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THE EXPERIENCE OF CHILDBIRTH FOR SURVIVORS OF INCEST

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ABSTRACT

The purpose of this research was to discover what experiences, including feelings, women who are survivors of incest have during childbirth. The recognition that the childbirth experience may trigger memories of incest that will then alter the course of childbirth was the framework for the study.

This exploratory research was undertaken using a phenomenological approach. The six participants were obtained through networking and issues surrounding confidentiality and consent were of a high priority. The data consists of transcripts of taped, one to two hour, in-depth interviews. During interviews each woman recalled her experiences and feelings during and surrounding childbirth.

Qualitative analysis was undertaken, the results indicating that memories of previous abuse may be provoked by childbirth but that it is a very individualised response. The effect of these memories on the childbirth experience is also variable but does occur. Privacy, control and touch are important aspects of these women's childbirth experiences. The results and interpretation of findings presented in this report centre around the labour and delivery experiences of the women. The variety of women's needs demonstrated in this project emphasise the importance of individualised care by midwives and doctors involved in the care of child bearing women.

INTRODUCTION

It is unknown whether there is an association between a woman's past history of incest and her subsequent childbirth experiences. In this author's midwifery practice a possible association has been noted. In one instance, a labouring woman's contractions ceased in response to nipple stimulation. She was a survivor of incest and although her breasts had never been a part of her abuse, she did not like them being touched. However, she consented to nipple stimulation but in self defence she 'turned off' her labour. After a short period of total privacy the woman's labour resumed and she had a normal delivery.

This woman's experience stimulated the author's interest in survivors of incest and their experiences of childbirth. As there is no published research in the area and there has been only recent mention of a connection between the two experiences in the childbirth literature the author chose to undertake the following project.

The conceptual framework for the project (see figure one) is based on the similarity of some of the characteristics of the two experiences, incest and childbirth. They are both experiences that involve self esteem and confidence, relationships - particularly parent/child relationships, sexuality, touching, and the manipulation of the genital organs. Thus, when an element of the incestuous experience is relived in childbirth, feelings similar to that past event may be felt. Such feelings may then effect the childbirth experience itself. Therefore it may be possible that some women's experience of childbirth are affected by their previous experience of incest.

The number of women who are of child bearing age and who are survivors of incest is unknown. A study by Goldman & Goldman (1988) found that there had

been some kind of sexual exploitation by an older person of 28% of Australian girls. It follows therefore, that a substantial number of the over 62,000 women who give birth in Victoria each year (Health Department Victoria 1990) must also be incest survivors.

Definitions of incest vary throughout the literature on the subject. Coker (1990) and Lowery (1987) stipulate an age difference, for example, whereas Felitti (1991) does not. Incest almost universally implies sexual activity between family members but the definition of 'family' varies (Cahill et al. 1991), usually direct *and* step relatives are included. The sexual activities, which may or may not be defined (Lowery 1987, Felitti 1991), sometimes only refer to physical contact (Zdanuk et al. 1987, Brown & Garrison 1990) or can include all forms of sexual exploitation (Rew 1989, Coker 1990). For the purpose of this paper, the broader definitions of family and sexual activity will apply.

A survey of survivors of sexual abuse has shown that 67-75% of the survivors of incest believe that the abuse had a damaging effect on their lives (Baker & Duncan 1985). It has been demonstrated that many incest survivors may have specific long term problems. Some long term problems of survivors may include: feelings of powerlessness; sexual dysfunction; low self esteem; depression; menstrual problems and problems with relationships and touching (Lowery 1987, Briere & Runtz 1987, Rew 1989, Felitti 1991, Cahill et al. 1991).

It is unknown whether there is a specific cause and effect between incest and the long term symptoms, or whether the outcomes are the result of a dysfunctional family situation (Felitti 1991). Becoming a parent can cause the incest survivor to recall unresolved feelings and to see themselves as similar to their parents (Bass & Davis 1988).

Some researchers have noted that certain aspects of the incest experience will influence whether long term effects will be present and to what degree. The age incest began, whether there were multiple perpetrators; whether the victim was believed by her mother, and whether intercourse took place were some of the criteria identified by Morrow (1991) that influenced the survivors concept of themselves. Long term effects are also more likely to occur and become chronic without treatment (Lowery 1987).

The possibility that certain life events may trigger symptoms and issues regarding prior abuse has been mentioned by a number of researchers (Lowery 1987, Cahill et al. 1991). Heins et al. (1990) note that transition points in psychosexual development such as the birth of a child are risk periods for survivors of incest and Gelinias (1983) calls these 'developmental triggers'. Whether childbirth is one of the these developmental triggers has not been established, although Kitzinger (1984) maintains that childbirth is a part of a woman's psychosexual experience. The body image changes of pregnancy are among reasons that Grant (1992) uses to show that pregnancy could also be a trigger and Courtois & Riley (1992) believe an abusive memory will be triggered due to the many psychological implications of pregnancy.

Zdanuk et al. (1987) present a case study of an adolescent's pregnancy that is the result of an incestuous relationship but little mention is made of the adolescent's perceptions of her birth experience. A number of sometimes unreferenced, apparently anecdotal papers are also present in the childbirth literature. One case is discussed by Tobert (1990) where a woman who had been raped before her marriage had an 'horrendous' birth experience and had no sexual feeling afterwards.

Childbirth was recognised as being like a repetition of a past abusive experience by some of the survivors interviewed by Kitzinger (1992). Christensen (1992), a survivor of incest, writes of her birth experience as a form of rape and urges care givers to identify whether their clients are survivors of abuse. Grant (1992) believes that inclusion of a history of abuse in a woman's antenatal history is appropriate and Courtois & Riley (1992) believe that such discussion will allow the planning of management strategies. Wescott (1991) suggests discussing the issue in childbirth education classes, however Lowe (1992) and Breitenbucher (1991) emphasise that arbitrarily mentioning this to clients should not be done.

Aside from seeing birth as rape (Christensen 1992, Lipp 1992) other important aspects of the childbirth experience for survivors have been mentioned. These include feelings of distaste and numbness (Lipp 1992), a need for control (Lowe 1992, Wescott 1991, Lipp 1992, Grant 1992), dissociation from the body (Gray 1992, Christensen 1992, Rose 1992), and lack of trust in their own body and in their carers (Wescott 1991, Lowe 1992, Grant 1992, Rose 1992). That memories about incest may be provoked during the childbirth experience is mentioned by Christensen (1992), Courtois & Riley (1992), Lipp (1992) and Rose (1992).

Preliminary results of a pilot study by Van Der Leden & Raskin (1993) indicate that there is a connection between previous childhood sexual abuse and a subsequent pregnancy. They found that 10% of their pregnant population (of 144) were survivors of childhood sexual abuse and that these women had shorter labours than those women with no stated history of abuse. It is suggested that the ability to dissociate from painful experiences was a cause for the shorter labours.

This recent interest in the incest survivor's experience of childbirth indicates that

there is a place for research in this area. That further empirical research about incest is needed is recognised by most researchers, indeed Rew (1989), encourages phenomenological inquiry to increase our knowledge of how incest has influenced survivors' lives.

The purpose of this research is to discover what experiences (including feelings) women who are survivors of incest have during childbirth. The project has relevance to the clinical practice of all midwives by making them more aware that the women to whom they provide care *may* be survivors of incest. The study also highlights the special needs that some women who are survivors of incest may have during childbirth.

The project's two major variables, childbirth experience and incest experience have been defined as the physical and emotional experience of these events as reported by the subject. The following four research sub problems or objectives have also been identified:

1. To learn whether the childbirth experience provokes memories of the incest experience.
2. To determine what aspects of the childbirth experience provoke memories of the incest experience.
3. To establish if remembering the incest experience effects the childbirth experience and if so how.
4. To ascertain personal or practical protective mechanisms that allow some incest survivors to consider their childbirth experience as positive.

METHODS

This exploratory research has been undertaken using a phenomenological

approach. Such an approach involves the use of in-depth interviews focusing on descriptions of the participant's experiences and what those experiences mean to them (Patton 1990). The project consisted of two interviews undertaken with each participant. The interviews were semi-structured, conversation-like and guided by the responses given by each woman. The first interview was 1 - 2 hours in length and the second interview, 4 - 8 weeks later, lasted 30 minutes. All first interviews had been undertaken prior to any second interviews and all interviews were audio taped. All interviews took place in Central Victoria. The participants home was the usual venue for interview although two interviews took place at the local sexual assault centre and one at the local women's health service.

The sample consisted of six adult women, who had had at least one experience of incest and at least one experience of childbirth. No limit was put on when the least recent childbirth experience was because, as shown by Simkin (1991), women's memories of childbirth may be quite vivid for many years.

Approval of this project was obtained from the Human Experimentation and Ethics Committee of the university attended by the author prior to the study's commencement. Issues surrounding confidentiality and consent have taken a high priority during this project. The results have been presented, including the use of pseudonyms, in such a way as to ensure the anonymity of the various participants.

The participants were obtained by networking. One woman was a previous client and the remaining five women were accessed via incest support groups. The potential participants or their support groups were contacted by the researcher and given written information about the project. The women were then invited to

contact the researcher if they were interested in participation.

At the initial interview the purpose of the study, how it was to be conducted, and the possible consequences of participation for the subjects were discussed. It was recognised that this study may trigger distressful memories for the participants and they were informed of a variety of psychological supports available to them if required. Respect by the interviewer of the interviewee's right to withdraw from the study or her refusal to discuss a particular area was emphasised and confidentiality was assured. When the researcher was sure the participant had comprehended this information and any questions had been answered a consent form was signed. This consent form was dated and initialled prior to the second interviews. The use of the tape recorder was also discussed and the participant was given access to turn it off if she desired.

The data collection commenced at the first interview where participants were asked to speak about their childbirth experiences. The interviews were directed toward understanding the participant's perspectives on their experiences as expressed in their own words. The researcher's role was to respond by listening, reflecting and occasionally directing the conversation with a question. A predetermined list of issues to be covered was glanced at occasionally by the researcher during the initial interviews. The sequence and wording of questions were determined at the time of the interviews. The second interview was essentially the same as the first interview except that specific questions were asked regarding the transcript of the first interview.

In an attempt to enhance the quality and credibility of the research the following techniques were used. Firstly, added to the transcriptions of the interviews were field notes on the behaviour of the participant at the time and the possible effects

of the presence of the researcher on the data collected. During the interviews every attempt was made to have the researcher put aside her own knowledge, ideas and experiences so that an understanding of the participants perspective on the issues could be attempted, this technique is called bracketing (Patton 1990). The second interviews allowed validation of the information obtained from the first interviews. A further strategy involved having the co-supervisors of this project review the transcripts and coding.

Data analysis was a continuous process even during the interviews. Each interview tape was transcribed and lines were numbered using a word processor and The Ethnograph (Seidel et al. 1988). Code words were allocated to the various topics addressed by the participants in the conversations. After reflection on the research sub problems and the coded segments of the transcripts, five coding categories were defined. The coded segments were sorted into these related categories. The establishment of categories allowed the organisation of the mass of coded segments represented by code words into manageable groups which could then be related to the research sub problems.

RESULTS

The participants were aged between 27 and 43 years and two were sisters. Two women were separated at the time of the interviews, and four were in stable relationships; two of these women had had many previous relationships.

Three of the participants were abused by their father and three by an older brother. There was more than one perpetrator involved with four of the participants and for one of these women it is apparent that her's was some kind of ritualistic abuse. Two of the perpetrators were medical practitioners. The age that the abuse began was between 0 and 7 years, a majority of participants

believe they were probably babies or toddlers when it began. One participant was raped about nine years prior to this study and one abused alcohol and drugs for many years.

Half of the six participants were unaware of the incest in their lives until after childbirth; they have begun to remember their abuse over the past 9 months to four years prior to the interviews. The way the participants recalled the events vary. For some the memories are predominantly 'feelings', or smells, others have 'flashbacks' and some women have dreams.

A brief summary of the reproductive history of the six participants includes 19 childbirth experiences, all women having had more than one child. The longest period since any of the women had experienced childbirth was 8 years. Seven babies were born at home and 12 in hospital, one was premature. Seven of the labours were described by the women as long, hard, difficult or complicated. All were vaginal births and one was a forceps delivery with epidural, three of the women were told they may need a caesarean section. The descriptions of nine of the deliveries implied that they were very fast. At the time of the study, the ages of the participant's children ranged from 21 years to 6 months. Two participants had had pregnancies terminated and three women had experienced more than one miscarriage. One woman also had secondary infertility treated for eight years before she conceived again, naturally.

Interviews with the participants yielded over 260 pages of transcripts. From the transcripts approximately sixty code words were determined, each representing segments of the text. These segments were seen by the researcher to be related to the particular theme represented by that code word. Five categories were used to organise the code words, these are described in Table One and

illustrated in Table Two. Allocation of code words to the first three categories was not always clear cut, at times it appeared that a code could fit into more than one category. For example the code word 'touch' included segments where touch provoked a relationship between the two events (category one) but also included segments where rejection of touch was provoked *by* the relationship of the two events (category two). This problem was overcome by continually referring back to the original segments of transcript. It was recognised that more specific coding would have avoided this difficulty at the outset.

The participants' experiences as expressed in their own words are the essence of this research and the following section of the report attempts to capture this for the reader. These excerpts are used to consider the four objectives of the project, presented below. Following each segment is the participant's pseudonym, the number 1 or 2 representing whether it is from the first or second interview, numbers representing the lines of the transcript from which the excerpt is taken, and then the code words for that particular segment or part of the segment.

The first objective is to learn whether childbirth provokes memories of the incest experience. That it does provoke memories is illustrated by Kate, who is reminded of a feeling of vulnerability:

One thing I did not like when I was in labour, was everybody coming in ... doing internals ... I felt quite vulnerable and that took me back to the way I felt when I was a child.

(Kate1; 14 - 25; birth, control, privacy, feelings, security, touch, memory, midwife/nurse/dr)

Ruth also spoke about how she is reminded of her past abuse:

If something happens without me realising it's going to happen and it touches a part of the me that has a memory, which is often genitals or breasts then that's going to give me a fright, and without consent, just, lots of things that I don't even recognise can just spin me backwards.

(Ruth2; 347 - 357; control, fear, knowledge, touch, body image, memory)

For some women a specific memory is not provoked but the similarity of the two events causes a response used in the past, during the abuse, such as dissociation or 'shutting down':

It's sort of like, when you're being raped and bashed you've got no control over what's happening and its the same with giving birth, you can't really control it, the contractions keep coming, you haven't got a choice, and because the pain is so painful, it might not be on everybody but, I found it very painful, so it was like it was better, the only way I could control the pain was by shutting down.

(Alison1, 236 - 247; control, birth, rape, pain, turn off)

It is possible that the likelihood of more conscious memories being provoked is related to whether the memories of the abuse are present. The three women who knew of their incestuous experiences did have more specific memories or feelings related to the abuse during their childbirth experiences.

Robyn had no memory of the sexual abuse at the time of childbirth but she was aware of a fear she had of the placenta or cord being pulled or moved:

With all the births the part I hated the most was the placenta, I wouldn't deliver that on my own.

(Robyn1; 1035 - 1038; birth, privacy, control, feelings)

At her first interview Robyn could not define why she was so sensitive about the

placenta, but at her second interview she explained:

A few days later [after the first interview] ... all these flashbacks came and it sort of made it clear ... why the placenta really worried me, and I think it goes back to this ... abuse ... I had a child and it was dragged and pulled out of me and I was only ... 14 or something myself and it was just this pulling and ... bits that I could remember was just this constant screaming and someone just pulling, just pulling and I was thinking that's probably why the placenta was such a scary thing.

(Robyn2; 447 - 464; birth, memory, incest, fear)

The second objective, to determine what aspects of the childbirth experience provoke what memories of the incest experience is obviously a very individualised response and not something that the women could necessarily determine prior to the event. Indeed, even if something had been provoked once it may not necessarily happen in a subsequent childbirth, or it may happen again despite the woman not expecting it to recur:

I was really surprised, I mean I didn't think I would react in that way, the same thing happened when I had the second baby, I mean, that was just an automatic reaction to her and they tried to put her on the breast and I just pushed her away.

(Alison1; 460 - 466; bonding, knowledge, midwife/nurse/dr, touch)

Certainly the participants viewed touching in various ways, by various people and in various areas of the body as related to the incest experience. For some participants touching *provoked* the recall of a memory of abuse, whereas for others touching or rejection of touch was *part* of the response to some other, possibly unknown, trigger.

Touch was not liked by Alison, however it appears to be lack of control which relates the event to her past:

With the people touching me when I was having the baby, that left me at a vulnerability stage ... being in all that pain and not being able to control the pain and being at the mercy of every body else ... I didn't like them touching me.

(Alison1; 1280 - 1289; security, birth, pain, control, midwife/nurse/dr, touch)

Lisa tensed up her vagina when she had vaginal examinations and she would not allow her doctor to suture the tear she had:

He couldn't sew [the tear] ... I only wanted him to do what he had to do, deliver the baby and leave me alone, I didn't want him to look at me or touch me or have anything to do with my vagina, that part of me ... I didn't let them examine me or anything ... I didn't want anybody down there.

(Lisa2; 95 - 129; midwife/nurse/dr, pregnancy, self concept, touch, perineum)

Alison could not touch her babies until some time after their birth:

After having both [babies] I didn't want them near me ... I had beautiful babies it's just I didn't want them near my breast, or near my body ... it was later [that I wanted them], when I was back at the ward and I'd had a shower and that and it was all sort of the mother stage

(Alison2; 186 - 202; bonding, touch, expectations)

However for Kate, the touch of her baby immediately after delivery was very positive:

The first thing I felt when they put him on my stomach, I thought to myself,

I feel clean, you know like all that bad stuff was washed away.

(Kate1; 1016 - 1020; birth, midwife/nurse/dr, memory, clean/dirty, feelings, touch, incest, bonding)

Privacy or lack of privacy seemed to work in a similar way to that of touch.

I think that [my husband's] presence was good ... but I didn't really even want him there either, I didn't want anybody there, but I did notice when he did go out it was harder for me to concentrate ... but I didn't want any touching from him or anything either ... after the baby was born ... well it was nighttime and they took the baby away ... they wanted to top him up and they wanted to do lots of things that I didn't want, he became a part of my privacy in a way, I didn't want them doing anything to him either ... I ended up leaving the hospital after about three days because they were interfering too much with him and I wasn't allowed to say over what I wanted.

(Robyn1; 135 - 162; privacy, protection, touch, bonding, separation, midwife/nurse/dr, control, breastfeed, support, birth)

Robyn further explained why privacy was important to her. Privacy allows control and concentration, Robyn's need for privacy during birth was related to the abuse:

I think that's very much tied up with the abuse because privacy to me is where I'm in control of myself and I'm safe and I don't have to concentrate on other people and what they are doing.

(Robyn2; 347 - 353; birth, privacy, control, security, incest)

Pain was another response which may cause a memory, as for Alison, however more often any memory was bypassed and a response to pain used in the past

was automatically used again:

I was able to repress how I felt and act like [my father] wanted me to feel ... its really difficult to know just how much effect that had ... I think I certainly learnt tricks of disassociating myself from pain and feelings of discomfort. (Susan1; 211 - 218; pain, feelings, turn off, control, father, knowledge)

Its just something I have learnt as a child, to really be very good at dissociating and I've always been, like even the dentist can do anything to my teeth but I can cut myself off from pain and I used the same technique in my childbirth ... I've known I've been able to do it and that's why I thought I can do it with this birth.

(Robyn1; 245 - 261; turn off, pain, birth, knowledge, protection, incest)

Dissociation provided one way for some participants to have some control over what was happening to them. Susan felt her births were 'easy' and that dissociation helped:

I think I always would have given birth fairly easily, but I think that being able to dissociate ... and to have sort of accepted interference as a matter of course might have meant that in some ways it was less traumatic.

(Susan1; 765 - 771; birth, control, turn off, incest)

Many of the excerpts shown above illustrate how control or its absence was an important issue for all participants although not something that necessarily provokes direct memories of the abusive experience. Kate related the following experience back to her childhood:

The doctor ... he came across as very cold and I didn't like that and it made me feel uncomfortable, when he was sewing me up, just because I

happened to move my legs, I had cramps, he told me off, because I was up in those stirrups, but the epidural had given me cramps in the legs, and just because I'd moved he told me off sort of told me to stay still and I mean that felt horrible.

(Kate1; 641 - 653; birth, midwife/nurse/dr, understanding, feelings, control, privacy)

Pethidine use was often seen as negative because of the lack of control it provoked:

I was ... on pethidine that made it very hard being on pethidine ... made it very hard for me to do anything about anything you know ... both [physically and emotionally] ... I couldn't stand up for myself I couldn't physically get up and do anything anyway and ... I couldn't separate [dissociate] myself properly either.

(Ruth1; 617 - 627; pethidine etc, turn off, control, birth)

I can remember I didn't like [the pethidine] and like it's possible that drugs were used on me as a child so ... it mucked up my feeling of control.

(Susan1; 498 - 502; drugs, control, feelings, pethidine etc, birth)

The gender of the baby also provoked responses such as fear, although not specific memories:

They said it's a girl and that was the first time I felt, I felt something so different, I felt very scared and I said oh no, no, that's all I said, and they all looked at me, they knew I had ... boys so they couldn't understand me I suppose, my husband couldn't understand me, but now I look back I was scared.

(Lisa1; 1361 - 1370; midwife/nurse/dr, fear, bonding, gender,

understanding, feelings)

I think I felt fearful that she was a girl and I didn't know why, I felt touching her was a lot easier, I tended to cuddle her a lot more, I didn't have that barrier that I had with the boys.

(Robyn1; 1133 - 1138; touch, fear, knowledge, feelings, gender)

Lack of trust in herself and in her carers and lack of knowledge about events are two other issues recognised by some women as being related to both events but again their presence did not appear to provoke memories. Ruth talks about why she chose the attendants at her birth:

It's being safe, ... I made the choice and I knew who was going to be [at the birth] and I knew those people and so I'm never going to feel like I'm on display.

(Ruth2; 295 - 304; midwife/nurse/dr, responsibility, trust, knowledge, privacy, security)

Lisa believes, coming from an incestuous family situation, her knowledge was restricted:

I remembered that I'm a survivor of [my father's] abuse, and it all fell into pattern, out of that now 9 months later I know why I couldn't tell my children that I loved them, I know why my mother couldn't teach me anything about sex, I know why I got pregnant because they wouldn't teach me about contraception, they didn't tell me how to have a baby, they told me the afterbirth is the worst, they didn't tell me about contractions, they didn't tell me about breastfeeding, about the cord, about circumcision, I was so confused with circumcision, they didn't tell me about washing little boys, I only learnt today that you've got to look after

little boys as well, not push the foreskin back yet but you still got to clean them ... nobody ever helped me when I was crying, alone, with these little babies, I'm lucky they survived.

(Lisa1; 1591 - 1614; pregnancy, birth, support, feelings, stress, breastfeed, knowledge, incest, memory)

The third objective of this project is to establish if remembering the incest experience effects the childbirth experience and if so how. As determined above there are aspects of both experiences that provoke a variety of responses which effected each individual's childbirth experience to some extent. Generally these effects were subtle and more subjective for the woman such as the feelings she had about the event. Responses such as dissociation, rejection of touch, stress, fear, guilt and feeling sick may not be obvious to the care giver or may be misinterpreted. For example, Alison did not want to be touched, when she was touched she felt like being sick:

I couldn't stand people, when I was in labour, trying to make me feel better by rubbing my back, that makes me feel like I want to spew up, no I don't like anybody really touching me ... or trying to say this is going to be alright or make you feel better, no I can't stand that just didn't like it at all ... I didn't even want my husband in the room really, I did but I didn't, he went and sat in a corner somewhere [laugh], I told him to go sit in a corner.

(Alison1, 845 - 868; touch, midwife/nurse/dr, birth, support, feelings, sick, control)

However some effects were more objective though possibly just as easily misinterpreted. Tensing of the vagina so that examinations or suturing is difficult is an objective effect, this is what Lisa did in response to being touched in this

area. Ruth explains below how she dissociated in response to a touch which may be 'dirty':

Well for me what happened in incest was that I learnt to separate myself from my body to a certain extent ... whether that means that you're somewhere else or you actually somehow become incredibly objective ... when the [touching] started all of a sudden I was on display ... and I was totally separate and felt like it was a stage act and I was waiting to perform and all I felt was this pressure to perform and felt this sort of sick feeling that would have been attached to the incest like a memory somewhere so ... most of the problems came from the separateness, trying to maintain that, so that I wouldn't get caught with anything that was dirty [laugh].

(Ruth1; 422 - 442; turn off, body image, touch, birth, memory, privacy, feelings, sick, control, clean/dirty)

The 'problems' she spoke of were having and maintaining contractions. The concentration involved in dissociation or 'separateness' caused her contractions to temporarily cease, a more objective effect which was observed by her birth attendants. Alison also described an objective effect which dissociation had on her first labour:

I heard the doctor say 'we've got to get the baby out, no matter what, we've got to get the baby out' ... [my husband] was really worried about me at that time ... the doctor said 'we can't get her to come round at the moment we've got to get the baby out' that was more their concern and anyway I heard them say 'the baby's heartbeat is slowing right down', and it was when they said that suddenly something just clicked and I sort of come into my head and I thought of the baby ... I was killing my own baby,

and that was when I started to come round again and the baby's heart beat picked up and I decided I was going to go through with it 'til the end, because that baby was important, that baby should get out in that world ... it was like will power, I will power myself to turn off ... when you set your mind to it ... I'd never really done that before ... I have sort of left my body in times of really bad situations like rape and stuff but with this it was sort of like, I was controlling my whole body, controlling my heart, my mind, the way I was thinking, everything, I'd just made my mind up, that was it, I was going, I wasn't going through with any more, the pain was [un]bearable, it was better to die so I just shut down all mechanisms of the body.

(Alison1; 188 - 229; midwife/nurse/dr, responsibility, control, bonding, rape, pain, turn off, birth)

This experience frightened Alison so that with her second labour, although she used dissociation to help the pain to a certain extent, she did not 'shut down' so thoroughly:

I didn't shut down this time, because I realised just how dangerous it was and I just kept pushing, the pain was worse with [my second labour] than it was with [my first].

(Alison1; 693 - 697; pain, turn off, birth)

As mentioned earlier, the descriptions of nine of the deliveries implied that they were very fast. It is possible that the length of these labours was influenced by the participant's ability to dissociate:

Well, yeh [I had about 40 minutes of contractions] that I was aware of ... I may have been [in labour earlier], like when I said to [my husband] 'I think I'm in labour' I probably was in labour but it's just that I really did cut myself so much off from what my body was doing it was like me saying to

my body 'right take over, do what you have to do, I won't be there but just do what you have to do' and then when it really started working hard I had to sort of think oh yeh I better slow down now and concentrate on what's going on.

(Robyn1; 633 - 646; turn off, control, birth)

Having such apparently short labours is an objective effect as is whether or not there are birth attendants present. Robyn's need for privacy or isolation was so strong that with her fourth and fifth labours she was able to manipulate events so that her midwife and doctor did not arrive until after the delivery of these babies:

I knew I had to work this out so that they wouldn't be there when the baby was born [laugh], it wasn't even as conscious, my last one was even more conscious, it was like I planned it I don't know how you can plan these things but it was like you do.

(Robyn1; 976 - 983; birth, knowledge, midwife/nurse/dr, control)

The final objective of this project is to discover if there are any protective mechanisms that allow some incest survivors to consider their childbirth experiences as positive. The process of dissociation, although negative for some women and seen as related to the incest by others, made childbirth a positive and controlled experience for two participants. These two women, Robyn and Susan, had no memories of the incest at the time of childbirth and this is possibly the reason for the positive response to dissociation.

It appears that the more a woman's needs are met, the more positive experience of childbirth she may have. Needs identified in this study include an increase in knowledge, privacy, and trust.

I still didn't like having, I suppose a lot of women don't like having to

spread their legs in front of strangers, because I mean every time you go up to the hospital you got someone different it's not like you have the one person, I didn't sort of worry about it when I was in labour, because they didn't sort of run in every second fidgeting round they sort of left me a bit which I liked.

(Kate1: 597 - 608 midwife/nurse/dr, birth, privacy)

Continuity of care was a need identified by Kate, a midwife's clinic seemed to fulfil that need:

When I started going [to the midwife's clinic] I felt more comfortable, because I saw the one sister all the time ... she was really nice and supportive ... it wasn't just sort of medical [laugh].

(Kate2; 243 - 259; support, midwife/nurse/dr, comfortable, pregnancy)

Security is important and Robyn chose isolation to attain this:

My isolated situation in which I was living was protecting myself from the outside world because I knew that I could cope in a situation where I'm isolated because I've only got me to deal with then and I could sort of hide, I could go bush, I could do what I had to within my own isolation.

(Robyn1; 908 - 916; knowledge, protection, isolation)

More than a third of the participant's births were at home reflecting their needs for security and privacy. One woman needed to be separated initially from her baby whereas others deeply required closeness to their infants. However the one need which seems to underlie all other apparent needs is that of control, whether control of what the woman herself does or what is done to her by others.

Robyn used dissociation to stay in control and interference from the midwives made her loose concentration and then control:

I had cut myself off from the whole process of birth and in a way I just let my body take over and the baby was just born, I can't remember any - feeling discomfort maybe - but no pain that I could say, I was really annoyed because they were saying 'oh you're slowing up the baby's birth because your bladder is full' and in the end they started putting stuff up to try and empty the bladder and that really annoyed me because it stopped my concentration on what was happening with the birth and that would be the time that I lost control of my own body.

(Robyn1, 87 - 102; birth, pain, control, midwife/nurse/dr, turn off)

Control over her emotions was important for Susan and dissociation helped:

It meant that I had more control over myself ... I would have felt I'd failed if I'd got upset which now it seems a really silly thing, but if I'd cried I would have felt that I had failed in some way, which is interesting relating it to the abuse.

(Susan1; 636 - 643; birth, turn off, control, upset, feelings, sound, incest, good girl)

Ruth recognised control as a major issue for her:

I have an overwhelming need to control ... myself ... I don't drink alcohol for that reason ... because I don't like losing control, I don't smoke dope any more because I don't like losing control and I'm scared of drugs in childbirth because of that same reason, that I lose control ... in some ways I'm scared of pain because of the same reason ... control is a really huge issue, that I be able to control what's happening and so one of the lessons from [my second daughter's] birth ... was that I could still let go and have control, which I hadn't known I could do, ... screaming isn't being weak.

(Ruth1; 1158 - 1177; control, birth, alcohol, drugs, pethidine etc, pain, birth, turn off, sound)

DISCUSSION

A number of limitations have been recognised, restricting the ability to generalise this work. The study is retrospective in nature and some of the participants recognised that they noticed more things retrospectively than they did during the childbirth event. Several of the births discussed were many years ago, one as long ago as 21 years, so it was necessary for the researcher to assume that the participants would accurately and honestly recall their experiences and feelings. Tape recording interviews on such a sensitive subject *may* have inhibited some responses the participants made. Another possibility is that this researcher's perspective as a midwife in private practice and a feminist may have influenced the results in some way. It should be noted that of 19 childbirth experiences, seven babies were born at home, although only one of these was to a participant who was a previous client of the researcher.

This paper is primarily about the labour and birth experiences of women who are survivors, therefore it focuses on that aspect of the childbirth experience. However, it is recognised that the participants saw their childbirth experiences as more than merely the labour and birth. Indeed, the data available from this study includes valuable information about other parts of the childbirth experience such as bonding, breastfeeding, parenting, and relationships with health professionals. It is intended that these issues will be covered in future papers.

The results of this research do indicate that the childbirth experience can provoke memories of the incest experience, although the memories may be vague. This is supported by Courtois & Riley (1992), who specifically state that

childbirth can trigger memories of abuse. All papers addressing survivor's birth experiences acknowledge that a connection between the two events does occur (Christensen 1992, Grant 1992, Kitzinger 1992, Lipp 1992, Lowe 1992, Wescott 1991, Breitenbucher 1991). However, Lowe (1992) speaks of a number of 'uneventful' births which survivors had prior to their memory return. It is not clear whether these survivors can now see, retrospectively, a connection between the two events. The majority of births that the survivors in this study had could be called 'uneventful' whether or not the participants had remembered their abuse at the time. Lipp (1992) also describes the birth experience of one woman which caused her existing memories to recede.

Which aspects of the childbirth experience actually provoke memories of the incest experience are more difficult to determine due to the individuality of each woman's experience. The findings indicate that privacy and touch are important to the participants; Grant (1992), too, has noted that touch may be 'unnerving' for some women. Furthermore, pain may provoke a memory, or it can automatically cause a response. Gray (1992) and Rose (1992) also describe this experience, while Christensen (1992) believes that the vaginal and rectal trauma she sustained provoked memories of her abuse. Additionally, the importance of control has been illustrated in the results. Kitzinger (1992) implies that the lack of control that some women may experience during childbirth may cause them to view childbirth as an abusive experience. Although there is no evidence that any of the participants in this study were so strongly effected by their lack of control, it certainly appeared to cause them to view some of their experiences in a negative way.

It is apparent from the results that remembering the incest experience does effect the childbirth experience. However, it seems that the effect is more likely to

be a subjective one rather than an objective one. Van der Leden & Raskin's (1993) quantitative study has shown one objective outcome for the survivors of sexual abuse, namely decreasing the length of their labours. The authors of this paper posit that dissociation is the reason for these shorter labours but they present no evidence to support this theory. The experience of dissociation for at least one of the participants in this research would, nevertheless, appear to support this theory.

Grant (1992) notes that the trance-like state that a woman may be in when she has dissociated may be misinterpreted as an hysterical behaviour or psychiatric illness. In this study, although the care givers may have been somewhat puzzled by the behaviour of a woman who is dissociating, it does not appear that anyone saw it as a psychiatric problem. Christensen (1992) and Rose (1992) show that past abuse can effect the childbirth experience, while Lowe (1992) demonstrates that it will not necessarily effect the experience. It is apparent from this research that it is very likely there will be some effect on the subjective experience of birth but that there may be little or no effect on the actual *process* of birth, that is, the objective experience.

In identifying the varying needs necessary for the survivors to experience a positive birth experience, such as trust, continuity of care, privacy, security and knowledge, it has become clear from the results that control is the predominant need of all the participants. Control, trust and security are also mentioned as important issues for survivors by Grant (1992), Wescott (1991), Lowe (1992) and Lipp (1992). Rose (1992) and Courtois & Riley (1992) discuss the value of providing a verbal assurance of safety and encouragement to stay in the present rather than dissociate. The need for individualised care is emphasised by Lowe (1992) and is supported by these research results.

This study indicates that the childbirth experience for a survivor of incest is a complex and individual one. There is by no means a simple cause and effect relationship between a memory of the initial incestuous events and its effects on childbirth. Nevertheless, memories in a variety of forms are sometimes provoked at differing times during the childbirth experience and the effects on the woman are diverse.

The variety of women's needs demonstrated in this project emphasises the importance of individualised care by midwives and doctors involved in the care of child bearing women. As care givers will not necessarily know if a woman is a survivor of incest (indeed the woman herself may not know) it seems appropriate that care to ALL child bearing women should be given in as individualised manner as possible with special regard to maintaining the woman's integrity. Such care includes asking permission from a woman before touching her or her baby; respecting and protecting that woman's privacy; and enabling her to participate in making decisions about her care.

Although quantitative research in this area to determine the incidence and type of difficulties encountered by survivors during labour would be beneficial, it will be difficult to achieve. The area is a sensitive one and many survivors have little or no memory of incest for much of their life. Further phenomenological studies about childbirth must be undertaken to increase the body of knowledge about incest survivors' experiences. Qualitative research in this area is important in validating women's experiences of childbirth and in understanding the relationships between past and present events in women's lives and the effects on their childbirth experiences. As control has been identified as an important issue for survivors, further research in this area, perhaps in combination with investigation into dissociation and the touching and privacy aspects of childbirth

would be most valuable.

Figure One: Model of Framework



Table One: Description of categories:

Category One:	Aspects of the childbirth experience which are related to aspects of the abuse - codes which occurred when there was a relationship between the two events discussed.
Category Two:	Consequences or reactions to the childbirth experience when it is related to the abusive experience, this includes protective mechanisms used at this time.
Category Three:	Needs recognised - mechanisms which would or did allow a positive experience to occur.
Category Four:	Incest experience.
Category Five:	Childbirth experience.

Table Two: The five categories of code words representing segments of text referring to these themes.

CATEGORY 1	CATEGORY 2	CATEGORY 3	CATEGORY 4	CATEGORY 5
< control	alcohol	comfortable	believed	abortion
<knowledge	body image	>control	catholicism	birth
pain	depression	>knowledge	clean/dirty	bonding
<privacy	drugs	listening	counselling	breastfeeding
touch	fear	protection	dreams	complications
< trust	feelings	>privacy	family	expectations
	gender	responsibility	father	midwife/nurse/dr
	guilt	security	good girl	perineum
	isolation	separation / or not	incest	pethidine etc
	mothering	> trust	memory	pregnancy
	panic attack	understanding	permission	preparation
	self concept		rape	support
	sick		release	
	sound		secrecy	
	stress		sexuality	
	touch (rejection of)		shocked	
	turn off (dissociation)		sister	
			violence	

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