

# South Australian Perinatal Practice Guideline

## Sexual abuse in childhood – pregnancy, birth and postnatal care considerations

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**Note:** This guideline provides advice of a general nature. This statewide guideline has been prepared to promote and facilitate standardisation and consistency of practice, using a multidisciplinary approach. The guideline is based on a review of published evidence and expert opinion.

Information in this statewide guideline is current at the time of publication.

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Health practitioners in the South Australian public health sector are expected to review specific details of each patient and professionally assess the applicability of the relevant guideline to that clinical situation.

If for good clinical reasons, a decision is made to depart from the guideline, the responsible clinician must document in the patient's medical record, the decision made, by whom, and detailed reasons for the departure from the guideline.

This statewide guideline does not address all the elements of clinical practice and assumes that the individual clinicians are responsible for discussing care with consumers in an environment that is culturally appropriate and which enables respectful confidential discussion. This includes:

- The use of interpreter services where necessary,
- Advising consumers of their choice and ensuring informed consent is obtained,
- Providing care within scope of practice, meeting all legislative requirements and maintaining standards of professional conduct, and
- Documenting all care in accordance with mandatory and local requirements

#### **Explanation of the aboriginal artwork:**

The aboriginal artwork used symbolises the connection to country and the circle shape shows the strong relationships amongst families and the aboriginal culture. The horse shoe shape design shown in front of the generic statement symbolises a woman and those enclosing a smaller horse shoe shape depicts a pregnant women. The smaller horse shoe shape in this instance represents the unborn child. The artwork shown before the specific statements within the document symbolises a footprint and demonstrates the need to move forward together in unison.



**Australian Aboriginal Culture is the oldest living culture in the world yet Aboriginal people continue to experience the poorest health outcomes when compared to non-Aboriginal Australians. In South Australia, Aboriginal women are 2-5 times more likely to die in childbirth and their babies are 2-3 times more likely to be of low birth weight. The accumulative effects of stress, low socio economic status, exposure to violence, historical trauma, culturally unsafe and discriminatory health services and health systems are all major contributors to the disparities in Aboriginal maternal and birthing outcomes. Despite these unacceptable statistics the birth of an Aboriginal baby is a celebration of life and an important cultural event bringing family together in celebration, obligation and responsibility. The diversity between Aboriginal cultures, language and practices differ greatly and so it is imperative that perinatal services prepare to respectively manage Aboriginal protocol and provide a culturally positive health care experience for Aboriginal people to ensure the best maternal, neonatal and child health outcomes.**

### Purpose and Scope of PPG

This guideline is intended for use in the identification and support of women who have experienced childhood sexual abuse and who are pregnant, giving birth and in the postnatal period.

# Sexual abuse in childhood – pregnancy, birth and postnatal care considerations

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# Sexual abuse in childhood – pregnancy, birth and postnatal care considerations

## Summary of Practice Recommendations

1. Childhood sexual abuse survivors can experience significant trauma when they become pregnant, give birth and adjust to parenting.
2. Childhood sexual abuse is experienced by many women and women will often not disclose their history with caregivers.
3. Employing principles of respectful maternity care and continuity of carer is beneficial for the development of trusting, supportive relationships between women and caregivers when they have experienced childhood sexual abuse.

## Abbreviations

CSA	Childhood Sexual Abuse
PTSD	Post-Traumatic Stress Disorder
GP	General Practitioner
e.g.	For example

## Definitions

Post-traumatic stress disorder	PTSD can follow traumatic events. PTSD affects multiple body systems, such as the brain, immune, cardiovascular, cellular, endocrine and metabolic function. <sup>1</sup>
Vaginismus	A genito-pelvic pain/penetration disorder that is both an emotional and pain disorder. <sup>2</sup>
Trauma informed care	Person-centred care organised around an awareness and sensitivity to the possibility that all health consumers, carers and families may have experienced or be experiencing trauma in their lives. A trauma informed approach accommodates the vulnerabilities of trauma survivors, avoids inadvertent retraumatisation and facilitates consumer participation in treatment and care.

# Sexual abuse in childhood – pregnancy, birth and postnatal care considerations

## Childhood sexual abuse (CSA)

Childhood sexual abuse or CSA is defined as:<sup>3</sup>

“Any act which exposes a child to, or involves a child in, sexual processes beyond his or her understanding or contrary to accepted community standards. Sexually abusive behaviours can include the fondling of genitals, masturbation, oral sex, vaginal or anal penetration by a penis, finger or any other object, fondling of breasts, voyeurism, exhibitionism, and exposing the child to or involving the child in pornography. It includes child grooming, which refers to actions deliberately undertaken with the aim of befriending and establishing an emotional connection with a child, to lower the child’s inhibitions in preparation for sexual activity with the child.”

Individual Australian state and territory governments have their own legal definitions for childhood sexual abuse<sup>4</sup> but every jurisdiction has legislation that criminalises sexual acts involving a child who, at the time of the offence, was below the legal age of consent.<sup>5</sup>

Because of the varying legal definitions **behavioural** definitions are often used to identify abuse.<sup>4,6</sup> They can be classified into three types:

1. non-contact sexual abuse (e.g. threats of sexual abuse, verbal sexual harassment, sexual solicitation, indecent exposure, exposing the child to pornography);
2. contact sexual abuse involving sexual intercourse (i.e. sexual assault or rape – see below); and
3. contact sexual abuse excluding sexual intercourse but involving other acts such as inappropriate touching, fondling and kissing.

CSA is perpetrated by an adult or another child (by age or development) who by age or development is in a relationship of responsibility, trust or power and where the abuse satisfies the needs of the other person.<sup>7</sup>

CSA is often carried out without physical force, but rather with manipulation (e.g. psychological, emotional or material). It may occur on a frequent basis over weeks or even years, as repeated episodes that become more invasive over time, and it can also occur on a single occasion.<sup>8</sup>

CSA survivors can experience a range of common feelings that are likely to be triggered/re-experienced during pregnancy, birth and postnatally, these include:

- Shame
- Humiliation
- Helplessness
- Loss of control
- Feelings damaged /ruined
- Fear/terror
- Anger
- Despair

Childhood sexual abuse is a global problem with an estimated prevalence of between 12-20% of all children worldwide thought to be impacted.<sup>9,10,11</sup> The 2016 Australian Bureau of Statistics Personal Safety Survey found that one in six Australian women had experienced physical or sexual abuse before the age of 15.<sup>12</sup> Childhood Sexual Abuse has long-term negative physical and psychological effects.<sup>13</sup> Health care providers must be aware of CSA and the potential implications for pregnant and birthing women. Respectful maternity care with open communication and individualised care can benefit the woman/healthcare provider relationship and result in women feeling empowered and supported through their transition to motherhood.<sup>14</sup>

# Sexual abuse in childhood – pregnancy, birth and postnatal care considerations

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## Impact on pregnancy, birth and parenting

Pregnancy and childbirth can be challenging times for women who have experienced CSA. Clinical care can trigger memories of their CSA,<sup>14</sup> and some women can experience significant trauma throughout pregnancy, childbirth and early transition to parenting.<sup>15</sup>

Most women who have experienced CSA do not disclose to health care practitioners and may not be distinguishable from women who haven't experienced abuse.<sup>14</sup> Their experience of CSA is likely to cause significant ongoing distress.<sup>14</sup>

Research indicates that women who have experienced CSA have higher levels of fear, higher stress levels, they also experience pregnancy complications including pre-term birth at higher rates than women who have not experienced CSA.<sup>9,16,17</sup>

CSA may be recalled by women for the first time during pregnancy, birth or the postnatal period. It may not become an issue for a woman in her first pregnancy but may in subsequent pregnancies.

## Intrafamilial CSA

Clinicians should be aware of the impact of intrafamilial CSA on women in terms of the complex family dynamics when CSA has occurred within the home. These women may have limited social support due to complex family dynamics and/or family involvement that is likely to cause distress in the woman.

## Respectful maternity care

Respectful care principles applied universally to all women, can help minimise the trauma experienced by women who have been exposed to CSA.

Continuity of caregiver for women who have experienced CSA can have additional benefits. Continuity of caregiver allows a relationship to develop and can increase the chances that the woman will feel comfortable in expressing her needs. Care for women who have experienced CSA should be individualised, person-centred, culturally sensitive, flexible, compassionate, respectful, trauma informed, and woman led.

## Antenatal care

Screening of pregnant women for CSA is necessary in order to assess survivors' physical and psychological well-being.<sup>13</sup> The first antenatal visit provides clinicians with an opportunity to enquire about a history of CSA. Often women will not feel comfortable sharing their experiences and may not respond to a direct question.<sup>14</sup> As trust develops with her health care providers a woman may feel more comfortable disclosing her history of CSA. Health care professionals should be open to conversations about CSA even if at the first antenatal visit the woman says she has no history of CSA. It is important to provide appropriate access to a female caregiver for women whose main spoken language is not English.



# Sexual abuse in childhood – pregnancy, birth and postnatal care considerations

## Identification of women who have experienced CSA

Sensitive questioning by health care professionals is important and phrases such as the following may be appropriate;

*'Sometimes difficult incidents that have occurred to women in their lives can be stirred-up by the experience of pregnancy and birth. If you feel anything like this, please feel free to discuss it with me if you feel comfortable or with your general practitioner (GP).'*' or

*'Sometimes women have traumatic experiences in childhood that can stir up difficult feelings in pregnancy and child birth. If you have any feelings like this it can help to talk to a midwife, counsellor or your GP. It's also important for us to know how we can best support you during your pregnancy and in child birth'* or

*'If you were sexually abused as a child, pregnancy and its physical, emotional and psychological changes might bring back painful memories. If you have had any history of childhood sexual abuse it can be helpful to talk with your doctor or midwife.'*

Women with a history of CSA may present with an extreme fear of the birth<sup>16,18</sup> and sensitive and trusting relationships with maternity care providers may provide the woman with opportunities to explore her fears. Continuity of care provider can assist women to develop those relationships.

## Antenatal indicators of CSA

The different phases of pregnancy and bodily changes during pregnancy can trigger memories of CSA.

Words and physical contact by health care providers can act as triggers.<sup>17</sup>

A combination of the following markers should alert the clinician to a **possible** history of CSA. It is important to be aware that **not all** women who have experienced CSA will exhibit these behaviours and women who **have not** experienced CSA can also experience the following:<sup>17,19</sup>

- Non-attendance
- Increased stress, anxiety, depressive symptoms and suicidal ideation
- Concerns over, or declines examinations that require intimate contact e.g.
  - abdominal palpation
  - breast examinations
  - venepuncture
  - ultrasounds
- Difficulties with vaginal examinations or vaginismus
- Substance use
- Fear of labour/birth
- Concerns regarding parenting

## If a woman discloses CSA

Ensure that her experience is acknowledged and empathise with her. Evaluate her existing social supports. In consultation with the woman, determine the need and priority for perinatal mental health and social work involvement in her care. If the woman has existing support services in place, discuss working together to support her through her pregnancy, birth and postnatal journey. If the woman agrees contact her support services to develop a care plan.

It is not necessary for the health care provider to know the details of the CSA to support her.

# Sexual abuse in childhood – pregnancy, birth and postnatal care considerations

Use non-judgemental language and an open-minded, opinion free approach to communication that relays understanding and empathy in relation to the traumatic effects of the abuse. Empathy involves listening and understanding the woman's fears and concerns yet still being able to recognise her feelings as distinct from themselves.<sup>20</sup>

Discuss the potential impact on pregnancy or birth and how you can work together to minimise any potential for trauma or re-abuse. Offer information on appropriate support services (e.g. social work, women's health state-wide, perinatal mental health).

Recommend a model of care that offers the woman continuity of caregiver with a caregiver that she is comfortable with.

Identify if there are any signs of PTSD e.g. flashbacks, intrusive sensory memories, repetitive intrusive thoughts, nightmares, autonomic arousal (e.g. tension, jumpiness, flinching) and arrange referral to allied support services as indicated (e.g. social work, perinatal mental health nurse, psychiatrist).

## Antenatal Clinical Care Considerations

**Any** physical contact from the health care provider in the antenatal period can be potentially distressing for the woman who has experienced CSA.<sup>19</sup> Additional trauma can be reduced by ensuring open communication, discussion of rationale, listening to the woman's requests and respecting her wishes if she declines any procedure/intervention or recommendation. Ensure the woman is not rushed to make any decisions about her care. Inform her of the recommended care in pregnancy in advance so she has time to consider aspects of care prior to each presentation. Fear of procedures such as vaginal examination can lead to non-attendance for care.<sup>19</sup>

Mode of birth can be discussed with the woman and her health care providers. When health care professionals are able to build a positive and safe relationship with the woman they should discuss the potential that a male health care provider may be involved in her care, particularly in obstetric emergencies. She should be reassured that if she wishes no contact from a male health professional that staff would attempt to meet her needs.

Explain to women that they do not have to agree to any examination at any time.

### **Vaginal examinations and vaginal ultrasounds**

Vaginal examinations and ultrasounds are a frequent trigger for trauma associated with CSA.<sup>17,19</sup> If a health care provider recommends a vaginal examination or vaginal ultrasound, they should ensure the rationale is explained and informed consent gained and documented.

Ensure a chaperone and/or support person is present.

Aim for a quiet environment, with minimal noise and minimal activity outside the room and ensure privacy is maintained.

Reassure the woman that the examination will stop any time at her request. Pace the procedure to the woman's needs, look for cues that she may be distressed and explain actions at all times.

Ask the woman if she would like to hold/insert the ultrasound probe herself to maintain control.

# Sexual abuse in childhood – pregnancy, birth and postnatal care considerations

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## Intrapartum care

Women who have experienced CSA may experience fear of the physical process of labour, sense a loss of control. Trauma responses may include:

- Dissociation from labour and birth
- Flashbacks of abuse
- Passive compliance
- Childlike behaviour
- Fear of pushing
- Overly aggressive
- Controlling behaviour

Labour and birth can be particularly challenging with feelings of loss of control directly related to: epidurals, contact with many unknown health care professionals, pain, intimate examinations and a process that is somewhat out of the woman's control.<sup>15,17,19</sup> Being naked and having a male care provider can also contribute to fear and stress for CSA survivors.<sup>18</sup> Health professionals should be receptive to the woman's needs that may include an upright labour and birth and remaining clothed.<sup>19</sup> Utilising the principles of respectful maternity care and a continuity of care model can prevent pregnancy, birth and early parenting from re-traumatising the woman. Clinicians involved in the birth should also remain vigilant to the vulnerability of the birthing woman; a woman who has experienced CSA is likely to associate vulnerability with danger.

Epidural anaesthesia, even when desired, can act as a trigger during birth as the loss of sensation and confinement to bed can remind women of the physical and emotional paralysis experienced during their assaults.<sup>19</sup>

If the woman is birthing in the hospital, then selection of a birth room is important for some women who do not wish to have their back to the door as they wish to see who is entering the room.<sup>19</sup> Spotlights on the woman's genitals can also act as a trigger for some women.<sup>19</sup> Clinicians should aim to ensure the birth environment is quiet and calm as the woman is likely to be experiencing a degree of hyperarousal, that could easily intensify with unnecessary commotion and activity.

PTSD responses related to labour and birth can be heightened in women with a history of sexual abuse.

Women who have experienced CSA can experience fear that others will see that she has been sexually abused by the damage to her genitals. This can trigger feelings of shame and humiliation for the woman.

Women may wish to bath their baby immediately after birth.<sup>19</sup>

Pain in the vulvo-vaginal region or perineal pressure in second stage can be triggers for flashbacks or other associations to childhood sexual abuse.

Lack of consent for medical procedures can trigger PTSD symptoms.<sup>19</sup>





# Sexual abuse in childhood – pregnancy, birth and postnatal care considerations

## Appropriate medical / midwifery responses

Sensitive care throughout pregnancy and childbirth can minimise the potential of retraumatising women with a history of CSA, learn more about their body and control over their physical well-being. Although the following recommendations form a part of routine care they can be very important when caring for women who have experienced CSA:

- Use clear and supportive language
  - Inappropriate language may be a trigger for memories of past abuse
  - Use language that describes procedures in equal and adult terms
  - Avoid derogatory language
  - Avoid language that encourages shame and/or mistrust in her body, for example, 'failure to progress'
  - Ensure a female interpreter is offered if required
- Avoid authoritative or patriarchal approaches, including perceived aggressive posturing (potential to alienate the woman and return her to a vulnerable, childlike state)
- Obtain permission from the woman before any personal or intimate contact
- Ensure women understand that all procedures depend on their informed consent
- If women are experiencing flashbacks or dissociating, allow time. When able, encourage the woman to resume eye contact and focus on the clinician's voice (connects woman with the present).
- Obtain permission from the woman before attending any care for her baby.<sup>19</sup>
- Maintain the woman's privacy at all times.

## Postnatal care

For women with a history of CSA, the transition to motherhood may provoke fear and anxiety about.<sup>13,19</sup>

- Breastfeeding and skin to skin contact (may trigger memories / flashbacks of abuse)
- Their maternal / infant relationship

After birth women can develop symptoms of distress, such as PTSD, depression and dissociation.<sup>13</sup>

Offer the woman a post birth debrief to explore the impact of the experience on the woman's wellbeing.<sup>19</sup>

## Breastfeeding

Generally, women with a history of CSA are able to move through these memories and breastfeed without problems. For some, the association with the abuse may be too strong and they may decide to artificially feed their babies. Women should be supported in their choices.

### Appropriate support

The clinician should employ 'hands off' breast feeding assistance. Clinicians can use teaching aids such as dolls to facilitate education without the need to touch the woman's breast.

If it is necessary for the clinician to use 'hands on' to assist with breast feeding, as with any woman, ask for her permission before touching her breast(s).

If the woman is concerned about breastfeeding, explore her concerns with her and find solutions that are acceptable to the woman.

Reassure the woman that her feelings are okay.

Offering alternative feeding methods where appropriate (e.g. when suckling at the breast triggers flashbacks). If the woman opts to artificially feed, ensure this is communicated to other health care providers so the woman does not need to explain her choice again.

# Sexual abuse in childhood – pregnancy, birth and postnatal care considerations

## Maternal infant relationship

Women with a history of CSA may have anxiety / fears about:

- The gender of their baby
- Fear of damaging their baby
- Fear of loving their baby
- Fear of intimate contact with baby (e.g. bathing baby or changing nappy)
- Potential risk of postnatal depression or general depression
- The baby's safety (overly concerned)
- A fear of being separated from her baby (if nursery care is required)
- Fear of her baby being cared for by strangers that she doesn't know and trust (if nursery care is required)

## Appropriate support

Explain that daily activities related to the care of baby (e.g. bathing, changing nappies) arise from the baby's hygiene needs and are not related to sexual abuse.

Reassure the woman that she is not responsible for her history of CSA and affirm her maternal abilities.

Provide education to the woman about mother-infant bonding, explore and encourage ways to promote bonding. This is especially important for women who have experienced intrafamilial CSA.

Explain that it is normal to have a short period of sadness that peaks three to five days after birth.

Explain that the woman's memories of sexual abuse may be reactivated when the child reaches the same age as when her CSA occurred.

Communicate understanding and sensitivity about how the woman is feeling. Remember she is responding to the effects of being subjected to childhood sexual abuse.

## Additional considerations

### Risk

Health professionals should consider risk and safety for the woman and her baby.

Questions to consider include:

- was her abuser prosecuted?
- are they still in her life?
- is her baby at risk?

Concerns about risk for the woman or her baby should be managed depending on the woman's circumstance. If necessary urgent referrals should be made to escalate the level of support offered to the woman and her baby.

### Considerations for the Health Professional

Health professionals should be aware of the possibility that the distress the woman experiences can cause distress in the health professional too. They should be careful not to project this onto the woman.

Health professionals may be required to tolerate a high level of distress from the woman at times, they should understand that her feelings cannot be fixed and should not be dismissed or minimised. Offer support and reassurance and wait for distress to pass.



# Sexual abuse in childhood – pregnancy, birth and postnatal care considerations

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Organise appropriate support and debriefing with colleagues and recognise the emotional strain of caring for a woman who has experienced CSA.

Access staff counselling services as required.



# Sexual abuse in childhood – pregnancy, birth and postnatal care considerations

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## Support Services

Women who have experienced CSA should be offered support. Referral to services relevant to her situation and with her permission is important for her long-term care and her transition to parenthood.

### Perinatal Infant Mental Health Service (PIMHS)

#### Perinatal and Infant Mental Health Services at Metropolitan Hospitals:

- Flinders Medical Centre: Telephone (08) 8404 2551
- Lyell McEwin Hospital: Telephone (08) 8282 0794
- Women's and Children's Hospital: Telephone (08) 8161 7227

#### General Practitioner (+/- referral to Mental Health Practitioner)

#### Rural and Remote Telemedicine/Tele-Psychiatry Unit

Telephone (08) 7087 1660

#### CAMHS

Women's & Children's Health Network

Telephone: (08) 8161 7198

### Helen Mayo House

Provides tertiary level inpatient and outpatient treatment for mothers, their infants, partners and their families where there are post natal mental health problems.

226 Fullarton Road

Glenside SA 5065

Telephone: (08) 708 71030 or (08) 708 71031

[www.wch.sa.gov.au/hmh](http://www.wch.sa.gov.au/hmh)

### Childhood Sexual Abuse Counselling Service, Uniting Communities

First Floor, 10 Pitt St Adelaide, SA 5000

08 8202 5190

Hours: Mon - Fri 9am - 5pm

Eligibility: Men, women, children and young people who want to address the effects of childhood sexual abuse in their lives. Appointment required

Fees: Sliding scale according to income

### Blue Knot Foundation

Leading national organisation working to improve the lives of adult Australians who have experienced childhood trauma.

Phone: 1300 657 380

Email: [helpline@blueknot.org.au](mailto:helpline@blueknot.org.au)

Monday-Sunday, 9am-5pm AEST/ADST

<https://www.blueknot.org.au/>



# Sexual abuse in childhood – pregnancy, birth and postnatal care considerations

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## Relationships SA

Adult childhood sexual abuse support available to people over 16 years of age, who were sexually abused as children. Services include counselling, referrals, information and resources available at [www.respondsa.org.au](http://www.respondsa.org.au). They also provide support for others affected such as partners and family members.

Phone: 1300 364 277



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## When you need more help

If you experience any of the following, please speak with your healthcare provider or general practitioner:

- > flashbacks
- > crying
- > nightmares
- > fast heart beat
- > sweaty hands
- > tension
- > jumpiness
- > fear of being alone
- > thoughts of self-harm

Your doctor or midwife can put you in contact with some additional support.

## Support Services

### Childhood Sexual Abuse Counselling Service Uniting Communities

First Floor, 10 Pitt St Adelaide, SA 5000  
Telephone: (08) 8202 5190

### Blue Knot Foundation

Leading national organisation working to improve the lives of adult Australians who have experienced childhood trauma.

Phone: 1300 657 380

Email: [helpline@blueknot.org.au](mailto:helpline@blueknot.org.au)

### Relationships SA

Telephone: 1300 364 277

A 24 hours a day crisis support service.

### Lifeline

Telephone: 13 11 14

### Perinatal and Infant Mental Health Services at Metropolitan Hospitals:

Flinders Medical Centre:

Telephone (08) 8404 2551

Lyell McEwin Hospital:

Telephone (08) 8282 0794

Women's and Children's Hospital: Telephone  
(08) 8161 7227

### Local General Practitioner

(+/- referral to Mental Health Practitioner)

### Rural and Remote Telemedicine/ Tele-Psychiatry Unit

Telephone (08) 7087 1660

### CAMHS

Telephone: (08) 8161 7198

### Helen Mayo House

Provides tertiary level inpatient and outpatient treatment for mothers, their infants, partners and their families where there are postnatal mental health concerns. Requires medical referral.

226 Fullarton Road

Glenside SA 5065

Telephone: (08) 708 71030

[www.wch.sa.gov.au/hmh](http://www.wch.sa.gov.au/hmh)

## For more information

Department of Health, South Australia

SA Maternal Neonatal & Gynaecology

Community of Practice

Women's and Children's Health Network

Regional Office,

72 King William Road

North Adelaide, SA 5006

[www.sahealth.sa.gov.au/perinatal](http://www.sahealth.sa.gov.au/perinatal)



[www.ausgoal.gov.au/creative-commons](http://www.ausgoal.gov.au/creative-commons)

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SA Health

# Childhood sexual abuse and your pregnancy

Information for women



SA Health

## Childhood Sexual Abuse

Childhood sexual abuse affects as many as one in six children. It involves physical, emotional and psychological abuse.

Survivors can feel a range of emotions that include:

- > Shame
- > Humiliation
- > Helplessness
- > Loss of control
- > Feeling damaged /ruined
- > Fear/terror
- > Anger and despair

## Pregnancy, birth and after your baby is born

As you progress through your pregnancy, birth or after your baby is born some of the negative feelings associated with childhood sexual abuse can be triggered or re-experienced. This can be very traumatic for some women.

## Care choices

Continuity of caregiver can help you establish a trusting relationship with your doctor or midwife. The support from a known care provider can help you manage your experience the way that you want it to be managed. You may feel safer to talk to your doctor or midwife about the way that you are feeling.

You might find that requesting a female care provider can make you feel safer. If English isn't your first language then an interpreter can be organised for you.

## Strategies to help with medical appointments

Childhood sexual abuse survivors can use several strategies to help them through pregnancy, birth and after the baby is born.

You may wish to make sure that you have your partner, a trusted friend or relative with you for all your appointments to help you feel more comfortable.

You are entitled to say no to any procedure that the medical or midwifery staff recommend to you. You may also choose to ask for more time to think about recommendations.

Some women experience extreme fear of procedures such as vaginal (internal) or breast examinations.

During your pregnancy and birth, vaginal examinations may be recommended. These are recommended to monitor the health and wellbeing of yourself and your baby and plan for your care. All procedures are voluntary, and you can change your mind at any stage. Your care provider will be able to answer any questions you may have.

You may also wish to have a friend or family member present for support should you agree to the examination.

## Labour and Birth

Labour and birth can be particularly challenging with feelings of vulnerability and a loss of control. This can be because you will meet many unknown health care professionals, experience pain and require examinations which can feel invasive. Being exposed or having an unknown care provider can also contribute to fear and stress for survivors.

If you feel comfortable, talk to your doctor or midwife about how you are feeling. They may be able to use some strategies to make the experience more acceptable to you.

## After the birth

You may experience fear and anxiety about breastfeeding or your relationship with your baby. If you are feeling these things talk to your doctor or midwife if you feel comfortable.

It is normal to experience a few days of sadness a few days after birth but if symptoms increase or persist seek assistance.





South Australian Perinatal Practice Guideline

# Sexual abuse in childhood – pregnancy, birth and postnatal care considerations

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# Sexual abuse in childhood – pregnancy, birth and postnatal care considerations

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