbirth with expectations of how they would like their birth to take place including how they will be supported as they negotiate the event. The majority of women realise they have minimal control over the physical aspects of the birth process, but they do have expectations of how they will be helped to cope with them. They do expect carers to 'get on board' with them to provide comfort, encouragement, guidance and protection. The characteristics that women look for in their attendants, besides clinical competence, are human qualities such as warmth, good communication, empathy, connection and understanding. A deep sense of betrayal coloured the accounts which described carers lacking in these human qualities. On the whole, it seems that these interviewees had realistic expectations of the physical demands of

labour and birth. What they were not prepared for was the absence of humanity and compassion that could be reasonably expected from people in a so-called 'caring profession'. Claire's betrayal by her father's indifference to her suffering at the hands of paedophiles was re-enacted in the inhumane nature of the labour care she received:

> . . . they were all men, which I found horrendous and they weren't particularly gentle [. . .] and it was just a matter of 'Keep still! Open your legs! This is what I'm going to do!' And there was no talking you through like they do now or like the urologist does . . . they just did it and they stuck things in you and parted your vaginal lips and all that, and stuck a hand up and got on with it.
>
> Claire

Sadly, her female attendants showed the same lack of compassion and respect:

> . . . the sister said, 'Open your legs!' and sort of parted my vaginal lips and just had a look and said, 'No, I can't see the baby's head yet. You'll be ages yet.' [. . .] When I cried or moaned, I was told to shut up and get on with it basically. I can remember them saying, 'You're making a fuss about nothing. A lot of mothers have it far worse than you do, so just shut up!'
>
> Claire

As a result of this cruel and callous treatment, Claire vowed that she would never go through childbirth again, a promise that she had kept. Her birth was uncomplicated, quick and apparently required no interventions. Her decision was based entirely on the conduct of her 'carers':

> I knew it would hurt. I think what was worst was the lack of care. The fact that they weren't bothered how upset I was . . .
>
> Claire

This comment reveals two of her expectations concerning the experience: first, that birth would be painful; second, that she would be treated with humanity and given the emotional support that she needed to endure.

Amanda's comment about her perineal suturing experience also reveals a deep sense of betrayal at treatment that reduced her to a mere 'body part':

> But for me the stitches and the way they treated me were absolutely awful and complete disregard for the fact that I was crying [. . .] I was just . . . my vagina was a body part that needed to be sewn up and that was it, and there was no person behind the body part. I was just a body part . . .
>
> Amanda

Likewise, a particularly recurrent theme in Sally's first birth story was the manner

in which she felt betrayed by carers' lack of compassion, which she referred to as the 'no care attitude'. This reminded her strongly of her abusive stepfather, and clearly caused her a good deal of distress. Her words strongly resemble Claire's comment about her carers:

> . . . with him [stepfather] there was no care for who you were . . . He always reckoned he loved you but there was no care for who you were, which is why when there's like the midwives and the doctors that are just 'Oh, I've got to do my job' sort of attitude – it's that 'no care' the same as what he gave . . .
>
> Sally

Sally's expectations, of compassionate and emotionally supportive carers, are revealed in her comment about being coerced into having an epidural for her first birth:

> I was 15 and it was all a big shock . . . But there was none . . . none of this sort of trying to calm me down and help me out like I would have expected.
>
> Sally

Some women revealed their sense of betrayal at carers' lack of communication and discussion with them. Both Lynne and Amanda described their midwives talking among themselves but failing to communicate with them. Kerry was separated from her daughter for 12 hours immediately after the birth when she was admitted to the Special Care Baby Unit. However, she was given no information on her daughter's condition leading her to prepare herself for the worst-case scenario:

> I just assumed that there were things wrong and I had to let her go and that was it . . .
>
> Kerry

Rosie, who chose an epidural because she was not receiving the support she needed for her long 'typical first labour', said:

> If somebody had sat down with me and said, 'This is the latent phase of labour. This can take days to establish,' and sent me home, then I think things would have been different . . .
>
> Rosie

As it was, her labour became, she felt, unnecessarily medicalised, leading to a loss of control and a birth experience she did not want to repeat.

Some of the interviewees recounted scenarios in which the actions of professional carers left them feeling exploited or abused. Kerry, a midwife, described her feelings of exploitation and betrayal when, having endured a complicated

and frightening birth experience, she was 'invited' to help with the daily chores on the ward by a work colleague:

> . . . no one hugged me, no one said, 'Well done!' No one said, 'You've got a beautiful little baby' [. . .] I was just a member of staff, rather than a mother, rather than a mother who had just given birth. So even that was taken away from me. [. . .] So I just felt exploited again.
>
> Kerry

Sharon expressed her feelings of violation on being examined by an obstetrician during a hospital antenatal appointment. She was several days past her expected birth date and expected him to perform a membrane sweep in order to encourage labour to start. On realising that he had not performed the sweep, she felt betrayed, perceiving that the procedure had been done for his benefit and not for hers. Obviously, for her, this had connotations of abuse.

Brenda obviously felt betrayed by the way in which her first birth was managed by hospital staff. The final insult was an unexpected routine episiotomy:

> The doctor, as the baby's head crowned, came at me with scissors to cut into my skin. The fucker didn't give me any anaesthetic!!!!!! Nor did he tell me. I still cannot decide which was worse. Here, again, another loss of control. Another man deciding what he was going to do with my body.
>
> Brenda

Many of these accounts strongly reflect those of other qualitative research on traumatic or negative birth experiences. These women experienced feelings of insecurity, fear, hurt, bitterness and anger also displayed by women who encountered uncaring midwives in Beck's[27] and Halldorsdottir and Karlsdottir's research.[24] Women going through the process of childbirth clearly need attendants who are emotionally available, warm, caring and understanding. When their expectations are met with coldness, indifference and a lack of empathy, the result is betrayal. This is damaging for any woman but for survivors of sexual abuse, it may constitute a re-enactment of their abuse.

HUMILIATION

Humiliation, shame and self-blame are frequently associated with sexual abuse; victims often feeling responsible for what has happened to them, Giving birth is potentially a situation in which these negative emotions can be re-experienced and reinforced. The humiliation suffered by some of these women as a result of the treatment they received during childbirth profoundly influenced their ongoing perception of the event. It was strongly associated with the 'conveyor belt' ethos of hospital routine, coupled with the unspoken assumption that women's bodies and babies are the property of the institution. One of the most shocking

accounts of 'ritual humiliation' was given by Claire, who, despite having given birth more than two decades ago, could still recall the incident with amazing clarity:

> They gave me an enema to start with . . . An old-fashioned one with the rubber tube . . . Foul! And then they said, 'Have a bath', and I'd still got this enema; and I can remember walking down [. . .] a long corridor to the bathrooms and I walked down with a nurse walking behind me with a mop, because I was . . . I was leaking. [. . .] And then I sat in the bath. She went, and I'd got all this muck round me when I was in the bath. It was dreadful! I don't think I will ever forget that because it was degrading, it was humiliating. I mean I can still remember the face of the nurse walking behind me with the mop and it wasn't the poor girl's fault; that was what she had to do. But, you know, it's so degrading. And then to get in the bath and, of course, warm water and you've just had an enema and I mean the effects are, you know, it was just all in the bath and you're supposed to be washing yourself clean so you can have a tiny baby . . .
>
> Claire

It is interesting to note that she recognised that both she and the 'nurse' were equally powerless in these circumstances, providing an extreme example of the dehumanising impact of institutionalisation on both clients and workers. Claire stressed that the humiliation of this scenario plus her attendants' coldness and indifference to her suffering were the most painful and damaging features of her birth experience.

Both Jo and Lynne reported that their contractions ceased during the second stage of labour. This may be an example of 'stalled labour', which, as we have already seen, may be linked with a history of CSA. Lynne, whose fear that in hospital things would be 'taken out of her hands', found her fears realised when she was obliged to rely on her carers to tell her when to push. In Jo's case, she recalled staff being impatient for her to give birth but being unable to comply with their demands:

> And I can remember, you know, saying to them 'I'm really sorry, but . . .' and they were saying, 'Do you want to push, do you want to push?' And I'm, 'I can't! I'm not feeling anything.' There was nothing. [. . .] They gave me an episiotomy to get all that along, to speed it up, I assume. [. . .] And I remember the midwife huffing and puffing and . . . and I just felt so [laughs] completely useless because I had no urge at all . . . to push this baby [. . .] I just felt totally inadequate. [. . .] And I can't really remember an awful lot about delivering her to be honest with you. It sounds dreadful, but I can't, and I feel really sad that I missed . . . missed out on that . . .
>
> Jo

Many women find giving birth 'against the clock' problematic and, sadly, the time factor is, to some extent, what now defines birth as normal or abnormal. In neither of these instances above was there a suggestion of foetal distress; it appears that the women were simply failing to comply with arbitrary time limits placed upon their labours. Consequently, they were left feeling humiliated and inadequate, that their bodies had failed them, requiring them to rely on others at this crucial time.

Several respondents gave very similar accounts of humiliation in the context of perineal suturing. For some, this procedure was the most traumatic aspect of giving birth and was particularly powerful in recreating the sensations and emotions they associated with sexual abuse:

> I was definitely reliving lots of things with my brothers [abusers]. Because they're not gentle, are they? [. . .] They're sticking great tampons, they're swabbing blood, and I've seen it done [. . .] It was humiliating. It was embarrassing. It was painful. It was frightening. I was going through this whole gamut of feelings and emotions, and I just felt absolutely destroyed, and I thought, 'I'll never have another baby. I'll never go through this again. I will never do this again!'
>
> Amanda

Amanda's sense of humiliation arose out of the lack of respect for her dignity and the rough, uncaring attitude of the practitioners. The result, she said, was to objectify and dehumanise her, mirroring her experience of abuse: 'I felt like a piece of meat and I felt just like I had when I was being abused.'

Some women felt they were at fault for not coping with the routines and rituals of the system. Kerry's experience is somewhat similar to Amanda's and reveals a shocking disregard for a woman's dignity. It appears that practitioners' single-minded focus on a procedure blinded them to Kerry's needs for privacy and respect:

> . . . I think the final humiliation was um . . . being sutured [. . .] by a registrar that I knew, which was bad enough, but at the time, the bed, the bottom of the bed was facing the door coming in, so my legs were in the lithotomy position, and the porter was pushing the breakfast trolley past the sliding door and the door was open and he waved to me. So that was the final humiliation. And that is a very clear memory, and he waved to me and I thought 'OH – MY – GOD! This is just awful and this is, this is supposed to happen . . .'
>
> Kerry

It appears that Kerry's response to the situation was to blame herself for not coping with it. She felt she had no right to question her treatment and, just as she had stifled her sobs and cries for help as an abused child, she suffered in silence. Similarly, Jo lamented the lack of privacy she experienced while undergoing perineal suturing:

> And it was undignified and embarrassing and people were coming in and out [. . .] and you're on view and . . . your bits are all in shreds and [laughs] and it was just horrendous. That was the worst part. It was really bad.
>
> Jo

Sally described her feelings of acute embarrassment and shame when midwives and others would enter her bed space without her permission when the curtains were closed. Privacy and dignity were of great importance to all the women and failure of staff to respect these proved to be a great source of distress.

Chloe's humiliation arose out of the paternalistic and prescriptive attitude of her midwives. She spoke of being 'made' to have a 45-minute bath during labour, and being sent back to it 'like a naughty child' when she got out before the prescribed time had elapsed.

> So it sort of felt like I was being punished . . .
>
> Chloe

Whatever the rationale for a 45-minute bath might be, Chloe perceived that it was not for her benefit, and the incident reinforced her already acute sense of shame.

Some women found the issue of breastfeeding and the 'support' provided by harsh and insensitive staff to be a cause of great humiliation, in some cases resulting in a decision to formula-feed. Breastfeeding is a sensitive subject for some survivors and several of these interviewees found the idea of it problematic because their abuse had been centred on their breasts. During my time as a hospital midwife I, like Tilley, saw many breasts 'grappled with' in the name of breastfeeding 'support'[28] and many screaming babies 'shoved' unceremoniously onto breasts, while mothers looked on helplessly. These women's accounts supported Simkin and Klaus's observation that women's first experience of breastfeeding in hospital usually consists of a nurse holding her breast and pushing the baby onto it.[29] Their stories illustrated professionals' lack of respect not only for their bodily integrity but also for their status as mothers. They also illustrate the disempowering nature of the 'expert' model in relation to yet another area of childbearing.

Despite being averse to breastfeeding, Stacey decided that she would do it to avoid coming under pressure from midwives on the postnatal ward. However, her description of the 'assistance' she received from a midwife is more reminiscent of a sexual attack:

> . . . she pulled the front of my nightdress down and she grabbed my breast and latched him on, and I was like that . . . [makes strangled sound of disgust]
>
> Stacey

Because of her history, she felt unable to refuse the 'help' but did manage to put

up a certain amount of resistance. The midwife, however, intent on carrying out her 'breastfeeding support function', was undeterred:

> . . . and I did say, 'I have fed him before', and she's, 'Well, I'll just get it . . .' 'But I've fed him before!', 'Well, I'm just latching him on for you.'
>
> Stacey

Rosie's account is similar. She describes midwives coming into her room, grasping her nipple, squeezing it and 'shoving' her baby onto the breast and then walking away.

Jo recalled that on one occasion, as she was gently encouraging her baby daughter to wake up and breastfeed, she was assailed by a nursery nurse:

> . . . she [nursery nurse] grabbed her off me, sat her on her knee and scraped under her foot with her nail and the poor child just screamed, and she just shoved her . . . on to my breast to get her to latch on . . . and she held her there, and she was crying, you know, she was absolutely screaming her heart out. She wasn't interested at all in feeding by then. She was going red, holding her breath, really getting cross, and I said, 'Look, just leave it, leave it! I can't do this any more, I can't!' I was in tears, she [daughter] was in tears, this nursery nurse was, 'You've got to be more forceful with her'.
>
> Jo

What struck me about all the accounts of breastfeeding 'help' was the sheer brutality of it, not only for the women but also for the unfortunate babies. In Jo's account, the rough and 'authoritative' approach of the nursery nurse contrasts starkly with her tender and gentle handling of her baby. It appears that this kind of 'breastfeeding support' is also something that is 'done' to women and does not involve their active participation. Arguably, in this way, the busy health professional can feel that she has discharged her responsibility and the routine is completed quickly, with the minimum amount of effort or personal engagement.

In many of these accounts, all three emotions, powerlessness, betrayal and humiliation, are present. Betrayal occurs when a person's expectations that they will be helped, respected and valued by someone in a caring role are not met. It is particularly poignant when there is a large disparity in power between the participants. Humiliation does not automatically arise out of powerlessness, but, as is seen from these accounts, does form the 'medium' in which it can occur. Arguably, humiliation is far more damaging than powerlessness alone because it robs an individual of dignity and humanity and has connotations of shame. Disturbingly, it is also highly visible in situations involving torture, violation and abuse and research suggests that interpersonal traumas carry a higher risk for the development of extreme stress disorders than accidents or natural disasters.[30,31]

THE ONGOING IMPACT

Some of the women described having difficult relationships with their children and in most cases these difficulties were closely linked with their history of abuse. As we have seen, women who have experienced CSA are more at risk of perceiving their births as traumatic, which in turn may have a negative impact on their parenting.[22,32,33] Rosie, whose first birth was a distressing experience in hospital, went on to have a very positive home birth for her second child. She compared the ease with which she bonded with this baby with how she felt about her firstborn. She attributed the differences to the circumstances surrounding their births:

> What makes me think it's possibly something to do with the birth was . . . she [second child] was a horrendous baby, he was quite a good baby [. . .] he was a lovely placid child, very easy to get on with, whereas she was horrible – a really horrible child [. . .] and yet still I physically far more bonded to her even though she'd drive me mad.
>
> Rosie

Veronica, who described her first birth as 'a nightmare' in which she 'felt raped over and over again', recalled that she had great difficulty bonding with her daughter for the year following her birth. Kerry suffered from severe depression for nine months after her daughter's birth, which she attributed, partly, to the traumatic nature of the event. It is very likely that the women's early parenting problems stemmed from a combination of their abusive histories and their traumatic birth experiences, although it would be impossible to isolate the impact of each factor.

What we see from looking at these women's stories is that survivors of CSA face many difficulties in regard to pregnancy and childbirth. It is clear that some approach the idea of pregnancy with fears resulting from their early experiences. Some report feeling 'invaded' by their growing foetus' and others may feel afraid of giving birth. Many are very anxious about what will be required of them or done to them during the birth process by maternity carers and saw themselves as being obliged to place themselves in situations which would mimic their abuse.

Three major themes emerged from the birth stories of these particular women: that of powerlessness, betrayal and humiliation; and these were mostly associated with giving birth in the highly medicalised setting of the consultant unit. Powerlessness occurred when things were taken out of their hands, when they were not consulted and when they were 'processed' with little regard for their individual needs. In these circumstances they ceased to be active participants in the birth experience, but passengers, and consequently 'absent'. They were frequently deprived of their husbands or partners who would have been in a position to support them and promote their needs. Some were 'absent', in the sense that they dissociated in order to cope with emotions that threatened to overwhelm them.

Betrayal occurred when the women's expectations of compassion and humanity from staff were met by coldness, non-communication and a focus on routine rather than on them. They looked to their carers for more than clinical competence and expected relational care in which emotional warmth and genuine concern were present.

Humiliation arose out of a lack of respect for women, their dignity and need for privacy but also for their status as mothers. The dehumanisation of their bodies replicated the sense of shame and humiliation already present in the survivors. Breastfeeding 'support' could leave women feeling violated by the rough and insensitive way in which it was carried out.

As we can see, the vast majority, if not all, these factors are linked with giving birth within the industrial, 'assembly line' model, which emphasises speed, efficiency and calculability and has little time for individuality either in its workers or users.

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CHAPTER 7

CSA and midwives: the impact on midwives' practice

As I heard the accounts of the midwife interviewees, I began to realise what a huge impact their early experiences could have upon them and their practice, but also how useful their insights were into caring for survivors. Eight were practising midwives at the time of their interview, two were students, one had practised and was waiting to start a 'Return to Midwifery' course and one was on maternity leave. Six had been practising midwives at the time when they gave birth. Their comments are invaluable because they were able to view the maternity services from the dual perspective of both users and healthcare professionals. The issues that the midwives felt constituted good practice involved giving women choice and control, good communication, treating them as individuals and acting as advocates on women's behalf. However, the medically dominated process-driven environment in which maternity care is delivered works against this and these midwives were often obliged to seek ways in which they could lessen its impact. Some found subtle ways to support women's choices while other more assertive characters took a more confrontational stance and could subsequently find themselves being censured by colleagues.

AWARENESS OF THE POTENTIAL FOR ABUSE IN MATERNITY CARE

The midwives were very much aware of the potential for abuse to take place within maternity care and often saw their own abusive experiences echoed there, particularly in the labour ward setting. Ruth recalled a scenario that triggered memories of her abuse, causing her to break down in tears and leave the room during a particularly distressing instrumental birth with which she had been involved:

> I'm sure she had a failed ventouse delivery, 'cause I can remember the cap coming off and, like, it hitting the wall. It was just horrific and she was screaming and her partner or husband, or her mum, whoever were there were horrified

> and it was just like a mad, everybody were like frantic running around and . . . and it really upset me and I really felt that she had . . . she'd been assaulted, that we'd caused her this pain . . . [. . .] And I don't know how, you know, how she got on or . . . in her life, or how that affected her postnatally, but it was quite horrific I thought. And I didn't want to be part of that.
>
> Ruth

Other midwives described their, or others', reluctance to work on labour ward using phrases such as 'ritualised abuse' and 'brutality'.

However, these women seemed determined to use their early experiences as a positive force in guiding their approach to practice. They readily acknowledged the hugely painful impact that CSA had had on their own lives, but were grateful for the depth of understanding this had given them into other women's pain. Several spoke in terms of possessing a heightened awareness of women's needs and also knowing intuitively when women they were caring for were survivors of CSA, despite it not having been disclosed. The manner in which they worked was influenced to a large extent by their understanding of their own needs, and several commented, or implied, that they approached their practice from the premise that every woman was a potential sexual abuse survivor.

WHAT THE MIDWIFE-SURVIVORS CONSIDERED TO BE GOOD PRACTICE

Offering choice and control

There appeared to be a readiness on the part of these midwives to empower the women in their care by affording them the maximum amount of choice and control. This desire often arose out of their own identity as survivors, as Rhoda explained:

> I think that's the biggest thing that's come out of it [being a survivor of CSA] really [. . .] that I want them to have some power and I want them to feel good about themselves and their body and their experiences.
>
> Rhoda

The importance of truly informed consent, defined by Vickie as 'the proper sort of consent, not just that they've said yes', was highlighted by many of the midwife interviewees. In some cases this was couched in terms of 'asking' or 'asking permission' which suggests a very different client–carer relationship than that implied by the term 'gaining consent'. It could be argued that 'gaining consent' is often seen as the first part of undertaking a procedure or an intervention rather than a precursor which actually determines whether or not the procedure takes place. As I pointed out previously, intimate and invasive procedures are some of the particularly sensitive areas in maternity care in which the issues of power

and control are highly visible and this subject came up repeatedly. Several of the midwives described their strong dislike for performing VEs and two reported struggling with the perception that, when doing so, they themselves were acting abusively. Most were reluctant to carry out the procedure on a routine basis in normal labour because they felt they should be kept to a minimum. Some described their readiness to employ other methods of monitoring progress in labour such as observing the woman's behaviour.

Kerry started from the premise that VEs were a part of her practice, but offered the women some degree of choice over the frequency at which they would occur:

> I will always say to women, 'It's not my practice to do more than one or two vaginal examinations during labour. If you would like more than that, will you tell me; if there are complications it may mean I have to offer you the chance.' The way I word things is that they will always feel they can ask me for it rather than me ask them for it.
>
> Kerry

The importance of the woman being able to call a halt to a procedure, despite having consented to it, was discussed by several of the interviewees. Rosie recalled encountering women in her practice who (like Maggie Smith's client) had reacted in unexpectedly extreme ways when undergoing invasive examinations:

> But, you know, you get women that are ridiculously upset when you examine them. Obviously, it's distressing for any woman, but who get very, very distressed when you examine them and then I just stop. I'm not prepared to keep examining somebody who's . . . that distressed.
>
> Rosie

As we have seen, women may give their consent to a procedure in theory but find themselves unable to tolerate it in actuality. Some of the midwives explained that informing the woman before undertaking the examination that she could ask for it to be stopped formed part of their regular practice. However, stopping a procedure relies on the woman being able to voice her needs and some are unable to do this. Unfortunately, some clinicians assume that once the woman has given her consent they are entitled to press on regardless.

Several of the midwives also described their willingness to be flexible in their approach as to how and where to perform VEs. They attempted to remove the ritualistic element identified by Bergstrom *et al.*[1] as depersonalising to both practitioner and client by asking the women how they would like the procedure to be done. Some drew attention to the possibility that lying flat on a bed might be distressing for survivors of CSA and would therefore suggest alternatives that might be more acceptable to them:

K: . . . and I will also talk through it as I'm doing it – 'Is this comfortable? Is there a particular place where it would be better for you to have this done?' So that if it's lying flat on their back, which is the position that most people would have been abused in, then I will offer – you know – I will offer for them to tell me where's best for them to have it done.

L: So altering their position, maybe, say, standing up?

K: Standing, maybe sitting even because you can do a VE efficiently, maybe not as well as, but effectively to get a reasonable amount of information, which um . . . which is important. And if, if a woman has a technique of taking her through that, I will ask her about it – 'If you've had to have this done before, is there any way that you have found better in coping to have this done – i.e. holding my hand so that I'm only using one hand, or do you like me to look at you while talking?' So I take a lot of time about talking how to do this procedure before we even start.

Kerry

This approach helps the woman to lead the practitioner, enabling her to feel more in control of the situation and lessening the potential for abusive memories to be triggered. In this context Vickie also emphasised the importance of minimising the impact of the clinical environment even when performing clinical procedures:

> I don't use a trolley, I put things on the bed and I sit on the bed, so that I'm not over . . . someone. If someone's in the pool I do the examination in the pool. You know, if they're in a chair . . . I just try and do it . . . I make it as normal as I can.
>
> Vickie

As I pointed out in the previous chapter, the trappings of medicalised birth, which have become largely invisible to practitioners, may be hugely threatening to women who have suffered sexual abuse:

> A woman seeing a tube of K-Y gel might just freak her out. Especially if you were a child being abused and the abuser couldn't penetrate. Seeing a tube of like . . . or Vaseline, is a complete no-no.
>
> Kerry

Kerry was the only one of the midwives to specifically refer to K-Y jelly, but I found her suggestion that something as apparently innocuous could be problematic for some women challenged me to examine some of my own 'blind spots'. It is a strong argument for the re-evaluation of our general perception of what constitutes an appropriate birth environment not only for survivors but for all birthing women.

Good communication

The importance of good personal communication was prominent in the midwives' accounts and was very much associated with the issues of choice and control. There was much discussion on explaining procedures and talking women through VEs. However, Kerry's was the lone voice that sounded a note of caution with the indiscriminate use of this approach:

> Then, whilst I'm actually doing it I will ask her if she wants me to talk to her while I'm doing it to tell her what I can feel or 'would you prefer me not to?' because some abusers talk through what they're doing. And that might be distressing. My father used to do that to me.
>
> Kerry

Arguably, most midwives would consider talking women through invasive procedures to be good practice. However, Kerry's revelation that this could be construed as abusive by some is a timely reminder of the importance of avoiding the 'standard approach' by taking the lead from the woman. Good communication was generally perceived to be far wider than mere verbal interaction, but in terms of relating to women as fellow human beings. Kerry defined this as being a 'professional with a human face', another way of describing 'professional intimacy'.[2] The value of self-disclosure was highlighted by some of the interviewees. This did not necessarily involve revealing their history of CSA (although one midwife described disclosing to a client) but in sharing something of themselves and their experiences as women. Stacey told me about an encounter she had had with a mother who was struggling to learn how to perform a clinical procedure on herself, and it is a lovely example of a midwife who, by sharing something of her personal experience, was able to encourage another:

> . . . I don't often say to women, 'This happened to me', but that . . . was um . . . a classic instance where she needed to hear that the professional looking after her had been through the same thing. And that's what I did, and she said that it helped her tremendously.
>
> Stacey

After explaining how to go about it, she recounted to her the first time she herself had tried it, with somewhat disastrously comic results:

> . . . then she said, 'I can just imagine you sitting there doing that', and then we laughed. She cried, I cried, then we laughed.
>
> Stacey

The concept of communication was perceived to be a dialogue and a means whereby the midwives could gain an understanding of their clients' needs and, consequently, empower them. On the other hand, information-giving, beloved

of the health service, could be described as a means of enabling patients to understand the clinician's intentions and, consequently, comply.

Treating women as individuals

The comments of the midwife interviewees revealed an awareness of the potential for women to become depersonalised by the production-line ethos of institutional maternity care. When asked how care for women might be improved, one suggested 'not to treat everyone . . . as . . . a protocol' and another spoke about the importance of women retaining their identity by wearing their own clothes rather than being obliged to wear a hospital gown. Interestingly, none of the midwife interviewees said that they treated women as they wished to be treated themselves. This approach, which, at first glance, appears to be an acceptable premise on which to base practice, represents just another manifestation of the standardisation of the delivery of care which has its focus on the caregiver rather than the receiver. These midwives emphasised their commitment to identifying the needs of individuals and tailoring their care accordingly:

> As far as I'm concerned, whatever the woman wants . . . it's my role to ensure that she gets that.
>
> Rosie

In an environment where routines and protocols dictate so much of what takes place, the midwives attempted to free the women as much as possible from these influences in order to provide individualised care. Several explained how they would inform women of hospital policy but then state their willingness to support them should this conflict with their own plans or wishes. Vickie explained that she always gave a little 'spiel' to women on admission:

> There are lots of things in a hospital that we do as a matter of routine, but you don't have to have any of it and if you say to me that don't want it then you don't have to have it. It's as simple as that.
>
> Vickie

However, having discussed the importance of giving the women the opportunity to choose for themselves, she made this very interesting observation:

> Actually, some people want to be told 'This is what's going to happen'. Do you know what I mean? So you have to judge it, don't you? You just have to try the best you can to think 'How's this person going to feel the safest?' because some people don't want it all loose like that . . .
>
> Vickie

This demonstrates the frequently paradoxical nature of the midwife's role and the importance of being constantly alert and open to the needs of individuals.

As Lynne pointed out, there is no one specific approach which is appropriate for all survivors of abuse:

> I think you're going to tie yourself up in knots looking for a specific approach and it's just trying to be aware that if you have said something and you notice a reaction, then you can say, 'Oh, maybe I've said something wrong there', and that you keep asking me, 'What can I do to help the situation? What's going to make it easier for you?'
>
> Lynne

It would appear, then, that the most useful guide to providing appropriate care for a woman with a history of abuse is the woman herself.

Continuity of carer

All the issues discussed above are only truly effective in the context of continuity of carer. Several of the midwife survivors referred to it specifically, but in other accounts it was implied. The interviewees who expressed an opinion on giving women the opportunity to disclose a history of CSA felt that one continuous carer was a prerequisite. Kerry described her reluctance to disclose in terms of losing control of her 'secret'. The impression given by the midwife survivors was that they believed that good quality maternity practice was embodied in one-to-one care, which enabled midwives to fulfil their role of supporting and protecting women. Providing survivors of CSA with a continuous carer, they suggested, would help to minimise the feelings of loss of control by confining the information within strict limits.

Amanda, drawing on her own traumatic experience, also expressed the need for all midwives to be competent in suturing in order to avoid the situation which occurred in several cases referred to in Chapter 6, in which a stranger is brought in to perform this potentially traumatic procedure:

> . . . if I could change anything about the care in this country, especially in big maternity units, it would be the continuity of care [. . .] and the midwives suturing, rather than bringing in a complete stranger and them treating you like a piece of meat.
>
> Amanda

It seems that perineal suturing is one of the most potentially distressing procedures for survivors of CSA, which makes a strong case for continuity of carer to be provided for all childbearing women as many survivors of CSA pass through the maternity services unidentified. A one-to-one relationship could provide a context in which disclosure might be a possibility, or even, as one of the interviewees suggested, make disclosure unnecessary.

Advocating/protecting

It was clear from their accounts of working with women that these midwives placed great importance on their role as advocates. Several recounted scenarios in which they fought to protect women from the 'system'. However, their attempts to practise in a manner which they felt was appropriate often cut across what was required by the organisation in which they worked. Supporting women and giving them choice sometimes forced midwives to place themselves in the firing line. Rosie recounted on one occasion caring for a young woman whose baby was lying in the occipito-posterior position (in which the baby's back lies to the mother's back and often results in a long, painful labour). Labour had been long and arduous but the baby had shown no signs of distress; therefore, Rosie had given the woman more time than is usually 'allowed' in order to give her every opportunity to give birth spontaneously. The woman eventually became exhausted, however, and seemed too tired to make the final effort. The medical team became involved, informing the woman that they were going to 'give her a hand'. Rosie then explained to the woman exactly what the options were and asked her what she wanted. This was not well received by the doctor:

> And the doctor pulled me aside and said, 'I can't believe you've done that!' I said, 'What?' She went, 'She's asking your advice and you give her options and ask her what she wants to do!' I said, 'Well, yes, it's her body.' She said, 'But you're the expert!'
>
> Rosie

This scenario provides an illustration of the mismatch between the medical 'expert' model and the equitable midwifery ideal. Rosie was one of the more assertive midwives who felt more able to confront authority than many of the other interviewees and, consequently, often found herself 'hauled over the coals' as a result. She had been working as a midwife for two years at that particular hospital but was aware that she might not be able to continue fighting indefinitely:

> I certainly feel I do end up fighting a lot of battles on women's behalf, but I'm happy to do that. Whether or not I can last out in the hospital . . .?
>
> Rosie

One of the other midwife interviewees also described a scenario in which she defended a labouring woman against a doctor who would not accept her refusal to be examined by him. He appeared unable (or unwilling) to comprehend this:

> I said, 'She really does not want to be examined by you, because you're a man.' He said, 'Go back in there, and tell her I'm a doctor.'
>
> Stacey

Having been refused as a man, he repeats the request, this time as 'a doctor'. In asserting his position as a medical professional, he is declaring his authority over both the woman and her midwife. Stacey stood her ground, however, despite continued pressure until, fortunately, the woman birthed spontaneously without the examination.

Generally, these midwives felt that there should be no distinction between caring for survivors of CSA and any other women, as Rhoda pointed out:

> . . . if all midwives could respect all women, then it wouldn't be that much of an issue I guess really, would it? Certainly, there are perhaps things that . . . survivors might want specifically, but at the end of the day, if each midwife . . . sort of treated each woman as an individual and just went with what she wanted, then it perhaps wouldn't be such a big issue anyway.
>
> Rhoda

From the accounts of the midwives, it appears that the key ingredients of maternity care which is appropriate for any woman, regardless of whether or not she is a survivor of CSA, are respect, good communication (with the emphasis on listening), a willingness to treat her as an individual and to facilitate and support her choices. In the 'process-driven' environment of the large consultant unit this is a particularly tall order. Practising in this way demands that practitioners be supported to make informed clinical decisions, free from arbitrary time limits, the demands of institutional 'routines', and the mentality that sees women's choices as threatening to the authority of the organisation.

THE PRESSURE TO CONFORM

Sometimes, however, the pressure on the midwives to conform proved overwhelming and gave rise to situations in which they felt that they had acted abusively:

> . . . in the early days [. . .] I constantly felt I was doing things I shouldn't have been doing. I can remember doing an episiotomy when I didn't want to but I'd got a member of staff behind me handing me the lignocaine and then the scissors . . .
>
> Vickie

Many midwives, myself included, would be able to give similar accounts of succumbing to pressures exerted by the organisation, at the same time feeling they are not acting in the women's interest. It seems to me that the task of the hospital midwife, who truly wants to provide individualised and woman-centred care, has suffered a sea change, from supporting normal birth to repelling boarding parties intent on bringing birth and women under control. Unfortunately, many midwives do not feel strong enough to resist, and those who have a history of

CSA are especially disadvantaged. As I pointed out in the previous chapter, several of the interviewees did not find it easy to confront authority. Consequently, they superficially surrendered to the system while quietly fighting a rearguard action behind closed labour ward doors. Sharon, who had qualified relatively recently, explained that she used her junior status and inexperience in order to avoid compliance with hospital policies when she felt they contradicted the women's wishes. Jo, a student at the time of her interview, would encourage the woman to follow her body's cues only when her mentor was out of the room. She was reluctant to take a confrontational stance because of her inability to challenge authority; consequently, she found a non-confrontational strategy to achieve her ends. It was clear that Jo experienced a conflict between representing the woman's interests at the same time as meeting the demands of the system and was therefore obliged to practise 'undercover midwifery'. It is well known anecdotally that midwives often resort to some kind of subterfuge in order to support and protect women from having their births hijacked by hospital policy.[3] Vickie provided a good example of this when she recounted caring for a colleague during labour:

> . . . all I did literally was, I listened in as minimally as I could and, you know, a bit of poetic licence in the notes. It looked as though I did it every 15 minutes but – you know, you have to, to protect yourself. Not to protect myself in terms of if anything happened and we went to court, but . . . the doctors that come and read the notes . . .
>
> Vickie

It is also well known in midwifery circles that cervical dilatation is deliberately underestimated, and confirmation of full dilatation is often delayed, in order to give women more time within a system that uses the clock to define the parameters of normality. Midwives who want to provide care suited to individuals rather than the production line, however, may find themselves estranged from colleagues in the protocol-infested waters of the hospital environment. Most of the midwives expressed their reluctance to universally apply the routines and rituals of institutional maternity care, at the same time perceiving that, as a result, their practice was continually being scrutinised or discussed by others:

> What I find is that the midwives in charge . . . and you're aware that people are talking behind [. . .] your back.
>
> Rosie

> I do get criticism sometimes and whatever, for not doing vaginal examinations as standard. You know when . . . you work in this big teaching hospital and you admit someone and you sort of come out the room and everyone looks at you because they want to know for the staffing and the workload and the blah, blah, blah, whether the woman's in labour or not and I say, 'Well, I don't know.'
>
> Sharon

Jenny, who practised in Australia, found that battling against what she described as 'abuse of women' made her unpopular with colleagues, which was costly in terms of the impact it had on her:

> I battled on, and fought for these women, yet working in this environment was destroying me.
>
> Jenny

Midwives learn from their earliest contact with the clinical environment that, from a popularity point of view, it is more prudent to comply with the status quo than to challenge it. Acquiescence, however, is a habit that is particularly difficult to break and not only disempowers the midwife but also the women in her care.[4]

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CHAPTER 8

Coping with the inescapable: survivors' dissociation, 'professional dissociation'

From initially knowing almost nothing about dissociation, I found that, as the interviews progressed, it loomed ever larger as a major theme. There appeared to be several manifestations of it: long-term amnesia surrounding the events of childhood; a short-term unconscious reflex action which occurred when the woman was confronted by overwhelming circumstances in which she was powerless to act; and a deliberate moving out of her body when in a traumatic situation, using techniques such as focusing on a flower on the wallpaper. The latter, in contrast to the first two, was often referred to quite positively and was considered to be protective. However, I soon began to realise that dissociation was not only confined to the survivors. Midwives, when presented with situations in which they felt powerless to act, often 'escaped' them emotionally, displaying an amazing degree of detachment, apparently rendering them oblivious to the distress of others. As I discovered, several of the midwife interviewees perceived certain incidents they had witnessed on labour ward as abusive and, as a result, avoided working in the area. Dissociation has strong links with post-traumatic stress disorder (PTSD)[1,2] and may occur in any situation in which the person feels helpless when extreme emotions such as fear, terror or horror are evoked.

Pierre Janet, a French physician, psychiatrist and philosopher, first identified dissociation in the latter part of the 19th century. It is based on the doctrine of 'association', the belief that memories are brought to consciousness by an association of ideas and occurs when memories of a traumatic event are unavailable to be associated.[3] The concept fell out of favour for several decades owing to the influence of Sigmund Freud and his psychoanalytic theories which emphasised repression in preference to dissociation.[4] Today, however, the phenomenon of dissociation is widely recognised within the fields of psychology and psychiatry and has recently attracted a good deal of research interest. Dissociation is believed by most theorists to be a defensive mechanism in which an individual develops

the capacity to separate him/herself psychologically in order to escape from overwhelming physical or psychological pain associated with traumatic events.[5,6] Sanford refers to dissociation as 'walling off what cannot be accommodated'.[7]

Dissociation exists as a continuum starting from normal everyday experiences extending to disorders that interfere with everyday functioning. At one end of the scale are activities considered to be normal such as becoming 'lost' in a good book or performing everyday actions involving a simultaneous multiplicity of tasks without an awareness of one or more of them, such as driving a car.[8] At the other end of the continuum are out of body experiences and dissociative disorders. A small percentage of traumatised individuals also develop the syndrome of dissociative identity disorder (formerly multiple personality disorder). In its more extreme forms, dissociation is known to result from the experience of a traumatic event (or events) and is believed by many authorities to be highly predictive of the development of PTSD.[9–14] When faced with a highly stressful event, in order to protect ourselves from being overwhelmed, we distance ourselves from it at the time, thereafter gradually integrating the experience until it becomes part of our consciousness and incorporated into memory. However, failure to integrate the memory on a semantic or linguistic level can lead to long-term psychological morbidity in the form of dissociative disorders, intrusive re-experiencing of the event/s and fragmentary memories.[15,16]

TYPES OF DISSOCIATION

According to van der Kolk, van der Hart and Marmar psychiatry recognises three distinct but related mental conditions within the scope of 'dissociation', referred to as primary, secondary and tertiary.[17]

Primary dissociation may occur when an individual is unable to integrate what has happened into consciousness, when the experience is split into its individual somatosensory components without integration into personal narrative. It may manifest itself in flashbacks, intrusive distressing memories and nightmares, although the sufferer may also experience long-term amnesia concerning the event.

Secondary dissociation occurs when the person, in a traumatic state of mind, experiences a separation of mind and body. They may describe leaving their body during a traumatic episode and viewing the scene from a distance. Thus the individual is able to carry on as if nothing had happened because s/he is 'anaesthetised' from the strong emotions that would normally arise from such a situation. Many survivors of CSA will have been repeatedly subjected to trauma and, as a result, continue to experience dissociative responses into adulthood when faced with distressing life events or situations which trigger similar emotions to the original trauma.

Tertiary dissociation refers to the development of distinct ego states or personalities that may contain elements of the emotions associated with the traumatic events. Other ego states within the individual may remain completely unaware

of the trauma and therefore carry on with the routine functions of everyday life. It is this that is described by the term 'dissociative identity disorder'.

Dissociation is not a phenomenon confined only to survivors of CSA but is commonly reported among those suffering from PTSD of whatever origin, including war, accidents and natural disasters.[2,10,11,13,] However, van der Kolk maintains that interpersonal traumas, such as sexual abuse or incest, are likely to have more profound and complicated effects than impersonal ones, because children are at a critical and impressionable stage in their social and psychological development.[18] This not only affects psychological or social development but can result in developmental delays in cognitive, language and motor skills, and a whole range of behavioural problems from learning disabilities to aggression against self and others.

DETACHMENT AND EMOTIONAL NUMBING

Severe trauma frequently results in emotional numbing, derealisation (the sense that the world is not real) and depersonalisation, in which an individual experiences a sense of detachment from their physical or psychological being.[3,8] It is thought that hyper-arousal experienced by victims of trauma exhausts the biological and psychological resources required to experience a wide variety of emotions, including pleasurable ones.[19] Although dissociation can be an effective way to continue functioning while the situation is ongoing, its continuation once the trauma has past often leaves the individual with a sense of 'deadness' and disconnection from others which interferes with everyday life.[1] It is interesting to note that this psychological defence mechanism can also have a profound impact upon an individual's perception of physical pain. Emotional numbness has often been associated with self-injury and van der Kolk suggests that some people are motivated to self-mutilate in order to find relief from emotional numbness.[1] He reports on an unpublished research project in which he collaborated with eight self-harming individuals, measuring their responses to painful stimuli during times when they felt a strong urge to cut themselves. Six of the eight participants registered no pain response to any stimulus that could be 'applied within ethical limits'. From this he postulated that these individuals had developed a 'conditioned analgesic response to an environmental stressor' (p. 189). Interestingly, one of the interviewees described herself as experiencing a profound degree of emotional numbness, and engaging in self-harm because:

> it was almost like I could almost feel that . . .
>
> Judith

She was the only interviewee to report giving birth painlessly and she attributed that to being dissociated at the time.

NORMAL LIFE EVENTS AND DISSOCIATION

As we have seen, dissociative responses form a continuum, with normal, healthy responses at one end. A minor degree of dissociation may be experienced by perfectly healthy individuals to cope with stressful, but not traumatic, everyday events.[20] Sanford describes how, following a fall in a restaurant, rather than feeling the expected emotions of embarrassment, pain or fright, she became obsessed with retrieving the shoe she had lost.[7] Unable for that moment to comprehend what had happened, she became focused on an irrelevant detail. Although birth could not be described as an everyday event, it is within the realms of normal expected human experience. It is possible that the increasingly popular technique of self-hypnosis, now being promoted as a method of pain management during childbirth, is an example of the positive use of a dissociative technique.[21–23] Mongan, a practitioner of hypnobirthing, describes it as being similar to daydreaming or becoming engrossed in a good book, or staring into a fire, when you lose touch with what is going on around you.[21] The woman is encouraged to enter a state of deep relaxation and use visualisation in order to distance herself from the physical sensations surrounding labour. This not only helps her to deal with the pain of labour but also gives her the perception of control by placing a coping strategy at her disposal. One hypnotherapist describes herself having a 'wonderful time' in labour visiting, in her mind, all the places she had seen on her travels around the world.[24]

Women using self-hypnosis for childbirth have even reported 'out of body experiences', describing how they watched themselves giving birth from another part of the room. Clearly, the degree and type of dissociation achieved using these techniques can be very positive and helpful when under the control of the individual and used appropriately. However, survivors may find that what began as an escape route from an unacceptable reality can persist throughout their lives and may come into play (sometimes inappropriately) when feelings or circumstances arise which are similar to those surrounding their abuse. For example, three of the interviewees reported dissociating when engaging in sexual activity with their husbands or partners.

WHAT CAUSED THE WOMEN TO DISSOCIATE?

Many of the survivors interviewed referred to their ability to 'switch off' when confronted by situations in which they felt threatened, in pain or out of control. Two of the interviewees found themselves beginning to dissociate during their interviews, presumably because the telling of their stories elicited the emotions linked with their abuse. Several of the women had also experienced traumatic amnesia and for many years had no conscious memory of their abuse. The most common triggers for dissociation (cited by eight of the 11 women who dissociated) were intimate examinations and invasive procedures, particularly when performed by males.

Five of the interviewees clearly recalled dissociating during the birth of at

least one of their children and three others may have done, but their accounts were ambiguous in that their seemingly dissociated states could be attributed to their being under the influence of pethidine or Entonox at the time. Of these three, Jane recalled that during labour she spoke with a 'deep psychotic voice' that she believed to be her brother's. Arguably, this may have been an example of tertiary dissociation, i.e. dissociative identity disorder, which lies at the extreme end of the spectrum of dissociative responses. It is interesting that she was unique among the interviewees as having had, for some time in her past life, an alter ego:

> I didn't realise until it'd gone that I was actually like two different people. [. . .] She'd even got a name, her name was Jenny – I went on holiday and she . . . died within me, which was really hard and really wonderful. I can't explain any of it but it wasn't until she'd died that I knew that there was this other personality, or person or whatever.
>
> Jane

Five women admitted that they continued to dissociate during times of extreme stress in which they felt powerless and out of control – in other words, scenarios which either resembled their abuse or which elicited similar emotions.

COPING WITH THE INESCAPABLE

The issue of whether or not the ability to dissociate is volitional is questionable. The data from this study seems to suggest that some individuals do have a degree of control over it in some cases. More than half of the interviewees indicated that they used what could be described as secondary dissociation to cope with both physical and psychological trauma. Many of them had employed this coping strategy during the time of their abuse when, as children, they were powerless to stop it happening:

> I'm excellent at moving out of my body when I don't want to be in it – when it's too difficult to be in it.
>
> Lynne

The intentional use of dissociation was also seen in the account of one of Parratt's interviewees,[25] who described making a conscious decision to dissociate in order to avoid the overwhelming pain of labour. Survivors' accounts of CSA often contain references to counting flowers on wallpaper, focusing on an object in the room and disappearing into it, separating mind from body in order to cope with abuse.[26,27] This could be described as an attempt to maintain emotional integrity while their physical self is being violated. The survivors in this study also reported using similar coping strategies:

> I used to be able to just pick like that little mark up on the paintwork and I could disappear into it and it was like I wasn't here.
>
> Judith

> While it was happening, while the abuse was taking place . . . although I was there, stood with him physically, my mind was not there . . . and it sounds silly and I can still remember there was a crack on the ceiling and I used to look at the crack . . .
>
> Ruth

Others appeared to dissociate spontaneously when encountering a 'trigger'. Jo described it thus:

> I can do it at the switch of a . . . press of a button . . . I can go off and just not be aware at all . . . which is quite useful sometimes . . . but at the same time you don't hear what people are saying and you don't really take anything in because you're not really there.
>
> Jo

Another interviewee, who had been continuously abused by her father from before the age of 3 until she was at least 17, described how each episode would commence with him gripping her upper arm. Her automatic response to this cue would be to dissociate immediately. Later in life she found that the procedure of having a blood pressure cuff put on her arm would trigger the same response:

> . . . one of the key things that they [medical staff] kept being concerned about was how low my blood pressure kept plummeting in theatre and after surgery and retrospectively, I think that my body was responding to that because my blood pressure always drops because I dissociate. It doesn't go up, it drops, but it drops very, very low. It's almost like everything stops.
>
> Kerry

It is interesting to compare this account with that of Parratt's interviewee[25] (*see* Chapter 3), whose dissociated state appeared to have a harmful effect on her baby's heart rate during labour. Although Kerry's account of dissociating on having her blood pressure taken suggests that this response was not under her conscious control, we saw that the interviewee in Parratt's research, once she realised that her baby might be in danger, managed to bring herself round.

DISSOCIATION DURING THE BIRTH PROCESS

As previously stated, five of the interviewees reported dissociating to a certain degree at some time during the birth process. Despite having had no memory

of her abuse until after the births of her children, Judith explained that dissociation had helped her to enjoy giving birth because she felt no pain. Sharon also found that dissociation formed an effective coping strategy during her first birth experience (at home), which she described as 'positive' and 'affirming':

> . . . I think when I was in labour I just . . . thought, 'It's not happening to me', and just completely switched off . . . and just laboured really quickly.
>
> Sharon

Dissociation during the birth process did not always result in a positive experience, however. Jo found herself dissociating during her first birth (in hospital) which she described as deeply distressing:

> I felt so spaced out and just not in the same room as the room I was giving birth in even. I just did not feel like I was there [. . .] I was dissociated from what was going on . . .
>
> Jo

Similarly, Lynne also reported feeling traumatised by her first birth, which took place in hospital. When asked if the actual act of giving birth had caused her any problems she said:

> No, I think I was dissociated. I knew it was painful and I knew it hurt . . . but my head was somewhere else.
>
> Lynne

It appears that the women who described their dissociated birth experiences positively felt that dissociation had given them a measure of control, whereas those who gave negative accounts appeared to view dissociation more in terms of damage limitation.

WHICH WOMEN WERE MOST LIKELY TO DISSOCIATE?

Although it is difficult to draw conclusions from such a small sample, generally the women who dissociated tended to have been: a) abused from a younger age, b) suffered for a longer period of time and c) have more extreme abuse histories. These findings reflect those of other research.[28–31] One of the respondents, although she had been subjected to repeated rape by her stepfather for four to five years, had never dissociated either during the assaults or in any other situation. Neither did she suffer amnesia surrounding the events. There seems to be little to account for this except that her abuse started when she was 12 years old, later than most of the women who dissociated. Furthermore, evidence suggests that the response to trauma is highly individual, and influenced by diverse factors such as personality type, beliefs, family circumstances and the degree of perceived

support.[19,32,33] Interestingly, despite being severely abused by her father and a group of paedophiles from the age of around 4 years, Claire did not mention ever using dissociation as a coping strategy. She did, however, describe having vivid flashbacks to the abuse, precipitated by any kind of intimate examination.

One of the behaviours linked with PTSD is that of avoidance, in which situations or people that might act as triggers for memories of the trauma are avoided.[19,32,34–42] Claire's decision to have no more pregnancies following the birth of her son is an example of avoidance. Being deeply traumatised by the experience, and having no other psychological coping strategy at her disposal, she thereafter avoided placing herself in situations which might generate the same emotions. Most of the other women, despite some having been traumatised by their first birth, went on to have other children and found alternative ways to avoid traumatisation. Jenny, the woman who had suffered a single episode of abuse, a rape when in her teens, had not experienced dissociation or amnesia in relation to her attack. Despite this, however, she did have flashbacks to the sensory and emotional aspects of the event during her instrumental birth.

DISSOCIATION AND HOME BIRTH

Two of the women who gave birth at home reported dissociating during the birth. One was Ruth, who had two very positive home births, saying that she had coped with them using the strategy she had used when being abused – focusing on a crack in the ceiling. She felt very much in control of her birth experience and being able to use her own coping mechanism contributed hugely to that perception. The other, Sharon, also reported a high degree of satisfaction with her first birth. When asked how she had coped with procedures such as palpations, and VEs, she said:

> . . . that's the big thing isn't it, with vaginal examinations, is being touched, but I think I'd completely disassociated from my body and I think that I've never minded anything like that happening to me.
>
> Sharon

However, despite her second home birth being uncomplicated and quick, her memories of it were of feeling out of control and in extreme pain. At the time of her interview, her baby boy was six months old and she reported having ongoing flashbacks to his birth, was experiencing psychosexual problems and emotional distress as a result. She felt that this stemmed partly from her inability to effectively use her dissociative coping strategy during this birth:

> . . . there was nothing really that should have been traumatic but, actually, it was. But I think that . . . I've worked quite hard to stop dissociating with my partner you know, and he's been very supportive about all the things that have

> happened to me and I felt that it was really unfair to do that when I was with him in any way, emotional, or when we were having sex and I'd worked really hard to stop doing that and then when I was in labour I couldn't do it I don't think, or certainly not to any decent extent . . .
>
> Sharon

This suggests that for some survivors of CSA dissociation may have a protective effect and is associated with the perception of control. This supports the findings of other qualitative literature.[25,43,44] It may be that the relinquishment of mind control during labour leading to an altered state of consciousness also describes a degree of non-pathological dissociation which is a normal response to the intense sensations of the process.

WHERE THE POWER LIES

It would seem, then that positive reports of dissociation were usually associated with the woman being able to use her coping strategy to deal with the physical sensations of labour and birth, which fall within the boundaries of expected normal human experience. Negative accounts were nearly always linked with feelings of powerlessness and the perception that control lay in the hands of others who were perceived as unsympathetic and uncaring. As I discussed earlier, women have expectations that their caregivers will support them both physically and emotionally during labour. Arguably, encountering non-caring and emotionally detached carers lies outside the realm of expected human experience.

It appears, then, that the issue which determines whether dissociation is perceived positively or negatively is that of who has control. It can be used as an effective coping strategy when in the hands of the woman; conversely, it can be an involuntary response to overwhelming feelings of powerlessness as a defence against even more damaging states of terror.[17] It is this type of experience which is strongly linked to PTSD[14,45,46] and, for many of these women, birth scenarios in which they felt helpless and out of control constituted a re-enactment of their childhood abuse.

Harvey and Bryant conclude from their qualitative investigation into the organisation of traumatic memories that dissociation could be described as a form of avoidance in order to cope with and cut from traumatic memories.[16] It formed just one of the strategies by which the survivors attempted to avoid losing control over what happened to them. Other avoidance strategies included giving birth at home, delaying admission to hospital until labour was well advanced and, as I suggested, in Claire's case, avoiding pregnancy altogether. These women felt unable to challenge the way in which 'institutional' maternity care was delivered, but found ways to avoid contact with it or to minimise its impact. They either literally avoided situations in which they would experience powerlessness, or, when faced with inescapable circumstances, dissociated. Dissociation, then,

could be described as an avoidance strategy occurring when literal avoidance is impossible.

CONTROL AND LABOUR 'STYLES'

Rhodes and Hutchinson[43] in their study on survivors giving birth in hospital identify four 'labour styles' of sexually abused women: 'fighting, taking control, surrendering and retreating', dissociation forming part of the latter two. They suggest that these 'styles' might alert carers to the possibility that the woman they are attending may have a history of sexual abuse. The authors state that these 'styles' are not mutually exclusive and that women could display several different behaviours during the same labour. However, as I previously pointed out, it appears that in the majority of cases the particular style of behaviour occurred more as a response to the way in which it was managed by caregivers, rather than the 'normal', physiological sensations of labour. Certainly, this was the case for my interviewees. Some of them recounted engaging in what could be described as 'fighting' and 'taking control' behaviours but the majority coped using passive, non-confrontational strategies of which dissociation was one.

There is an increasing body of evidence that women who have no apparent history of sexual abuse or psychological trauma are coming away from childbirth suffering from PTSD and this is a cause for grave concern.[14,38,41] Given that PTSD symptoms are brought about by what Olde *et al.* describe in terms of 'vehement emotional reactions' which occur at the time of or after the traumatic event such as 'intense fear, helplessness, loss of control and horror. . .' [14] it is very disturbing that women should be experiencing emotions of this type and magnitude in relation to 'normal' childbirth.

'PROFESSIONAL DISSOCIATION'

The women's stories suggest, however, that survivors of CSA are not alone in dissociating and that lesser degrees of dissociation are employed by midwives and other caring professionals in order to cope with the huge demands placed upon them. Many reasons could be put forward to explain this and most are associated with the characteristics of the organisation providing maternity care. They include: the emphasis on the medically oriented concept of 'professionalism' (objectivity and detachment), lack of emotional or psychological support, the avoidance of the conflict between personal ideals and that of the 'service', self-protection from the emotional impact of others' pain, and burnout. Whatever the reasons, it was manifested in the failure on the part of some carers to engage with women and care for them emotionally, resulting in negative birth experiences.

'Professionalism'

In the last few years much has been written and said about the problems of recruitment and retention within the midwifery profession and the difficulties

caused by the ongoing staffing crisis in many areas.[47–51] The medical or 'technocratic' model,[52] which dominates today's maternity services, fails to acknowledge the importance of 'relational' care, which is arguably what attracts most women to enter the profession of midwifery. It would seem that both midwives and their clients have similar struggles with the nature of the maternity services and that some midwives, as well as women, feel powerless, betrayed and dehumanised. Anderson in her article on humanising institutional midwifery describes the midwife under the regime of technocracy as a machine, expected to function fully at all times regardless of her own personal needs or problems. She is chastised for getting too involved with clients as this is considered to be unprofessional.[53]

While I was engaged in writing this book, I took part in an annual update for midwives which included manual handling. I was dismayed to hear that if a woman in our care appeared to be about to fall, we were not to attempt to catch her, but to stand back and allow her to fall. We were then shown how to walk with a client and 'support' her in such a way that we would be able to easily free ourselves of her should this situation arise. The trainer then recounted an incident in which a nurse had indeed allowed a patient to fall and, despite receiving complaints from witnesses to the event, the trust, she said, was backing the nurse involved 'to the hilt'. Although I can see the rationale for this, to me, it demonstrates one of the major flaws in the institutional model of care. The fact that trusts are encouraging carers to override their natural caring responses in one situation while expecting them to behave with compassion and respect towards clients in others is demanding the impossible. It does indeed require workers to behave like machines, rather than human beings.

Professionalism, in this milieu, is equated with qualities such as efficiency, objectivity and detachment. Midwives are required to fit the model despite the fact that the essence of midwifery is relational, with feminine qualities at its core. They may well have entered the profession motivated by the desire to be 'with woman' but soon discover that, instead, they are required to be 'with CTG', 'with notes', 'with doctor'. As Shallow discovered, midwives are expected to function equally well in all areas of maternity care, regardless of their own particular preferences or strengths.[46,47,54,55] There is little or no support for those who find this difficult or who encounter distressing or traumatic events in their work situation. Kerry, an experienced community midwife, recounted an anecdote from her clinical practice in which she was called out to a house in the early hours of the morning to find a seriously ill young woman who had just given birth alone to a dead, macerated baby. Despite the seriousness of the situation, she was unable to access any help; nor did she receive any practical or emotional support from colleagues in the hospital:

> . . . my supervisor didn't come out to me, to assist me and I couldn't get the GP to respond to me. I actually had to deal with five shocked and distressed people. That included the two ambulance men. [. . .] I took her into hospital, wrote an initial report, handed over. No one said to me, 'Go home, go home!'

> I actually carried on working the whole of that day and continued working and then took 'til December (that was in the September. The December was when I actually went off sick and collapsed).
>
> Kerry

The lack of support in the system, both clinically and emotionally, for midwives who are struggling was a great source of frustration to Kerry. The fact that midwives in such extenuating circumstances are expected to continue functioning as if nothing had happened can have serious consequences:

> They either have to go off sick . . . or get private help or counselling or anti-depressants or whatever, or they block it out and carry on and become – you know – more consumed, if you like, with professionalism.
>
> Kerry

The concept of 'professionalism', as Kerry describes it here, is clearly that of a coping strategy, a means by which personal distress can be 'switched off' or blocked, in order for the individual to continue functioning. Because midwives are expected to perform perfectly at all times regardless of the circumstances, they are obliged to assume a 'professional persona' for use at work to protect themselves from their own, and others', distress. Hunter,[58] drawing on the work of Hochschild[59] on emotional labour, quotes a midwife doing this very thing – 'putting on a professional mask' as she changed into her uniform which enabled her to 'leave behind her personal self' and to perform in the manner appropriate to her role as midwife.

Arguably, most of us do have a 'professional persona' to some extent, but can this not allow for individuality, humanity and kindness? Although I am in no way suggesting that professional dissociation is a pathological response, it does have echoes of the alter ego present in dissociative identity disorder. This persona can remain unaware of, or untouched by, the trauma, allowing the clinician to continue functioning unencumbered by messy personal feelings.

Avoiding personal conflict

It appears that for many midwives who want to remain working within the organisation but do not wish to spend their time fighting, there is little choice other than submitting to its demands, regardless of their own personal philosophy of birth. Unfortunately, this may bring about an internal conflict, as Jo, a student midwife at the time of her interview, admitted:

> I just feel sometimes that we really are doing them [women] harm . . . and that's a horrible thing to have to live with.
>
> Jo

In order to cope with this a choice may be made (consciously or unconsciously)

between continually swimming against the tide, or dissociating from clients, which involves focusing on the demands of the system rather than on the needs of women. Just as secondary dissociation provides survivors with a means of coping with the unthinkable, this serves to minimise the emotional impact on the midwife and enables her to continue functioning. Instead of disappearing into a crack in the ceiling or a stain on the wallpaper, the midwife may focus on protocols, routines and rituals, thus disappearing into the system.

Sharon, a fairly newly qualified midwife, had discovered, to her surprise, that she enjoyed working in emergency situations on labour ward. When asked to explain exactly what she found enjoyable, she said:

> I don't know, maybe it is the rushing about. I don't know whether I take satisfaction in treating women with some degree of compassion and kindness and respect in dreadful situations, or whether the emergency side of it stops me having to emotionally engage with women . . .
>
> Sharon

It appears that these emergency situations may be directing her focus away from the women's needs and providing a 'legitimate' reason not to engage with clients. Her account demonstrates the powerful influence the medical and institutional paradigm has on midwifery practice and the ease with which women's needs may be eclipsed by other considerations. Moreover, midwives may align themselves with the organisation and dissociate from women in order to protect themselves from internal or external conflicts that arise from the disparity between clients' wishes and the requirements of the system. This may be more comfortable than supporting women in choices that are not endorsed by the organisation and which, if allowed, could make the midwife vulnerable to ostracism.

On one occasion, I had to transfer a client into hospital for suspected foetal distress, although she had planned to give birth at home. I remember wrestling with my own emotions on seeing her undergoing several VEs in succession, knowing that she had been the subject of sexual abuse in the past. She coped reasonably well at first, as the examinations were performed by a midwife. However, when a male doctor tried to examine her, she kicked out and resisted him, pleading with him to stop. I can only describe the process going on in my head at the time as a debate between whether I should defend her right to refuse the procedure, or whether to please the doctor by helping her to cope with it. When I was an NHS midwife, this is almost certainly what I would have done. I would have to normalise what I was seeing in front of me – a woman resisting what she felt to be a violation – and protect myself from the emotional impact of it by focusing on the institutional agenda, or I would have to focus on her needs and stand with her in her determination not to be examined again. I chose the latter, but it was not easy, as I have to admit I did not want to be seen as confrontational, thereby incurring the wrath of the organisation.

Focus on routine and ritual

Practitioners' focus on routines and procedures is an issue that cropped up frequently in the accounts of the women. Bergstrom and colleagues' study on the conduct of VEs in the second stage of labour identified two major themes: the VE as a healthcare 'ritual', and the personal disembodiment of the caregiver.[60] The ritualistic aspect, they assert, allows the intimate aspects of the procedure to be ignored by all participants, who become 'role players' instead of real people. The disembodiment of caregivers enables them to dissociate from their own subjective response and become objective in a situation in which they may be inflicting pain or doing something which goes beyond the boundaries of normal social interaction. Not only do these mechanisms protect caregivers from the full emotional impact of what they are doing but they also provide a means of avoiding the need to question the efficacy or desirability of it. Significantly, one of the midwife interviewees described herself staring at the clock while performing VEs, rather than looking at the woman. This may have been an attempt to protect herself psychologically using a degree of dissociation.

As discussed in Chapter 6, several of the women gave accounts in which, despite their obvious distress, caregivers persisted in completing procedures. It appears that carers' focus on the routine shielded them from experiencing the full impact of the situation. I would suggest that this has echoes of the abused child focusing on a crack on the wall or a flower on the wallpaper in order to 'escape' the reality of what is happening in her body.

Focus on risk

As birth has become increasingly medicalised and issues of risk and litigation ever more pressing, the autonomy of the midwife has been gradually but relentlessly eroded. Midwives working within today's maternity services are acutely aware of the pressure on them to conform to policies, protocols and 'guidelines' intended to eradicate all risk from the birth process but in which they have little or no input. As Anderson says, midwifery policies are mostly written by senior obstetricians who have the power to say what will or will not happen to their patients. Midwives who withstand this authority may be either bullied into submission or will decide to leave the service for lack of autonomy.[53]

Rhoda described the community midwife she was allotted during her second pregnancy as not a nice woman, but as someone she 'got on with [. . .] on a sort of professional level'. Despite having had a successful first birth at home, this midwife, knowing that she had requested a home birth, chose to focus on risk, sending her for a scan to estimate foetal weight when the baby's head did not engage in her pelvis at 37 weeks. When the weight was estimated at nine pounds 10 ounces, she effectively denied her request for a home birth by threatening her with the death of her infant: 'If you have this baby at home and it dies, it'll be your fault!' By focusing on the concept of risk, she could effectively justify her actions by believing that she had acted in her client's best interest. From the medico-legal

perspective, she had acted professionally and responsibly in protecting her from the possible consequences of her actions. However, this strategy provided a means by which she could avoid becoming emotionally involved with Rhoda and the resultant conflict that may have ensued from a decision to support her.

When I was working as a community midwife in the NHS, I vividly (and shamefully) recall being asked by a woman who had had a caesarean section if I could support her in a home birth for her second child. Despite feeling that her request was not unreasonable and being aware that the risks were fairly minimal, I knew that this was contrary to hospital policy and that the other members of my team would probably not support it. I therefore felt obliged to put my own beliefs and philosophy to one side, and put on my 'professional persona' who avoided engaging in a discussion as to her reasons. 'She' (the professional) then emphasised the risks of vaginal birth after caesarean (VBAC) at home and declined to support her. I used my alter ego, and 'her' perception of risk, to protect myself from involvement with the woman thus avoiding putting myself in the firing line. However, I did not approach this scenario from a position of strength. My own powerlessness was the motivating force behind my response and is what ultimately led to the woman being disempowered and isolated.

'Professional' detachment and emotional numbing

Midwifery is a profession which involves a high level of direct contact with people, often in highly emotional or stressful situations. Consequently, midwives are particularly susceptible to 'burnout syndrome' in which physical and emotional exhaustion leads to low morale and a loss of concern, empathy and job satisfaction. Burnout, argues Sandall, is often exacerbated by lack of support and understanding from colleagues and is correlated with an inability to achieve goals because of unrealistic policies, excessive caseload and isolation.[61]

She interviewed midwives who had been providing continuity of carer for several years and reported that people in this position often coped by distancing themselves psychologically, which was harmful both to clients and to themselves. I suggest that this is highly reminiscent of the 'emotional numbing' and 'detachment' aspects of dissociation discussed earlier. In today's maternity services, pressure is exerted on midwives from all sides, not only by the medical and legal constraints of their position, but also by organisational and managerial requirements. In addition to that, a strong culture of self-sacrifice pervades midwifery, causing many individuals to place unrealistic expectations on themselves.[62] Consequently, emotional numbing and distancing may not only occur as a result of these pressures but also act as a coping strategy, enabling individuals to continue functioning. This emotional distance and apparent lack of interest in the women as individuals was deeply distressing to some of the interviewees, to whom it had connotations of abuse. We saw in Chapter 4 how the complete lack of concern shown by her labour attendants triggered Claire's memories of her father calmly watching her being abused. Sally also commented on her carers' attitude, which reminded her of her abusive stepfather:

> They just carry on with their job. That's their job, it doesn't matter whether it upsets you or not. There's a few people like that [. . .] and it was just like . . . a couple of them just seemed to . . . the ones that were upstairs on delivery suite just seemed to have locked themselves away . . .
>
> Sally

This is echoed in Amanda's account who described her experience of perineal suturing as traumatic:

> I felt like there was no dignity to it, there was no thought for my feelings. I was crying my eyes out and there was nothing . . .
>
> Amanda

She recalled being so impressed with a young Irish midwife who had cared for her during labour and birth that she had named her child after her:

> I'm just thinking that, if she could have sutured me, maybe it would have been different, but the fact that you have these men who just come in, took over the care without any feeling, they didn't know who I was from Adam!
>
> Amanda

'Professional dissociation' could be described as the antithesis of 'professional intimacy' which Halldorsdottir and Karlsdottir define as a combination of closeness and distance, which, at the same time as creating space for the receiver of care, also allows for connection.[63] It combines clinical competence with the human qualities of caring, warmth, good communication and genuine concern for women. This was particularly observed in both Rhoda's birth accounts. She described her first midwife as 'a lovely woman and a lovely midwife', implying that they related first and foremost as women. The midwife who attended her second birth she described as 'supportive [. . .] but not in my face', which, it seems, is the epitome of 'professional intimacy'. Consequently, she declared: 'I felt really powerful.' Conversely, as was seen in the accounts of other survivors, birthing women attended by dissociated, uncaring midwives often find their birth experiences disempowering and frightening.

To sum up, dissociation, which is closely associated with PTSD, has been explained as a defensive mechanism that enables traumatised individuals to separate themselves from physical and psychological pain associated with traumatic events. It exists as a continuum which has its origins in normal human behaviour, but which can be pathological when an individual is exposed to events eliciting feelings of horror, helplessness and extreme fear. Dissociation also encompasses emotional disorders such as numbing, derealisation and depersonalisation, which often interfere with the activities of daily living.

There were many reports of dissociation from the women interviewed. Some described dissociating in order to cope with their abuse as children, using

strategies such as focusing on something other than what was happening to them physically. Several interviewees reported using this coping mechanism to deal with the sensations of labour. Interestingly, this type of dissociation was used in the context of home birth and was considered by the women to be protective. Others described experiencing flashbacks and reliving abusive scenarios when they encountered 'triggers' or situations that reminded them of their abuse. The issue of who had control determined whether they viewed dissociation positively or negatively. Dissociation also appeared to be an avoidance strategy, acting to limit the emotional damage incurred when literal avoidance was not possible. There is some evidence to suggest that health professionals may also use a degree of dissociation in order to cope with working in an environment in which there are many pressures and potential conflicts. 'Professional dissociation' could be described as a survival strategy deployed to protect the individual from the emotional and psychological consequences of their own powerlessness or to lessen the impact of causing pain or distress to others. It is the antithesis of professional intimacy and is ultimately harmful to women, midwives and midwifery.

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CHAPTER 9

What women want from their maternity carers and why the industrial model cannot deliver

RELATIONAL CARE

In my interviewees' accounts the issues of control, relational care, security, trust and good communication were very much in evidence, reflecting the findings of previously discussed research on birthing women's needs.[1–5] All stressed the importance of the human qualities of their carers. They wanted to be cared for as individuals, by individuals who engaged with them and worked with understanding, compassion, humour and all the other attributes that encourage good relationships. What caused them distress was the feeling that they were being processed by a system which neither knew nor valued them as individuals; as Lynne so eloquently put it, being treated like 'an object on a conveyor belt of vaginas'.

Claire, who described her birth attendants as 'abrupt' and 'not gentle', felt that a little humour might have made the difference to her experience:

> Even if somebody had come in and had a bit of a laugh – that sort of thing.
>
> Claire

Chloe, when asked what would have made her two births less traumatic, said:

> . . . I think just someone sort of . . . just being there and being a bit more understanding.
>
> Chloe

Sally's repeated reference to her attendants' 'no-care' attitude testified to her need for human warmth and understanding. She spoke highly of a student midwife,

who in contrast to some of the older, qualified staff, was emotionally supportive of her:

> . . . she knew the pain I was going through. She seemed to understand it all.
>
> Sally

This comment echoes those of the Icelandic women interviewed by Halldorsdottir and Karlsdottir whose perception that midwives understood what they were going through helped them to achieve 'successful' births.[2]

CONTINUITY

Alongside good relationships with carers, many of the interviewees expressed their need for continuity of carer. Not only would this be conducive to forming supportive relationships but, for those women who wished to disclose their history of abuse, it ensured that their story would not have to be retold on meeting each new professional. In addition, their secrets could be confined within manageable boundaries, thus minimising the feeling that they had lost control over them:

> If you tell one midwife something, and then next time you see another midwife, you don't want to keep repeating it over and over again.
>
> Amanda

> I think if there is a good continuity of care system it shouldn't need to be wrote in the notes because the midwife that you're going to see is going to be in a relationship with you that she knows you as an individual, that she knows that you've been abused – and that should be enough.
>
> Ruth

Several expressed their need to be able to confide in a consistent sympathetic carer throughout pregnancy, which was a time of great anxiety for some:

> . . . someone I could just talk to so they knew what I was feeling and what things had frightened me because sometimes things could frighten me for a couple of days and I'd get over it and I'd think how stupid I was . . .
>
> Sally

Veronica, who had never before told her story, obviously felt that having a sympathetic professional confidante with whom she could have formed a relationship might have lessened the trauma she experienced in relation to pregnancy and birth. Having read the transcript of her original interview she added a postscript stressing the importance she attached to continuity:

> In a nutshell, had I been able to have a one-to-one relationship with the same

> person monitoring my pregnancies from start to finish, I might have had a very good chance of depositing my inner trauma on the OUTSIDE and lessened the damage INSIDE. It's negative and useless to say 'IF ONLY . . .' but looking back I do say 'if only'. My whole life might have been less traumatic and difficult, my marriage more 'normal' – I feel I've been punished and judged always for what I didn't do – because I couldn't, daren't speak out. Both pregnancies were a nightmare that a one-to-one midwife could have maybe made an enjoyable experience instead of the dreadful one it was.
>
> Veronica

Claire, who was pregnant in the 1970s at a time when care was particularly fragmented, expressed a similar opinion:

> . . . each antenatal clinic that I went to you saw a different doctor – I don't think I saw the same one twice. [. . .] but it would have been much nicer if you could have built up some form of relationship with one or even two.
>
> Claire

As we have seen, one of the major impacts of sexual abuse on a child is the destruction of trust and many survivors find that they distrust health professionals and people whom they perceive to be in a position of authority. Continuity of carer provides the environment in which trust can be rebuilt, as Judith observed:

> . . . part of what has been destroyed is trust, so rebuilding that takes quite a long time so if you're continually changing the person that's working with you, you can't get to that stage if it's more than one person . . .
>
> Judith

Kerry's account of her therapeutic relationship with her GP, on the other hand, provides an excellent example of the benefits of continuity. She explained that owing to her chronic health problems and her abusive history, she had previously had no trust in doctors because: 'all they ever did was cut me open, take things out of me.' However, latterly she had been able to build up a trusting relationship with her GP who had consistently counselled and supported her through turbulent times. Consequently, she had recovered some of the trust that had been destroyed not only as a result of CSA but also in the context of medical treatment:

> . . . he hung on to me and he kept going and I didn't get admitted. [. . .] But, for me, that trust that he put into his care for me was the right thing. I'm not saying it would be for everyone, but it certainly was the right thing for me because he knew me better than anyone else.
>
> Kerry

Clearly, to be successful, continuity of carer must be with the right person. As Lynne observed, survivors not wanting to rock the boat might feel unable to express dissatisfaction with a carer and consequently persist with an arrangement that was detrimental to them. Rhoda's account of her first pregnancy, on the other hand, is an example of the great benefits to be had from a good ongoing relationship between a woman and her midwife. It is significant that Rhoda trusted her midwife to the extent that it was not necessary to disclose her abusive history. She received the consistency and quality of care she needed without having to identify herself as someone with 'special needs'.[6] Interestingly, when I asked her if she thought it would have made any difference if her midwife had been aware of her history, she replied:

> No, I don't think it actually would have made any difference because she was just a lovely woman and a lovely midwife and I didn't really need anything extra from her than she gave me anyway . . .
>
> Rhoda

This suggests that continuity of carer with the right person, in which the woman and her midwife are able to develop a good, trusting relationship, may, in some cases, negate the need for disclosure. It could also be argued that if all midwifery practice were of this high quality and standard then fewer women would be coming away from childbirth traumatised and broken. However, although the concept of continuity is promoted by mainstream maternity provision, it is rarely realised to any great extent.

GOOD COMMUNICATION AND THE OFFERING OF GENUINE CHOICE

The need to be kept informed and involved in decision-making was central to the women's perception of control. Survivors of abuse, as we have seen, may not feel able to make their needs known and, consequently, suffer in silence. Kerry's complicated footling breech birth was made all the more traumatic because of her carers' failure to communicate:

> . . . I wasn't informed my baby's heartbeat was even there. I didn't know whether she was dead or alive and was too afraid to ask.
>
> Kerry

Her perception of powerlessness was strongly linked with not being given relevant information. Similarly, Judith felt that her experience of maternity care would have been better if staff had exercised good communication skills:

> They just sort of – 'Come on, do this, do this, do this!' Not sort of, 'Oh well, we'll need to do this because . . .'
>
> Judith

Many of the women's accounts illustrate a lamentable lack of communication and information giving on the part of carers. Some, like Rosie, found themselves being subjected to various unwanted interventions, with little explanation of what was going on, others were given pain relief without their consent, some were not kept informed of their sick baby's condition following the birth. All these factors were a source of great anxiety, causing the women to feel they had lost control.

Some of the interviewees commented on the importance they attached to being able to call a halt to a procedure at any time if it was proving unbearable. As with the woman encountered by Maggie Smith,[7] despite wanting to cooperate, survivors often find that their bodies respond in unconsciously defensive ways:

> If they'd say 'open your legs' you close them.
>
> Claire

Busyness and pressure of work are the factors which often cause carers to press on regardless. Sadly, as seen in the scenario recounted by Burian[8] (*see* Chapter 3), in situations where the woman is perceived to be uncooperative or demanding, professionals may react by becoming more forceful and authoritarian, which is counterproductive for both parties. Judith described a scenario in which a friend was unable to allow a doctor to perform an internal examination. Because of her apparent non-cooperation, he became impatient and attempted to force the issue:

> . . . the end result because of how the doctor was behaving was that he couldn't perform the examination and she went away feeling that she's never going to allow anybody to try that again.
>
> Judith

It is significant that both Claire and Judith were enabled to cope with intimate procedures by male consultants who were prepared to work collaboratively with them and respect their limitations. Despite the fact that intimate examinations by males were a potential source of trauma to these women, the sympathetic and respectful attitude of their carers helped them to endure the procedures without suffering long-term psychological damage. As we have seen from the literature and the data, birthing women, including those who have a history of CSA, place great value on the humanistic characteristics of the midwife's role. All women expect their midwives to be competent and knowledgeable but place equal importance on being cared for by individuals who relate to them with genuine warmth, show respect, communicate well, and offer them choice.[1,2,9,10] When this relationship functions well and women feel nurtured, supported and valued, the result can be truly empowering.

Female carers

Many of the women in this study also indicated that the gender of their carers was important to them, and most felt they preferred to be cared for by women. In situations in which they felt vulnerable, male carers were more likely to trigger flashbacks to abusive scenarios:

> When a man's examining you internally, there comes a point when it could be any man doing it. You can lose sight of the fact that that is a doctor. That could be your abuser.
>
> Wanda

Three of the interviewees had been abused by women, but all had suffered CSA at the hands of men and therefore perceived them as potentially abusive. As a result of their early experiences most had felt unable to refuse demands made upon them by males. In effect they had little choice but to endure intimate and invasive procedures by male practitioners, some taking refuge in dissociation, others reliving their abuse in flashbacks.

WHY THE INDUSTRIAL MODEL CANNOT DELIVER

The medicalisation of birth

For thousands of years, midwives have been attending birthing women and until relatively recently enjoyed a good deal of autonomy. The institution of midwifery was based on the premise that birth is a normal event to be attended, not manipulated or interfered with. Birth traditionally took place in the home and was a social event embued with great spiritual significance and was understood to be an exclusively female event in which men did not get involved.[11–14] Apart from her midwife, the woman was usually supported by lay women and female relatives who probably encouraged her with stories of other successful births, including their own. Their nurturing skills grew out of their own mothering experiences and were handed on from mother to daughter. Herbal remedies and folk medicine may have been used to ease the woman's pain, but labour was allowed to take its own time and course unhindered.[14] Midwives learned their profession by experience, and in the medieval era this was often through apprenticeships with established midwives.[12,15] In the case of normal birth they had a high degree of autonomy and only in the event of abnormality were they obliged to call for help from the medical profession. The 'barber-surgeons' were practitioners of abnormal delivery and would use various instruments in order to extract the child from its mother, often resulting in foetal, if not maternal, death.[11] The power of midwifery lay in its ability to define normality.

However, the 17th century marked the beginning of a long power struggle not only over who should be in attendance at birth but also over who should be responsible for defining normality. During the 18th century, men began to

promote themselves as male midwives and attendants of normal birth, thus progressing from their role as emergency practitioners only.[12] This brought them into direct competition with female midwives. The invention of the obstetric forceps in the early part of the century was highly significant as they enabled male practitioners to deliver the foetus alive, whereas, in the past, instruments had been employed to destroy it in order to save the mother's life.[16,17]

As they increased in popularity, male birth attendants attempted to destroy the reputation of female midwives by portraying them all as ignorant, meddlesome and dangerous, as I am sure, some were. By the middle of the 19th century not only had midwifery suffered a serious decline[18] but even the word 'midwife' had been brought into disrepute, thanks, in part, to creations such as Dickens' drunken, unscrupulous Mrs Gamp.[12,19]

During the early part of the 19th century, males who specialised in midwifery started to refer to themselves as obstetricians rather than midwives. The derivation of the word 'obstetrics' comes from Latin, 'ob' and 'stare' literally meaning 'to stand before', which suggests objectivity, dominance and 'scientific' observation. This has very different connotations than those of the old English word 'midwife' (with woman). Obstetrics then created for itself legal and social boundaries in order to protect its own interests. Midwives were obliged to depend upon their professional rivals, doctors, for their training and eventually became subject to state regulation under the medical profession at the beginning of the 20th century.[16,17] Obstetrics succeeded in placing an exclusion zone around childbirth by defining it as a process, the 'normal' course of which was known only to obstetrics.[11] It has now became the remit of medicine to set the limits on normality[20] and gradually but inexorably that definition has become increasingly restrictive and rigid. This effectively disqualifies many women from receiving midwifery-led care by placing them in a 'high-risk' category requiring obstetric input.

Scientification

During the 17th century a philosophy emerged which, in contrast to the previously held belief that the earth was a living organism, assumed that the universe was mechanistic and followed predictable laws which could only be understood through science and manipulated through technology.[21] The belief that science and technology could and should be employed to manipulate the natural world legitimised a huge increase in childbirth interventions (under the control of men-midwives) which were perceived to enhance and improve the efficiency and functioning of the birth process and went a long way towards promoting the concept of women's bodies as faulty.[11,22] Murphy-Lawless[17] argues that scientification is underpinned by the need to 'control' the uncontrollable, that is, death. Childbirth, with its uncertainty and perceived danger, represents a challenge to obstetrics, which has a profound belief that its remit is to rescue women from death. However, as she points out, it is not a remit which is shared by those it primarily affects, i.e. birthing women, but belongs exclusively to itself. Thus obstetrics has become the champion of 'safe' childbirth and the protector of

women from themselves and their substandard bodies. The responsibility for birth (including normal birth) has been taken from the hands of women and midwives, stripped of its emotional, spiritual and social components to become the property of medical 'science'.

Institutionalisation

Having been medicalised and scientificated from the 17th century onwards, during the 20th century birth also became subject to institutionalisation. Although the idea of institutional birth was not a new one, lying-in hospitals having been established in the 18th century, birth in hospital was far from being the norm for most women. In Britain, the move to promote universally institutionalised birth started in the 1920s and over the next 50 years the percentage of women delivering in hospital rose steadily to a level of 95.6% in 1974.[23] In the intervening years the responsibility for providing the maternity services had become that of the NHS with its inception in 1948. During the latter half of the century, papers such as the Peel Report[24] along with continued pressure from the Royal College of Obstetricians and Gynaecologists, brought birthing women and their midwives into hospital and successfully fixed the concept of birth as a medical, rather than a social, event. British midwives had long since surrendered a good deal of their autonomy to the medical profession and the move into hospital brought them further under medical dominance by reason of proximity. The idea of institutionalised birth being generally accepted as not only desirable but socially responsible, childbearing women and midwives became increasingly subject to the control of obstetrics and the organisation.

The medical profession and the institution represent a powerful symbiotic relationship, the institution providing the medium in which medical authority can be expressed, while 'medical technology' offers the possibility of minimising unpredictability, thereby increasing the efficiency of the institution. One major impact of this relationship has been to confine and define birth within strict time parameters. This is beneficial to both parties. Constructs such as active management of labour[25] enhance the system's requirements for speed and efficiency and have had a profound influence on hospital and even home birth. Because time parameters are partially used to define 'normality' in childbirth, the perceived need for medical intervention has escalated, further strengthening the apparent indispensability of obstetrics.

Industrialisation

The organisation of the NHS has been heavily influenced by the industrial model, with its emphasis on efficiency, bureaucracy and hierarchy, which in turn has impacted upon women and midwives. Taylor's 'scientific management' model, based on his time and motion studies,[26,27] had a huge impact on the structure and running of large organisations and the mass production methods of industrialists such as Henry Ford. Previously, commodities were produced by small numbers of knowledgeable craftsmen, who were engaged in the process

from conception to realisation. Under Taylor and Ford's influence, the process became fragmented, and separated into small tasks, requiring little skill and no ingenuity. This model relies on large numbers of unskilled workers prepared to perform the same repetitive action day after day, without having the satisfaction of seeing the end result. Taylor described the characteristics of the ideal worker as 'stupid and phlegmatic', having the mental disposition of an ox.[26,27]

Ritzer, the proponent of the concept of the 'McDonaldisation' of society, warns of the dehumanising effect industrialisation and rationalisation (the process which undergirds industrialisation) have had on human society.[27] He suggests, referring to the work of Bauman,[28] that the Holocaust provides the ultimate example of the dehumanising effect of rationalisation: people viewed as cargo, processed and exterminated in huge numbers using the most efficient, cost-effective means. The four principles underpinning McDonalisation (efficiency, predictability, calculability and control through non-human technology) provided the focus of the operation, allowing 'production line workers' to avoid recognising the humanity of the 'product'. These methods, when applied to processing people are, of necessity, dehumanising both for workers and users.

The vast majority of our national institutions, including the NHS, are built on hierarchies and the unspoken assumption is that hierarchy is necessary for the smooth running of a large organisation. Hierarchies are built on hegemony, which, by its nature, is unreceptive or antagonistic towards other ways of doing things. Much of the effort of the hierarchical organisation goes into maintaining the superior position of those at the top, while those in the lower ranks are expected to follow orders. Consequently, power is concentrated at the upper end of the structure, rendering it inflexible and intransigent. Those in the lower levels have very little influence or control over their working arrangements, which can lead to resentment, irresponsibility and disenfranchisement. The phrase 'hierarchy maintenance work' was first coined by Kitzinger *et al.*[29] who used it to describe the various tactics employed by midwives to manipulate doctors without upsetting the hierarchical status quo. I am sure that most midwives are aware of having used these strategies at some time. However, as Kirkham argues, working in this way demonstrates to clients our lowly role in the hierarchy, which in turn conveys to them that they are even more powerless.[20] Furthermore, the hierarchical nature of the structure delivering healthcare provides an ideal environment in which paternalism can flourish, working against the notions of collaborative relationships and the offering of free choice.

Much has been written of the negative impact industrialisation has had on the provision of healthcare, including the maternity services.[27,30,31] Davis-Floyd[21] describes the hospital as 'a highly technocratic factory' while other commentators have referred to the 'conveyor belt' or the 'process mentality' of large consultant units.[30,32,33] As Taylor suggests, the industrial model works best when served by workers possessing an 'ox-like mentality'. The smooth running of an industrial organisation is threatened by users who demand individual treatment and workers who are innovative and individualistic. Clinicians who want to provide

care on women's terms rather than on those of the system may be perceived as a threat to the organisation and therefore find themselves being censured and isolated.[34–37]

Industrialisation has also brought about the fragmentation of the maternity services. Whereas, in the past, one midwife would be responsible for one woman with whom she could form a relationship, today's mainstream maternity provision relies on care being provided by numerous individuals each responsible for their part on the conveyor belt, which has proved unpopular with both women and midwives.[38,39] After the publication of *Changing Childbirth*[40] the problem of continuity in maternity care was ostensibly addressed in many areas by the setting up of midwifery teams. However, the consensus of the respondents in Edwards' research into women's expectations and experiences of meeting and getting to know midwives during pregnancy, was that being cared for by a number of midwives does not, in fact, provide continuity and that merely 'meeting' midwives does not equate with 'knowing' them.[41] Research suggests that women actually define continuity in terms of getting to know their midwives and the quality of their relationships.[41–45] As I discussed previously, the women I interviewed indicated that a one-to-one relationship with a carer was a prerequisite for the building of trust shattered by abuse and for minimising the potential for re-traumatisation. Unfortunately, it appears that the importance of continuity of carer often goes unacknowledged and many of the initiatives designed with the aim of providing continuity, such as the Albany Practice, have been discontinued or are obliged to fight for survival.[46–50] I would agree with Kirkham[51] when she suggests that the organisation is not wholeheartedly in favour of midwives and women forming relationships because women's needs then become the primary focus of care in preference to its own.

THE DISEMPOWERMENT OF MIDWIVES

Without a doubt, medicalisation has redefined birth, but it has also brought about a radical change in the identity of the midwife and the devaluation of her role as was demonstrated by the accounts of the midwife survivors. Anderson observed the impact of this on women entering midwifery without a nursing background.[52] Having never been socialised into the hospital environment, their initial exposure to the paraphernalia surrounding medicalised birth can be profoundly disturbing, causing them stress and confusion as they struggle to reconcile what they see in reality with their own philosophy of midwifery.

Davies also makes a similar point, arguing that the definition of 'normality' in childbirth has been reconstructed in such a way that student midwives may suffer an identity crisis on qualification.[53] Having been inculcated during their training with notions of birth as a 'normal life event', the discrepancy between theory and practice generates acute anxiety in those who are based in large medicalised units to the extent that some are 'terrified' of working on labour ward. Interestingly, midwives in Shallow's research into integration also used the word 'terrified' in

the same context.[54] This sentiment was also expressed in the comments made by some of the midwife interviewees. Jenny, the Australian midwife, wrote:

> I have worked in some women-centred midwifery units, and some backward 'cattle-yard' environments. My most difficult time as a midwife was when I worked within a level 3 hospital in the public delivery suites. I saw some terrible 'abuse' of women.
>
> Jenny

As we have seen, several of the British midwives also referred to what went on in the labour ward using words such as 'brutality', 'assault' or 'abusive'. Sharon described witnessing scenarios on labour ward (as a student midwife) in which she felt that women had been 'raped'. Labour ward is one of the environments in which the impact of 'technomedicine'[55] is most keenly felt, and its need to be actively managing birth conflicts strongly with the midwifery philosophy of watchful inaction. Rosie voiced her frustration with the lack of knowledge displayed by some doctors in her unit regarding the nature of 'normal' birth:

> . . . I just think they're so far removed from understanding anything about what normal birth is . . . I mean, to have an SHO [senior house officer] say to me 'What is . . .', or 'What are you talking about – spontaneous pushing?'
>
> Rosie

Despite the fact that midwifery has learned much from obstetrics, this has rarely been reciprocated. In the hospital environment particularly, midwifery knowledge is marginalised by the dominant discourse of medicine. Having the ability to define the boundaries of normality ensures that medical hegemony is perpetuated and the dominance of this model has meant the decline of many of the traditional midwifery skills as the identity of the hospital-based midwife has been transformed to that of 'obstetric nurse'.[12,56] Midwives are required to become competent in, and rely on, medical technology in preference to the 'tricks of the trade' previous generations of midwives employed to facilitate normal birth.[57] This has had far-reaching consequences for women. Weston, a mother and campaigner for normal birth, describes how her community midwives, who had been 'confident and competent professionals' when caring for her at home, 'became invisible under the bright hospital lights'.[58] Invisible midwives result in invisible women.

The demands of the organisation

Recent research reveals the immense pressure under which midwives work and the demoralising effect the organisation's demands can have on their self-esteem. As was seen from the accounts of the midwives, working in the hospital environment was a continuous struggle to protect women from the influences of the medicalised production-line. Rhoda explained how the pressures of the

low staffing levels in her unit caused her to feel she was failing in her responsibility to the women, which was one of the reasons she avoided the labour ward environment:

> It's just the level of the work, you know, you get thrown at you when you're down there [labour ward] so you end up looking after two or three women [. . .] a woman comes in perhaps quite frightened and . . . needing some support and I felt able to give it for a certain amount of time and then I've been called away because something else is happening somewhere else and by the time I've gone back, they've just lost it really and I don't feel I can get them back on . . . and you know, even if I did, it probably wouldn't last that long before I had to go again . . .
>
> Rhoda

Many of the midwives interviewed by Ball *et al.* in their study entitled 'Why do Midwives Leave?' reported their distress as their own needs for continuity, autonomy and respect were being sacrificed daily on the altar of 'service needs'.[38] One described herself driving home from the hospital sobbing, feeling she never wanted to set foot in the place again. Shallow described how midwives, who had been confident in their role and skills before integration, when obliged to work in any area of maternity care at any time suffered from fear, anxiety and a lack of confidence.[54]

Kacary, a midwife working in the NHS at the time, observed that expecting midwives to be expert at everything is insanity and would only result in mediocrity, causing those who strive for excellence to become frustrated and subsequently leave the profession.[59] By 2004, however, she herself had left the NHS to become independent. Others who are unwilling or unable to take this option may find other ways in which to cope, such as taking non-clinical posts or courses in further education.[38]

As we have seen, the industrial model actually requires the objectification of its workers in order to function most efficiently. However, this paradigm fails to take into account the human need for companionship, collaboration and social interaction. Coping with change is acknowledged as hugely stressful,[60] but midwives working within this environment may be encountering it on an almost daily basis. The evidence shows that without the support provided by ongoing collegial relationships and the confidence which comes from working in a safe and familiar environment, they become demoralised and disempowered.[38,54,61–63] Consequently, they will be in no position to empower the women in their care.

'Continuous midwife monitoring'

As I previously discussed, surveillance was somewhat of a theme in the accounts of the midwives, who described themselves and their practice as being scrutinised or criticised by colleagues. Kirkham's paper on the culture of midwifery

in the NHS reported that midwives felt that they were being 'policed' by their colleagues.[64]

Horizontal violence and workplace bullying have been the subject of much debate and discussion in recent years.[36,65–68] According to Mander, bullying thrives in large, 'caring' organisations and serves to prevent innovative and imaginative practice by ensuring that departures from the norm are quickly stifled.[68] The devastating impact that workplace bullying has upon the lives of midwives cannot be underestimated. Midwives may leave the profession,[38] suffer from depression and other psychiatric illnesses and even, as in the case of Jodie Wright, commit suicide.[36] Disciplinary action in the form of suspension not only means loss of reputation and identity but, to many midwives, their livelihood. Flint refers to the case of Deborah Hughes, a midwife who, unaware that the maternity unit had been closed, was suspended for assisting at the birth of a woman who was brought to a London hospital by ambulance in advanced labour.[69] Clearly, this was a 'no win' situation for her, because, as Flint points out, suspension would have been the outcome if she had stood by with her arms folded. Richards also gives an account of two midwives who were suspended for failing to adhere to trust policy when the woman they were attending at home refused to leave the birthing pool to give birth.[70] There was no suggestion of malpractice, the mother was happy with her care and her baby was born in good condition. More recently we have seen the striking off of Deborah Purdue (an independent midwife) after 25 years of unblemished practice when a client's baby, who was apparently in good condition when admitted to hospital *in utero*, died later following a doctor's breech delivery.[71] It seems that disciplinary action in these cases was not solely concerned with protecting the public but about bringing wayward midwives to heel, thereby sending a clear warning to other would-be renegades.

Risk and woman management

During the 20th century the concept of risk has become increasingly prominent and the avoidance of it forms the basis of much social policy. As Furedi points out, there has been an explosion in the perception of risk in recent years, to the extent that risk avoidance has become a new moral imperative.[72] Heightened public awareness of safety is perceived as an indication of responsible citizenry and risk taking, he claims, once seen as 'an admirable enterprise' is now perceived as irresponsible and worthy of condemnation. The concept of avoiding or minimising risk has now become one of the main foci of healthcare provision in Britain and is one of the major reasons behind the maternity services' reluctance to allow women true choice and autonomy.[73] Risk management strategies, protocols, policies and guidelines are devised to minimise the likelihood of the unexpected (which is invariably seen as risky and dangerous) occurring, in an attempt to remove the potential for litigation. The recent introduction of the Clinical Negligence Scheme for Trusts (CNST) has added a new dimension to the equation by giving trusts the incentive to produce ever more stringent protocols and 'guidelines' in order to save money on insurance premiums, which, as Evans

points out, 'leads to more fear of stepping out of the narrowing parameters', decreasing choice for women and deskilling workers.[74]

Litigation, or the fear of it, has had a major influence on maternity care because of the magnitude of damages incurred.[75] Bassett *et al.*, however, suggest that the medical and legal professions enjoy a relationship which is mutually beneficial.[76] They argue that not only do these two professions work cooperatively (medicine providing the clinical practices and documentary evidence upon which litigation depends; law influencing the development of clinical standards) but that they evolve in parallel because of 'shared political, economic and cultural determinants'. Walsh *et al.*[75] point out that, ironically, although obstetricians may fear litigation, the most common outcome of successful cases is that lack of obstetric input is identified as the cause of the adverse outcome in question, thus reinforcing the perceived need for medical involvement and intervention.

The concept of risk avoidance has also provided the organisation with a powerful means of controlling both women and midwives. The current focus on the foetus as a 'patient' in its own right has been facilitated by the invention and widespread use of foetal surveillance technology such as electronic foetal monitoring and ultrasonography. Consequently, in addition to protecting women from death, obstetrics has expanded its remit, suggest Bassett *et al.*[76] to become 'foetal champion', 'defending the interests of the foetus against those of the mother'. The rhetoric used by maternity providers may be that of choice and empowerment, but the measures deployed to ensure compliance are increasingly authoritarian in nature.[73] Women who attempt to stray beyond the institutionally defined safety barriers may be seen, and treated, as deviant or irresponsible. Healthcare professionals then feel justified in using 'worst-case scenarios' to warn them of the consequences of their actions. In many cases, however, the information consists only of the 'bad news; there is no attempt to balance the argument. Rosie (who was not a midwife at the time) gave an example of this when she described meeting with a hospital doctor to request a home birth:

> [He] told me about the cost implications for the flying squad when things go wrong, and . . . why did I feel that [. . .] I should have special treatment? . . . and was I aware of the risks? and all this kind of thing . . .
>
> Rosie

As Levy points out, information-giving can be used as a 'strategy for behaviour modification' rather than empowerment.[77] This is often reported by women requesting home births. As we have seen, Rhoda (one of the midwife interviewees) was effectively denied a home birth for her second child by her community midwife's threats that she would be putting her baby at risk. A woman who requested a home birth in Edwards' study was denied her request on grounds such as insufficient staffing and told by her midwives that she was ill informed and irresponsible.[78] When she persisted, however, having exhausted their arsenal

of small arms, they launched the ultimate deterrent, telling her that she would be putting her own life, and that of her child, at risk. Howells' account of planning a home birth in Glasgow shows that this is not an isolated incident.[79] She was repeatedly cajoled, threatened and hampered in her attempts by midwives and managers who focused on the perceived risks of water birth. For women planning medically managed births, however, the risks are rarely mentioned.

Lowdon comments that the recent Royal College of Obstetricians and Gynaecologists (RCOG) guideline on 'Birth after caesarean' reveals the organisation's continuing doubts about the safety of vaginal birth following a caesarean section, despite evidence to the contrary.[80] While examining the document, she realised that 'trial of VBAC' was, in fact, seen as an intervention while a repeat elective caesarean section was considered to be the norm! Despite claims that practice is informed by, and based on, scientific evidence, some practitioners seem reluctant to accept findings that contradict long-held beliefs. As was seen in the midwife interviewees' accounts, midwives working within the system are often faced with the impossible choice between compliance with the organisation and its treatment of birth as a risk-laden event, and the betrayal of women and their own ideals. As Davies concludes, neither path leads to happiness.[53] She describes the 'cruel division of loyalties' which is experienced by midwives who wish to support women but are employed by an organisation which promotes fear of birth. The threat of risk, along with obstetrics' 'foetal champion' status, have greatly enhanced the power of the organisation and medicine, effectively depriving women of responsibility for their own bodies and babies. Not only has it provided an alternative focus away from women's needs, but is also an effective weapon by which the organisation can bring about compliance.

THE SEPARATION OF MIDWIVES AND WOMEN

Professionalisation of midwifery

The professionalisation of midwifery has had a profound impact on the relationship between midwives and women and although the term implies that midwifery has autonomy and equity with all other professions, in practice this is not the case.[20,81,82] As Kirkham observes, the relationship of midwifery with medicine has been enabling only for doctors.[20] It has, to some extent, contributed to the separation of midwives and women. At the heart of midwifery lie feminine concepts concerned with relationship, reciprocity, 'being with', empathy and caring[83,84] but in order to survive, it has been subsumed into a system which super-values objectivity, rationality and positivism, which places midwives in a confusing and frustrating position.[20,51] Midwifery has failed to formulate its own definition of professionalism and has espoused itself to the medical paradigm. This, observes Wilkins, supports the notion that the health carer is in a privileged position in relation to her/his clients by dint of possessing specialist knowledge.[85] Obviously, this ethos favours maintaining a suitable distance between professionals and their clients and is in direct conflict with the traditional 'with

woman' role of the midwife. Kerry, one of the midwife interviewees, highlighted the impact of this when she explained:

> . . . professionalism for some midwives, obstetricians, means coldness, sticking to the clinical aspects and not mixing in the personal and humanistic aspects of dealing with women.
>
> Kerry

Woodward draws attention to the dichotomy involved in the concept of 'professional' caring and the tendency for 'instrumental' care (what is done by the practitioner) to be emphasised at the expense of 'expressive' care (the way in which it is done, which includes an emotional element).[86] Sharon's interview was interesting in that it clearly demonstrated this conflict at work. At the time she was fairly newly qualified and when asked if she found it difficult to be part of the system, said:

> I sometimes feel that I'm . . . I'm not able to give the care to women that I ought to because I'm, I'm also in a situation where I have to get things done and I do find that it's balancing the care that you can give to women with . . . with the needs of the job.
>
> Sharon

It is interesting that she perceives 'the job' (i.e. her 'professional' responsibility) and providing care for the woman as separate issues. However, she was beginning to realise that, as she wanted to ascend the career ladder, her strategy, using her junior status to avoid compliance, would have to be abandoned.

The straitjacket of time constraints

One of the most important aspects upon which effective midwifery care and 'successful' birth depend is time. Traditionally, midwives saw their role as one in which they waited and watched with the birthing woman, supporting her through the twists and turns of labour until (usually) nature took its course. Women who have experienced normal childbirth often express surprise because their perception of time is altered during labour. This kind of time, defined as 'polychronic' by Hall, is not linear in nature but is experienced as a point at which events or relationships occur.[87] In other words, events dictate the time rather than the clock. This is expressed in the naturally altered state of consciousness which labouring women enter when not under the influence of anaesthesia and is quite possibly similar to 'time distortion' spoken of by proponents of 'hypnobirthing'.[88] Birth, however, having become defined by obstetrics and confined to the institution, is now subject to monochronic (clock) time, in which time dictates the event. This is essential for the effective functioning of an industrialised society.[89] In the Western world, it is a dominant feature of almost all major institutions. Parkins, in her article on the significance of time in the practice of

slow living with reference to the 'slow food movement', observes that having time for something endows it with significance by giving it attention.[90] Conversely, it could be argued that not having time or placing the emphasis on the temporal rather than the event is to detract from its significance. She also highlights the centrality of 'care', (both caring for and caring about) to the meaning of 'attention'. By its emphasis on time and efficiency, the organisation gives little opportunity for true caring to take place, and consequently has stripped birth of its significance.

The issue of time was prominent in the accounts the survivor midwives gave when speaking about what they felt was good practice. Time formed the 'growing medium' in which good care, women and midwives could blossom and flourish. Information-giving, explanations, doing procedures slowly and carefully and being prepared to stop are all time-consuming. Forming a relationship with women and their partners in order to understand what is important to them is time-consuming. Building up damaged trust takes time. Midwives and women spending time together and getting to know one another is at the heart of women's satisfaction with maternity provision which offers continuity of carer.[42,44,91–93] Time, or lack of it, is one of the major reasons why midwives are leaving clinical midwifery because they feel that they are prevented from giving women the support and care they need.[38] Midwives are expressing their frustration and distress because they feel they are failing women and not living up to their own ideals. Tellier describes her reasons for leaving midwifery after practising for only two years as the intolerable strain the huge workload placed upon her, causing her to feel that she was putting people's lives at risk.[94] Wells, in her article entitled 'Leaving the conveyor belt', explains that, despite the fact that she was 'passionate about midwifery', because of the excessive demands made on her she was prevented from providing families with the kind of midwifery care she wanted to give and which she felt they deserved. She described herself leaving the hospital at the end of each shift 'feeling drained, dehydrated, and hoping that something vital hasn't been forgotten'.[95] Sadly, I have heard midwives describe this situation repeatedly and it seems that it is being played out in over-stretched consultant units across the country on a daily basis. One of Ball and colleagues, midwife interviewees expressed her frustration that midwifery practice had changed from spending an 'appropriate' amount of time with each mother and baby in order to provide optimum care, to 'running from one woman to the next, whilst thinking about the one after'.[38]

It is clear that many midwives working in this way are unhappy with this state of affairs but spend their time at work just trying to survive. As Parkins points out, people who have time to think and reflect are more likely to change their practices, habits and ideas.[90] It could be argued, then, that maintaining a high level of activity among its employees is advantageous to the organisation because workers consequently have neither the opportunity nor the inclination to question or pose a threat. It seems that the system is more comfortable with the automaton than with the autonomous.

THE DISEMPOWERMENT OF WOMEN

Separation from social context

We have seen that birth has been removed from its original context, the home and the heart of the community of women, and now takes place, largely, in the isolation of hospital. Consequently, birthing women have ceased to be at the centre of the event, in an environment with which they are familiar, and instead are thrust into an alien culture characterised by very different social norms. The sense of being in an alien environment emerged strongly from the women's accounts of traumatic birth in hospital, even from those who were midwives. I asked Kerry whether she felt her familiarity with and pre-knowledge of the hospital system had empowered her as a birthing woman. She replied:

> It disempowered me, because I was the bed-maker, because I was a member of staff so denied even the cup of tea in the bed that the other women got. No, it didn't help me. [. . .] Probably, my shame, and my re-abuse is the way I term that experience, was impacted more upon by being, um . . . being in a place that I didn't feel I could trust.
>
> Kerry

Despite her familiarity with the hospital, she did not consider it to be a place of safety and it appears that her status as a midwife in her own hospital blinded her colleagues to the fact that she was a new mother in need of care and comfort. Women birthing in the institutional environment are separated from familiar surroundings, family and social support and disempowered by virtue of being on someone else's territory where others make the rules and are familiar with the culture and functioning of the organisation.[96,97]

Hospitals, especially large consultant units, place strict limits on the number of birth partners who can attend at any one time and in some cases women may even be separated from their husbands/partners (as were several of the interviewees in this study). They are thereby deprived of those who might act as advocates and challenge the authority of the institution. This may resonate stridently for the survivor of sexual abuse who, during the time in which the abuse was taking place, will have found herself powerless, isolated from those who were able to protect her.

Negation of women's knowledge

The Enlightenment, which occurred during the 18th century, brought about a radical change in thinking and men became increasingly concerned with the mastery of the natural world, perceiving that this would give them control over their own destiny. Childbirth, under the auspices of the institution and medicine, has been stripped of its original spiritual, social and mystical properties. All other influences having been removed, obstetrics now claims to have the 'authoritative voice' in the realm of childbearing. As Jordan points out, as one kind of knowing is legitimised it tends to negate other discourses, dismissing those who have

alternative knowledge systems and beliefs as backward, ill-informed or merely troublemakers.[98] This applies to both midwifery and women's knowledge, which, being enshrined in feminine ideals and ways of thinking, are alien to the prevailing Cartesian mode of thought. The discourse of technomedicine[55] assumes that the woman has no useful information or insight concerning her body or the process of birth and that the successful production of a healthy baby rests solely upon the authoritative knowledge of medicine and medical technology.[99] We see an illustration of this in Lynne's account, when her severe labour pains were dismissed in favour of the 'scientific' data produced by a non-functioning tocograph.

The biomedical model of birth relies on the 'expert' (i.e. the practitioner), rather than the woman, to 'diagnose' and legitimise not only pregnancy itself but also the various stages of labour.[100] It places a strong emphasis on the role of the professional as decision-maker and action-taker, whereas the woman is expected to be passive and accepting.[99,101] I gave birth to my children in the 1970s and one of the clear memories of my second birth was being obliged to endure a painful and humiliating VE by a doctor while clearly in the late stages of labour, for him to pronounce that I was, indeed, in labour!

Jordan gives a more recent example of this in her description of a birth taking place in a highly technological US hospital.[98] The woman's labour was being videotaped and Jordan was present as an observer taking part in a large research project on the dynamics of care during the second stage of labour. The woman makes it clear to her carer (a 'nurse technician') that she has the urge to push. However, protocol dictates that a doctor must confirm that she is ready and then perform the delivery, but he does not appear despite being paged several times. The woman becomes increasingly distressed but is not allowed to follow her body's urgent promptings without being given 'permission' by the doctor. Both her knowledge, and that of her carer, count for nothing in an environment where medical knowledge is the only authority.

Weston describes a similar scenario which occurred during her first birth, in a British hospital.[58] Suddenly, at what she described as her 'darkest hour' she felt the contractions change and knew that her baby was finally going to be born. Her midwife was called, examined her and confirmed that her cervix had reached full dilatation. However, despite feeling urges to push, she was told that she must await the arrival of a doctor who would have to reconfirm this with another VE. On discovering that this would mean waiting another 15 minutes, Weston exclaimed, 'I have waited 24 hours to have this baby. I am not waiting any longer. You are a midwife! Do your job!' (p. 6). Sadly, it is questionable whether a survivor of CSA would have had the confidence to challenge her midwife in this way.

Medically controlled birth

The picture of birth today is very different from that which was the norm throughout most of history. Gone are the female helpers with their birth stories providing comfort and encouragement to the woman, to be replaced by a 'gaggle' of guidelines. These may provide comfort and encouragement to Risk Management, but frequently cause anxiety and discouragement to women. In this environment birthing women are provided with pharmaceutical pain relief, medical technology and a midwife who (as in Rhoda's story) may have to share her time between several other women. In the current climate of staff shortages, fragmentation and emphasis on time/resource management, it is almost impossible for midwives to provide the depth of emotional support women in normal physiological labour may require. It is therefore not surprising that they 'take the analgesia/anaesthetic approach',[102] and this was demonstrated in some of the interviewees' accounts; two reporting being given pethidine without their consent and two being pressurised to consent to epidural anaesthesia. The impact of medicalisation on birth was particularly in evidence in Rosie's account of her first birth (*see* Chapter 6). No one took the time, on admission, to explain to her the usual timescale of a first labour; she was consequently given diamorphine too early, which, she explained, had the effect of slowing labour; then, because labour was progressing slowly, she requested an epidural in order to sleep. This further impeded progress, which was then countered by the siting of a Syntocinon infusion. The end result was an experience in which one of her few memories was of feeling 'completely out of control'.

Some of the accounts in this study suggest that, on occasions, epidurals and pharmaceutical forms of pain relief may be actively promoted by caregivers contrary to women's own wishes; this is true in my experience and is also supported by other anecdotal evidence.[13,103] Although there is no denying the usefulness of the epidural in certain circumstances, this study and other research suggests that women affected by CSA may find that the feelings of helplessness and immobility they experience as a result of epidural anaesthesia and the consequent medicalisation of their births can replicate those associated with abuse.[14]

Depersonalisation

As was seen in several of the accounts, the concept of being subjected to medical scrutiny may be particularly difficult for survivors of CSA as it has connotations of voyeurism. Lopez-Dawson and Kitzinger both make the link between the 'watching' and 'observing' elements of maternity care and voyeurism.[104,105] This was seen in Jo's account of the traumatic incident which occurred during her first pregnancy when a consultant performed a VE on her surrounded by medical students. As I mentioned previously, Lynne also found that the objectification of being 'stared at' in a medical context would be likely to trigger memories of her abuse (*see* Chapter 4). Watching, in this context, implies scientific or educational interest, in which the woman herself has little or no significance, clearly

reminiscent of the abuser/victim relationship. This also came out in the interviewees' accounts of attendants who focused exclusively on their genitalia, at the same time ignoring them. They were unanimous in their opinion that this caused them to perceive their treatment as abusive. Intimate procedures undertaken by carers who showed kindness, respect and took a genuine interest in them as people were not problematic. This is supported by other literature on maternity care for survivors of sexual abuse.[106–114] The process-driven hospital environment may render maternity workers impervious to women's needs for privacy and dignity. The accounts of staff wandering in and out of the room where damaged perinea were 'on display'; Kerry's 'final humiliation' (*see* Chapter 6); Sally's midwives entering her bed space without permission; maternity workers grabbing women's breasts, all testify to this. For women who have suffered the shame and humiliation of CSA, it may result in birth-related PTSD.

INSTITUTIONALISED CHILDBIRTH AND SEXUAL ABUSE

> . . . sexual abuse is all about power, not sex.
>
> Stacey

There has been much talk recently of improving the delivery of maternity care and offering more choice to birthing women. There have also been some attempts to make cosmetic changes to the hospital environment to make it less clinical and more homely.[115] Antenatal care has been made more accessible by placing it predominantly in the community. However, as I pointed out in Chapter 6, despite some changes for the better, it appears, comparing the more recent birth accounts with those of 20 or 30 years ago, that the power of the institution and medicine over women and birth remains largely unaltered. It is merely expressed in different ways. Furthermore, the psychological aspects of pregnancy and birth are often seen as irrelevant or 'not my job' by busy practitioners. Rhodes and Hutchinson report that they elicited the opinions of several midwives and a physician when proposing to undertake their research into the labour experiences of survivors of CSA.[116] When asked how research-based information about sexual abuse would change their 'management' of labour, one replied that they did not have time to 'open this can of worms' and that it took long enough to get through an antenatal appointment without taking on the job of social worker. Clearly, this person (the researchers do not specify whether it was a midwife or the physician) felt that taking individual needs into consideration was not part of his/her role. It is far easier to rely on following protocols and policies, enacting routines and rituals, than to engage with people as individuals. It also enables the professional to retain their position of superiority and power. As I have pointed out, it is possible that the majority of survivors who pass through the NHS system do not disclose their history. Consequently, health carers with this mind-set, encountering women who react unexpectedly or who appear

excessively demanding, may dismiss them as merely being awkward, and lose patience, thereby subjecting them to 'childbirth abuse'.

CHOICE AND CONTROL: THE RHETORIC

In the closing decade of the 20th century, the publication of *Changing Childbirth*[40] engendered a spirit of optimism and hope among midwives and childbearing women. At the time it appeared to mark a highly significant change in thinking which was set to redress the balance away from the wholesale institutionalisation and medicalisation of birth which had steadily taken hold during the century. The introduction explains how, in March 1992, the House of Commons Health Select Committee challenged the conclusions of the Maternity Services Advisory Committee, that women should be 'encouraged' to give birth in hospital on grounds of safety with the statement that, having looked at the evidence, they felt that this policy could not be justified.[117] The select committee went on to say that: 'a medical model of care should no longer drive the service' and advocated that women be given unbiased information and genuine choice over the type of maternity care they receive, including the options of birth at home or in small maternity units. The Expert Maternity Group set out what they considered to be the 'Principles of Good Maternity Care'.[40] These placed the focus on women, emphasising the importance of their feeling in control of what was happening to them, involving them in planning and decision-making regarding their care, making services easily accessible and community-based. It also recommended that women should be involved in the monitoring and planning of maternity services in order that they should be 'responsive to the needs of a changing society' (p. 8). Sadly, the elation and hope which surrounded the launch of *Changing Childbirth* gradually turned to disappointment as the vessel was soon to founder on the rocks of financial constraints, lack of commitment and cynicism. Now that the dust has settled, very little appears to have changed.

Some 11 years after *Changing Childbirth* was published, the National Service Framework for Children, Young People and Maternity Services appeared, once again stressing the need for choice to be at the heart of maternity provision.[118] 'NHS Maternity care providers and Primary Care Trusts', it states, '[should] ensure that: the range of ante-natal, birth and post-birth services available locally constitute real choice for women (including home births)' (p. 28). At the time of writing, the government has said that women are to be promised the legal right to choose where they give birth, including the option of home birth.[119] Will this legislation prove any more effective than its forerunners?

Despite the ongoing rhetoric on choice and control and the evidence which demonstrates their importance to birthing women,[5,120–124] in reality, it has largely failed to make the transition from rhetorical to practical. Women continue to be denied true choice over how and where they give birth.[125] The choices may not be as limited as Henry Ford's purported 'any colour as long as it's black', but women's options are very much determined and restricted by the organisation.

Documents such as *Changing Childbirth* advocate the three 'Cs', choice, control and continuity, but the maternity services respond by offering a wider range of antenatal screening tests, a choice of hospitals or care by large teams of midwives. However, these and similar issues have merely contributed to the 'illusion of choice'[126] and do not necessarily offer women what they truly want. The organisation's needs for efficiency and its aversion to risk prove to be strong incentives against treating people as individuals and offering genuine choice. While creating the impression of offering choice and control for women, the organisation charged with providing them only functions efficiently when these are denied. Consequently, a woman may be offered a choice as to which day she is admitted to hospital for induction of labour or whether her baby has injectable or oral vitamin K, but should she request something not on the menu, or refuse what is offered, she may find herself being accused of irresponsibility or putting her baby at risk. As Weaver points out, a woman who is offered a choice between giving birth in a small GP unit or a large consultant unit will not perceive herself to have had a choice at all if what she really wanted was a home birth.[122]

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CHAPTER 10

What is the answer? Conclusions drawn from the women's positive experiences

CARERS WHO 'GOT INTO THE BOAT'

Despite the fact that the vast majority of negative accounts concerned hospital births, there were several that contained examples of positive birth in hospital. Without exception, these were associated with good, supportive and sensitive care by health professionals and highlight the importance of the midwife–mother relationship.

Vickie recalled being cared for by a 'wonderful' student midwife during her second birth, whom she remembers trying to be an advocate for her:

> . . . and they wanted to break my waters [. . .] and I said to her I didn't want my waters broken [. . .] [she] kept going out and saying, 'No, she doesn't want her waters broken!' and I can remember feeling awful that I was putting her on the spot, and they wanted me to be monitored, and I didn't want to be and . . . Anyway, eventually I said yes, they could break my waters – so they did . . .
>
> Vickie

Unfortunately, in this instance, the 'system' prevailed, probably because Vickie felt the need to protect the student who was valiantly trying to protect her. However, she did go on to have what she described as a 'wonderful normal birth', causing her to feel pride and elation. Despite the fact that her advocate was not able to protect her entirely from unwanted interventions, the fact that this student respected her wishes and stood with her empowered her to an extent.

Other women spoke warmly of hospital midwives who had treated them with respect and consideration. As I have mentioned previously, Sally, who had criticised the coldness and insensitivity of some carers, spoke highly of

the younger, more recently trained midwives who were emotionally warm and showed respect for her privacy. Louise, whose body bore the marks of self-harm, praised her midwife for the sensitive way in which she kept her covered and 'jumped in' to examine her before the doctors could, in order to protect her from her greatest fear, the exposure of the scars. Lynne described her third birth in hospital as 'a good birth' partly because it was quick, but also on account of the two 'nurses' who admitted her and cared for her, placing the baby on her chest as soon as she was born. Wanda, despite having feelings of disgust about birth, appeared to attribute the fact that her second birth (in hospital) was 'fine' to 'wonderful staff'.

Rhoda, despite the fact that she had been manipulated into choosing a hospital birth for her second child by her unsupportive community midwife, described this birth in very positive terms. In order to minimise the possibility of losing control in the hospital environment, she had arranged for a midwife friend to care for her at home for the majority of her labour, only transferring into hospital in the latter stages. She attributed her positive experience to being 'with somebody I wanted to be with'. When asked how this midwife made the experience good, she said:

> . . . she just let me get on with it really, . . . yeah, she just let me get on with it, but was there when I needed her.
>
> Rhoda

All of these accounts show that it is possible for women, including survivors of sexual abuse, to have very positive experiences of birth in hospital, but there was a strong correlation between maternal satisfaction and the attitudes of carers. However, as we have seen, the hospital environment is one in which women's needs may collide with those of the institution.

IT'S NOT WHAT YOU DO, BUT THE WAY THAT YOU DO IT!

As I stated previously, women who have been subject to CSA often find invasive and intimate procedures traumatic, or at least difficult. It was clear, from what these women said, that any kind of procedure, intimate or otherwise, had the potential to be perceived as traumatic or abusive depending on how it was done and the attitude of the practitioner doing it. It is highly significant that some of the women reported having totally opposite reactions to identical procedures performed by different people and it is very revealing to compare their accounts. Amanda, who perceived her experiences of VEs and perineal suturing as traumatic with her first birth (*see* Chapter 6), described having a very different reaction to a VE during her second:

> . . . and she [midwife] said, 'May I examine you?' And I let her examine me as well. [. . .] She asked my permission first and said, 'This is what I can do' and

> I gave her my permission, and she went ahead and did that. She was very, very gentle, she was lovely.
>
> Amanda

Stacey, one of the respondents who had also found perineal suturing traumatic following her first birth (*see* Chapter 6), recalled coping well with the procedure after a subsequent birth when it was performed by the midwife who had attended her during labour and birth. She described this midwife as 'very courteous' and when asked why she perceived this procedure so differently, she said:

> They asked my permission. 'Is that ok?' [. . .] That was the difference, yes. It wasn't, 'We're going to suture you, put your legs in these stirrups and . . .' you know.
>
> Stacey

It is clear, comparing these accounts with those of their first births, that being given genuine choice by respectful, caring midwives enabled them to cope with the procedures without being traumatised. In Stacey's case, the fact that her midwife did not require her to be restrained in stirrups was a great relief to her. Claire, whose only birth experience was so traumatic that she never became pregnant again, recounted a single positive experience of an intimate procedure during the perinatal period, which stood out to her because it involved kindness and honesty:

> I think I might have had one [midwife] twice who was exceptionally nice because I had to have stitches and they said they'd put the self-dissolving one in and they hadn't and when she came one time [. . .] I couldn't stand up straight, let alone walk! And she just said, 'These stitches haven't gone' [. . .] She had to take them out and that was very painful but she was – I can remember her being extremely nice. She said, 'It's going to hurt because I've got to pull because the skin's growing over them.' But she was as gentle as she could be and was very nice to me . . .
>
> Claire

These accounts demonstrate the immense difference that humanity and respect on the part of carers can make. The midwives who showed genuine concern for their clients, asked their permission, gave them choice and tried to be gentle, enabled the women to cope with the procedures without causing them further traumatisation.

HOME BIRTH: A DIFFERENT WORLD

Owing to the high incidence of home birth among the interviewees, I feel it is important to look at why the women opted for it and what they found beneficial.

As we have seen, it is possible for women to have positive and empowering births in hospital, but the medical and institutional ethos in which hospital maternity care is enshrined makes it uncertain. To a large extent, women's experiences depend on their individual attendant's birth philosophy and readiness to withstand the pressures from the system. It seems that several of the interviewees felt that the only certain way to achieve the birth experience that they wanted was to avoid exposing themselves to the hospital environment. Sadly, in some cases, this was only after a traumatic first birth experience in hospital. Of the 20 women interviewed, nine had home births for at least one of their children, which reflects the findings of Parratt who also found a high number of home births among survivors.[1] Others said that they would have liked a home birth but for various reasons did not achieve it. There was only one negative report associated with home birth and this was from Sharon, who found her second home birth traumatic partly because she was unable to dissociate, a coping strategy she had used during her first birth. In addition, it was very painful and quick, leading to a perceived loss of control because she felt her carers did not keep her sufficiently informed. Nevertheless, she explained, it would have been the same in hospital, if not worse.

Why home birth?

In almost all the interviews, the reason given for choosing to give birth at home was based predominantly on avoiding the loss of control hospital birth was perceived to entail. This is also the rationale for many non-survivors planning home births,[2,3] and many of the women who book my services as an independent midwife give similar reasons for their choices. One of my clients stated that she would 'rather give birth in a field full of sheep than go back to the hospital' and another that she would 'rather die than have another caesarean'. These women had suffered traumatic first births in hospital and felt that the only way to avoid a recurrence of the situation was to give birth at home where they would be in control. Certainly, the motivation underlying most interviewees' choices appeared to stem from the need to avoid hospital, rather than a positive belief in home birth per se. Interestingly, Amanda and Jo both used the same phrase – 'no way in a million years' – to emphasise their determination to avoid repeating their traumatic experiences of perineal suturing in hospital. Others spoke about their aversion to the dehumanising effect of the 'conveyor belt':

> . . . patients lose their identity, more or less on arrival to labour ward. You know, 'Pop that on!' 'Put that gown on, jump up!' [. . .] I think you stop looking at the person as an individual and what need she might have, you're just on a conveyor belt.
>
> Ruth

> I didn't want to be part of the conveyor belt system, so I decided I was going to have a home birth.
>
> Rhoda

Rosie's highly medicalised first birth had a negative impact on her, but, interestingly, it was not until she had witnessed the so-called 'cascade of intervention'[4] in action during a friend's hospital birth which she attended during her second pregnancy that she decided to plan a home birth:

> . . . observing her going in and kind of the whole routines around that and then her ending up with a ventouse delivery for this tiny little baby that – you know, having an epidural. The whole lot, the whole cascade happening and watching that from the outside, I just walked out of the hospital and said to myself, 'I am not having my baby in hospital!'
>
> Rosie

Edwards, in her study on women planning home birth, observed that for them home stood for control and connection while hospital signified loss of control and separation.[3] In their homes the women would be able to remain connected to their own social support networks, surrounded by all that was familiar and helpful to them. Home was a place of safety where they would have the power to decide what was done to them and their attendants would be in the position of guests on their territory.

The women's perception of home birth

The comments about their experiences of home birth were, with the exception of Sharon's second, very positive. Choosing to give birth at home enabled the women to free themselves from the system, to strip away all other influences that would inevitably be brought to bear on them in the hospital environment. Consequently, they were able to concentrate all their energies into coping with the natural, physiological sensations of birth, rather than finding strategies to avoid or endure whatever was demanded of them by the production line. Home birth also gave the women access to many of the factors they felt were necessary for a good birth experience: continuity of carer, one-to-one care and the opportunity to form a relationship with their midwives. As has been seen, a good relationship with a supportive carer goes a long way towards facilitating the perception of control and mastery, which can have a hugely positive impact on the women's self-esteem and ability to parent:

> It was a wonderful, wonderful experience. I felt it really set me up for, you know, being a first time mum.
>
> Rhoda

Opting for a home birth gave the women control in many ways. First, it redressed the balance of power normally at work in the hospital environment:

> . . . those midwives were guests in my home, you know, that was my house. If they wanted to go to the loo, if they wanted a drink, you know, we provided it for them. So I felt that we were in control – well, I was in control of the situation, which benefited me, because I needed to feel that I was in control.
>
> Ruth

Birth at home gave them control over their environment; the ability to choose who and how many would be present. There would be no strangers walking in and out of their room at will. Consequently, their need for privacy was met. They also saw home as the place where they could labour in their own time, free of the constraints that would be placed upon them in hospital:

> . . . it was quite long, it was very painful, . . . it took me two hours to push him out and I think to this day, if I'd been in hospital, there's no way I would have had a normal vaginal birth . . . It would have been a forceps or some – I'm sure it would've been.
>
> Rhoda

The women spoke of being attended at home by caring and sympathetic midwives, who listened and provided security and emotional support:

> I laboured and birthed at home. The midwives were wonderful. Respectful, kind and gentle. They let me make *all* the decisions. [. . .] They took care of my needs not only clinically but emotionally. They heard me when I spoke and I felt loved and nourished by them.
>
> Brenda

Amanda contrasted her second birth, at home, with her first birth in hospital:

> A: . . . It was hellishly painful again, but I didn't do any screaming, I didn't have the fear.
> L: So, it's not the pain that's the problem really?
> A: No, it's not the pain, it's the actually, for me, it was the way they were in your face. They were in my bits. They were there and they were so aggressive and so my second delivery couldn't be any more different from the first. It was so very different. But because I took control of it and I think it helped that I had a really good relationship with the midwife.
>
> Amanda

It was obvious, she found birth very painful, but this, as she said, was not the issue, and the support of her 'gentle' and sensitive midwife empowered her.

A positive birth experience also had a 'redemptive' effect on Rhoda's previously poor relationship with her body:

> I felt . . . like I'd lost control over my body when I was small and I don't think I ever really felt much in control of it after that [. . .] I've certainly never liked my body but once I'd had, you know, it had sort of served me well after these two births and I thought, 'God . . . actually, it's a pretty good body!' you know, 'It's done two wonderful things', and I felt really powerful.
>
> Rhoda

Rosie's comments summed up exactly how the different ethos of home birth empowered women and enabled them to achieve mastery:

> And it was lovely! Absolutely perfect! Exactly what I wanted. [. . .] I felt like I was, it was me, and everybody was fitting around me, was that birth. It was what I wanted and the other birth it was like I went into hospital and fitted around them. [. . .] I wouldn't do it any other way . . . I really wouldn't. [. . .] It was all about control . . . and me feeling that I was being listened to and that I was doing it. You know, my first birth I kind of felt like . . . they were doing it . . . you know, they were getting the baby out of me . . . or they were managing my labour, whereas the second time I felt very much like . . . I was convinced my body could do it and I could do it and at the end of it I felt this huge sense of achievement that I'd done it. Whereas, I think with the first baby it was – 'We did it. The baby's here.' It wasn't so much, 'I did something great'.
>
> Rosie

The comparison between these stories and many of the hospital birth accounts is startling. Women who birth at home are very much present at and centre stage of their birth experiences, while their attendants play a supporting role. The pain and hard work of labour are accepted as a normal and inevitable part of the process through which it is necessary to pass on the journey into motherhood and not as something to be controlled or avoided at all costs. The women are listened to, respected and their needs take precedence. Consequently, they emerge triumphant.

Many women, however, still have difficulty achieving home birth under NHS care. A recent Nursing and Midwifery Council (NMC) document identified the most common barriers to women accessing home birth as: confidence and competence of midwives; perceived conflict between risk and a woman's choice; and lack of resources.[5] Despite the fact that women's right to choose home birth has been repeatedly prominent in government documents[6,7] and although midwives have a duty of care towards women birthing at home, it appears that obstacles are frequently placed in the way of those who plan home birth. This was borne out by some of the interviewees' accounts in this study, as well as the work of Edwards[3] and also by the stories of women who responded to a request by the

Association for Improvements in the Maternity Services (AIMS) for descriptions of the various 'challenges' they had encountered when booking a home birth. The difficulties they experienced ranged from being restricted to a certain narrow time frame, through being accused of selfishly putting undue strain on overworked midwives, to the woman who was told, when she went into labour, that there was no midwife to attend her at home.[8] Some of my clients come to me having fought long and hard to procure an NHS home birth, jumped through innumerable hoops, been bombarded with stern warnings from numerous health professionals but still not having achieved their aim.

Home birth, however, is not appropriate or desirable for all women, but there are alternative birthing environments and models which offer a more holistic approach to care and promote equitable relationships between client and clinician. Despite the fact that none of the interviewees in this study had experienced them (they either gave birth in consultant units or at home), I suggest that they would be able to offer women, including those with a history of CSA, a real alternative to the current model of care. These are midwife-led units (MLUs) and free-standing birthing centres (FSBCs), caseload midwifery and independent midwifery care. I shall discuss these in the final chapter.

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CHAPTER 11

What can be done?

As I said at the end of the previous chapter, there are other models of midwifery care that could provide viable alternatives to the standard paradigm. These are midwife-led units (MLUs) and free-standing birth centres (FSBCs), caseloading, or one-to-one midwifery and independent midwifery.

MLUs and FSBCs were set up with the intention of providing a midwife-led model of care as distinct from the type of midwifery care which is delivered within the framework of the technocratic institution. Some MLUs may share the same premises as an obstetrically led unit and are often in close proximity within the hospital. FSBCs are MLUs that are geographically remote from the consultant unit to which they are usually linked. According to Hodnett *et al.* in their systematic review, MLUs are associated with a reduction in medical interventions and increased maternal satisfaction.[1] There is some debate around what actually defines midwife-led care and as Hughes and Deery point out, much of the literature on the subject focuses on policies, protocols, booking and exclusion criteria, or neonatal and maternal outcomes rather than a description of the characteristics of this model.[2] Hatem *et al.*,[3] however, define it as being based on the premise that pregnancy and birth are normal physiological processes with the emphasis on promoting normality and providing psychosocial support. The outworking of this ethos was observed in many ways by Walsh in his study on an FSBC.[4] He describes how his pre-conditioned notions of maternity care were profoundly challenged by a model that was not based on the 'process mentality'. Very early on in his study he wrote in his diary how unsettled he felt by the lack of 'activity' he observed in this environment, asking himself if throughput should be increased a bit so there would be more to do!

He also identified an absence of hierarchy in this setting. The need for hierarchy in large organisations is rarely questioned, but Fairtlough,[5] in his book *The Three Ways of Getting Things Done*, poses a very pertinent question when he asks whether it is preferable to have a plant operated by staff who take pride in working safely, or merely do so because they are afraid of the boss. He asserts that identifying discipline with hierarchy is a grave mistake because what really matters is the professionalism of the workforce.

As this comment implies, environments which encourage this kind of ownership and personal responsibility for good practice are framed within a structure which is non-hierarchical and empowering to the individuals working within it. The result is a workforce that functions safely, efficiently and takes pride in providing a good service. Reading Walsh's thought-provoking book, one is struck by the passionate degree of ownership clearly felt by the staff.[4] If a room needed decorating they would hunt for bargains which could be used in the project. Midwives converted a disused storeroom into a complementary therapy room in a single day and would bring in their own items in order to make the centre more homely for the women. In this environment birth was, in Walsh's words, 'taken off the assembly line', each woman treated as an individual, each labour acknowledged as unique.

There is a good deal of evidence to say that midwives function best and are happiest when able to work autonomously and provide woman-centred care.[6] The MLU and FSBC have, for many years, provided midwives with an opportunity to work in this way and offered women the chance to give birth in an environment which is focused on their needs. The fact that women value this kind of maternity care is often demonstrated, ironically, by the fervent support shown by them and their families when one of these units is threatened with closure.[4,7] The evidence also suggests that birth centres are financially good value[8,9] and achieve outcomes which compare very favourably with 'standard' hospital care, particularly in the promotion of normal birth and maternal satisfaction.[1,10,11] The emphasis on the psychosocial aspects of birth which characterises the midwife-led model[3] would appear to correspond well with the needs of women, such as survivors of CSA, who are psychologically vulnerable.

As I pointed out previously, this study did not include any women who had given birth in MLUs or FSBCs and, until such time as research on survivors birthing in these environments is done, we cannot say for certain whether or not they do provide a better experience of birth for these women. My recommendations concerning MLUs and FSBCs are based upon the data which indicates what aspects of 'typical' maternity care that they found problematic: 'conveyor belt care', powerlessness, and fragmentation of care; and what they said they wanted from the maternity services: to form trusting relationships with staff, to be free from time constraints and to be given choice and control over what was done to them. Clearly, that kind of care is more feasible in an environment where hierarchy is minimal, midwives have more autonomy and are less pressurised by hospital routines. We have seen how the marginalisation of women's knowledge and the midwifery model of birth leave women exposed and vulnerable to 'childbirth abuse'. The empowerment of midwives and the promotion of birth as a healthy life event would do much to empower women.

Caseload midwifery has also proved popular with both women and midwives[12–14] For midwives, it offers the opportunity to work more autonomously and to utilise their midwifery skills to the full. It allows clients and midwives to form trusting relationships, which is beneficial to both. The Independent Midwives

Association (IMA) devised and proposed an NHS Community Midwifery Model inspired partly by the Albany Midwifery Practice (AMP) paradigm which would enable more midwives to work in this way.[15] Under this scheme, women would not only be able to receive continuity of carer, but also choose their own midwives, thus benefiting from an increased variety of choices. Moreover, because this would be financed by the NHS it would potentially improve choice for all women (unlike current independent midwifery care for which clients are required to pay) including those who are vulnerable or disadvantaged. It would also, to an extent, remove the current emphasis on geographical boundaries, placing the onus on the needs of individuals.

This model enables midwives to provide women with continuity of carer throughout pregnancy, birth and the postnatal period by carrying their own caseload. Midwives often work in partnerships, usually within groups of six to eight individuals, and are commonly responsible for around 40 high- and low-risk clients per year, attending births at home or in hospital as appropriate. It is an approach which enables care to be woman-centred and individualised, while giving midwives a good deal of flexibility in their working patterns. The parameters are determined by the caseload, rather than the institution.[16] Stevens and McCourt[16] in their evaluation of midwives' perceptions of the first one-to-one scheme to be set up, in response to the recommendations of *Changing Childbirth*,[17] found that clinicians appreciated this way of working because they experienced a high degree of autonomy, and were enabled to practise what they described as 'real midwifery'.[16,18–20] Page *et al.*[21] in their study comparing the clinical outcomes of this one-to-one scheme with those of 'standard' care found a reduced rate of caesarean section and assisted deliveries, lower uptake of epidural anaesthesia and a reduction in the numbers of episiotomies among the women cared for by one-to-one midwives. According to Andrews *et al.*[22] in their review of caseload midwifery, these findings have been replicated repeatedly by other research. Walsh, in his study of women who had experienced both 'standard' care and one-to-one midwifery, found that women placed great value on being cared for by a known midwife, with whom they had developed a trusting relationship.[12] Furthermore, Sandall *et al.*[14] report that women cared for by the AMP rated their midwives as 'kinder, warmer and less rushed' than other practice midwives. Women giving birth under AMP care also experienced fewer interventions, assisted and operative births than those receiving standard care. Neonatal outcomes were comparable in both groups but AMP care proved to be more efficient in terms of bed occupancy as these women had fewer antenatal admissions and were discharged earlier postnatally. Bearing in mind what the interviewees in this study said about individualised, relational care and continuity of carer, I would suggest that caseload midwifery would be welcomed by many survivors of CSA.

ALTERNATIVES, BUT NOT AVAILABLE TO ALL WOMEN

MLUs, FSBCs and one-to-one midwifery schemes, however, do not exist in all areas of the country and despite their popularity, many have been terminated along with other apparently successful midwife-led initiatives.[7,9,23–26] At the time of writing, even the Albany Practice is fighting for survival.[27–29] Frequently, the reason given for closure is financial and, undoubtedly, this does have a huge influence, but Page argues that often the reluctance to continue with innovative practices stems from the 'fear of excellence'.[23] Because these schemes are seen to create a situation of inequity in the service, it is considered preferable to return to the mediocre status quo rather than seeking to raise the general standard for all women. Regardless of the evidence which demonstrates the success of these small practices,[30] and despite public support, many MLUs have already closed and the majority of those remaining are under threat. Robotham and Hunt[7] comment that, despite the overwhelming evidence and ongoing government edicts that indicate they are a good thing, there is no authoritative body responsible for protecting MLUs.

The Royal College of Midwives has also revealed recently that despite 'rocketing' birth rates, midwifery budgets are generally falling. They found that nearly a fifth of heads of midwifery reported that their budget had been cut and almost a third have been asked to reduce their budgets.[31] Furthermore, the fact that the government declined to back the 'One Mother One Midwife' campaign at a national level[32] suggests that this concept is not considered sufficiently important. Inevitably, dwindling midwife numbers and centralisation will lead to women having even less choice and control over where and how they give birth and will bring midwives further under medical and institutional control. Midwives are leaving the profession because they no longer feel they can practise in the way that is demanded of them.[33] Sadly, the ability to 'opt out' of the system is not open to the majority of pregnant and birthing women and the current closures of MLUs and plans for centralisation means alternatives will become rarer.

INDEPENDENT MIDWIFERY

Independent midwifery (IM) practice is characterised by caseloading and the provision of one-to-one care, but it is practised by midwives who have stepped outside of the NHS. They may work as individuals, pairs or small groups. A recent study by Symon *et al.*[34] revealed that IM care results in better outcomes than 'traditional' care for many factors including higher breastfeeding rates and unassisted vaginal deliveries and lower uptake of pharmacological analgesia and admission to neonatal intensive care. The one outcome that appeared to be worse in the IM care group was that of the incidence of stillbirth and neonatal death. However, when 'high-risk' cases from both cohorts were excluded it revealed a non-significant difference between the two. Some women may choose to 'opt out' of the system altogether by booking the services of an independent midwife. However, this option is not, in practice, available to all women, partly because

of the financial considerations involved, but also because of the scarcity of IMs in some areas. Furthermore, at the time of writing, the future of IM is uncertain owing to the government's decision to make indemnity insurance mandatory.[35] Moreover, because it offers an alternative to both women and midwives, and is to some extent outside the control of local authority NHS maternity providers, it is perceived as a threat by some obstetricians and senior managers. Consequently, individual midwives have been subjected to apparently unwarranted disciplinary action. Several have been suspended and obliged to fight lengthy and expensive legal battles in order to survive.[36–39] From a global perspective, Wagner describes the 'witch hunt' against home birth midwives and those who have a non-conformist involvement in birth as 'part of a global struggle for control of maternity services, the key issues being money, power, sex, and choice'.[40] He states that, over the years, he had been asked to consult or testify in 20 cases across the globe at investigations into the practice of health professionals. Alarmingly, 70% were midwives and 85% were women. It appears that the struggle which began in the 17th century with the advent of male midwifery is set to continue while women and midwives strive to assert their right to unadulterated birth.

The women's stories revealed that feelings of betrayal, powerlessness and humiliation were associated with traumatic birth. As I stated previously, a significant number of the women having hospital births found some aspect of their experience traumatic or emotionally distressing. This was strongly linked with 'institution led' care, epitomised by attendants who were 'dissociated' and whose focus was on the needs of the organisation rather than on them. The interviewees' positive experiences were frequently associated with carers who were emotionally 'present', showed compassion, warmth and treated them as individuals. Their accounts confirmed the great importance survivors of CSA attach to feeling in control during the birth process. Their perceptions of control were linked with good communication skills and information giving by caregivers, being involved in decision-making, control over their environment, respect for privacy and dignity and being given genuine choice. These particular women did not appear to expect that they should have control over the physiological sensations of birth. As we have seen, the work of Halldorsdottir and Karlsdottir[41,42] and others indicates that what birthing women find helpful is carers who are clinically competent but who also engage with them, showing genuine interest and warmth, thereby creating a birthing environment in which they feel secure and protected. My findings suggest that the needs of survivors of CSA are no different, but that because of their histories they may be predisposed to perceive their births as traumatic. They demonstrate the ongoing damage which can result from the marring of the midwife–woman relationship which is at the heart of 'successful' and empowering birth experiences for many women, including those affected by CSA. As we have seen, midwives have become disempowered by their loss of identity following the redefinition of birth by obstetrics coupled with the dehumanising and controlling nature of institutionalised maternity care, based on the industrial model.

Women and midwives have also been separated to some extent by the professionalisation of midwifery, which has taken for its model that of the medical expert rather than its former, egalitarian, 'with woman' identity. Obstetrics, coming from a standpoint of risk, has enhanced its control over the birth process by imposing strict limits upon it, which is beneficial both to itself (by increasing the need for medical involvement) and to the organisation's need for efficiency and throughput. This was seen both in the accounts of the women who gave birth and in the midwives' stories. The women birthing in the hospital environment were disempowered by being separated from their social context and support network, a disregard for their needs for privacy and dignity, the negation of their own knowledge by the authoritative knowledge of medicine and the impact of the technocratic model of maternity care on the birth process.

EVERYWOMAN

Survivors should not be perceived, however, as an alien race requiring special treatment and making unreasonable demands. They are normal women, who have been subjected to abnormal experiences, leaving them vulnerable to psychological harm and emotional difficulties. Their response to trauma is only that which could be expected of any other human being in similar circumstances. Therefore, maternity care must be appropriate for any woman, regardless of her background, circumstances or history. Gutteridge[43] suggests that maternity services must be 'sensitive to the fragility of the unseen "layers"' which form part of each individual and treat every woman as though she has experienced emotional trauma of some kind. If that were so, she suggests, women living with secrets of CSA would be spared some of the feelings that might trigger flashbacks to, and memories of, being a helpless child. Surely, if all childbearing women were treated with respect, dignity, kindness and consideration, far fewer would be coming away from childbirth emotionally scarred and traumatised, and the issues around disclosure might even become irrelevant.

OFFERING WOMEN GENUINE CHOICE CONCERNING MODE OF DELIVERY

As we have seen, several of the women in this study, having experienced a traumatic first birth, expressed deep fears concerning future pregnancies, one interviewee subsequently avoiding pregnancy altogether. For this, and other reasons, some women may request elective caesarean sections. While some may be enabled to cope with vaginal birth given the appropriate, sensitive care, others may not. It is therefore essential that these women should be able to give birth by elective caesarean section if that is their choice. It is well known that some obstetricians actively promote caesarean sections, but midwives can be equally guilty of promoting their favoured mode of delivery, vaginal birth, in the belief that this is best for all women. The findings of Hofberg and Brockington,

that tocophobic women who were denied their requests for caesarean section suffered higher rates of psychological morbidity than those whose wishes for operative birth were achieved,[44] demonstrates the psychological damage that can occur when clinicians decide what is best for women on the basis of their own preferences.

HOME BIRTH

As I have pointed out, it appears that the desire for home birth among survivors of CSA may be higher than that of the general population. There is also evidence that some women may consider giving birth unattended at home if they are unable to find support to do so within the NHS.[45] It is important, therefore, that the rhetoric surrounding the choice of home birth should become a reality. The promotion of caseload midwifery, because it gives midwives the opportunity to develop confidence and competence in all areas of pregnancy care, would pave the way for home birth to become more readily available.

A MIDWIFERY DEFINITION OF PROFESSIONALISM

As I have suggested, the professionalisation of midwifery has done nothing to enhance the relationship between midwives and women, being heavily influenced by the male-oriented medical model of professionalism, which places the emphasis on the professional as superior. There is an urgent need for midwifery to return to its roots, and to reaffirm its commitment to being 'with woman', rather than 'with institution' or 'with women'.[46] Halldorsdottir and Karlsdottir's phrase 'professional intimacy'[42] could provide a useful foundation upon which to base a definition of midwifery for the 21st century. The concept of being 'professional' should denote the midwife's competence and confidence in supporting women to give birth successfully, while that of 'intimacy' should reflect the manner in which care is delivered. It implies finding the delicate balance between suffocating closeness and aloofness, between practice based merely on 'clinical evidence' and that solely guided by human qualities such as intuition, common sense and empathy. Midwifery must free itself from the notion that successful birth is measured only in terms of the physical outcomes of mother and baby and reassert its commitment to care for women and their offspring holistically. A professional model for midwifery which reaffirms and celebrates the traditional values of the vocation, along with knowledge gained from sound research and practical experience, would go a long way towards improving midwifery for midwives and care for women.

STAFF TRAINING, SUPPORT AND REFERRAL STRUCTURES

As the scenario of Maggie Smith's coffee room demonstrates, the issue of attending women with a history of CSA is one that sparks a number of different

reactions in midwives. Some may feel unprepared or perplexed as to how they can provide appropriate care, while others may be unwilling to acknowledge the existence of CSA. In June 2002, 'Sanctum for Midwives' was founded with the aim of helping 'those working through child sexual abuse issues that impact on their midwifery practice' and to 'create a national programme of awareness, training and implementation'.[47] At its inception many midwives contacted Sanctum to share their personal experiences of caring for survivors, which suggests that practitioners may feel that there is a lack of appropriate support and training in their workplace. Gutteridge identified a serious deficit in knowledge and awareness among healthcare workers about the very sensitive issue of CSA, and particularly in midwifery, where, as she points out, 'the intimate is particularly personal'.[43] It is therefore of vital importance that all healthcare professionals (including medical staff) working with women should be informed and receive appropriate training in providing care for survivors. This should include teaching concerning the signs and symptoms that might suggest a history of sexual abuse; strategies to help women maintain the perception of control; communication skills (including the avoidance of words and phrases which might act as memory triggers); and how to avoid scenarios that might be perceived as abusive. Consequently, even though women may not disclose their history, caregivers may be able to understand if they encounter certain responses such as dissociation and know how to respond appropriately.

The creation of the position of consultant midwife in recent years has been beneficial in promoting good midwifery practice and providing clinical leadership. Consultant midwives, with the remit of providing and promoting good care for vulnerable women (including survivors of CSA), are an essential resource and information base. As well as working in the clinical area, they should also act in an advisory capacity for midwives who feel they need support in caring for a survivor or to whom women could be referred if necessary. This would relieve the burden of responsibility on the individual midwife, who may feel out of her depth in caring for certain women, and, from, the woman's point of view, provide specialist care if she has particular problems as a result of her experiences.

Furthermore, as this project demonstrated, there are midwives who themselves have histories of sexual abuse, which can have a profound influence on their practice, and, in certain circumstances, cause them a good deal of psychological distress. It is important, therefore, that all midwives should be enabled to better understand their own emotional responses to this issue as well as gaining an insight into the needs of women with such a history. Raphael-Leff speaks of the value of promoting psychodynamic understanding of emotional processes among maternity care workers in order that they should become more aware of their own and their clients' needs.[48] Deery highlights the need for psychotherapeutic concepts and group work theory to be used in enabling midwives to cope with the demanding emotional nature of their work, particularly in the area of midwifery education.[49] She also refers to the work of Progress Theatre[50] which provides participative and interactive theatrical presentations on sensitive topics

such as bullying and sexual abuse, enabling midwives to jointly explore their own responses to these issues.[51] I have been involved with Progress Theatre on several occasions, both as a student midwife in a learning situation and also at study days as a speaker on sexual abuse, and I can testify to the invaluable impact that it has had on my understanding of these important issues and on my own self-awareness. The use of resources such as Progress Theatre, not only in the training of student midwives but in the ongoing education of maternity caregivers could do much to enhance the emotional care for survivors of CSA.

CARING FOR, OR CARING ABOUT?

The thread running through the entirety of this project was that of women's need for 'care' in its widest sense. Arguably, the concept of 'care' within the industrialised maternity services has been reduced to a process perceived to 'guarantee' a healthy product with optimum efficiency and minimum risk. Several of the interviewees described traumatic experiences in which they were 'cared for' according to this definition. It seems that the heart-cry of birthing women is not merely to be 'cared *for*' but to be 'cared *about*'. Van der Kolk, van der Hart and Marmar[52] state that it appears that people's psychological and biological systems are protected from becoming overwhelmed, provided they are able to find a way to avoid the inevitable or feel 'taken care of' by someone more powerful than themselves. The protective power of individualised, sensitive care for women is largely ignored in today's industrialised, depersonalised maternity services. Arguably, the system finds this too simple a concept to take seriously; it prefers to take a more 'scientific approach'. Thus, the cries of women for human contact and comfort are met by medical science with epidurals, pharmaceuticals, active management of labour and a host of other technological 'advances'. The organisation responds with team midwifery, integration of hospital and community midwives and centralisation. Sadly, rather than meeting women's needs, these factors are often instrumental in creating the potential for more trauma, betrayal and disillusionment. Whether they are survivors of CSA or not, it appears that childbearing women who feel they have been well cared for and had their needs met by compassionate, sensitive people are far less likely to suffer trauma as a result of birth.

I am aware that, at this point in the final chapter, I might be expected to give a list or summary of things to avoid or to do in order to care for survivors of CSA appropriately. However, I have resisted the temptation to do that, as I feel that this would have the potential to become just another formula – 'How to care for women who have been sexually abused'. If my research showed anything it was that women, whether they are survivors or not, should be treated as individuals and with equal respect and, besides, many survivors pass through the maternity services unidentified as such. Instead I would ask readers to reflect on these women's stories and consider how the findings of this research could have a bearing on their individual practice.

We have seen that the problem with institution-led, industrial style maternity care is that the individual is of little significance. The organisation has taken on a life of its own and those who use it or work within it are obliged to dance to its tune. The power discrepancy between women and the system is highly reminiscent of that present in the abusive relationship and therefore predisposed to traumatise those who are vulnerable. The three main themes, betrayal, humiliation and powerlessness, arise out of this disparity and the focus on the demands of a system rather than on the needs of women. Our task as health professionals is to ask ourselves how we can minimise that imbalance of power and empower the women in our care. For instance, we have seen that betrayal results when women's expectations of genuine, expressive care, communication and collaboration are met with coldness and uncaring attitudes. Humiliation occurs when women are treated disrespectfully with no regard for their dignity or feelings. Powerlessness results from being ignored, ill-informed and denied genuine choice based on balanced, unbiased information. It is our responsibility to ask ourselves on an ongoing basis what we can do to prevent these sequelae, as we come into contact with each individual woman. As I have said, there is no magic formula, because each woman and each pregnancy is unique. Let us truly listen to women, as we have listened to the voices of the women contained in this book. Let us take their advice:

> I think you're going to tie yourself up in knots looking for a specific approach and it's just trying to be aware that if you have said something and you notice a reaction, then you can say, 'Oh, maybe I've said something wrong there', and that you keep asking me, 'What can I do to help the situation? What's going to make it easier for you?'
>
> Lynne

To reiterate, the most useful guide to providing appropriate care for a woman with a history of abuse is the woman herself. We must always bear in mind that the woman we are caring for right now may be a survivor of CSA but, equally, that no one is without 'baggage' of some sort. Survivors may not disclose their history, they may not even have memories of it, but they are still vulnerable to traumatisation. Everyone needs to feel cared about as well as cared for and it is not necessary to know a woman's history in order to care for her sensitively.

This all seems a tall order in the face of huge workloads and the financial and legal pressures that are bearing in on health carers every day of their working lives, but I believe it is possible to make a difference for individual women. I would suggest that our methods of delivering maternity care need to be rethought out and the current structures redesigned in order to create a working and a birthing environment that is nurturing for both women and their carers. Unless, or until, that happens, each of us has a responsibility to do whatever we can to protect women from the devastating impact of iatrogenic birth trauma.

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Organisations that can help

- Birth Crisis – 01865 300 266
  www.birthcrisis.sheilakitzinger.com
  Helpline for women who have been traumatised by birth
- Birth Trauma Association
  PO Box 671
  Ipswich, IP1 9AT
  www.birthtraumaassociation.org.uk
  UK charity offering support to women who have had a traumatic birth experience
- Breaking Free – 0845 108 0055
  Helpline providing safe support for survivors of child sexual abuse
- CIS'ters – 023 8033 8080
  admin@cisters.org.uk
  Survivor network actively campaigning for incest awareness
- First Person Plural – fpp@firstpersonplural.org.uk
  Survivor-led association for dissociative trauma and abuse
- Lantern Project – lanternproject.org.uk
  Website for survivors of childhood sexual abuse, maintained by survivors
- National Association for People Abused in Childhood – 0800 085 3330
  (freephone support line)
  42 Curtain Road
  London
  EC2A 3NH
  www.napac.org.uk
- SAFE – 01722 410 889
  Telephone helpline for survivors of ritual abuse
- Sanctum Midwives – Kathryn.gutteridge@tesco.net
  For consultancy, advice and education regarding sexual abuse and childbirth
- The Survivors Trust
  www.thesurvivorstrust.org
- Survivors UK – 0845 122 1201
  www.survivorsuk.org
  For men who have been sexually assaulted
- Voice UK – 01332 291 042
  www.voiceuk.org.uk
  People with learning disabilities who have experienced crime and abuse

Further reading

Simkin P, Klaus P. *When Survivors Give Birth: Understanding and Healing the Effects of Early Sexual Abuse on Childbearing Women*. Seattle, WA: Classic Day Publishing; 2004.

Sperlich M, Seng J. *Survivor Moms: Women's Stories of Birthing, Mothering and Healing after Sexual Abuse.* Eugene, OR: Motherbaby Press; 2008.

SURVIVORS
OF CHILDHOOD SEXUAL ABUSE AND MIDWIFERY PRACTICE

CSA, BIRTH AND POWERLESSNESS

Many midwives will care for women who are survivors of childhood sexual abuse (CSA), whether these women disclose this or not. Pregnant and birthing women commonly experience their bodies becoming 'public property', a variety of sometimes intimate medical procedures, and limited choices on where and how care is provided. For CSA survivors, who have suffered loss of ownership over their bodies as children and may experience recurring feelings of powerlessness and loss of control, these factors can combine with impersonal and medicalised settings and practices to deeply traumatic effect.

'Sexual abuse is all about power, not sex.' – interviewee

Many midwives also experience powerlessness and loss of control as professionals as a result of these same settings and practices, and those midwives who are themselves CSA survivors bring a particularly acute awareness of this and of the needs of survivor mothers. This unique study sets out to gain a deeper understanding of the needs of these mothers by exploring them alongside the parallel experiences of survivor midwives. It explores the insights and reflections they together bring to midwifery, and the positive results of more collaborative, personal, communicative and ultimately empowering practices for all involved.

'The significance of this book is therefore far wider than its immediate subject, for it offers us the opportunity to rethink our professional coping strategies. If we seek to make all our professional relationships ones of equality and opportunities for growth, as would benefit someone who has suffered abuse, then we can all grow and flourish.' – from the Foreword by Mavis Kirkham

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