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.

Purpose and Scope of PPG
This guideline provides clinicians with information on how to identify women who have experienced child sexual abuse, potential impact on perinatal mental health and possible effects during pregnancy, labour, birth, breastfeeding and maternal-infant bonding. It includes information on health professionals’ responses to women and care considerations.
Sexual Abuse in Childhood – Pregnancy Care Considerations

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Summary of Practice Recommendations

Women may recall abuse for the first time during pregnancy, childbirth or in relation to their new parenting role
Routine medical procedures during pregnancy and childbirth may be interpreted as abuse by women with a history of CSA
Women who have been subjected to violence and childhood sexual abuse may suffer from post-traumatic stress disorder (PTSD)
Dealing with symptoms of PTSD may improve maternal and infant outcomes
Vulva or perineal pain or sensations of pressure in second stage can trigger flashbacks or other associations to childhood sexual abuse

Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>CSA</td>
<td>Childhood sexual abuse</td>
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<td>PTSD</td>
<td>Post-traumatic stress disorder</td>
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<td>et al.</td>
<td>And others</td>
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<td>e.g.</td>
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<tr>
<td>RCOG</td>
<td>Royal College of Obstetrics and Gynaecology</td>
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<td>SA</td>
<td>South Australia</td>
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Sexual Abuse

One in three women and one in six men experience some form of unwanted sexual encounter during childhood. Sexual abuse (CSA) includes but is not limited to:

- Touching
- Masturbation
- Oral sex
- Vaginal or anal penetration
- Pornography
- Kissing
- Exposing / flashing
- Watching
- Comments
- Bestiality

Background

Women may recall abuse for the first time during their pregnancy, childbirth or in relation to their new parenting role. Memories of CSA may only become evident (in response to an environmental or situational trigger) in later pregnancies. Women report that memories are triggered during the birth process, possibly because of the similarities between abuse and birth (e.g. lack of control over their body, intimate contact and inspection of the woman’s genitals by clinicians, feeling of powerlessness). The experience of pregnancy and birth and routine medical procedures may be interpreted as abuse by women with a history of CSA. In labour, women with a history of CSA may fear that their body has been damaged and will be unable to respond to the normal process of labour. Women who have been subjected to violence and childhood sexual abuse may suffer from post-traumatic stress disorder (PTSD). In pregnancy, routine medical investigations and vaginal examinations may trigger unexpected responses consistent with PTSD. Dealing with symptoms of PTSD appropriately throughout maternity care may improve maternal and infant outcomes.

Antenatal care

Identifying women with a history of CSA

The first antenatal booking appointment provides the clinician with an ideal opportunity to inquire if the woman has a history of sexual abuse. Use sensitive and appropriate dialogue e.g. ‘Sometimes difficult incidents which have occurred to women earlier in their lives can be stirred-up by the experience of pregnancy and birth. If you experience anything like this, please feel free to discuss this with me if you wish, or with your general practitioner.’ Women may not openly disclose that they have been subjected to CSA.
Antenatal indicators for a suspected history of CSA

> The different phases of pregnancy and the body changes during pregnancy can trigger memories of CSA. Words, touches by obstetricians, midwives or the fact of becoming dependent on others may also act as a trigger.14
> A combination of the following markers should alert the clinician to a possible history of CSA. However, not all women with these issues will have a history of CSA, and not all CSA survivors will exhibit these behaviours
  > Non attendance
  > Increased stress, anxiety, depressive symptomatology / suicidal ideation14
  > Concerns or refusal of examinations that require intimate contact e.g. abdominal palpitations, breast examination, venepuncture, ultrasounds14
  > Vaginal examinations: difficult to examine or vaginismus
  > Substance use14
  > Fear of labour / birth
  > Concerns regarding parenting14
  > Refusing consent

If a woman does disclose information about CSA, appropriate responses are:

> Believe what she tells you
> Acknowledge and empathise with her experience
> Assess existing social supports
> Offer practical support e.g. referral to social work (only if the woman agrees)
> Establish if there is a need to prioritise immediate referral to social work / perinatal mental health

> It is not necessary for the caregiver to know the details of the abuse to support the woman appropriately
> Use non-judgemental language that relays understanding and empathy in relation to the traumatic effects of the abuse. Pace all interactions to the woman’s needs4
> 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)
> Recommend a model of care that offers the woman continuity of caregiver with a person whom the woman 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)

Specific antenatal care considerations

Vaginal examinations

> RCOG recognizes that vaginal examinations are medical interventions that should be undertaken only when necessary15
> Women are legally within their rights to refuse any treatment regardless of the consequences to their self or their unborn child. The woman does not have to give a reason16
Clinician considerations

> Inform women that they can have a support person with them during a vaginal examination
> Obtain and record informed verbal consent for the vaginal examination
> Before beginning the procedure, explain the reason for the examination. During the vaginal examination, explain your actions in a step by step manner, pacing the procedure to the woman’s needs and stop the procedure if she requests it6,17,18
> Explain the required frequency of examinations in relation to the woman’s care and establish on-going communication in relation to any intimate examinations

Vaginal ultrasound

> Ensure the procedure is carried out in a sensitive manner to assure that the woman maintains control of the procedure
> Verbal consent and explanation as in clinical considerations above
> Offer women the option of holding and or inserting the vaginal probe as appropriate

Intrapartum care

Women who have been subjected to childhood sexual abuse may experience:

> Fear of labour and physical process involved, sense of loss of control over the process (e.g. dissociation from labour and birth, flashbacks of abuse, passive compliance, childlike behaviour, fear of pushing, overly aggressive or controlling behaviour)
> Post-traumatic stress responses related to labour and birth are heightened in women with a history of sexual abuse
> Fear that people will see that she has been sexually abused by the damage to her genitals
> Pain in the vulvo-vaginal region or perineal pressure in second stage can be triggers for flashbacks or other associations to childhood sexual abuse

Appropriate medical / midwifery responses

> Sensitive care can help a pregnant woman with a history of CSA to learn more about her body and take control over her physical well-being
> Inappropriate language may be a trigger for memories of past abuse19
  > Use language that describes procedures in equal and adult terms
  > Avoid authoritative or patriarchal approaches (potential to alienate the woman and return her to a vulnerable, childlike state)
  > Avoid derogatory language (e.g. sweetie)
  > Ensure that the language indicates that all procedures depend on the woman consenting to them
> 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). Use clear and supportive language
> Obtain permission from the woman for any personal or intimate contact
> Obtain permission from the mother before attending any care for her baby
> Maintain the woman’s privacy at all times
Sexual Abuse in Childhood – Pregnancy Care Considerations

Postnatal care

> Generally, new mothers are concerned about bonding with their newborn and breastfeeding
> For women with a history of CSA, the transition to motherhood may provoke fear and anxiety about:
  > Breastfeeding and skin to skin contact (may trigger memories / flashbacks of abuse)\(^14,17\)
  > Their maternal / infant relationship

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 even as to preclude breastfeeding

Appropriate support

> The clinician should employ ‘hands off’ breast feeding assistance
> If it is necessary for the clinician to use ‘hands on’ to assist with breast feeding, ask the woman for her permission before touching her breast
  > If the woman is concerned about breastfeeding, support her to explore helpful solutions
  > Acknowledge that the woman’s feelings are okay
  > Offering alternative feeding methods where appropriate (e.g. when suckling at the breast triggers flashbacks)\(^4\)

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)\(^17\)

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
> Explain that it is normal to have a short period of sadness that peaks three to five days after birth
> If you suspect a women is not responding to her child, consider what might be the cause of it
> Explain that the woman’s memories of sexual abuse may be reactivated when the child reaches the same age as when the mother’s 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
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References


4. Stojadinovic T. “For the first time somebody wants to hear”. A research report for health professionals, Women's Health Statewide; 2003.


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