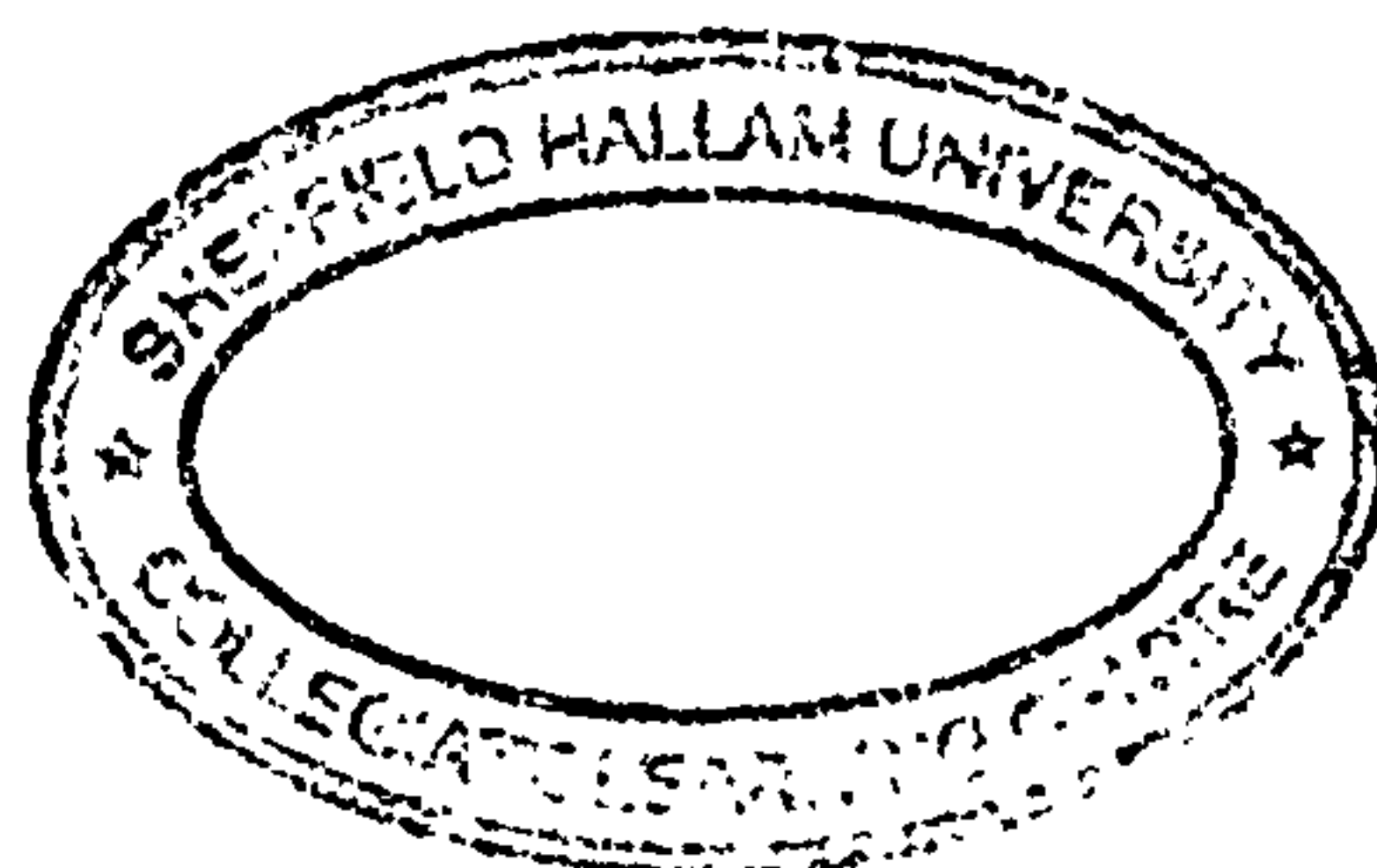


The childbearing experiences of survivors of childhood sexual abuse

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Abstract

This project was initiated by Maggie Smith, whose interest in the topic arose as a result of her experiences as a practising midwife. It seeks to gain understanding into the problems and difficulties encountered by childbearing women who have a history of childhood sexual abuse (CSA). It consists of twenty in-depth interviews with mothers with such a history, half of whom were also midwives at the time of their interview. Recruitment was in two phases: the first consisted of women who were contacted via survivors' support groups; the second, of midwives recruited via the letters pages in midwifery journals.

The exact extent of childhood sexual abuse is unknown, but some authorities suggest that as many as half of all women will experience some kind of sexual abuse in their lives (Kelly 1988). The shame and secrecy which surrounds CSA means that, inevitably, it is under-reported and consequently many maternity workers will inadvertently come into contact with survivors during their working lives. The aim of this study was to gain an insight into the lived experiences of survivors of sexual abuse during pregnancy, birth and early parenting, in order to inform those working in the maternity services, to enable them to provide appropriate, research-based care for these women.

The project was undertaken from a feminist standpoint in that it was conducted through the promotion of a non-hierarchical reciprocal relationship between the respondents and myself. Data was analysed using grounded theory techniques coupled with the voice-centred relational approach propounded by Mauthner and Doucet (1998).

The findings suggest that there are direct parallels between the dehumanising effects of sexual abuse and the experience of giving birth within a medically dominated organisation driven by its own needs for efficiency, calculability and predictability. The interviewees appeared to have realistic expectations of the physical sensations of labour but were unprepared for uncaring and impersonal encounters with maternity staff. Re-traumatisation was more often than not associated with a routine-focussed approach by caregivers and failures in communication resulting in the women experiencing powerlessness, betrayal and humiliation. Good relationships with carers, in which the women perceived themselves to be valued and respected as individuals appeared to have a protective effect.

The data also suggests that there is no 'standard' approach to providing care for survivors of CSA, but that it is incumbent on practitioners to collaborate with each individual in order to discover how best to care for her.

Dedication

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

Acknowledgements

I would like to thank all the women who participated in this project for their generosity in sharing their, often very painful, stories with me. Their courage has been an inspiration to me.

I am sincerely grateful to my supervisor, Professor Mavis Kirkham, whose guidance, encouragement and understanding have been truly enabling.

I would also like to thank Dr Nadine Edwards for her advice and suggestions on the first draft, and Stuart Chesters for his help with the intricacies of word processing.

Finally, my eternal thanks go to my husband, Fred, who has always supported, encouraged and loved me. I could not have done it without him.

Table of Contents

Introduction	1
Chapter 1: How the meaning of birth and status of childbearing women have changed	4
1.1 Introduction	4
1.2 The struggle to control birth	4
1.2.1 Scientification	7
1.2.2 Institutionalisation	8
1.2.3 Industrialisation	9
1.2.4 Risk	11
1.3 Choice and control – the rhetoric	12
1.3.1 The statutory duty of midwives – the impact on choice	14
1.3.2 The Illusion of choice	14
1.4 Summary	16
1.5 A personal reflection on a recent episode of maternity care	16
1.5.1 The story ...	17
Chapter 2: The needs of birthing women	21
2.1 Introduction	21
2.2 What are the needs of birthing women?	21
2.2.1 Caring and understanding	22
2.2.2 Security and trust	23
2.2.3 Control of self and circumstances	24
2.3. The concept of ‘mastery’ and its relationship to control	27
2.4 The link between carers and control	30
2.5 What constitutes control?	31
2.6 Loss of control – the impact on childbearing women	32
2.7 Post traumatic stress disorder	33
2.8 Traumatic childbirth	33

2.8.1	What causes birth trauma?	35
2.8.2	Why do women perceive birth as traumatic and how does it affect them?	37
2.8.3	Birth trauma and the betrayal of trust	39
2.8.4	Birth trauma and sexual violence	41
2.8.5	Birth trauma and sexual dysfunction	41
2.8.6	Birth trauma and its impact on the mother/baby dyad	42
2.8.7	Birth trauma and its impact on subsequent pregnancies	44
2.9	Summary	45
 Chapter 3: Literature review		48
3.1	Introduction	48
3.2	What is childhood sexual abuse?	48
3.2.1	Prevalence	51
3.3	The potential sequelae of CSA	52
3.3.1	Betrayal	53
3.3.2	Stigmatisation	53
3.3.3	Powerlessness	53
3.3.4	Traumatic sexualisation	53
3.4	The far-reaching impact of CSA	54
3.4.1	Issues survivors bring with them to pregnancy	55
3.5	The impact of CSA on childbirth	55
3.5.1	The body is the battlefield	56
3.5.2	Barriers to becoming pregnant	57
3.6	Survivors, childbirth and control	58
3.6.1	Loss of control over the body	60
3.6.2	The significance of touch	61
3.6.3	'It felt like rape'	64
3.6.4	Pain in labour	66
3.7	Dissociation	67
3.7.1	The impact of dissociation on labour	68
3.8	Postnatal issues	69

3.8.1	Relationship with baby	69
3.8.2	Breastfeeding	70
3.9	Lack of professional understanding	71
3.10	The impact of caregivers	72
3.10.1	Trust and betrayal	73
3.10.2	Emotional warmth	74
3.10.3	Being listened to	75
3.11	Summary	76
 Chapter 4: Methodology		79
4.1	Introduction	79
4.2	The rationale for the project	79
4.2.1	Aims of the study	80
4.3	Maggie and I	80
4.3.1	Maggie's motivation	80
4.3.2	Taking the baton – my influence	81
4.4	Another culture, another world: how are the mighty fallen!	82
4.4.1	Surveillance and discipline	83
4.4.2	'Normal' birth	83
4.4.3	Hegemony and hierarchy	84
4.4.4	Bullying into submission	85
4.4.5	Rehabilitation	85
4.5	My philosophy of midwifery	86
4.5.1	From technomedicine to holism – my place on the continuum	86
4.6	My philosophy in research	88
4.6.1	From positivism to postmodernism – my place on the continuum	88
4.7	Hearing the women	91
4.7.1	'Life' stories	91
4.7.2	From 'life' stories to birth stories	93
4.7.3	'Official' stories	94
4.8	Grounded Theory	95

4.9	A feminist standpoint	96
4.9.1	A partnership of equals	98
4.9.2	Understanding, not proof	99
4.10	Common ground	100
4.10.1	Invisible women	100
4.10.2	Loss of innocence	102
4.11	Summary	103
 Chapter 5: Method		105
5.1	Introduction	105
5.2	Ethical issues	105
5.2.1	Ethics clearance	105
5.2.2	Clinical supervision	106
5.2.3	Consent and confidentiality	106
5.2.4	Power, exploitation and abuse	106
5.3	Recruitment	108
5.4	The interviews	109
5.4.1	Location	109
5.4.2	The importance of time	110
5.4.3	Structure – avoiding the clinical ‘gaze’	111
5.4.4	Soft focus	111
5.5	How the interviewees responded	113
5.5.1	Telling stories	113
5.5.2	‘Blanking out’	114
5.6	The transcripts	114
5.6.1	Translation from the spoken to the written word	114
5.6.2	Field notes and additional information	116
5.6.3	The women’s reaction to their transcripts	117
5.6.4	Through the eyes of the beholder	118
5.7	The impact of the research on me	119
5.8	Myself in the research	121
5.8.1	My background	121

5.8.2	From midwifery to research	122
5.8.3	Positioning	123
5.9	Handling the data	125
5.9.1	Using Grounded Theory	125
5.9.2	The 'voice-centred relational method'	126
5.10	Summary	129
 Details of interviewees		 130
 Chapter 6: The sequelae of CSA in the lives of these women		 138
6.1	Introduction	138
6.2	The far-reaching effects of CSA	138
6.2.1	Trauma and memory	140
6.2.2	Amnesia and the recovery of 'lost' memories	141
6.2.3	Intrusive re-experiencing of traumatic memories	143
6.2.4	'Predictable' triggers	145
6.2.5	The media	147
6.3	The uniqueness of trauma resulting from CSA	149
6.4	Betrayal	150
6.4.1	Tacitly collusive other carers	152
6.4.2	Betrayal by those in authority	153
6.4.3	Abusive mothers	155
6.5	Stigmatisation	156
6.5.1	Poor self image/esteem	158
6.5.2	Dirty bodies	160
6.6	Traumatic sexualisation	161
6.7	Powerlessness	164
6.7.1	Compliance and silence	164
6.7.2	Disclosure did not mean empowerment	167
6.8	Vulnerability – the end result	168

6.8.1	Vulnerability and everyday life	169
6.8.1.1	<i>Sleep</i>	169
6.8.1.2	<i>Other aspects of daily life</i>	170
6.8.2	Vulnerability and authority	171
6.9	Summary	177
 Chapter 7: The women's experiences of childbearing		179
7.1	Introduction	179
7.2	How the women approached pregnancy	179
7.3	The impact of maternity care on the women	181
7.4	Powerlessness	185
7.4.1	Absent mothers	185
7.4.2	Mothers absenting themselves	188
7.4.3	Absent fathers	189
7.4.4	Vaginal examinations and intimate procedures	190
7.4.5	Controlling pain: controlling women?	194
7.5	Betrayal	197
7.6	Humiliation	202
7.7	The ongoing impact	207
7.8	What did the women want?	208
7.8.1	Female carers	208
7.8.2	Relational care	209
7.8.3	Continuity	210
7.8.4	Good communication and the offering of genuine choice	213
7.9	Good experiences	215
7.9.1	Carers who got into the boat	215
7.9.2	Intimate procedures: it's not what you do, it's the way that you do it!	217
7.10	Home birth – a different world	219
7.10.1	Why home birth?	219
7.10.2	The women's perception of home birth	221
7.11	Summary	224

Chapter 8:	How did a history of CSA impact on the practice of the midwives?	226
8.1	Introduction	226
8.2	Awareness of the potential for abuse in maternity care	226
8.3	Using their experiences positively	227
8.4	What did the midwife survivors consider to be good practice?	228
8.4.1	Offering choice and control	228
8.4.2	Good communication	231
8.4.3	Treating women as individuals	232
8.4.4	Continuity of carer	234
8.4.5	Advocating/Protecting	235
8.5	The pressure to conform	237
8.6	Care which respects all women	239
8.7	Summary	240
Chapter 9:	Dissociation	241
9.1	Introduction	241
9.2	Types of dissociation	242
9.2.1	Detachment and emotional numbing	243
9.3	Normal life events and dissociation	244
9.4	What caused the women to dissociate?	245
9.4.1	Coping with the inescapable	247
9.5	Dissociation during the birth process	249
9.6	Which women were most likely to dissociate?	250
9.7	Dissociation and home birth	251
9.8	Where the power lies	252
9.8.1	An avoidance strategy	253
9.9	Control and labour styles	253
9.10	'Professional dissociation'	254
9.10.1	'Professionalism'	254
9.10.2	Avoiding personal conflict	257

9.10.3	Focus on routine and ritual	257
9.10.4	Focus on risk	258
9.10.5	'Professional' detachment and emotional numbing	259
9.11	Summary	261

Chapter 10: What is problematic about institutional birth? 262

10.1	Introduction	262
10.2	The limitations of the study	264
10.3	A retrospective	264
10.4	'How did the devil come? When first attack?'	266
10.5	The disempowerment of midwives	267
10.5.1	The medicalisation of birth	267
10.5.2	The demands of the organisation	269
10.5.3	'Continuous midwife monitoring'	271
10.6	Risk – woman and midwife management	273
10.7	The separation of midwives and women	276
10.7.1	The assembly line	276
10.7.2	The professionalisation of midwifery	278
10.7.3	The straight-jacket of time constraints	280
10.8	The disempowerment of women	283
10.8.1	Separation from social context	283
10.8.2	Negation of women's knowledge	284
10.8.3	Medically controlled birth	287
10.8.4	Depersonalisation	289
10.9	Institutionalised childbirth and sexual abuse	290
10.10	Everywoman	292
10.11	What are the alternatives?	292
10.11.1	Home birth	293
10.11.2	Midwife-led units and free-standing birth centres	294
10.11.3	Case load, or one-to-one midwifery	296
10.11.4	Alternatives, but not available to all women	298
10.11.5	Independent midwifery	299

10.12	Summary	300
Chapter 11:	Conclusions and recommendations	302
11.1	Introduction	302
11.2	Conclusions	302
11.3	Dissemination of findings	304
11.4	Further research	305
11.5	Recommendations	305
11.5.1	Free-standing birth centres and midwife-led units	306
11.5.2	Caseload midwifery	306
11.5.3	Home birth	307
11.5.4	A midwifery definition of professionalism	307
11.5.5	Staff training, support and referral structures	308
11.5.6	Offering women true choice concerning mode of delivery	310
11.6	Caring for, or caring about?	310
References		312

Candidate's Statement

This project was initially conceived by Maggie Smith as a result of her experiences as a midwife. She set up the project and recruited the first group of interviewees. Having been diagnosed with terminal cancer, she invited me to collaborate with her and I became involved from the early stages. We interviewed one respondent together and thereafter I took responsibility for the interviews as she was too ill to travel. Maggie died in February 2001 just a few months after starting the project. Since that time I have been solely responsible for the work.

The objective of the research was to gain an understanding into the problems encountered by survivors of childhood sexual abuse in childbearing, with particular reference to their contact with the maternity services. As this is an area which has received little research interest, it was hoped that the findings would provide evidence to guide and inform the practice of those who work with childbearing women.

The Childbearing Experiences of Survivors of Childhood Sexual Abuse

Introduction

This project was first conceived by Maggie Smith, who, as a student midwife was working on the delivery suite of a large consultant unit. A woman was admitted and assigned to Maggie's care. Part of the admission routine included a vaginal examination, but despite verbally consenting to the procedure, each time Maggie tried to examine her, she closed her legs tightly and wriggled up the bed repeating 'you'll go through me....you'll go through me!' She was clearly very distressed and agitated. Maggie fetched her mentor who also tried to examine her without success. Following that a number of other staff members got involved and tried to persuade the woman to be examined. Their approaches, says Maggie in her account (Smith1998a) ranged from 'kindly reassurance' to 'cajoling' and 'reproaching her'. Several members of the midwifery staff tried to examine her and despite giving consent, the woman was unable to allow the procedure to take place. Eventually, the midwife in charge of labour ward became impatient and told the woman that she would have to notify the medical staff. A male doctor duly arrived and made another attempt, but with the same result. By this time the woman was so distressed that further attempts had to be abandoned.

Later that day, the scenario was being discussed by a group of midwives in the staff coffee room. Maggie's suggestion that the woman's behaviour might have been indicative of a history of childhood sexual abuse met with many different reactions. Some gave accounts of women they had cared for whom they suspected might have such a history, while others appeared unaware that certain behaviours might be symptomatic of sexual abuse. One midwife appeared to find the whole idea distasteful and dismissed it with the words:

...she's just being awkward and anyway, it's only the NCT types¹ who won't let you examine them (Smith 1998a p 20)

Following this experience Maggie decided that she would like to study the subject in greater depth with a view to examining how childbirth affects women with a history of sexual abuse and how midwifery practice could be improved to meet their particular needs. In order to do this, she undertook a case study of a woman who was a survivor of incest and the mother of two children. The report of her findings formed her dissertation for her BSc in Midwifery and a précis of this was eventually published in *The Practising Midwife* (Smith 1998 a, b,c).

A literature search on birth for survivors of sexual abuse revealed a fair amount of anecdotal evidence and advice about the provision of care for these women, but a great paucity in research on the topic. Having qualified as a midwife in 1997, Maggie then decided to take her interest in the subject further and enrol at The University of Sheffield for a Masters degree with a view to converting to a PhD at a later date. She envisaged a small-scale qualitative study involving in-depth interviews with survivors of abuse who had given birth. Her method of recruitment was to contact survivors' support groups throughout England with a letter requesting women who felt they would like to be involved to contact her. She also forged links with a consultant clinical psychologist with a particular interest in the area of sexual abuse, who could provide advice and guidance or to whom she could refer respondents if their involvement in the research had a detrimental impact on their psychological wellbeing.

¹ The NCT's mission statement reads: "The National Childbirth Trust is the leading charity offering information and support in pregnancy, childbirth and early parenthood. We aim to give every parent the chance to make informed choices."

It was launched in 1957 with the expressed purpose of devolving more power to women and their partners by providing them with information which, until that time, had been in the domain of the medical profession. It was felt that if women had knowledge and were enabled to make their own choices, this would contribute to their experiencing less fear, pain and psychological harm when giving birth. The NCT now offers a whole host of non-medical services surrounding pregnancy and childrearing including antenatal classes for expectant couples, breastfeeding counsellors, support groups and equipment hire.

The "NCT type" is a stereotype feared by some maternity health workers because she is well informed, questioning and aware of her rights. She may present in labour at hospital with a birth plan carefully detailing her aspirations for the birth, including her wishes concerning certain obstetric interventions such as amniotomy or episiotomy. She may be seen as a threat; someone who is able to question the authority of the dominant medical ethos. It is feared that she will not comply with the demands of routine care and consequently will demand more time and effort from her carers. She may also be perceived as a potential source of litigation.

Maggie had interviewed two women when she was diagnosed with cancer. It was then that she invited me to join her in the project, as her prognosis was uncertain and her health steadily deteriorating. Maggie and I had trained together as student midwives and shared the same philosophies on birth, and in many ways, life in general.

We did our first (and last) interview together at Maggie's home, as she was too ill to travel and the respondent happened to be visiting the area for a meeting. After this I undertook the interviews alone, as most entailed travelling significant distances, reporting back to Maggie and discussing the emerging themes on my return.

Maggie died in February 2001, five months after the initial interview.

Chapter 1

How the meaning of birth and the status of childbearing women have changed

1.1 Introduction

In order to provide context to the accounts of the women's experiences, this thesis begins with an examination of the influences which have contributed to making birth in this country what it is today. The interviewees' stories range over a 30-year period, during which time the maternity services have seen many changes but what has changed little over that time is the dominance of the medical profession and the institution.

The chapter begins with an examination of the struggle for control which took place over several centuries as men became increasingly involved in the birth process. It then outlines the various influences that have re-defined birth: scientification, institutionalisation and industrialisation. The impact of the current emphasis on risk is then discussed.

The next section examines the recent rhetoric surrounding the issues of choice and control in the delivery of maternity care and discusses the reality of choice, drawing attention to the mismatch between women's concept of choice and that of the maternity services.

The chapter concludes with a reflection on a scenario in which I was involved in 2006, which illustrates many of the influences described above and their impact on one woman, her husband, a hospital midwife and myself as an independent midwife. I feel that not only does this give relevance to the findings of this study, but also an insight into the conflict of interest which may be experienced by health carers in such an environment.

1.2 The struggle to control birth

For thousands of years, midwives have been attending birthing women and until relatively recently enjoyed a good deal of autonomy. The institution of midwifery was based on the premise that birth is a normal event to be attended, not

manipulated or interfered with. Birth traditionally took place in the home and was a social event endued with great spiritual significance (Arney 1982; Donnison 1988; Arms 1994; Kitzinger S, 2006a). It was understood to be an exclusively female event in which men did not become involved. Often the woman was also supported by lay women and female relatives and according to some authorities the origin of the word 'gossip' stems from the ritual sipping of an alcoholic beverage brought by these women (Godsips) to sustain the labouring woman (Leap and Anderson 2004), although some believe the word is derived from "god-sibs", literally, "sisters in God" describing those who came from the surrounding neighbourhood to provide practical and emotional support (Kitzinger, S 1997). Whatever their etymological derivation, it is most probable that they encouraged the woman with stories of other successful births, including their own. Their nurturing skills grew out of their own mothering experiences and were handed on from mother to daughter. Herbal remedies and folk medicine may have been used to ease the woman's pain, but labour was allowed to take its own time and course unhindered (Kitzinger S, 2006a)

Midwives learned their profession by experience, and in the medieval era this was often through apprenticeships with established midwives (Donnison 1988; Hobby 1999). In the case of normal birth they had a high degree of autonomy and only in the event of abnormality were they obliged to call for help from the medical profession. The 'barber-surgeons' were practitioners of abnormal delivery and would use various instruments in order to extract the child from its mother, often resulting in fetal, if not maternal, death (Arney 1982). The definition of, and decision over what constituted normality lay with the midwife and therein lay her power (Arney 1982). However, the 17th century marked the beginning of a long power struggle not only over who should be in attendance at birth, but also over who should be responsible for defining normality.

During the eighteenth century, men began to promote themselves as male midwives and attendants of normal birth thus progressing from their role as emergency practitioners only (Donnison 1988). This brought them into direct competition with female midwives. The invention of the obstetric forceps in the early part of the century was highly significant as they enabled male practitioners to deliver the fetus alive, whereas, in the past, instruments had been employed to destroy the fetus in order to save the mother (Tew 1990;

Murphy-Lawless 1998). This served to further increase the popularity of male birth attendants, and to encourage the belief in some quarters that the use of instruments to expedite all births was desirable (Donnison 1988; Murphy-Lawless 1998).

The status of male midwives in comparison to their female counterparts was enhanced because they offered their services only to the rich, thus they were able to command higher fees than female midwives and indeed, it became somewhat of a status symbol to be able to employ the services of a man-midwife. The perception gradually arose that women, particularly those from the higher social classes, were 'delicate' and therefore unable to give birth without the assistance provided by male practitioners. At the same time, lying-in hospitals were founded in a limited number of locations in order to provide care for poor women. In exchange for nursing care and food, these women were expected to provide the material for research as well as for the teaching of medical students and midwives. Consequently, as Murphy-Lawless (1998) observes, the idea of the female body as feeble and flawed soon spread down the class ladder. Furthermore, male birth attendants attempted to destroy the reputation of female midwives by portraying them as ignorant, meddlesome and dangerous. By the middle of the nineteenth century not only had midwifery suffered a serious decline (Davis 1997), but even the word 'midwife' had been brought into disrepute, thanks in part to creations such as Dickens' drunken, unscrupulous Mrs Gamp (Donnison 1988; Coates 1998).

During the early part of the nineteenth century, males who specialised in midwifery started to refer to themselves as obstetricians rather than midwives. The derivation of the word '*obstetrics*' comes from Latin, '*ob*' and '*stare*' literally meaning '*to stand before*'. This has very different connotations than those of the old English word 'midwife' (*with woman*), and suggests objectivity, dominance and 'scientific' observation. Obstetrics then created for itself legal and social boundaries in order to protect its own interests. Midwives were obliged to depend upon their rivals, doctors, for their training and eventually became subject to state regulation under the medical profession at the beginning of the twentieth century (Tew 1990; Murphy-Lawless 1998). Then, as Arney (1982) points out, in order for men to replace women as attendants at all births (including normal birth), birth had to be redefined and re-assigned a meaning

different from that which it had in the hands of midwives. Obstetrics succeeded in placing an exclusion zone around childbirth by defining it as a *'process which had a trajectory, the "normal" course of which was known to obstetrics'* (Arney 1982 p 8). It has now become the remit of medicine to set the limits on normality (Kirkham 1996) and gradually but inexorably that definition has become increasingly restrictive and rigid. This effectively disqualifies many women from receiving midwifery-led care by placing them in a 'high risk' category requiring obstetric input.

1.2.1 Scientification

During the seventeenth century a philosophy emerged which, in contrast to the previously held belief that the earth was a living organism, assumed that the universe was mechanistic and followed predictable laws which could only be understood through science and manipulated through technology (Davis-Floyd 1992). As a result of this fundamental change in thinking, nature came to be perceived as a system of *'dead, inert particles moved by external, rather than inherent forces'* (Merchant 1983 p 193; quoted in Davis-Floyd 1992 p 45). The belief that science and technology could and should be employed to manipulate the natural world legitimised a huge increase in childbirth interventions (under the control of men-midwives) which were perceived to enhance and improve the efficiency and functioning of the birth process and went a long way towards promoting the concept of women's bodies as faulty (Arney 1982; Silverton 1993).

Murphy-Lawless (1998) argues that scientification is motivated by the desire to render the risk of death less unpredictable and therefore, seemingly, more under control. Childbirth, with its unpredictability and perceived potential dangers therefore presents a challenge to obstetrics. Obstetric science, she suggests, has a profound belief that its remit is to rescue women from death: however, it is, as she says, *'a remit which belongs entirely and exclusively to itself, and not to women as those principally affected'* (Murphy-Lawless 1998 p19). Thus obstetricians became the champions of 'safe' childbirth and the protectors of women from themselves and their substandard bodies. Consequently, the responsibility for birth was taken from the hands of women

and midwives and became the property of medical 'science', stripped of its emotional, spiritual and social components (Arney 1982) to become a medically controlled event.

1.2.2 Institutionalisation

Having been scientified and medicalised from the seventeenth century onwards, during the twentieth century birth also became subject to institutionalisation. Although the idea of institutional birth was not a new one, lying-in hospitals having been established in the eighteenth century, birth in hospital was far from being the norm for most women. In Britain the move to promote universally institutionalised birth started in the nineteen twenties and over the next 50 years the percentage of women delivering in hospital rose steadily to a level of 95.6% in 1974 (Huntingford 1978). In the intervening years the responsibility for providing the maternity services had become that of the National Health Service with its inception in 1948. During the latter half of the century, papers such as the Peel Report (Department of Health and Social Security 1970), along with continued pressure from the Royal College of Obstetricians and Gynaecologists, brought birthing women and their midwives into hospital and successfully fixed the concept of birth as a medical event rather than a social one. British midwives had long since surrendered a good deal of their autonomy to the medical profession with the regulation of midwifery at the beginning of the century and the move into hospital brought them further under medical dominance by reason of proximity. The idea of institutionalised birth being generally accepted as not only desirable but socially responsible, childbearing women and midwives became increasingly subject to the control of obstetrics and the organisation.

The medical profession and the institution represent a powerful symbiotic relationship: the institution providing the framework whereby medical authority can be expressed, 'medical technology' offering the possibility of manipulation or control of unpredictable events thereby increasing the efficiency of the institution. A major impact of this relationship was to confine and define birth within strict time parameters. This was beneficial to both parties: the system's requirements for speed and efficiency were met by medical constructs such as

active management of labour (O'Driscoll et al 1973) which had a profound and far-reaching influence on hospital and community labour care. Because time parameters are used to define 'normality' in childbirth, the perceived need for medical intervention has escalated, strengthening the apparent indispensability of obstetrics

1.2.3 Industrialisation

The organisation of the NHS, including maternity care provision, has been heavily influenced by the industrial model with its emphasis on efficiency, bureaucracy and hierarchy, which in turn has impacted upon women. Taylor's (1947) 'scientific management' model, based on his time and motion studies, had a huge impact on the structure and running of large organisations and the mass production methods of industrialists such as Henry Ford. Previously, commodities were produced by small numbers of knowledgeable craftsmen, who were engaged in the process from conception to realisation. Under Taylor and Ford's influence, the process became fragmented, and separated into small tasks, requiring little skill and no ingenuity. This model relies on large numbers of unskilled workers prepared to perform the same repetitive action day after day, without having the satisfaction of seeing the end result. Taylor (1947, quoted in Ritzer 1996 p 110) described the requirements of the ideal worker as *'so stupid and so phlegmatic that he more nearly resembles in his mental make-up the ox than any other type'*.

As Taylor's comment suggests, models of mass production not only lead to, but actually require the dehumanisation of its workers. Ritzer (1996), the proponent of the concept of 'McDonaldisation'² warns of the dehumanising effect industrialisation and rationalisation have had on human society. He suggests, referring to the work of Bauman (1989), that the holocaust provides the ultimate example of the dehumanising effect of rationalisation, (the process which undergirds industrialisation); people viewed as cargo, processed and

² MacDonaldisation: *the process by which the principles of the fast-food restaurant are coming to dominate more and more sectors of American society as well as of the rest of the world* (Ritzer 1996) The principles of MacDonaldisation: efficiency, calculability, predictability and control through non-human technology, can be described as the basic components of a rational

exterminated in huge numbers using the most efficient, cost-effective means. The four principles [see footnote] provided the focus of the operation, allowing 'production line workers' to avoid recognising the humanity of the 'product'. Production-line methods applied to processing people are, of necessity, dehumanising both for workers and users.

The vast majority of our national institutions, including the NHS, are built on hierarchies but the desirability or effectiveness of such a system is rarely questioned. The unspoken assumption is that hierarchy is necessary and even desirable in the smooth-running of a large organisation. Fairtlough (2005) however, suggests that they may, in fact be a very ineffective way of getting things done. Hierarchies are built on hegemony, which, by its nature, is unreceptive or antagonistic towards other ways of seeing the world. Much of the effort of the hierarchical organisation goes into maintaining the superior position of those at the top, whilst those in the lower ranks are expected to follow orders. Consequently, knowledge, 'expertise' and power are concentrated at the upper end of the structure rendering it inflexible and intransigent. Those in the lower levels have very little influence or control over their working arrangements and clinical practice, which can lead to resentment, irresponsibility and disenfranchisement.

A hierarchy disempowers both those working within it and those whom it is intended to serve. The phrase 'hierarchy maintenance work' was first coined by Kitzinger et al (1990) who used it to describe the various tactics employed by midwives to manipulate doctors without upsetting the hierarchical status quo. I, and I am sure, most midwives, am aware of having, at some time used these strategies. However, as Kirkham (1996 p 190) argues *'If we work by deference and proxy we ensure that at best the more powerful profession is 'right' but that we also 'demonstrate to women our humble role in the hierarchy, which in turn implies that they are even more powerless'*.

Furthermore, the hierarchical nature of the structure delivering healthcare provides an ideal environment in which paternalism can flourish, which militates against the notions of collaborative relationships and the offering of free choice.

system. However, Ritzer (1996) argues that *'rational systems inevitably spawn irrational consequences'* and that they *'serve to deny human reason'* (p13)

1.2.4 Risk

During the twentieth century the concept of risk has become increasingly prominent and the avoidance of it forms the basis and motivation for much social policy. As Furedi (2006) points out, there has been an explosion in the perception of risk in recent years, to the extent that risk avoidance has become a new moral imperative. Heightened public awareness of safety is perceived as an indication of responsible citizenry and risk taking, he asserts, once seen as *'an admirable enterprise'* (p 26) is now perceived as irresponsible and worthy of condemnation.

The concept of avoiding or minimising risk has now become one of the main foci of healthcare provision in Britain and arguably, may constitute one of the major reasons behind the maternity services' reluctance to allow women true choice and autonomy (Hewson 2004). Risk management strategies, protocols, policies and guidelines are devised to minimise the likelihood of the unexpected (which is invariably seen as risky and dangerous) occurring, in an attempt to remove the potential for litigation. The recent introduction of the Clinical Negligence Scheme for Trusts (CNST)³ has added a new dimension to the equation by giving trusts the incentive to produce ever more stringent protocols and 'guidelines' in order to save money on insurance premiums, which as Evans (2003) points out, *'leads to more fear of stepping out of the narrowing parameters thus making choice less and experience and skills narrower'* (p11). This will provide yet another stick with which to beat midwives and women and as Mander (2004) suggests of evidence-based practice and NICE guidelines, may give bullies opportunities *'to impose their will on the target by demanding adherence rather than accepting the threat posed by innovation.'* (p321)]

³ The Clinical Negligence Scheme for Trusts was set up to provide indemnity insurance for Trusts and their employees. It is funded by contributions paid by member trusts and could be described as an in-house mutual insurer. In order to qualify for discounts on their contributions trusts are obliged to achieve certain 'clinical risk standards'. These are on three levels, each with an increasing degree of stringency, the highest of which attracts a discount of 30%. (www.nhs.uk accessed 24/02/06)) They therefore provide a strong financial incentive to impose the strictest controls on clinical practice thus discouraging innovation and client autonomy.

Litigation, or the fear of it, has had a major influence on maternity care because of the magnitude of damages incurred (Walsh et al 2004). Bassett et al (2000) however, argue that the medical and legal professions have a dialectical relationship which ultimately serves to benefit both. They assert that not only do these two professions work cooperatively, (medicine providing the clinical practices and documentary evidence upon which litigation depends; law influencing the development of clinical standards) but that they evolve in parallel because of '*shared political, economic and cultural determinants*' (Bassett et al 2000 p 524). Walsh et al (2004 p105) point out that while obstetricians may fear litigation, the most common outcome of successful cases is that lack of obstetric input is identified as the cause of the adverse outcome in question, thus reinforcing the perceived need for medical involvement and intervention.

1.3 Choice and control - the rhetoric

In the closing decade of the twentieth century, the publication of Changing Childbirth (Department of Health 1993) engendered a spirit of optimism and hope amongst midwives and childbearing women. At the time it appeared to mark a highly significant change in thinking which was set to redress the balance away from the institutionalisation and medicalisation of birth which had steadily taken hold during the century. The introduction explains how, in March 1992, the House of Commons Health Select Committee challenged the conclusions of the Maternity Services Advisory Committee (1984), that women should be 'encouraged' to give birth in hospital on grounds of safety with the statement:

On the basis of what we have heard, this committee must draw the conclusion that the policy of encouraging all women to give birth in hospitals cannot be justified on grounds of safety (p 1).

The Select Committee went on to say that:

...a medical model of care' should no longer drive the service and that women should be given unbiased information and an opportunity for choice in the type

of maternity care they receive, including the option, previously largely denied to them, of having their babies at home, or in small maternity units (p 1).

The Expert Maternity Group (Department of Health 1993) set out what they considered to be the 'Principles of Good Maternity Care.' These placed the focus on women, emphasising the importance of their feeling in control of what was happening to them, involving them in planning and decision-making regarding their care, making services easily accessible and community-based. It also recommended that women should be involved in the monitoring and planning of maternity services in order that they should be '*responsive to the needs of a changing society*' (p 8).

Sadly, the elation and hope which surrounded the launch of Changing Childbirth gradually turned to disappointment as the vessel was soon to founder on the rocks of financial constraints, lack of commitment and cynicism. Now that the rhetoric has died down and the dust has settled, very little appears to have changed (Bosenquet et al 2005).

Some eleven years after Changing Childbirth was published, The National Service Framework for Children, Young People and Maternity Services (Department of Health 2004) appeared, once again stressing the need for choice to be at the heart maternity provision.

NHS Maternity care providers and Primary Care Trusts, it states, [should] ensure that: the range of ante-natal, birth and post-birth services available locally constitutes real choice for women (including home births). (p 28).

There is a strong emphasis on choice in both these documents but as Gibb (1996) observes, that has to be 'informed choice'. Doctors, he argues, may take an obstructive stance when confronted by women who are informed but wish to make a choice with which they do not concur, such as home birth. This is not confined to the medical profession as was demonstrated by the midwife of one interviewee who threatened her with the death of her baby if she went ahead with her plans for a home birth [see pp 258-9, and 274]. Midwives, as Levy (1999) argues, are often complicit in denying women choice in the way in which they communicate information.

1.3.1 The statutory duty of midwives – the impact on choice

In 2000, the UKCC (United Kingdom Central Council for Nursing, Midwifery and Health Visiting) muddied the waters by issuing a position paper on home birth (UKCC 2000). Up until that time it was understood that midwives had a duty of care to attend when called by a woman birthing at home. However, the document identified the midwife's primary contractual duty as carrying out the wishes of her employer. It stated that the midwife would not be held to be in breach of her professional responsibility if she were unable to attend a woman requesting a home birth if her employer had declined to provide such a service. This marked a shift in focus away from women's needs and rights to the midwife's obligation to meet 'service needs' before all else. Not only was this a serious blow to women wanting home births but it also resulted in the dismissal or suspension of several midwives who chose to put women's needs before those of their employers (Flint 2004).

However, in March 2006 the Nursing and Midwifery Council (which had taken over from the now defunct UKCC) issued a circular which aimed to clarify the position of the midwife with regard to home birth. This document, unlike its predecessor (UKCC 2000), indicates that the ultimate loyalty of the midwife should lie with the woman. It states:

Should a conflict arise between service provision and a woman's choice for place of birth, a midwife has a duty of care to attend her (NMC circular 8-2006 13 March 2006).

This was warmly welcomed by pressure groups such as The Association for Improvements in the Maternity Services (AIMS) and all those with a special interest in home birth (Beech 2006; Edwards 2006; Thewlis 2006).

1.3.2 The illusion of choice

Despite the ongoing rhetoric on choice and control and the evidence which demonstrates their importance to birthing women (Humenick 1981; Hodnett 1989; Green et al 1998; Weaver 1998; Gibbins and Thompson 2001; Green and

Baston 2003) in reality, women continue to be denied true choice over how and where they give birth (Rogers and Littlehale 2006). Documents such as Changing Childbirth advocate the three 'Cs', choice, control and continuity, but the maternity services respond by offering a wider range of antenatal screening tests, a choice of hospitals or care by large teams of midwives. However, these, and similar issues have merely contributed to the 'illusion of choice' (Beech 2003) and do not necessarily offer women what they truly want because these are choices as defined by the organisation, not by women. As Edwards (2003a) asserts:

The current rhetoric of choice fails us in a number of ways: it has been captured by a particular belief system, and it is based on assumptions about people that do not fit with women's accounts of making decisions. (p 9)

Not only does the medicalised philosophy of the maternity services militate against offering genuine choice, but the organisation's needs for efficiency and risk avoidance prove to be strong incentives against treating people as individuals. Ritzer (1996), discussing the impact industrialisation has had upon the catering industry highlights the fact that despite an illusion of choice being projected, the reality is very different:

Pity the consumer who has a special request in the fast-food restaurant. The fast-food advertisement 'We do it your way,' implies that these chains happily accommodate special requests. However, because much of their efficiency stems from the fact that they virtually always do it one way – their way, the last thing that fast-food restaurants want to do is do it your way. (p 40)

Whilst creating the impression of offering choice and control for women, the organisation charged with providing them only functions efficiently if women are denied choice and control. Consequently, a woman may be offered a choice as to which day she is admitted to hospital for induction of labour or whether her baby has injectable or oral vitamin k, but should she request something not on the menu, or refuse what is offered, she may find herself being accused of irresponsibility or putting her baby at risk. As Weaver (1998) points out, a

woman who is offered a choice between giving birth in a small GP unit or a large consultant unit will not perceive herself to have had a choice at all if what she really wanted was a home birth.

1.4 Summary

Over centuries, the definition and meaning of birth has evolved from a social and spiritual event which was perceived as women's business, to a medical and institutional procedure in which women have little influence. Birth has become scientified, institutionalised and increasingly defined by male oriented criteria. In this environment, the boundaries which define normality have become ever more restrictive, stimulating the need for control, surveillance and management by 'experts'. Society at large now believes that birth is an unpredictable and dangerous event which requires medical supervision (Duff 2004; Morris 2005).

In recent years there has been much rhetoric around giving women choice and control over where and how they give birth which has failed to make the transition from rhetorical to practical. Although the choices may not be as limited as Henry Ford's purported 'any colour as long as it's black', women's options are determined and restricted by the organisation.

1.5 A personal reflection on a recent episode of maternity care

I decided to include this reflection in my thesis for two reasons. Firstly, some of the accounts of the women interviewed are of birth experiences which took place two or even three decades ago which might prompt the reader to dismiss their stories as outdated. Much has changed in the delivery of maternity care since that time and nowadays there is, ostensibly, more emphasis placed on the psychological needs of birthing women. Over the past few years this has been expressed, as discussed above, in the rhetoric around the issues of choice and control. However, as this vignette shows, the reality is often very different from the rhetoric. The notion of affording women true choice and control over their births is probably as alien to the culture of the large consultant unit as it has ever been. Not only is the dominance of the medical profession just as powerful,

but to that has been added the increasingly high-profile role of risk management with the resultant explosion in protocols, policies and guidelines which govern practice. As an independent midwife, I am regularly regaled with very recent birth stories in which women describe themselves feeling helpless, unheard and dehumanised, which is more often than not their motivation for seeking out an alternative model of care for subsequent pregnancies.

Secondly, I wanted to describe the impact the event had on me as a midwife and explore the thought processes that governed my actions, in order to gain some understanding of the various pressures with which midwives are faced in attempting to carry out their role as women's advocates.

1.5.1 The story ...

I was obliged to transfer a labouring woman into a large teaching hospital for suspected fetal distress and remained with her and her husband in the capacity of birth companion. This woman had given birth to her first child by emergency caesarean section and desperately wanted to give birth vaginally this time. Consequently, she planned to give birth at home as she felt that it would afford her the greatest chance of achieving her aim.

Once in hospital, she was attached to a fetal heart monitor. However, her choice of position (kneeling forward) meant that the machine was not able to consistently produce a satisfactory trace of the fetal heart rate. During contractions the machine would record a much lower heart rate, which was clearly maternal. This was confirmed by manually taking the woman's pulse and holding the transducer more firmly against her abdomen at which time the fetal heart rate (which was within normal limits) became audible again. However, prompted by the dictates of hospital policy, her midwife suggested that a fetal scalp electrode (FSE) should be applied. The woman consented to this and an FSE was duly applied. Another fetal monitoring machine had to be brought in, as the first did not have this facility. Unfortunately, it was not working. Another was tried, with the same result. Eventually the registrar (a male) was asked by the midwife if he could try and attach another electrode to the baby's head. The woman had already been subjected to several vaginal examinations within a short space of time and understandably was not keen to undergo yet another,

but reluctantly consented. However, during the procedure, she struggled and kicked out at him whilst telling him to stop. He ignored this and continued until the electrode was in place. Unfortunately, as soon as he took his hand away, the device became detached. Undeterred, the doctor then explained to the woman that the procedure would have to be done again, which she declined. Her refusal was not well received and resulted in him putting his case more forcefully, becoming ever more insistent, suggesting that she was putting her baby at risk by not being monitored properly. At this juncture I intervened by pointing out to him that she had in fact declined the procedure and then asked if I could speak to him outside the room. Previously, the woman had disclosed to me that in the past she had been subjected to an abusive vaginal examination by a male doctor. I thought that if he were made aware of this, he might understand her reluctance and show respect for her wishes. He, however, ignored my request, and when out of desperation I quietly disclosed this to him in a corner of the room, he immediately responded with "I know about that!"

Having been deprived of the FSE option, he then suggested that the woman should have an epidural because, in his opinion, she was not coping well with the pain. She was, in fact, experiencing normal labour and coping well provided that she was able to remain in her chosen position and consequently declined his offer. He persisted with his "advice" but she remained steadfast (despite the fact that by now, even her husband was colluding, suggesting to her that she might consider it).

During his unsuccessful attempt to locate the FSE, the doctor had reported that cervical dilatation was 8-9 centimetres. Shortly after this, having lost the battle over the epidural, he suggested that yet another vaginal examination should be performed. His rationale was to ascertain whether her cervix was indeed fully dilated because she was starting to feel the urge to push. Again, the woman declined and eventually he left. Happily, she gave birth to her son vaginally, without any further interference.

This scenario embodied many of the aspects about maternity care that the interviewees had found traumatic such as the huge power differential between doctor and client, the pressure exerted on them to accept the medical 'agenda', the reluctance to respect women's choices and the task orientated focus. It left me feeling distressed and disturbed and consequently I found myself reflecting

upon it for some time afterwards.

Firstly, I was obliged to acknowledge my own reluctance to challenge the doctor's actions. My role was to act as the woman's advocate, but I was keenly aware of the pressure on me to conform, to be a 'good midwife' in the eyes of the system. I realised that to do this I would need to 'normalise' the scenario in my own mind. I would have to ignore my own feelings on seeing a woman struggling to prevent herself being violated and concentrate on the medical agenda – that of achieving an acceptable fetal heart trace. This would mean dissociating myself from her distress and aligning myself with the system. I had a choice – I could 'support' the woman by helping her to cope while the doctor performed the unwanted procedure (which, I confess, is the option I frequently took as a hospital midwife) or I could truly support her by standing with her and defending her choice thus making myself unpopular.

Discussing the scenario later with the woman and her husband (a doctor) he too admitted to feeling under the same pressure to placate 'them' because, as he put it 'we were on their territory'. At this point she very forcefully reminded him that in fact, they had been trespassing on *her* territory – a concept which, until then, appeared to have eluded him.

Clearly, the doctor was concerned about minimising risk and it was this issue that caused him to perceive the need to achieve acceptable fetal monitoring as paramount. The fact that the fetal heart rate could be distinguished from the maternal pulse by less invasive technological means was discounted. As Davis-Floyd and Mather (2002 p500) point out when describing what they refer to as the 'technocratic model of medicine'; *'the most valued information is that which comes from the many high-tech diagnostic machines now considered essential to good health care.'* His focus was on the machine and on the pursuit of an optimal fetal heart trace. This apparently blinded him to the needs of the woman whose non-compliance was preventing him from achieving his goal. His non-acceptance of her refusal suggests that the concept of 'informed refusal' was alien to him (Robinson 1995). Furthermore, it demonstrates the use of the all too common means of woman control – the threat to the life of her baby if she does not comply. His dogged persistence in the face of her refusal is illustrative of the medical profession's general perception that women who withhold consent are merely ill informed, that if they are given more information, more

forcefully, they will eventually see the error of their ways and give the correct response. It is interesting that when clients give their consent to a procedure without question, it is never considered necessary to ascertain whether or not they are well informed.

Arguably, the suggestion that she should have an epidural was motivated by the need for “doctor relief” rather than pain relief. I (and, I later discovered, the woman) construed it as yet another ploy to achieve the goal of optimal fetal monitoring by rendering her compliant and ensuring that she sat quietly on the bed.

The fact that the doctor ignored my request to speak to him outside the room suggests that he felt this was a threat to his powerful position. Furthermore, his reaction to my disclosure is highly disturbing. If he was aware of her history, why did it not affect his practice? Even more disturbing is the possibility that if it had affected his practice, what was his usual practice like? On the other hand, did he feel that being in possession of such information was his right as a medical practitioner, whilst being exempt from the need to take it into consideration when dealing with the woman?

If I had any doubts about the relevance of this study and the importance of the findings, this scenario put them to rest. Although it is only one incident in the life of one woman and her midwife and therefore cannot be generalised, it provides a small insight into the dynamics at work in the realm of maternity care between women, their midwives, the medical profession and the institution.

Although practice has changed in recent years and education courses for most health care workers now include client/patient psychology, women continue to be traumatised by their birth experiences (Kitzinger, S 1992; Crompton 1996a and b; Gold-Beck-Wood 1996; Menage 1996; Williams 1996; Lyons 1998; Robinson 1999; Robinson 2001b; Church and Scanlon 2002; Robinson 2002; Soet et al 2003; Beck 2004a; Beck 2004b; Midwifery Matters 2004) due largely to the treatment they receive within the maternity services.

The following chapter looks at what is known about the needs of birthing women in general in order to gain an understanding of the common factors influencing women's perception of care during one of the most life-changing experiences they will ever have.

Chapter 2

The needs of birthing women

2.1 Introduction

In order to understand the needs of survivors of childhood sexual abuse (CSA) giving birth it is appropriate to examine the literature that addresses the needs of any birthing woman. No woman approaches birth without a history of some kind, and it is very likely that some will have previously suffered traumatic experiences not associated with CSA. Consequently, this chapter will initially discuss what is known of the psychological and emotional needs of childbearing women, drawing on the qualitative studies carried out by Halldorsdottir and Karlsdottir (1996 a and b) and on other qualitative research. This will be followed by a discussion on the recently acknowledged phenomenon of 'birth trauma' and the manifestation of post-traumatic stress symptoms by women when those needs are not met. The link between sexual violence and traumatic birth will be highlighted and some of the sequelae experienced by women who are affected by post-traumatic symptoms.

2.2 What are the needs of birthing women?

In order to identify the aspects of labour and birth that women might find problematic it is useful to first examine what is known about the psychological and emotional needs of birthing women. Halldorsdottir and Karlsdottir (1996a; 1996b) have undertaken some very useful phenomenological research into the experiences of mothers who gave birth in Iceland, with particular reference to their perceptions of midwifery care. Both studies reveal the huge impact that carers can have upon women's lived experience and lasting perceptions of childbirth. The women's accounts highlight three main categories of need as they journeyed through to motherhood: caring and understanding from those around them; security, which involved being kept informed of what was happening; and a sense of control of self and circumstances;

2.2.1 Caring and understanding

All the respondents in both Halldorsdottir and Karlsdottir's studies (1996a; 1996b) agreed that caring and understanding from staff were essential components of the birth experience. This included the valuing of human qualities such as kindness, connection, companionship, assistance and support.

I cannot tell you how much she [midwife] relieved my worries. It was just wonderful. She was great, she looked straight into my eyes and came to me [and] touched me warmly, in a personal way...like she was saying 'I am with you'....you know, an empowering touch which makes you stronger because you can sense that someone is with you in this....The birth progressed very fast after she came... (1996a p 54)

These findings were supported by the work of Berg et al (1996), who identified qualities such as friendliness, openness, interpersonal congruity, intuition and availability in midwives as important to women. They summarise these as 'presence' and observed that: *'If any of the mentioned features was lacking, the women felt that the midwife was "absently present" (p 13).* Lazarus (1997), in her studies of the needs of poor and middle class American women, (98 respondents in all), reports that while 'control' was more important to middle class women, the issues of caring, respect, warmth and emotional support were paramount to all the interviewees regardless of background.

In their survey of 2686 Swedish women examining maternal satisfaction with intrapartum and postpartum care, Waldenstrom et al (2006) report that taking all aspects of intrapartum care into account: *'those related to emotional dimensions of care seemed to influence women's overall assessment the most.'* (p 524)

These findings are also supported by Tarkka and Paunonen (1996) who report from their questionnaire-based study of 200 mothers, that those who were provided with good emotional support from their midwives described labour in more positive terms than those who received less support. Furthermore, women in Berg and Dalberg's (1998) study scoring the highest long-term satisfaction ratings *'had positive memories of the caregivers' words and actions'* (p24) and felt their birth experience had enhanced their self-esteem.

2.2.2 Security and trust

According to Halldorsdottir and Karlsdottir (1996a) the desire to feel safe and secure was met by the presence of a competent, caring midwife who would guide the women through the course of labour with reassurance and information:

I needed to feel safe. Not having to be afraid of anything [.....] that she [midwife] would see to it that everything would be all right...and that I could trust her one hundred percent and if something went wrong she would know what to do. (p 54)

The issue of being able to trust the competence and knowledge of caregivers was also a theme highlighted by the women interviewed by Berg and Dalberg (1998). The importance of a sense of security was mentioned by many of the women in Tarkka and Paunonen's research (1996), which similarly, they attributed to professional competence coupled with warm, supportive care:

The midwife was very professional, she explained and gave me advice and took account of all my needs. The midwife's calm and composed approach and her warm attitude helped to create a sense of security. It felt good to have a friend in with me. (p 73)

Conversely, failure on the part of midwives to provide a secure and caring atmosphere for the birthing woman could have disastrous consequences.

I felt very insecure throughout this whole period and I felt that I – and I didn't feel in good hands. I felt that II somehow felt that I was stuck with all the responsibility. That was not a comfortable feeling. I promised myself after this that I would not go through more births, and I have kept that promise. Never in my whole life would I go through a birth again! (Halldorsdottir and Karlsdottir 1996b p 374)

Clearly, trust, both in the competence and character of the midwife is an

important component in women's satisfaction with childbirth. Parratt and Fahy's (2003) small feminist constructivist pilot study contrasts the medical with the midwifery models of childbirth care and their impact on women's sense of self following birth. They postulate that the midwifery model i.e. '*a woman-centred way of practising that involves providing continuity and utilising the principles of individual negotiation, informed choice and consent, and shared responsibility*' enables labouring women to '*trust enough to let go of mind control and release their bodies*' (p 15). The relinquishment of the rational mind and the entering of an altered state of consciousness is a well-documented phenomenon, observed in women undergoing normal, un-medicated labours. Anderson (2000) describes it as an: '*instinctive primal survival technique*' (p 95) which occurs in response to the intensity of the experience of labour. The women interviewed by Anderson (2000) emphasised the importance of trusting their carers in this context, one referring to the midwife as '*the anchor that helps you go off into that altered state*' (p 101).

2.2.3 Control of self and circumstances

There is a good deal of recent evidence that one of the major determinants as to how women perceive their birthing experience is that of feeling in control (Humenick 1981; Hodnett 1989; Green et al 1998; Weaver 1998; Gibbins and Thompson 2001; Green and Baston 2003). Green et al (1998) in their Great Expectations study investigated the psychological outcomes of birthing women with regard to six 'conceptualisations' of control. Three were identified as 'internal': 1) control of own behaviour, 2) control during contractions, 3) making a noise; and three were 'external': 1) feeling in control of what was done to them, 2) involvement in non-emergency decision-making, 3) involvement in emergency decision-making. With the exception of 'making a noise', feeling in control in any of these areas was associated with positive psychological outcomes (Green and Baston 2003).

The women in Halldorsdottir and Karlsdottir's 1996a study also expressed the need for control over their birthing environment. Some of the interviewees spoke of being in their own private world where time did not exist (clearly referring to an altered state of consciousness) and felt it essential that this 'inner

space' should be protected and respected. The issue of the birthing environment was also the subject of a survey by the National Childbirth Trust (Newburn 2003). Of nearly 2000 responses, 94% strongly agreed that their surroundings could positively or adversely affect the ease with which they gave birth. Interestingly, the comments about the hospital environment reflected the findings of Halldorsdottir and Karlsdottir (1996a), highlighting the women's need to have some control over who and how many came into the delivery room.

There were too many people walking in and out.

I laboured all day in a room with three other women and had almost no privacy.
(Newburn 2003 p23)

Green et al (1998) also report that many people coming in and out of the labour room was significantly associated with women being dissatisfied with their birth experience. However, as Edwards (2003b) points out, the birthing environment should not be perceived merely in terms of décor and the number of people in the room: '...the material and ideological environment [sic] need to merge, to free women's minds, bodies, spirituality and sensuality' (p19)

Creating an environment in which birth can take place could therefore be seen as the responsibility of carers and the appropriateness (or not) of that environment is dependent largely on their ideologies and beliefs about birth. Significantly, in the Icelandic studies, the women's perception of control and mastery appeared to be rooted in the emotional quality of the care and support they were given and the focus of their midwives. One woman recounted how she was finding the pain of labour overwhelming until she had a change of midwife.

All of a sudden, I just stood there and I could feel that I was in control I managed to work with my body, instead of feeling overpowered by something I couldn't handle. It was truly amazing to see the difference in having a midwife who was task-oriented, who was mainly concerned with the pains and then to have a midwife who was woman-oriented. Her attention was first and foremost on me. (Halldorsdottir and Karlsdottir 1996a p53)

Berg and Dahlberg (1998) in their phenomenological study of women who experienced complicated birth also highlight the impact of positive carer support on the perception of control and consequently the ability to cope with the physical sensations of labour:

Affirmation also gave a feeling of control over the labour process and their own body, thus giving courage to meet the pain sensation and liberating inner strength with a raised level of pain tolerance. (p 27)

In their 1996b research, Halldorsdottir and Karlsdottir looked specifically at the effect caring and uncaring encounters with midwives had on birthing women. They refer to the importance women placed upon carers demonstrating 'genuine' concern for them and their partners. Part of being genuinely concerned, they argue, entails respect; taking the initiative when appropriate but also giving the woman space to choose for herself.

She [midwife] is comfortably close to the woman, not too close and yet not too distant. This combination of closeness and distance is what the researchers call "professional intimacy with a comfortable distance of respect and compassion" (p368 my emphasis)

An important aspect of 'professional intimacy', argue Halldorsdottir and Karlsdottir (1996b) is not trying to control or gain power over the woman, but to empower her. The women who had experienced caring encounters with their midwives spoke about their ability to maintain this delicate balance:

What I felt particularly comfortable about her was...a tender conduct and yet in such a way that she didn't try to control you.... (p 368)

She talked a lot to you, and in a warm tone of voice, and she was rubbing my back and of course that was very soothing and good. She was not trying to control what I wanted to do, like the other one. (p 368)

The researchers maintain that encounters in which a woman's needs for 'compassionate competence' were met, resulted in her perceiving herself to have had a 'successful birth' which is also supported by the work of Simkin (1991; 1992a).

Green et al (1998) however, report that women in their study who were the least satisfied were those who had the highest number of obstetrical interventions, which at first glance appears to somewhat contradict findings on the importance of relational care. However, they state that having interventions does not result in women feeling dissatisfied with how they are treated by staff, but that the quality of care they receive is assessed separately. This suggests that other factors such as 'how' interventions are carried out and whether or not women felt some degree of control over them may be more important than the procedures themselves. It could be argued that the scenarios in which the interventions occurred provided those women with more opportunities to experience substandard emotional care than those who had little intervention. Indeed, the researchers go on to say that issues such as control over what was done to them, information giving and communication were seen as key ingredients in the women's satisfaction (p 187).

2.3 The concept of 'mastery' and its relationship to control

Humenick, (1981) in her review, identifies a 'recurring theme' throughout the childbirth literature; that of the importance of mastery:

...childbirth is a psychologically important task for pregnant women. Control or mastery of that task appears to be closely related to overall satisfaction with birth experience. (p 81).

The importance of a sense of mastery over labour and birth is also highlighted by Seiden (1978), who emphasises the role of carers in either facilitating or hindering this:

A woman cannot achieve a sense of mastery if she is either at high risk of severe pain or death, or, on the other hand, if she is treated as an ill or

incompetent patient when, in fact, she is not. (pp 89-90)

Seiden (1978) speaks of childbirth in terms of it being an *'aggressive and libidinal task'* (p 92), the mastery of which is essential for confident, effective parenting. The woman who has mastery over labour is powerful and sensual which is reflected in the comments of one of Edward's (2005) interviewees:

...I do remember what a sexualising experience it was and how animal and sexy it was to give birth [...] and that was very powerful. That was very, very helpful to give birth. (p 241)

One of the women in Weaver's 'Control in Childbirth Study' (1998) expressed the opinion that control in labour was dualistic in nature:

There are two different kinds of control, one is mental about what you expect, or want other people to do for you to help the situation. And the other is whether or not you have and control over what your body actually does. [...] In fact you have very little control over the physical aspect of it. But you can have a certain amount of control over how it's managed. (p 92)

Clearly, as she points out, women can have very little control over the physical process of labour, but need to feel that they will be helped to cope in the situation. Helping a woman to achieve mastery over the rigours of labour could be likened to guiding and supporting someone sailing single-handed through tumultuous seas. The sea remains uncontrollable, but the sailor can gain an immense sense of mastery on reaching her destination having plumbed the depths of her own inner resources and emerged triumphant through the ordeal. It seems that women do not expect to control labour *per se*, but do look to their carers to 'get into the boat with them', to provide the support and encouragement they need, whatever that entails. Niven (1994), whose study focused specifically on coping with pain in labour, acknowledges that although it is desirable that midwives should be able to skilfully administer pharmaceutical pain relief, the midwife/mother relationship is more important because it *'allows the woman to utilize her own coping skills to the full'*. (p 116)

Anderson (2000) gives the account of Daniella, a woman who experienced a profound loss of control during the second stage of labour through severe pain, lack of trust in her body and also in her midwife. She described a second midwife who came in and 'took charge' as an 'angel'.

This midwife came in and took charge, almost with military precision, and you just felt confident with her. She said, Right, Mrs X, and she just looked at me and she took my arm and she was an angel sent from heaven. I suddenly had a surge of energy. (p 113)

Although it could be argued that this midwife was being controlling or too directive, her actions, were entirely appropriate for the woman who, at that time, needed to feel that someone was in control. Her focus was not on controlling the woman, but on helping her to gain mastery of the experience, thus helping her to regain a sense of control. *'It would seem', says Anderson (2000), that the worst option of all is for no-one to have control over labour, for the labour to be 'out of control' (p 95)*

This observation may, in part, provide the key to why many women feel a loss of control in childbirth. Inevitably, women enter labour with expectations or ideas of how events will unfold and how they would like to be cared for. When their expectations are not met, the resultant feelings of betrayal, bewilderment or shock, may make them vulnerable to traumatisation. This is demonstrated in Halldorsdottir and Karlsdottir's 1996b study, when women who reported uncaring encounters with midwives reacted with *'puzzlement and disbelief and an effort to make sense of the uncaring' (p 375).*

I always think badly about this woman. I felt she was so mean. She was so cold and rough and tactless. She didn't understand how you felt and....that you needed something special in connection with the birth. (p 374)

Women who are not provided with warm, sensitive support by their carers are unlikely to achieve mastery over the experience of birth, possibly leaving them with a sense that they have failed.

2.4 The link between carers and control

Halldorsdottir and Karlsdottir (1996a) conclude from their findings that high quality, supportive midwifery care appears to be a key element in women achieving successful birth experiences and consequently minimising the risk of psychological trauma:

It has been postulated in the literature that a long and difficult birth has the effect on the woman that she loses sense of control. However, the findings from the present study indicate that this can be the other way around, that is a woman sometimes loses sense of control because of a perceived lack of caring, control and security which seems to leave her with a feeling of helplessness and she perceives the birth as extremely long and terrible, or even as an unbearable experience. (p 60)

It would appear then, that a woman's sense of control during labour and birth may be much more dependent on the attitude and actions of her attendants than on the physical characteristics of the experience alone. In fact, being cared for and supported appropriately can alter a woman's perception of pain and help her to cope more effectively.

The desire of labouring women to be treated with 'genuineness' on the part of their carers is also important, in that women need to feel that their labour attendants have more than a 'professional' interest in them (Halldorsdottir and Karlsdottir 1996a;b; Berg and Dahlberg 1998; Edwards 2005; El-Nemer et al 2006). This is particularly in evidence in the work of Wilkins (2000) who examined the 'special' relationship between women and their community midwives. One of the women interviewed by El-Nemer et al (2006) described the desire for genuineness in their relationships with carers as being helped 'from the heart' (p81). Conversely, unsupportive and non-engaged carers may cause a woman to perceive her labour as more painful, out of control, and consequently traumatic. Significantly, all the respondents in both the Icelandic studies (Halldorsdottir and Karlsdottir 1996a; 1996b) had problem free pregnancies and normal births in hospital, so none of their dissatisfaction could be attributed to high levels of medical intervention, instrumental or operative

deliveries.

'If caring is the essence of a human service' argue Halldorsdottir and Karlsdottir (1996b), *'uncaring is malpractice and should be treated as such'*. (p 376) Uncaring, the authors point out in their 1996b paper, has been *'strangely neglected'* (p376) in nursing and midwifery research, but if the impact can be such that a woman may be deterred from ever giving birth again, the profundity of the issue must be acknowledged. Indeed, they suggest that it should be treated as a serious ethical and professional problem in nursing and midwifery.

2.5 What constitutes control?

As has been seen in the preceding paragraphs, control means many things to many different women. Women generally acknowledge that they cannot be in control of the physical manifestations of labour but need warm emotional support to cope with a highly challenging and intense experience, thus achieving mastery. It could be argued that, rather than having a desire to be in overall control, what women appear to fear most is suffering a loss of control and the resultant feelings of helplessness. In some circumstances 'control' may mean a midwife coming into a birth scenario and being directive, in others, it may be a midwife who unobtrusively enables the woman to access her own inner strength. More often than not, 'control', or lack of it, is concerned with the actions and attitudes of carers. Of the three major themes (caring, security and control) identified by Halldorsdottir and Karlsdottir (1996a), it could be argued that, in fact, women's perception of control is a consequence of, and dependent on, the existence of the first two.

Having identified control as a major determinant of women's satisfaction with childbirth, it is, however, impossible to arrive at one single definition of control because the perception and experience of it is seated within the individual and may change according to circumstances. Rotter (1966) suggested a 'Locus of Control Scale', a continuum, with individuals who perceive that life is primarily a consequence of their own actions at one extreme (internal locus), and at the other, people who believe that their lives are primarily influenced by external factors (external locus). Those at the 'internal' extreme, he postulates, tend to

be more assertive while those with a prevalently 'external' locus are more susceptible to depression or aggression associated with feelings of powerlessness. Raphael-Leff (1991) likewise suggests that there are two divergent types of birthing women at opposite ends of a continuum, the facilitator and the regulator. The facilitator, she asserts is focused on the process of pregnancy and birth taking their 'natural' course and '*gives in to the emotional upheaval of pregnancy*' while the regulator may feel 'invaded' by pregnancy and '*holds out against it*' (p80). Consequently, she is keen to use any means to avoid discomfort and maintain her self-control. However, one individual may react differently in diverse circumstances and depending on what options are available. Thus a woman who could be described as assertive and articulate in her employment situation, can become helpless and muted in a hostile birth environment. Waymire (1997) cites the case of a survivor of sexual abuse who '*screamed for an epidural*' (p49) during her first birth, (appearing to be a 'regulator') but opted for a natural, unmedicated birth for her second child. Her choice of pain relief during the first experience however, was made as a result of the non-supportive attitude of her carers. When, for her second birth, she was supported by a sympathetic nurse-midwife, she was enabled to make a genuine choice, to have a natural birth. The woman's behaviour was determined solely by the degree of support given by her carers. From this we can also see that control is strongly linked with the existence of true choice.

2.6 Loss of control – the impact on childbearing women

Clearly women's perceptions of, and need for, control are diverse and influenced to some extent by their own personalities, life experiences and subsequent expectations. The fact that control and mastery are of great importance to most women is undeniable. Conversely, lack of control and resultant feelings of powerlessness during the birth experience is one of the major traumagenic factors associated with psychological morbidity following childbirth. In recent years it has been recognised that a disturbingly substantial number of women are emerging from birth suffering from post-traumatic stress disorder, experiencing some of the symptoms or describing it as traumatic (Crompton 1996a; Crompton 1996b; Menage 1996; Reynolds 1997; Lyons

1998; Creedy et al 2000; Ayers and Pickering 2001; Church and Scanlon 2002; Bailham and Joseph 2003; Soet et al 2003; Beck 2004b; Moyzakitis 2004; Olde et al 2005).

2.7 Post-traumatic stress disorder

'Post-traumatic stress disorder' (PTSD) was first described among Vietnam War veterans and was initially associated with the psychological symptoms of men who had suffered horrific combat experiences (Reynolds 1997; van der Kolk, Waisaeth and van der Hart 1996). By the time it was listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM III) (American Psychiatric Association [APA] 1980) it also encompassed several other trauma-related syndromes i.e. 'rape trauma syndrome', 'battered woman syndrome' and 'abused child syndrome' (van der Kolk, Waisaeth and van der Hart 1996). There are strict criteria governing the diagnosis of the condition: the client must have: (1) experienced an event outside the normal range of human experience which would be markedly distressing to almost anyone; (2) repeatedly re-experienced the event in some way; (3) persistently avoided stimuli associated with the event or experienced emotional 'numbing'; (4) experienced persistent symptoms of hyper arousal; (5) experienced symptoms for at least a month (APA 1980). Since that definition appeared, the first criterion has been expanded to include '*direct personal experience of an event that involves actual or threatened death or serious injury, or a threat to the physical integrity of self or others*' to which the individual's response is '*one of extreme fear, helplessness or horror*' (APA, 1994 p424).

2.8 Traumatic childbirth

It is only since the last decade of the twentieth century that childbirth has become recognised as a potential trigger for the development of actual or partial PTSD (Alder et al 2006). The exact number of women emerging from childbirth with symptoms that fulfil all the criteria for the diagnosis of post-traumatic stress disorder remains uncertain, but research reveals that the number of women who are at least partially symptomatic may be substantial. Menage (1996), one

of the earlier researchers on the subject, in her practice as a GP, encountered women who were fearful of future pregnancies and gynaecological procedures and appeared to have suffered long-term psychological sequelae as a result of previous experiences. She hypothesised that trauma sustained during obstetric or gynaecological events might cause post-traumatic stress disorder and that there might be similarities between these events and sexual assault, particularly where the woman perceived herself to be powerless. Five hundred self-referred volunteers, who had undergone obstetric or gynaecological procedures, took part in her study, recruited via advertisements in local and national press, and in women's magazines. Six percent met the criteria for the diagnosis of PTSD, whereas 20% described the event as 'very distressing' or 'terrifying'. Later, Soet et al (2003), examining the prevalence and predictors of psychological trauma following childbirth, used questionnaires administered to women in late pregnancy and approximately four weeks after the birth. They found only 1.9% of their 103 respondents (recruited through childbirth education classes) met the criteria for PTSD, but 34% reported their childbirth experience as traumatic, while 30.1% were partially symptomatic. Olde et al (2005) collected data on psychological predictors of childbirth PTSD from women who gave birth in a suburban region of the Netherlands as part of a larger study looking into the effects of thyroid hormones on birth. They reported that 2.1% of their 140 participants were diagnosable with PTSD, while 21.4% described their birth experience as traumatic. Similar results were obtained by Ayers and Pickering (2001) in their prospective study on incidence of PTSD after childbirth, which included 499 women contacted through the antenatal clinics of four hospitals. They identified 2.8% of their respondents as suffering from PTSD.

Although the percentage of women meeting all the criteria for the diagnosis of PTSD is relatively small, the numbers describing their birth experience as traumatic and being partially symptomatic are disturbingly high. In 2005 *'Mother and Baby Magazine'* conducted a survey of 3000 British mothers in which 78% said they found their birth experience 'frightening', with more than half of them saying it was 'far more shocking than they thought' (Crompton 2005). None of these projects set out with the stated intention of examining the impact on women with a predisposition for trauma. It is reasonable to assume that although some of the respondents will have had a predisposition to PTSD, the

majority will not. Research suggests then, that as many as one in three women perceives her birth as traumatic and may suffer long term psychological morbidity as a result (Creedy et al 2000; Soet et al 2003; Olde et al 2005).

2.8.1 What causes birth trauma?

Research indicates that there are many diverse factors involved in women developing post-traumatic stress disorder following childbirth. Firstly, certain women may have pre-disposing antecedent factors such as a history of sexual violence, lack of social support, previous miscarriage or a higher trait anxiety (Reynolds 1997; Czarnocka and Slade 2000; Keogh et al 2002; Soet et al 2003). Indeed, Soet et al (2003) found that women who had been sexually abused were twelve times more likely to suffer PTSD than women who had not, although they do warn that the small numbers involved in their research means that their findings must be treated with caution. Other traumagenic factors that have been associated with the event of childbirth include high levels of obstetric intervention, extreme pain, emergency caesarean section, instrumental assisted delivery, fear for their baby's or their own life and (predictably) the birth of a sick or stillborn baby (Reynolds 1997; Green et al 1998; Creedy et al 2000; Soet et al 2003).

However, what is universally agreed upon is that women who experience loss of control, feel powerless or helpless for any reason during the birth of their baby are much more likely to perceive it as traumatic and develop long-term psychological sequelae (Lyons 1998; Church and Scanlon 2002; Soet et al 2003). This is highlighted by Ballard et al (1995) who examined the case histories of 4 women who suffered post-traumatic stress disorder as a result of their birth experiences. The first had undergone an elective caesarean section under epidural anaesthesia for transverse lie. Unfortunately, the anaesthetic was not fully effective and the woman experienced excruciating pain. During the procedure she was '*screaming shouting, and struggling to get off the operating table*' (p 525) but was held down by attendants who continued with the operation.

The second had what the authors describe as a 'problem free' delivery, but pain relief was 'not optimal'. However, she had been left alone for long periods

during labour and as a consequence, felt unsupported and un-cared for.

The third woman's birth was complicated by a shoulder dystocia and her baby suffered a cardiac arrest but was successfully resuscitated.

The fourth had planned to labour under epidural anaesthesia, but had been denied this by her midwife who 'did not talk to her at all'. She 'went into shock' on realising that that she was expected to deliver without her chosen means of pain relief. Furthermore, she was told by an authoritarian hospital sister that she could not possibly be in such pain. After delivery, her 'off-hand' midwife also ignored her request not to suture her perineum.

The researchers speculate as to a possible cause for the women developing post-traumatic stress disorder and highlight the fact that, in each case, the feeling of a 'lack of control' was described.

Clearly, the issue of post-traumatic stress disorder in the context of birth is a complicated one, but feelings of powerlessness and lack of control appear to be almost universal. The work of Soet et al (2003) may provide a partial insight into the reasons for this. Many of the women in their study expressed frustration at being confined to bed during labour because their medical practitioners had ordered continuous fetal monitoring. Consequently, the women were unable to use techniques they had learned in childbirth preparation classes and therefore felt powerless to control their pain. The perceived need for medical surveillance and control took precedence over their needs for comfort and mobility. These women were denied active participation in their labours because the medical agenda was considered more important. Women birthing within the hospital system do so, not on their terms, but according to the medical and institutional agenda. Pratton (1990) observes:

Too often modern medical aids have superceded [sic] human contact and emotional support, so that the mother's demands for attention in labour are responded to with analgesia, reaffirming the definition both of the situation primarily as painful and of herself as a passive patient. (p 50)

Women's needs in childbirth are interpreted through the technomedical 'lens' and often responded to with increasing levels of medical intervention thus further depriving them of control.

Creedy et al (2000) conclude from their study that maternity services should be reviewed in order to reduce the number of invasive obstetrical interventions during labour and birth, but their research failed to identify exactly why these procedures were perceived as traumatic. Soet et al (2003) and Reynolds (1997), stress the need for 'excellent' pain control, but also recommend that staff use good communication, offer women options and consider the psychological as well as physical impact of medical interventions. Alder et al (2006) in addressing the problem of post-traumatic symptoms after childbirth, suggest interventions such as counselling women during subsequent pregnancies and providing patient-centred information but offer no discussion on how maternity care could be improved in order to avoid traumatising occurring in the first place.

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

2.8.2 Why do women perceive birth as traumatic and how does it affect them?

The accounts of women who have perceived their birth as traumatic are shot through with references to cold and unsympathetic carers, staff who are task focused and/or fail to provide sufficient information or explanations.

One of the Icelandic women described her distress at her midwife's apparent lack of concern and interest in her as she was labouring:

What I really felt was demoralizing was that I felt that she – you know, I was completely alone, you see? She was completely indifferent, she was just out in the hall playing solitaire and peeked in every now and then, you see? And I mean she probably had delivered many hundred babies, maybe, and knows probably exactly how this happens, you see? So she knew more than I, she

didn't talk to me, you see? And she said to me, "Just wait for this, honey," and, you know, she was careless. (Halldorsdottir and Karlsdottir 1996b p 371)

Reflecting somewhat the findings of Green et al (1998), all the respondents in Moyzakitis' (2004) study of six women who reported their births as traumatic, had been subject to a high level of medical intervention in labour. However, Moyzakitis' data gives a valuable insight into exactly 'why' women found these situations traumatic. The interviewees spoke of 'carers' who did not listen to them, excluded them from any decision making and who misused their position of power:

All I remember is asking her to stop, that if I could just have five minutes to calm down.... There's me screaming: "Stop! Stop!"...She carried on stitching and stitching, which seemed to go on forever...and at that point I blanked out completely. (p 10)

Church and Scanlan (2002) describe the experiences of a woman ('Sally') who was referred to the Community Mental Health Team suffering from post-traumatic symptoms. It took several weekly 'sessions' before Sally was even able to recall the details of the birth, but eventually she explained that she had wanted a 'natural' birth. However, as her labour became complicated and increasingly medicalised, she felt a total loss of control and became convinced that she and her baby were going to die. However, many of her subsequent nightmares and flashbacks involved the behaviour of a doctor who, during the episode, had '*pushed his face towards her and shouted at her*' (p 11). This, she found abusive and predatory, but it also had a deep impact on her husband, who had witnessed the event, leaving him feeling '*emasculated and ashamed*'. (p 11)

The first volume of the AIMS journal in 2007, devoted to birth trauma, is also testimony to the lasting 'soul wounds' (Mauger 2007), sustained by women who have experienced this kind of treatment:

Like a lot of other pregnant women I was deceived, neglected, insulted, assaulted and ignored by hospital staff (Barnes 2007)

It is hard to explain the emotional assault of being cut open by people whom you know have no respect for you or your wishes, the feeling of utter powerlessness. (Stenson 2007)

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

2.8.3 Birth trauma and the betrayal of trust

Some women appear to experience a sense of betrayal when those responsible for their care treat them coldly and callously. One woman, interviewed by Moyzakitis (2004), recalled that she was screaming in pain, expecting her midwife to react with kindness and comfort but was shocked by her response:

I'll never forget her saying "Don't be silly now! Pull yourself together" (sternly). All I wanted was some reassurance. (p 11)

One of the women in the case report paper by Ballard et al (1995) referred to previously, portrays a sense of betrayal towards her attendants. She had been referred to the hospital in question specifically because it was able to offer a 24-hour epidural service, and clearly felt that delivering without this means of pain relief was not an option for her. Having been denied her request by her 'off-hand' and 'authoritarian' midwives, she felt she had been forced to endure unbearable pain. Long after the event she continued to have repetitive and intrusive thoughts about the 'out-of-date' punitive attitudes of the midwives; she said: *'It sounds awful, but I feel like beating this midwife to a pulp'* (p 257)

According to Williams (1996), whose article describes her experience of giving birth to a stillborn baby, the event was rendered all the more traumatic by her attendants' lack of empathy and communication. She felt that if these needs had been met, she might have been spared the profound psychological sequelae that ensued:

....had one midwife or another member of medical staff stayed with me while doctors concentrated on saving my life, taken responsibility for me, explained what was happening and interceded for me when I needed anything, the psychological dissociation with its long-term consequences might have been avoided. (p 528)

This sense of betrayal also emerges in the research conducted by Beck (2004a). She undertook a project which involved mainly Internet interviews with 40 women who had experienced birth trauma in several different English-speaking countries. She identified four themes running through her findings, the essence of which correspond closely to the needs of birthing women as defined by Halldorsdottir and Karlsdottir (1996a): 1) To care for me: was that too much to ask?; 2) To communicate with me: why was this neglected?; 3) To provide safe care: you betrayed my trust and I felt powerless; 4) The end justifies the means: at whose expense? At what price? The depth of emotional distress experienced by these mothers is heart-rending:

The labour care has hurt deep in my soul and I have no words to describe the hurt. I was treated like a nothing, just someone to get data from. (Beck 2004a, p 31)

Beck concluded:

Their protective layers were stripped away, leaving them exposed to the onslaught of birth trauma. Stripped from these women were their individuality, dignity, control, communication, caring, trust, and support and reassurance. (p 32)

The trauma-inducing factors in these women's experiences were, without exception, concerned with the manner in which they and their births were 'managed' by others. Their needs for control and mastery, human warmth, encouragement and information went unacknowledged and unmet.

2.8.4 Birth trauma and sexual violence

Disturbingly, women's accounts of birth trauma frequently resemble those of women who have been subjected to rape and sexual violence (Kitzinger, S 1992; Menage 1996; Beck 2004a; Beck 2004b).

I cried and shouted but was held down and told to stop making a noise...
(Menage 1996 p 533)

I felt like an animal being slaughtered (Kitzinger, S 2001 p 446)

I struggled up through my unconsciousness to tear away the oxygen mask. A bodiless hand mechanically replaced it, pushing me back down into abject airlessness. (Williams 1996 p 528)

Kitzinger, S (1992) describes how she and her daughters (who were working with female rape victims) compared the language used by 345 mothers who had experienced birth trauma with that of rape victims describing their experience of sexual violence. It was remarkably similar. Some spoke of being stripped of their sense of personal identity:

'He never even looked at the top half of me. I wasn't a person anymore.' 'I was merely a vessel with my contents to be offloaded.' (pp 72-3).

The common thread, running through all the women's accounts, states Kitzinger, was that of complete powerlessness. She also compares the various mechanisms at play in a rape scenario with that of the traumatic childbirth situation. Both groups of women may suffer acute pain and genital mutilation, both may be coerced into compliance by emotional blackmail or threats and both suffer forcible exposure of their genitals before strangers.

2.8.5 Birth trauma and sexual dysfunction

Not surprisingly, as a consequence of traumatic birth experiences, women may

suffer from long-term sexual dysfunction (O'Driscoll 1994; Smith 1998b; Bailham and Joseph 2003; Beck 2004b). This may be founded on the fear of becoming pregnant again, or, in some cases, because the sexual act triggers memories of the birth. One of Beck's (2004b) respondents reported having refrained from sex for six months following the birth of her child because the 'moment of penetration' caused her to have flashbacks to being pulled down the bed during an unsuccessful forceps delivery. Another, quoted by Kitzinger, S (2006a) described how sex with her partner caused her to have 'shooting pain' and 'a vision' of the doctor who sutured her perineum.

In addition, the woman's partner may also be traumatised by the event which will impact on their subsequent relationship (Church and Scanlon 2002; Kitzinger, S 2006b)

2.8.6 Birth trauma and its impact on the mother/baby dyad

The experience of birth trauma may have a negative impact on a mother's relationship with her baby. Reynolds (1997), Professor in the department of family medicine, University of Western Ontario, describes having contact with women whose chronic distress following traumatic birth not only affected their own sense of self-worth, but also their ability to breastfeed and bond with their children. They remembered their births only with '*pain, anger, fear or sadness,*' (p 833) or, in some cases, they were unable to recall anything, which, Reynolds postulates, suggests that they were experiencing traumatic amnesia.

Moyzakis (2004) reports that all six of her interviewees identified difficulties in their relationship with their babies which they attributed to their birth.

I didn't want him near me for a couple of days....It took me a while....if someone had taken him away.....and I'd never seen him again, it wouldn't have bothered me. (p 11)

Although this woman reported having difficulty relating to her infant for a short time, for others, it may take much longer to develop a satisfactory bond. Three out of the four women described by Ballard et al (1995) had ongoing difficulties

relating to their infants following traumatic birth. One (before giving birth) was described as outgoing and confident, happily married and welcoming of her pregnancy. Antenatally she had regularly sung and talked to her unborn child. Following her birth experience, however, she became clinically depressed, felt the baby was not hers and avoided all contact with him because of the 'intrusive recollections' he triggered in her. It took 19 months for her to recover, during which time her husband was obliged to take over caring for their baby and her parents moved house in order to be near enough to provide help and support. Discussion in the Midwifery Matters 'nettalk' pages (2004) also gives a moving illustration of the enduring problems and emotions that women may experience in relating to their children after traumatic birth. One reports feeling resentment towards her child, another that her relationship with her child (who was at that time ten years old) had been 'spoilt'. A third describes feeling that she had not given birth to her daughter but '*had her taken out instead....*' (p 39)

The work of Beck (2004b) provides one of the most useful insights into the world of women traumatised by birth. Her phenomenological study is a rich source of data on the lived experience of these women and is striking in its impact. Some of her respondents describe the well-documented 'numbing' and dissociation sequelae [see Chapter 9] associated with trauma (van der Kolk and McFarlane 1996; van der Kolk, van der Hart and Marmar 1996) which interfere with the task of mothering. Women felt themselves to be 'dead', their 'souls having left their bodies' and their existence continuing as a mere 'shell':

Mechanically I'd go through the motions of being a good mother. Inside I felt nothing. If the emotion did start to leak, I quickly suppressed it. (Beck 2004b p 219)

I wanted to feel motherhood. I wanted to experience and embrace it. Why was I chained up in the viselike grip of this pain? This was my Gethsemane – my agony in the garden. (Beck 2004b p221)

Emanating from many of these accounts is not only a profound disappointment and regret for what might have been, but a deep sense of isolation and guilt. Beck (2004b) describes how women traumatised by birth often isolate

themselves from other mothers and babies to the extent that one woman arranged to schedule her baby's clinic appointments 15 minutes before the clinic opened in order to avoid meeting other mothers.

2.8.7 Birth trauma and its impact on subsequent pregnancies.

Recently, the issue of women requesting elective caesarean section in order to avoid labour has been hotly debated (Carr 2003; Beech 2007) resulting in the popular stereotype of the woman who is 'too posh to push'. Although there may be some who eschew vaginal birth for relatively superficial reasons, it appears that many women feel unable to face normal labour for reasons more to do with their fear of losing control or of not placing themselves in situations which might be reminiscent of previous traumatic experiences (Beech 2007). Significantly, a study carried out in Stockholm (Sjogren, 1997) into reasons for women's anxiety about childbirth, reported that of the 100 respondents, 73% gave their main reason for fear as *'lack of trust in obstetric staff during delivery'* (p172).

Hofberg and Brockington (2000) examined the experiences of 26 women suffering from tocophobia, thirteen of whom suffered from secondary tocophobia (fear of childbirth resulting from a previous distressing or traumatic delivery). Of these, eleven arranged elective caesarean sections in order to avoid going through labour. It is also noteworthy that of the 26 interviewees, eight had experienced either childhood sexual abuse or rape. Their study also revealed that women who were refused their choice of delivery suffered higher rates of psychological morbidity than those who achieved their desired mode of birth. Of the three women who were forced to undergo vaginal birth against their wishes, all suffered from postnatal depression, two had symptoms of post-traumatic stress disorder and two experienced delayed bonding with their babies. From this longitudinal study (the women were seen over a two year period) it emerges that elective caesarean section may constitute an avoidance strategy employed by women who are unable to face their fear, avoidance being one of the diagnostic criteria for post-traumatic stress disorder.

Women are able to accurately remember the events surrounding their births for many years (Simkin 1991) and, as a result of a traumatic experience, may suffer long-term mental health consequences which interfere with the activities

of normal daily life. Kitzinger, S (2006b) quotes one woman who could not drive past the hospital where she had given birth without breaking out into a sweat. Other women have been known to avoid people who remind them of the 'perpetrator' or take detours in order to avoid going near the hospital building (Robinson 1999). Consequently, a substantial number of women who have had traumatic birth experiences may choose to give birth at home for subsequent births. Arguably, opting for a home birth may be described as an 'avoidance' behaviour in that it minimises the possibility of loss of control which is associated with exposure to 'the system'. One woman quoted in research by Rhodes and Hutchinson (1994) stated:

When it came right down to it there was no way that I was willing to put myself in the situation where anyone would have that kind of control over me. I had my baby at home with a midwife. (p 217)

Rose's account (1992) of her two births would also seem to convey the idea that home birth may, in some measure, constitute an avoidance behaviour. Her decision, to give birth to her second child at home, was strongly influenced by a lack of trust in medical staff. She explained:

...I'm sure the doctors could not have handled all of that emotionality and would have tried to use some kind of intervention. (p 218)

Furthermore, of the 19 births experienced by the incest survivors involved with Parratt's study (1994), over a third of them took place at home. Although it could be argued that this might have been predicted because Parratt is a home birth midwife, only one of her interviewees was an ex-client, the remainder having been recruited via incest survivors' support groups.

2.9 Summary

The literature indicates that the act of giving birth has a far greater significance to women than merely producing a healthy baby and is strongly associated with their subsequent psychological wellbeing, self-esteem, sense of mastery,

relationships with their partners and the ability to parent their children. In order to successfully navigate the rigours of the birth process, women need to be provided with appropriate care and support. The type of care women value is embodied in good, genuine relationships in which they feel valued, listened to and in which they can trust the character and competence of their carer. The work of Halldorsdottir and Karlsdottir (1996a) and other literature suggests that women's satisfaction with, and lasting perception of, their birth experience is greatly influenced by the quality of emotional care they receive at the time. The perception of having control during the process is highly indicative as to whether the event will be perceived as traumatic or not. It is, however, impossible to define the concept of 'control' as it clearly holds different meanings for different women, but the evidence that carers have a huge impact on enabling or preventing women from perceiving themselves to be in control is undeniable.

Recently, the phenomenon of 'birth trauma' has been recognised and research suggests that, although the percentage of women fulfilling the criteria for the diagnosis of PTSD is relatively low (between 1.9 and 6%), up to a third of all women may be experiencing their births as 'traumatic'. More often than not, birth trauma occurs as a result of the failure of maternity workers to provide the quality of emotional support and care identified by Halldorsdottir and Karlsdottir (1996 a and b) and others. Women are emerging from their birth experiences with symptoms identical to those suffered by individuals who have been subjected to *'rape, kidnap, automotive and industrial accidents, crime, civil disaster and various war-related events, such as combat, concentration camp or prisoner of war experiences'* (Menage 1996 p 532). The accounts of women who have experienced traumatic birth are characterised by loss of control and feelings of helplessness, often linked with the perception that caregivers are unsympathetic, emotionally cold and uncaring. Disturbingly, their accounts of birth trauma often strongly resemble those of victims of sexual violence and rape (Kitzinger, S 1992).

It would appear then, that post-traumatic stress disorder following childbirth is largely iatrogenic (Illich 1976). There is evidence that survivors of sexual abuse have a pre-disposition for post-traumatic stress disorder, but also that women who have no predisposing factors are emerging from birth with symptoms of PTSD.

The following chapter will look at what is known about childhood sexual abuse and its impact on women before proceeding to examine the literature specifically addressing the experiences of survivors in the context of childbearing.

Chapter 3

Literature review

3.1 Introduction

This chapter will discuss the definitions and prevalence of childhood sexual abuse and its potential sequelae, before going on to examine the impact this has on childbearing women. This will include the various psychological issues survivors bring with them to pregnancy and childbirth. The issues that are pertinent to their contact with maternity services will then be explored, such as control, touch, the parallels between birth and sexual violence and pain in labour. There will then be a short discussion on 'dissociation', a coping strategy which many survivors use to cope with such situations (Chapter 9 constitutes a fuller examination of this). There follows a discussion on the impact of CSA on breastfeeding and women's relationships with their offspring, after which there is an examination of the impact maternity carers have upon women with a history of CSA.

3.2 What is childhood sexual abuse?

It is only relatively recently that childhood sexual abuse has been recognised as a widespread problem affecting many individuals regardless of race, social class or culture (Holz 1994). Clearly, it is not a new phenomenon, and in the late 19th century, Sigmund Freud published a paper in which he linked 'hysteria'⁴ with early childhood sexual experiences. This arose out of his clinical practice and observations of his female patients. However, only one year later he re-interpreted his findings, stating that *'these scenes of seduction had never taken*

⁴Hysteria

Hysterical neurosis was the model on which Freud based his psychoanalytic theory and describes a 'simulation' of physical symptoms for which there was no detectable physical cause (Gross 2001). Originally it was thought that hysteria was confined only to women and was first linked to childhood histories of trauma as early as 1895 by the French psychiatrist Briquet. In the late nineteenth century the neurologist Jean-Martin Charcot described how "choc nerveux" could give rise to a condition which he called "hystero-traumatic autosuggestion". This was characterised by a so-called "hypnoid state", (nowadays recognised as dissociation) caused by the suffering of an unbearable experience (van der Kolk, Weisaeth and van der Hart 1996).

place, and that they were only fantasies which my patients had made up.' (Freud 1925/1959; p 34; quoted in van der Kolk, Weisaeth and van der Hart 1996 p54). Tragically, because of the respect afforded the work of Freud, this resulted in the widespread denial of the existence of childhood sexual abuse and consequently no research interest for a large part of the 20th century. During the latter half of the century however, with the rise of the feminist movement, society's changing attitudes towards women and new understanding about the impact of trauma on individuals, Freud's assertions began to be challenged. At last, childhood sexual abuse was acknowledged as a reality and sexual trauma was finally recognised as having long-term psychological sequelae comparable to those caused by other horrific events.

There are some variations in the definitions of what constitutes childhood sexual abuse but it is generally agreed that it is any kind of sexual activity which takes place between a child, who is not in a position to resist, consent to, or understand the significance of the act, and a sexually more mature individual. A 'child' is usually defined as someone under the age of 18 (Benedict et al 1999; Leeners et al 2006) although an 'abuser' is understood to be someone who is in a position of power over the child by dint of maturity or role, and who is fully aware of what is taking place. Thus, an older 'child' could be described as an abuser if his/her victim is significantly younger and less sexually aware. A useful definition is given by the American College of Obstetrics and Gynecology (2001 p311)

Childhood sexual abuse can be defined as any exposure to sexual acts imposed on children who inherently lack the emotional, maturational, and cognitive development to understand or to consent to such acts. These acts do not always involve sexual intercourse or physical force; rather they involve manipulation and trickery. Authority and power enable the perpetrator to coerce the child into compliance.

Simkin and Klaus (2004 p4) extend the scope of the definition to encompass 'psychological sexual abuse' which they say may include:

...exposing the genitals, voyeurism, intrusive interest in the child's sexual

development, or forcing the child to view pornographic materials or witness inappropriate sexual activities; and 'verbal sexual abuse', which includes 'erotic talk or innuendo, accusations of 'sexy', 'loose' or 'whore-like' behaviour, or other explicit language.

Sexual abuse of children can be perpetrated by a family member, a blood relative or someone the child believes to be a relative (incest), or by someone outside the family who is often in a position of trust or authority, such as a family friend, a member of the clergy, or a teacher (Holz 1994). Sexual abuse by strangers is less common (Kelly 1988; Satin et al 1992; Stenson et al 2003).

What is clear from the literature is that sexual abuse is largely concerned with the misuse of power and the betrayal of trust and therefore does not have to involve physical force in order to have a damaging effect. A child's essential dependence is the basis upon which an abuser is able to coerce and maintain power over his victim. Cooperation may be gained through manipulation using promises, threats, gifts or 'special' treatment (Rouf 2003; Simkin and Klaus 2004 p 17) The victim may not understand the significance of what he/she is experiencing, but may feel uncomfortable, frightened or confused about what is happening (Simkin and Klaus 2004 p21). The child will often be reluctant to disclose particularly if her abuser is someone to whom she looks for care and protection (Hobbins 2004; Smith 1998b) and sadly, disclosure may be met with disbelief and dismissal (Hobbins 2004; Robinson 2000; Rouf 2003). Summit (1983) suggests a paradigm to explain the behaviour of some abused children which he refers to as 'The child abuse accommodation syndrome'. This he defines by five categories; (1) secrecy, (2) helplessness, (3) entrapment and accommodation, (4) delayed, unconvincing disclosure, and (5) retraction. He argues that an abused child's normal coping behaviour may contradict the entrenched beliefs and expectations typically held by adults, laying him/her open to accusations of lying, manipulation and fantasising by the very people who are, theoretically, in a position to help. As a consequence, the child descends even deeper into self-blame, self-hatred and re-victimisation. Children who do disclose may be subjected to unwanted attention by authorities, experience a profound sense of shame and consequently some may recant or minimise their abuse (Hobbins 2003). Some children remain silent because of

various threats (such as physical punishment or removal from the family) made by their abuser (Rose 1992; Smith 1998b; Rouf 2003; Hobbins 2004). It is known that many children cope by suppressing their memories of abuse, [see Chapter 9 on dissociation] thus being enabled to continue with everyday life as if nothing were amiss (Chu and Dill 1990; Bass and Davis 1992; Hobbins 2004). Consequently, children are often trapped helplessly in abusive situations not only by their abusers, but also by the expectations and beliefs of a society, which, until very recently, has tended to look upon child sexual abuse as a rarity.

3.2.1 Prevalence

It is impossible to arrive at a definitive answer as to the incidence of CSA. Wilshaw (1999) argues that an 'accurate' assessment of the prevalence of abuse depends on the stage at which society is at in accepting its behaviour. However, this would appear to be somewhat simplistic. If abuse merely consisted of physical contact then it would be relatively easy to define. There are non-physical forms of sexual contact which are clearly abusive, but there are others which lie on the periphery, which are open to question and interpretation. To some extent, the idea of what constitutes CSA is socially and culturally constructed (Squire 2003). A certain proportion of the American population is clearly comfortable with the concept of the 'Little Miss' pageant, in which very young girls are dressed and made up to look like adult women. Other segments of that same society would perceive the whole idea as abusive and exploitative of innocent young girls.

The conflicting opinions about exactly how to define childhood sexual abuse results in a wide range of prevalence being quoted. Drawing on current research evidence, Community Health Sheffield (1998) cites a range of 12 to 51% of females reporting CSA, whilst the American College of Obstetrics and Gynecology [ACOG] (2001) puts the figure at approximately 20%. Other authorities suggest numbers may be as high as 54% (Kelly 1988), but studies undertaken in Sweden (Stenson et al 2003) and Germany (Leeners et al 2006) found prevalences of 8.1% and 15.9% respectively. It is highly likely however, that for multiple reasons, childhood sexual abuse is under-reported (Holz 1994;

Bohn and Holz 1996; Tidy 1996; Widom and Morris 1997; Robinson 2000). Not only are survivors kept silent by their own sense of shame, but, as previously discussed, some fail to speak out because of threats made by perpetrators to themselves or their family (Hobbins 2004). In addition, some women are affected by long term amnesia resulting from the trauma of their early experiences (Chu and Dill 1990; Hanan 2006).

It is possible then, that up to half of the women passing through the maternity services may have experienced some form of childhood sexual abuse. Given the probable scale of the problem, it is inevitable that midwives and other maternity workers will come into contact with a significant number of survivors during their careers (Simkin 1992b). It is, therefore, disturbing that so little apparent emphasis is placed upon making health care professionals aware of the implications of caring for these women.

3.3 The potential sequelae of CSA

Research shows that childhood sexual abuse results in a multitude of adverse short- and long-term effects in those who have been subjected to it. There is no single syndrome or cluster of symptoms which are universally present in survivors, but this kind of abuse has the potential to have an impact on every area of an individual's life. The work of Finkelhor and Browne (1986) has contributed significantly to our understanding of the effects of childhood sexual abuse. Their 'traumagenic model' suggests a conceptual framework of how and why CSA might have a damaging effect not only on a person's self-perception but also on how she views others and the world in general. Clearly, the sequelae of sexual abuse will differ from individual to individual and not all women appear to experience long-term psychological problems (Courtois 1988; Hobbins 2004). However, this model is particularly relevant to the data in this study and provides a useful insight into the problematic behaviours and psycho-social difficulties experienced by these women. It is defined by four categories: betrayal, stigmatisation, powerlessness and traumatic sexualisation.

3.3.1 Betrayal

Sexual abuse is characterised by a betrayal of trust particularly if it is perpetrated by someone whom the child loves and depends upon, such as a parent or guardian. Consequently, most survivors will experience difficulties with trusting others, particularly someone who is perceived as being in a position of authority (Grant 1992; Robinson 2000; Scalzo 2003; Simkin undated)

3.3.2 Stigmatisation

The entire issue of childhood sexual abuse is surrounded by a sense of shame. Many survivors are led to believe by their abusers that they are somehow to blame for what has happened to them (Summit 1983; Sanford 1991; Ainscough and Toon 1993; ACOG 2001; Rouf 2003) and consequently are burdened with guilt and self-blame. This not only ensures their silence, but leads to feelings of stigmatisation, alienation and social isolation.

3.3.3 Powerlessness

Childhood sexual abuse is, by definition, the exploitation of a weaker, dependent person, who is not in a position to resist, by a more powerful person. The child's natural vulnerability is exploited for the benefit of the abuser, resulting in feelings of powerlessness and helplessness in the victim (Sanford 1991; Simkin and Klaus 2004, chapter 2). These feelings are exacerbated by whatever means the perpetrator imposes as part of the abuse process i.e. coercion, threats, manipulation. The child's perceived (and actual) powerlessness is then reinforced when his/her attempts to halt the abuse are frustrated (Summit 1983).

3.3.4 Traumatic sexualisation

Victims of childhood sexual abuse are coerced or forced into premature sexual awareness and activity, which is inappropriate for their stage of physical, emotional, sexual and psychological development. This can result in a host of

sexually related problems later in life. The most common of these, according to the ACOG (2001) are issues such as fear of intimate relationships, dysfunctions of desire and arousal, flashbacks to abuse during sexual activity and feelings of repulsion. Other problems include high-risk behaviours such as dangerous sexual practices, promiscuity and prostitution (Mullen et al 1993; Holz 1994; Bohn and Holz 1996; Smith 1998a; 1998b; Dietz et al 1999; Seng et al 2004).

3.4 The far-reaching impact of CSA

As CSA occurs at a time when a person's psychological, social and emotional development is at an early stage, a survivor grows up with an image of her/himself and the world which is profoundly influenced by those experiences (Finkelhor and Browne 1986; Lipp 1992; van der Kolk 2003). Research has shown that adults who were sexually abused as children are also more likely to suffer from a whole host of inter-related emotional difficulties including depression, anxiety and excessive anger (Bachmann et al 1988; Benedict et al 1999; ACOG 2001). Amongst survivors of CSA there is also a higher incidence of mental health, psychological and behavioural problems, such as post-traumatic stress disorder, dissociation, eating disorders, self harm, addictions, substance misuse, low self esteem and phobias (Chalfen 1993; Holz, 1994; Tidy 1996; Heritage 1998; Benedict et al 1999; Squire 2003)

In addition to the huge influence on the emotional and psychological functioning of an individual, sexual abuse may also lead to somatisation. There is research evidence that women who have been subjected to sexual abuse in childhood are much more likely to experience chronic physical conditions than those who have not. These maladies include genito-urinary disorders, pelvic pain, gastro intestinal disorders, respiratory problems, frequent headaches, chronic fatigue, back pain, musculoskeletal pain, morbid obesity, insomnia and many others (Arnold et al 1990; Roberts 1996; Heritage 1998; American College of Obstetrics and Gynecology 2001; Taylor and Jason 2002; Scalzo 2003; Hanan 2006).

3.4.1 Issues survivors bring with them to pregnancy

All women entering into the experience of childbearing carry with them the impact of past events which have shaped their opinions and worldview. These factors will have a profound impact on their expectations of the experience, their subsequent perceptions of childbearing and adaptation to motherhood. However, women who have been affected by CSA will be approaching pregnancy with numerous antecedent factors which leave them with a pre-disposition for re-traumatisation (Weinstein and Verny 2004). Most will have experienced feelings of powerlessness at the time of their abuse, and for many this will have been exacerbated by being 'trapped' in abusive relationships which they were helpless to put a stop to. They may perceive themselves to have been betrayed not only by their abuser (often in the role of nurturer or carer), but also by others whom they felt were aware of their suffering but who failed to protect them (Buist and Barnett 1995; Kitzinger, J 1997). A significant number will have experienced psychosexual problems and many will have conflicting emotions around pregnancy. Some may have experienced chronic mental health problems or engaged in various 'destructive' behaviours such as alcohol misuse, eating disorders and self-harm. CSA is also known to be causally linked to post-traumatic stress disorder (PTSD) (ACOG 2001; Seng 2002a; van der Kolk 2003) and many survivors will have experienced at least some of the symptoms. Furthermore, a substantial number will have suffered long-term somatic disorders.

3.5 The impact of CSA on childbirth

A search of the literature on childbirth following childhood sexual abuse reveals the paucity of research specifically on that topic. The great majority of literature available to midwifery and obstetrics about the problems of sexual abuse survivors is anecdotal and has arisen out of the accounts of survivors or from the experiences of practitioners working with them (Christensen 1992; Courtois and Riley 1992; Lowe 1992; Simkin 1992b; Rose 1992; Holz 1994; Leckie-Thompson 1995; Tilley 2000; Gutteridge 2001; Rouf 2003; Scalzo 2003; Hanan 2006). There is, however, a small amount of qualitative work which is

particularly helpful in gaining an understanding into what birth is like for survivors of sexual abuse (Parratt 1994; Rhodes and Hutchinson 1994; Burian 1995; Kitzinger, J 1997; Smith 1998b; Seng et al 2002). These studies suggest that there are certain commonalities in the experiences of these women.

3.5.1 The body is the battlefield

The aftermath of violence is not 'all in the head' states Sanford (1991). What blows the mind or breaks the heart the body knows; it becomes a museum filled with artefacts from childhood (p 79).

Blume, (2004) in her preface to Simkin and Klaus's (2004) book 'When Survivors Give Birth' describes the abused woman's body, and in particular its sexual parts, as ... *the battlefield on which incest is played out* (p xxii). Like any other theatre of war, the resulting devastation of abuse lingers on long after hostilities cease, causing long-term suffering and hardship. The survivor of sexual abuse carries within her body, mind and emotions the consequences of the conflict and is unable to escape her personal war zone. According to van der Kolk (1996 Chapter 10) research in the area of post-traumatic stress disorder indicates that when an individual is confronted with reminders of their original trauma, psychophysiological and neuroendocrine responses occur indicating that they have been conditioned to respond as if they were re-experiencing the event:

...their bodies continue to react as if they are being traumatized even though the event may have occurred many years in the past. (van der Kolk 2002 p 65).

This is demonstrated in the birth account of Rose (1992), who found herself experiencing flashbacks to her abuse during childbirth. She described the memories of her abuse as being 'locked' into her birthing muscles, which had a profound influence on her birthing experience.

Survivors of sexual abuse may have difficult relationships with their bodies (Rouf 2003; Simkin and Klaus 2004). Simkin (1992b) suggests that some women may experience confusion and anxiety over body 'boundaries' owing to

repeated boundary violation suffered in childhood. However, she describes this in terms of survivors' resultant fear of invasive procedures such as pelvic examinations and vaginal ultrasound probes, which, arguably, may be more indicative of boundary confusion in the minds of maternity care providers than in the women. According to Kitzinger, J (1997) some survivors are dissociated from their own bodies or feel alienated from their sexual functions and this is seen in the account of Hanan (2006) who writes about her teenage lifestyle of heavy drinking and promiscuity which came about as the result of her feelings of self-loathing. The expression of her emotional and psychological pain was continually being replayed through her body '*I was just letting myself be abused again and again.*' (p 37) Similarly the survivor interviewed by Smith (1998b) became sexually active at the age of 12 and had had a number of sexual relationships by the time she was 15.

3.5.2 Barriers to becoming pregnant.

Thus, many women who have experienced childhood sexual abuse approach pregnancy with pre-existing problems concerning their physical and sexual selves (Weinstein and Verny 2004). Although most women will have concerns and conflicting emotions about childbearing, the issue of becoming pregnant may have profoundly disturbing implications for a woman who has suffered sexual abuse. The previously referred to study by Hofberg and Brockington (2000) reported that of 26 women suffering from tocophobia, five had been subject to CSA and three had been raped. Two respondents actually underwent terminations of planned and wanted pregnancies because they were unable to face giving birth, although the authors do not specify whether or not these women were survivors.

A high proportion of survivors will have experienced some kind of sexual dysfunction even if they are in stable, loving relationships, which may have made it difficult for them to conceive. 'Mary', the woman in Smith's case study (1998b) described how she had considerable difficulties with the sexual side of her marital relationship. This prompted her to consult a sex therapist who suggested that she and her husband should practise stroking one another. This she found impossible, much to the therapist's annoyance. The most she could

do, she explained, was to hold his hand. Moreover, during the time of their abuse, some women learn to view the idea of pregnancy with fear and dread. In some cases the pregnancy itself may be a result of abuse (Kitzinger, J 1997; Seng et al 2004; Simpkin 2006).

Many survivors welcome pregnancy however, and enjoy the changes occurring in their bodies. One woman quoted by Simkin and Klaus (2004) felt relief on becoming pregnant because at last her body was 'doing something right' (p35) causing her to feel normal. Heritage (1994) also writes *'I would have liked to stay pregnant forever. I loved my huge belly. I loved the private, middle-of-the-night talks with my baby. I loved feeling his kicks and squirms. (p 9)* Furthermore, Hanan (2006) found that she too loved pregnancy because, she explains, this was the purpose of her body. Sadly, this is not the case for all survivors. Lipp (1992), herself an incest survivor, describes most of the women she has contact with through self-help and support groups as *'terrified of becoming mothers'* (p 116). Some find their changing body image problematic (Aldcroft 2001). Seng et al (2004) quote one woman who felt as if her body had been *'taken over by aliens'* (p 609). It is also well documented that pregnancy and birth can act as 'triggers' causing memories of abuse to surface (Courtois and Riley 1992; Rose 1992; Parratt 1994; Burian 1995; Tidy 1996; Waymire 1997; Heritage 1998; Hobbins 2004)

3.6 Survivors, childbirth and control

It appears that the need for 'control' is of primary importance to all women, whether they are survivors of sexual abuse or not. Parratt (1994) concluded from her research investigating the experience of childbirth for survivors of sexual abuse that: *'the one need which seems to underlie all other apparent needs is that of control'* (p 36). Certainly, a review of the relevant literature supports this assessment. Burian (1995) in her study of 7 CSA survivors' birth experiences also identifies the subject of control as *'the single most important issue revealed in the interviews'* (p255). It is impossible to isolate the various issues concerning pregnancy and birth for survivors into clear, discreet categories as many are interconnected and overlap, but the element of control is present in the majority.

Rhodes and Hutchinson (1994) in their ethnographical field study identify four 'labour styles' displayed by survivors of sexual abuse; fighting, taking control, surrendering and retreating. However, it could be argued that the majority of these behaviours constituted the women's strategies to avoid losing control in a medicalised labour setting. The authors fail to make the important differentiation between women's response to obstetric or midwifery care during labour and the 'normal' physiological sensations of labour. It appears that the 'labour styles' displayed by the women in their study arose mainly in response to what was, or might have been done to them by caregivers;

The woman avoids eye contact, and the answer to attempted reassurances, such as 'just relax your legs open' may be an alarmed pleading of 'No! Please, no! (Rhodes and Hutchinson 1994 p 216)

Gutteridge (2001) suggests that phrases such as these, intended to calm and soothe, may be responsible for providing 'cognitive cues' that will cause the woman to re-experience her abuse. Rhodes and Hutchinson's study, despite containing some data from birthing women, is mainly composed of the perceptions of midwives caring for survivors, which limits its value in terms of providing understanding from the women's perspective. They suggest that a survivor may behave in certain ways in order to avoid triggering unconscious memories of her abuse and to:

...direct her childbearing experience in a way that is more satisfying to her by taking control of herself, her labor management, and her birth environment (p 217).

This statement would seem to indicate a researcher standpoint which is heavily influenced by the medicalised model of birth.

Burian (1995) also highlights what she describes as diverse 'control behaviours' adopted by her interviewees: 'aggression', 'submission', 'ritual' (which she describes as '*regulating every second and trying to do the same with those around them*' [p 255] similar to Rhodes and Hutchinson's 'taking control style') and 'living in a state of crisis'. With the exception of 'living in a state of crisis',

these are comparable to the findings of Rhodes and Hutchinson (1994). Seng et al (2002), who examined women's perceptions of maternity care practices for survivors of abuse-related post-traumatic stress using narrative analysis of interviews with 15 women, identify three categories of women; those who were far along in their recovery from trauma; those who were 'not safe' (i.e. those whose trauma was ongoing); and those who were not ready to know. Women in the first group, they assert, exhibited 'taking control' strategies firstly by seeking knowledgeable providers but also (like the women observed by Rhodes and Hutchinson 1994) by striving to maintain control over care issues that could constitute memory triggers such as; keeping males away from the delivery room; advising the midwife how to avoid painful scar tissue caused by a rape; trying to prevent people doing things to their bodies without their consent. Again, these assertions appear to reveal as much about the philosophy of the researchers as they do about the women. Interestingly, it was only the women who were well on the road to recovery in Seng et al's study who were able to manage their circumstances in order to achieve their ends. These were the women who were already empowered to some extent and therefore had the confidence to take control. It could be argued that the other women, who had not yet achieved that degree of healing, were obliged to rely on intrinsic strategies to avoid loss of control, such as dissociation, denial or retreating.

3.6.1 Loss of control over the body

As stated previously, women may feel that they have lost control over their bodies as a result of sexual abuse (Sanford 1991; Aldcroft 2001; Barlow and Birch 2004). However, this may be exacerbated during pregnancy. It seems that society in general views itself as temporarily immune from the normal social taboos governing touch and the passing of personal remarks when encountering a pregnant woman. On becoming pregnant, women often report that their bodies become the object of interest to relative strangers who may comment about their size or shape and even feel no qualms about patting their bellies (Rouf 2003; Barlow and Birch 2004; Hanan 2006). Hanan (2006), despite 'loving' her pregnancy was prompted to ask '*Why was my body now public property?*' (p 38) The perception of becoming 'public property' may be

further exacerbated by the women's contact with the maternity services. Once they become involved with the maternity care system women have little or no control over the extent to which they and their pregnancies are scrutinised; they become the property of the 'system'. Their only choice is between submitting to a degree of medical scrutiny and surveillance they may never have previously encountered (Gutteridge 2001), or opting out altogether and avoiding contact with the maternity services, which is the route taken by some survivors (Grant 1992; Kitzinger, S 1992; Burian 1995; Robohm and Bутtenheim 1996).

3.6.2 The significance of touch

Pregnancy and birth are 'loaded' with potential for women to perceive that they have lost control and to have their memories of abuse triggered. Clearly there is the issue of 'routine' care with its focus on the reproductive function of the woman and the very prominent role which invasive and intimate examinations play. Many women, (both survivors and non-survivors), are extremely anxious about how they will cope with this aspect of pregnancy (Devane 1996; Kitzinger, J 1997) and as a result, some opt out of the system (Robohm and Bутtenheim 1996). However, survivors who do commit themselves to the maternity care 'system' often discover that they are faced with a series of 'hurdles' which they must negotiate on their journey into motherhood.

The issue of touch is very prominent in the literature on childbearing and CSA. Firstly, by virtue of becoming pregnant, a woman is committing herself to a whole range of different 'touches'. As previously discussed, she may find herself the subject of unwanted attention from complete strangers, but during the course of her pregnancy and birth, she will also be touched by a host of professionals: midwives, doctors, phlebotomists, ultrasonographers and so on. Some survivors of sexual abuse may have already developed an aversion to being touched in any way, but the majority find invasive and intimate procedures problematic (Heritage 1994; Kitzinger, J 1997; Rouf 2003). Heritage (1994) recalls crying unexpectedly at each antenatal visit. At the time she had no memory of her abuse and could not understand *'the sudden terror, the shame and confusion'* (p9). Kitzinger, J (1990) gives an account of a 90-year-old woman who, in the process of being catheterised, appeared to re-live an

abusive episode in her childhood, crying out, *'Please don't do it daddy, please don't do it daddy'*.

The survivors interviewed by Kitzinger, J (1997) described their reluctance to submit themselves to intimate physical examinations while in the powerless position of a patient. Maternity carers often do not recognise the significance of their actions; a vaginal examination to them is a routine procedure and one which is particularly integral to obstetric and hospital midwifery practice. Caregivers fail to see that such an 'everyday' occurrence could be perceived very differently by their clients. Burian (1995) describes a woman for whom she was providing labour care who was displaying many of the behaviours indicative of a history of CSA. She had worked hard to gain her trust and the woman had allowed her to perform a vaginal examination when she requested an epidural. However, a doctor, whom the woman had never met, came into the room and insisted on repeating the procedure. Burian explained to him that the only way this woman could tolerate an examination was with one finger and her hand guiding his. During the process however, he suddenly grabbed her hand and completed the examination forcefully. She (Burian) immediately tried to comfort and reassure the woman, but without success:

I had lost her. She was sobbing. The bond I had worked so hard to establish had been destroyed. (p 252).

As seen in the discussion on birth trauma in Chapter 2, it is often this type of action by care providers which causes women to perceive their birth as traumatic. The vaginal examination and its conduct has been described as demonstrative of the power differential between caregiver and the woman (Bergstrom et al 1992; Stewart 2005). Robinson (2001a), commenting on the issues of consent in the context of intimate examinations states:

I gradually realized the problem arose not from defects in their [doctors] hearing or intellect, but in their ego. The woman who refuses their intervention or who tries to control it, is a challenge they cannot tolerate. They must demonstrate that they are in charge (p 708).

It is possible that in the above scenario (Burian 1995) touch is being used punitively, (Kitzinger, S 1997), the doctor asserting his power over the women (client and midwife) who have tried to control his actions. This gives opportunity to a plethora of emotions in the woman; betrayal of trust, loss of control and powerlessness, abusive memories, terror.

Touch does not necessarily have to be harsh or punitive however, in order to trigger memories of abuse. In Burian's (1995) study, one of the healthcare professionals involved remarked:

Touch is such an important piece for these women, because for the most part, they've never been touched in a kind way. (p 256)

However, this fails to take account of the fact that some abusers are neither violent nor brutal, but gain children's cooperation by exploiting their need to feel loved and special (Lipp 1992; Kitzinger, S 2006a). Consequently, many survivors will have been touched or fondled in a 'loving' and gentle way by their abusers. One woman quoted in Parratt's research (1994) stressed how unacceptable she found this kind of contact from maternity caregivers even though it was well intentioned:

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.... (p 35)

Another survivor quoted by Heritage (1998) commented that during labour she had been '*pestered by loving hands*' (p675)

Furthermore, the way in which people touch in the clinical setting reveals much about their perception of the power balance and '*conveys strong messages to the woman concerning her status vis a vis her attendants*' (Kitzinger, S 1997). It is not unusual to see a consultant patting a woman's leg or sitting on a bed next to her prone body resting his/her arm upon her leg whilst addressing her. At first glance this might appear to be a means of putting someone at ease or reassuring her until one tries to imagine the situation being reversed. This kind

of touch could be construed as paternalistic and is demonstrative of the unspoken and unquestioned hierarchical structure in which birth care in hospital is enshrined. However, it may prove too uncomfortable to be tolerated by a survivor who may have suffered abuse from a father or father figure. Kitzinger, S (2006a) describes how a survivor struck a midwife who persisted in resting her hand on the inside of her thigh. (p 55)

3.6.3 'It felt like rape'

Many survivors find that labour and birth can trigger vivid memories or flashbacks to abusive situations (Christensen 1992; Rose 1992; Parratt 1994; Smith 1998b). The evidence points to multiple causes for this. In some cases, it may appear to be rooted in the physical sensations of the experience. Rose (1992) describes how the pain of pushing her baby out during the second stage of labour caused her to flashback to a childhood abuse scenario

My mind was full of images of the rape I endured when I was 2 years old, when my mother's older relative tore me wide open from the top of my clitoris down to my urethra. (p 217)

The woman interviewed by Smith (1998b) reflected that, despite the fact that she had had what she felt was an 'easy birth', she came away from it feeling that she had been raped. She attributed this to having 're-lived' the sensation of penetration.

For one of the women in Parratt's study (1994), it was the lack of control over her body that reminded her of rape:

It's sort of like, when you're being raped and bashed you've got no control over what's happening and it's the same with giving birth, you can't really control it, the contractions keep coming, you haven't got a choice... (p 31)

However, in many other instances, the perception of violation appears to be more complex and has its origin in many negative emotions related to the original traumatic events. Survivors may experience powerlessness,

helplessness, depersonalisation, inhumane or unkind treatment by carers, as well as physical pain, each of which is reminiscent of their abuse. Rose (1992) describes how a particularly rough and insensitive speculum examination by a midwife triggered traumatic memories of her childhood:

the cold metal speculum felt just like the gun that my cousin had put into my vagina and raped me with when I was 10 years old. I felt very violated! (p 217).

Robohm and Bittenheim's questionnaire-based study (1996) comparing the experiences of 44 survivors with 30 non-survivors undergoing gynaecological procedures found that almost half of the survivor group reported being 'overwhelmed' by emotions such as panic, terror, helplessness, grief, rage and fear. Some reported crying uncontrollably and others said they felt violated, raped or tortured. Forty-three percent recalled having had body memories triggered by the procedures.

Of the 39 survivors interviewed by Kitzinger, J (1992), over half reported being reminded of sexual assaults by internal examinations, cervical smears or even dental treatment. One survivor (Rhodes and Hutchinson 1994) described how certain aspects of her labour had recreated memories of being tied up and abused by her father:

I was spread-eagled on a bed, my arms tied to drips (intravenous lines), someone fiddling around down there – it brought back the bondage (p 215).

Smith's interviewee (1998b) described a very similar scenario in her labour account:

....the feeling of powerlessness was there because in labour, you can't get out of bed in the same way as I could never escape as a child [...] I had to have a catheter and that was very much the feeling of just being messed about with down there. (p 25)

In each of these cases, it is the panoply of medicalised birth which is problematic, not the labour itself. The delivery of care for birthing women in an

environment which is highly routinised and task-focused may engender a sense of disembodiment and alienation for these women. As Kitzinger, S (1992) observes:

'the woman's body is fragmented, attention centred on the space between her legs. It is as if she does not exist as a person – only her genitals. (p 73)

The comparison with rape and abuse is inescapable.

3.6.4 Pain in labour

The issue of how survivors cope with the physical sensations of labour is a complicated one and the majority of the literature suggests that the only appropriate approach is that of individualised care, placing the emphasis on the relationship between the women and her caregivers (Heritage 1998; Howarth 1995; Robinson 2000; Hobbins 2004). The perception of control over their birth experience is of paramount importance, but, as has been previously pointed out, the definition of control varies from person to person. Thus one woman may feel that an epidural is necessary for the sense of control over labour, while another may need an unmedicalised, active birth, depending on her locus of control, previous life experiences and expectations of the event.

Some survivors find that the immobility produced by epidural anaesthesia causes them to feel they have lost control because it is reminiscent of their childhood experiences such as the woman quoted by Kitzinger, S (2006a) who had been repeatedly raped by her stepfather between the ages of 5 and 12 years, who said:

It wasn't the pain. It was being trapped, my legs splayed out and them doing things to me. (p 57)

On the other hand, an epidural, if it is her choice, can help a woman maintain a sense of control. Hobbins (2004) cites two contrasting cases in her paper: one, a woman who requested anaesthesia that would facilitate a 'painless' birth, and another who wanted labour and birth to be as natural as possible, including no

pain medications. Both had successful outcomes and were happy with their experiences.

Hobbins (2004) advocates a feminist model of care which: *'assumes that the woman does indeed know what her needs are'* (p 490) as the most appropriate approach to providing care for survivors of sexual abuse. Caregivers frequently have their own opinions on what form of pain relief women need, based on their personal philosophies and experiences of birth. Clearly, the satisfaction these women reported was based on the fact that they had been enabled to make true choices and had been supported in them by their caregivers. This is in stark contrast to the long-held medical belief that maternal satisfaction is largely linked with receiving adequate pain relief (Stuttaford 2005; Kitzinger, S 2006a). There is little research evidence on the impact of Pethidine or similar narcotic drugs on the survivor. What literature there is tends to be of the opinion that under the influence of this type of pain relief a survivor is likely to perceive herself to be out of control (Parratt 1994; Robinson 2000; Kitzinger, S 2006a).

3.7 Dissociation

The literature on survivors giving birth and traumatic birth is full of references to dissociation. Consequently, an entire chapter is devoted to the subject [see Chapter 9]. The anecdotal evidence shows that dissociation is viewed positively by some survivors as a means of escaping profoundly distressing circumstances and coping with intensely painful psychological or physical experiences which may be reminiscent of abuse. Many women considered the ability to dissociate to be protective and had developed this coping strategy during childhood (Chalfen 1993; Parratt 1994; Rhodes and Hutchinson 1994; Burian 1995; Smith 1998b; Seng et al 2004). The women's accounts of the mechanism of dissociation are very similar and often consist of focusing on a particular spot and disappearing into it, or removing their mind or spirit from their bodies, some even reporting that they were able to view the scene from outside their bodies (Rose 1992; Rhodes and Hutchinson 1994; Burian 1995; Smith 1998b). Often this response to labour goes unnoticed by attendants who are likely to consider these women to be excellent 'patients' who are to be admired for their ability to endure labour silently without demanding too much of

their time and attention (Rhodes and Hutchinson 1994; Burian 1995). *'She was just one of those people who you think are wonderful in labor'* commented one of the midwives interviewed by Rhodes and Hutchinson (1994), *'except they weren't there'* (p218).

3.7.1 Impact of dissociation on labour

There is little research evidence as to the impact of dissociation on the duration of labour. Parratt (1994) suggests that it may serve to shorten the process, but adds that a woman in a state of dissociation may only perceive her labour to be shorter because she may not be aware of her bodily sensations until it is well advanced. Benedict et al (1999) found no significant difference in the length of labour between survivors and non-survivors while Tallman and Hering (1998) postulate that survivors of sexual abuse are more likely to experience 'stalled labour' which they attribute, partially, to dissociation. On the other hand Rhodes and Hutchinson (1994) suggest that survivors who display what they describe as the 'fighting' style of labour (not those who surrender or retreat - behaviours encompassing dissociation) are more likely to experience longer labours and, consequently, higher levels of intervention, instrumental or operative delivery. A partial explanation for this may be that the body's response to stress, raising plasma levels of adrenaline and cortisol, interferes with uterine contractility (Niven 1994).

As Tallman and Hering's (1998) work suggests, dissociation can have negative consequences. One of Parratt's respondents (1994) felt that her being dissociated during labour was responsible for her baby becoming distressed. She described how, in an attempt to escape the 'unbearable pain' of labour, she *'shut down all the mechanisms of her body'* (p35) which resulted in a prolonged deceleration in the fetal heart rate. On realising the negative impact this was having on her baby, she *'started to come round again'*, at which time the heart rate returned to normal.

Rose (1992) describes how during her second birth, the physical sensations she experienced during second stage caused her to have flashbacks to her abuse. She recalls dissociating and viewing the scenario from outside her body, near the ceiling. Unlike some other accounts of dissociation in which the women

felt it had afforded them some measure of control, Rose's account is of a woman out of control and not functioning effectively in the birth process. It was only the patient encouragement and reassurance by her midwives that enabled her to be present for and involved in birthing her baby.

3.8 Postnatal issues

3.8.1 Relationship with baby

It is known that a history of sexual abuse can interfere with the bonding process and have a profound effect on women's ability to relate to their offspring (Buist 1998; Simkin and Klaus 2004 chapter 5). Some survivors of sexual abuse have an extreme response to the gender of their infant (Kitzinger, S 1992; Parratt 1994; Heritage 1998; Smith 1998b; Hobbins 2004). One woman may be anxious that she will be powerless to protect her daughter from sexual abuse, while another, feeling that all men are potential abusers, may find it difficult to accept that her baby is male. The interviewee in Smith's (1998b) case study expressed relief that her children were boys because *'it would have just been too much to watch myself grow up again.'* (p 26) One woman quoted by Kitzinger, J (1997) on first realising that her child was female, exclaimed *'Oh my God! It's a girl. I can't bear it if she has to go through what I've been through.'* (p 92). On the other hand, one of Parratt's (1994) interviewees felt that she related better to her daughter because she did not feel the barrier that existed between herself and her sons.

Some survivors find touching their infants problematic. For some women the reluctance to touch their babies appears to be linked with their personal aversion to touch as a sequela of abuse. One woman interviewed by Parratt (1994) refused to touch her newborn baby until she had showered and was back on the postnatal ward because that was when she felt she had reached the 'mother stage'. Others, having been subjected to inappropriate and unwanted touch during their own childhood, are unsure as to what constitutes abuse (Kitzinger, J 1997; Simkin and Klaus 2004 chapter 5). Lipp (1992) experienced this dilemma and describes her feeling of unease when changing her baby's nappy:

I pat his bottom. I pick up his penis and move it from side to side, making sure that I have cleaned him thoroughly. I am doing what I know a mother should. Then I think, 'Is this all right?' (p 115)

Furthermore, women who perceive their birth as traumatic may have difficulty bonding with their infants (Reynolds 1997) and, as discussed previously, survivors of childhood sexual abuse are predisposed to experience their birth as traumatic.

3.8.2 Breastfeeding

Research on the issue of breastfeeding and past sexual abuse is scarce but anecdotal evidence indicates that it can be problematic for some survivors particularly if the abuse involved the breasts (Lecky-Thompson 1995; Kitzinger, J 1997; Heritage 1998; Robinson 2000; Scalzo 2003; Hobbins 2004)

An interesting preliminary report on a study by Halliday-Sumner and Kozlick (1996) provides some useful information on exactly what difficulties survivors of sexual abuse may experience when breastfeeding. As the authors point out, the group of 42 women had a high incidence of operative and instrumental birth and nearly half experienced serious postpartum depression, all of which could be expected to have an impact on breastfeeding. However, the most commonly cited perceptions of first breastfeeding experiences appeared to be predominantly associated with CSA. They were:

- confusion and fear that breastfeeding might constitute inappropriate sexuality;
- shame or embarrassment about body, - "felt dirty";
- stress due to the triggering of sexual abuse memories.

These perceptions are borne out by other literature (Kitzinger, J 1997; Heritage 1998; Scalzo 2003; Klingelhafer 2007). Heritage (1998) describes a woman whose submerged memories of abuse were first triggered by trying to breastfeed her baby. One woman interviewed by Seng et al (2004) found herself experiencing 'physical and affective memories' which were particularly distressing when breastfeeding:

...every time [the infant] would latch on to nurse I would just sort of be hit with these uncomfortable...kind of nauseating...I call them flashbacks, [...] but it's just sort of the physical manifestation of the incident. (p 608).

One of the women described by Klingelhafer (2007) was averse to breastfeeding perceiving it as abusive because her baby had no choice and was unable to give his consent.

Survivors' problems with breastfeeding however, may be exacerbated by the inappropriate actions of caregivers (Klingelhafer 2007). Simkin and Klaus (2004 p 98) point out that women's first experience of breastfeeding in hospital usually consists of a maternity worker holding her breast and pushing the baby towards it in an attempt to induce him/her to latch on. Tilley (2000), a midwife and survivor of sexual assault, comments:

I have seen many a breast grappled with in the name of what is natural and best. (p 19).

It is reasonable to surmise that actions such as these could trigger memories of abuse.

Kitzinger, J (1997) also highlights the difficulty survivors have with the 'sensuality' of breastfeeding and their subsequent confusion over whether or not this constitutes abusive behaviour. Furthermore Simkin and Klaus (2004 p 98) and Hobbins (2004) suggest that their baby's frequent feeding demands may cause survivors to feel 'abused' or manipulated and consequently, out of control.

3.9 Lack of professional understanding

Until fairly recently, it was not acknowledged that a history of childhood sexual abuse could have repercussions for birthing women. It was considered to be something that had happened in the past from which women were expected to have recovered, moved on and which certainly had no relevance to their current situation (Courtois and Riley 1992; Tallman and Hering 1998). Rose (1992), in

the account of her first birth, recalls how her doctor and even her therapist both '*vigorously assured*' her that the issues concerning her childhood sexual abuse would not come up during her labour because she would be '*too busy just having a baby*' (p 215). However, the memories of her abuse had a deep impact on both her birth experiences.

3.10 The impact of caregivers

The importance of women's relationship with their maternity caregivers has long been underestimated but it is clear from the evidence that women's perception of the manner in which they are cared for is highly significant. Robinson (1999), who, as research officer for the Association for Improvements in the Maternity Services (AIMS), was privy to the accounts of many women who had contacted the organisation after a traumatic birth, comments:

I have never seen a case involving extreme pain and anxiety which did not also have a strong element of staff involvement. Invariably one or more doctors or midwives were seen as cold, uncaring, distant, authoritarian or even malevolent and women felt helplessly in their power. Postpartum PTSD sufferers seem to have more in common with torture victims than those who suffer PTSD after natural disasters. (p 684)

Arguably, the organisation charged with providing maternity care has repeatedly failed to acknowledge that childbearing women may require more than clinical competence from carers and a healthy baby from their experience of birth. However, as discussed in Chapter 2, recent evidence suggests that women want genuine relationships with their midwives and that being supported by known and trusted carers helps them to perceive their birth experiences positively (Halldorsdottir and Karlsdottir 1996a; 1996b; Gibbins and Thompson 2001; Waldenstrom et al 2006). Conversely, when these needs are not met, women are more likely to have negative perceptions of birth and up to a third may emerge with some of the symptoms of post-traumatic stress disorder.

3.10.1 Trust and betrayal

Arguably, one of the major traumagenic factors concerning contact with maternity care providers arises from women's expectations of care which are partly informed by literature which promotes the maternity services as a woman-centred agency of care. This creates the impression that they will enter into a collaborative relationship in which they will be able to discuss their needs, participate in decision-making and make free choices. However, the reality is often very different. A woman will undoubtedly be offered choices, (many of them concerned with the various screening tests provided by the institution) but these will be to a great extent determined (and strictly limited) by the medical or institutional agenda. The choices she might wish to make and the decision-making she may want to be involved in may be disallowed or not available [see Chapter 1 for a fuller discussion on the issues regarding choice and control]. Furthermore, she may find that the collaborative partnership exists only until she wants to make free choices. Consequently, she may experience feelings of betrayal, reminiscent of those engendered in situations in which a child's expectations of care and nurture are met with abuse (Courtois and Riley 1992; Grant 1992; Chalfen 1993; Kitzinger, J 1997; Hobbins 2004; Aldcroft 2001). Betrayal by a parent, nurturer or guardian often leads to an inability to trust others, because, as Rose (1992 p217) explains:

...there is something so intensely painful about being abused by someone you love. It makes it very hard to trust.

As previously pointed out, birthing women need to feel safe enough to let go of conscious control in order to allow their bodies to give birth (Anderson 2000; Tilley 2000; Parratt and Fahey 2003) This, as we have seen, depends to a large extent on whether or not they are able to trust their carers and on the quality of emotional care they provide. Relinquishing mind control entails entrusting themselves to individuals whom they have to believe will act protectively and beneficently. If their belief that health professionals cannot be trusted is confirmed, they may subsequently avoid all contact with the health services (Burian 1995; Robohm and Bittenheim 1996). An example of this was given by

one of the survivors interviewed by Kitzinger, J (1997). She had avoided vaginal examinations during 16 years on the contraceptive pill and for the duration of a pregnancy because of a traumatic smear test she had experienced in her twenties.

I can see myself walking out the hospital gate feeling guilty, not a good wife, dirty, in pain, humiliated. They were holding me down while the doctor tried to take a smear; they were shouting at me. It was painful, I just wanted to get away. They said my marriage wouldn't last and I should be ashamed of myself for carrying on like that. (p 88)

The unsympathetic and paternalistic way in which this procedure was handled by clinicians triggered memories and emotions associated with her abuse. As a consequence, she was thereafter reluctant to place herself in the situation where this experience might be repeated.

3.10.2 Emotional warmth

It appears that for all women the importance of warmth, kindness and emotional 'availability' in their caregivers is central to their long-term perceptions of birth (Burian 1995; Halldorsdottir and Karlsdottir 1996a; 1996b; Gibbins and Thompson 2001; Moyzakitis 2004). For survivors of sexual abuse, with their propensity for psychological trauma, the consequences of insensitive, non-relational care (often reminiscent of their abuser) can be to trigger memories and emotions related to their childhood experiences. One of Seng et al's interviewees (2002) described what lay behind her decision to change maternity carers in late pregnancy:

The doctor was kind of cold, not personable at all, and those feelings [emotional memory of being abused, shame, vulnerability, nakedness] would come back to me in his office, and I found myself crying at every visit (p 367).

Similarly, one woman interviewed by Parratt (1994), found her childhood memories triggered by the apparent attitude of a doctor who was suturing her

perineum. Unfortunately, unlike the woman quoted above, she was in no position to change the situation:

He came across as very cold and I didn't like that and it made me feel uncomfortable [...] he told me off, sort of, told me to stay still and I mean that felt horrible (p 33).

In a milieu in which strangers may be involved in extremely intimate contact with a woman, in order to de-sexualise the event, interactions may be highly ritualised and approached from an objective point of view (Bergstrom et al 1992). Caregivers may avoid making eye-contact or focus solely on the woman's genitals which may cause survivors to feel depersonalised and objectified, replicating their childhood experiences (Kitzinger, J 1997).

3.10.3 Being listened to

The importance of two way communication and being 'heard' is well documented as important to all birthing women (Kirk 1994; Kirkham 1989; Weaver 1998) but particularly so to those who have suffered abusive childhood experiences (Burian 1995; Seng et al 2002; Rouf 2003). One of Burian's interviewees (1995) described her frustration with her gynaecologist whom she felt was not listening to her when she consulted her repeatedly regarding chronic pelvic pain. She emerged from the doctor's office in tears:

I knew there was something wrong and it's like, why can't somebody see that I'm in pain?...hear my voice, hear me! Just don't say "Oh, there's nothing wrong with you," and "It's all in your head," and everything else. What I feel in my body is because of my head, because of the abuse I've been going through. (p 255)

It appears that this woman felt reticent about disclosing her history of abuse, but wanted her doctor to 'read between the lines' and enter into discussion as to the reasons for her physical discomfort. Similarly, another woman cited in her study described her willingness to disclose given the opportunity. However, the opportunity never arose because her caregivers did not create a dialogue in

which this would have been possible.

Rouf's personal account (2003) demonstrates how a midwife with excellent communication and listening skills can enable a survivor to have a positive birth experience. Rouf recalled her midwife as being sensitive to her needs, facilitating discussion about her concerns and listening to her feedback so that when labour started, she felt well prepared, supported and consequently, in control.

I felt that I had been listened to, and felt that my midwife was an ally who cared about what happened to me as well as my baby. (p 143)

As the above quote illustrates, the issue of being 'heard' lies at the heart of good relationships and results in the woman feeling valued and empowered. Conversely, the failure to 'hear' her may reproduce feelings of powerlessness associated with abuse. Rose (1992) described a situation as '*uncomfortably familiar – just like the abuses of my childhood*' (p 216-7), when undergoing a speculum examination by a midwife who ignored her claims that the instrument was causing undue pain and continued with the procedure apparently unconcerned. As we have seen, loss of control and powerlessness associated with the childbearing process are instrumental in traumatising any woman. The issue of being listened to and having the option of calling a halt to any procedure is therefore paramount, if women are to be spared the far-reaching sequelae of traumatic birth.

3.11 Summary

In recent years, childhood sexual abuse has been acknowledged as widespread and although the exact incidence is not known, estimates suggest that between 7 and 50 percent of girls may be subjected to some kind of sexual abuse, depending on definition. This holds implications for midwives and maternity workers, as it is inevitable that during their working lives, they will come into contact with survivors. Most authorities believe that, for various reasons, abuse is under-reported, and many survivors either do not wish to disclose their secret or are suffering from long-term amnesia as a result of the trauma they

experienced as children. As a consequence, maternity workers will often be unaware that their clients have suffered sexual abuse and are therefore predisposed to post-traumatic stress disorder.

Becoming pregnant involves a loss of control over one's own body, but in today's industrialised maternity care system, a woman is expected to commit herself to a package of care, in which she will be observed, touched (in many cases, intimately) and scrutinised in diverse ways, by a host of different professionals. This care is perceived as 'routine' by maternity workers, who may fail to recognise the significance of their actions and consider that some women might find it unacceptable. Because of their abuse, survivors bring a host of issues with them to pregnancy, childbirth and parenting and although they have similar needs to those of all women, their reactions, coping strategies and demands may appear extreme to those caring for them. Having lost control over their bodies, and in many cases their circumstances, during childhood, the survivor's need for control is paramount. This may give rise to many different control behaviours and strategies, such as the four 'labour styles' reported by Rhodes and Hutchinson (1994). However, these may constitute survivors' means of coping with the medical management of labour, more than the physical sensations of the natural process.

Many of the accounts of negative birth experiences are peppered with metaphors of rape and sexual violence - 'skewered', 'treated like a lump of meat' (Kitzinger, S 1992) 'like a carcass to be dealt with' (Menage 1996). It appears that what is important to survivors undergoing labour and birth, are human qualities, such as good communication, emotional warmth and compassionate caring. It is these qualities which protect women from feeling objectified and, as a consequence, re-living their abusive experiences. Failure to have their needs for emotional support met may result in women feeling a sense of betrayal mirroring that which they experienced as children abused by people they loved and relied upon for nurture and protection.

A survivor of sexual abuse can experience difficulties relating to her baby, some women finding that they are uncertain as to what constitutes abuse. Consequently, they may be reluctant to cuddle or caress their babies. Others find touch problematic because of their own aversion to being touched. In addition, women may find breastfeeding difficult, particularly if their breasts

were involved in their abuse. The kind of breastfeeding support they receive can be counterproductive, if it constitutes unwanted and inappropriate touch. Most of the literature concerning birth for survivors of sexual abuse emphasises the importance of the midwife/mother relationship and the positive impact that sensitive, individualised care can have upon these women (Kitzinger, J 1992; Rose 1992; Parratt 1994; Burian 1995; Page 1996; Smith 1998b; Tilley 2000; Seng et al 2002; Rouf 2003; Simkin and Klaus 2004 chapter 6). In an environment that is tightly controlled by medical protocols and in which institutionalisation imposes an 'assembly line' ethos upon birth and birthing women, it falls to the midwife to 'humanise' the process. It is she who is in the position to provide emotional and psychological care for birthing women.

Chapter 4

Methodology

4.1 Introduction

In this chapter I will discuss my own stance and how I feel this may have impacted on the women and the way I went about the research. Firstly, I will describe the original motivation for the project as it was conceived by Maggie Smith, followed by an examination of my own experiences as a midwife and how these have affected my view of the maternity services and my philosophy of midwifery. Following this, I will explain my standpoint as researcher, discussing my position on the continuum between positivism and postmodernism. The role of 'stories' is then discussed in terms of the development of personal narratives and their impact on individuals' perception of themselves and significant life events such as birth. Finally, I explain the rationale behind my choice of research method.

4.2 The rationale for the project

The research project was originally conceived by Maggie in response to what she perceived as the dearth of knowledge surrounding the impact of pregnancy and childbirth on women who had suffered childhood sexual abuse. From her experience (cited in the introduction to this thesis), it was clear that most midwives and others caring for women at this crucial time had probably never entertained the idea that during their working lives they would come into contact with many women who had closely guarded secrets that could have an immense influence on how they approached and perceived pregnancy and birth. Women who find vaginal examinations or intimate procedures difficult are often perceived as being awkward and many times I have been witness to the 'coffee room post mortem', in which they are dismissed with comments like 'Well, if that's how she behaves for V.Ex (vaginal examinations), I don't know how she got pregnant!' It was following a similar scenario that Maggie felt prompted to undertake her own research on the topic of sexual abuse and its impact on birthing women.

4.2.1 Aims of the study

The project was set up in order to identify and examine the experiences of survivors using the maternity services, in order to gain a more thorough understanding of the problems they encounter during pregnancy, birth and beyond. As Maggie had discovered, knowledge concerning the difficulties that these women face is sadly lacking, and relevant literature, particularly from a feminist stance, is scarce. As discussed in Chapter 3, women may speak of their bodies becoming 'public property' during pregnancy, having their bellies patted by relative strangers, or having their size or shape commented upon (Rouf 2003; Hanan 2006). This may be particularly difficult for survivors who have suffered the loss of ownership over their bodies as small children. During the course of their pregnancies, women are also subjected to many 'routine' medical procedures such as vaginal examinations, abdominal palpation, fetal heart monitoring and many others, which survivors may perceive as further loss of control and, therefore, abusive. This study was designed with the aim of (as much as is possible) entering into the world of pregnant and birthing survivors in order to gain an in-depth understanding of their perceptions of maternity care. It is hoped that, ultimately, bringing to light these women's stories will help to inform professionals working within the maternity services, in order that they may be confident that the care they provide is appropriate for the needs of all women, including survivors.

4.3 Maggie and I

4.3.1 Maggie's motivation

In order to describe the motivation and the ideology which underpins the work, I feel it is necessary to understand her approach to midwifery. Maggie described herself as a 'born midwife' but trained later in life, having raised her family first. Apart from the family, midwifery was her '*raison d'être*'. She was always truly 'with woman', regardless of background or status, but was particularly exercised in her commitment to improve the lot of marginalised or disadvantaged women. She was the type of midwife who had the ability to make every woman she

cared for feel special, and would always strive to honour women's wishes. It was this 'woman-centredness' that sometimes brought her into conflict with the prevailing medical ethos. However, she was undeterred; the women's needs were paramount (Smith 1998d).

I was privileged to join Maggie in the research when she first received her diagnosis, although, at the time, none of us knew what the future would hold. Although I could never place myself in the same league as her, my clinical practice has been profoundly influenced by her example; I have often asked myself 'What would Maggie do?' when confronted by a difficult situation. I have consequently endeavoured to continue the project in the spirit in which it was conceived and in a way of which, I think, she would have approved.

4.3.2 Taking the baton - my influence

Clearly, I will have brought my own ideas and influences to bear on the research, so it would be helpful to explain something of my background. Moreover, who I am as a person, a woman and a midwife has had a profound influence on how I went about the project. Like Maggie, I came to midwifery later on in life, having first had a career as a peripatetic music teacher and a life dedicated to making music. Being a musician is something which forms part of my identity and music has played a huge part in my life. It is both highly structured and, at the same time, interpretive. Although normally written with detailed instructions concerning tempo, dynamics and style, it also requires intuition and sensitivity on the part of the player. Music is both humanistic, in that it has the ability to portray the depths of human emotion, yet also spiritual, having the potential to take us beyond ourselves. Music making is often a communal affair involving individuals who are united in their aim to produce a performance of which they can be proud. As a solitary pursuit, in composition, or in performance with others, it can be truly 'inspired', as I have myself experienced many times. To me, the 'experience' of music is something which comes from deep within but also, in moments of inspiration, inexplicably, from outside of myself.

In my position as a teacher I had a good deal of autonomy and respect and was generally left to make my own decisions, plan my teaching, enter pupils for

examinations and festivals without having my judgement questioned. I was trusted to perform the task for which I was employed and was treated very much as a responsible adult. I had an excellent reputation and was generally considered to be a very competent teacher. Despite feeling very unconfident initially, with encouragement from increasingly good examination results and affirmation from colleagues my confidence grew. I know that the positive feedback given to me by others was crucial in the development of my competence and confidence.

4.4 Another culture, another world: how are the mighty fallen!

My initiation into clinical midwifery came as a total culture shock. I now realise that my expectations of midwifery were hopelessly naïve. I had envisaged kindly midwives and doctors working together with women to enable them to birth their babies in an atmosphere of warmth and encouragement. In the academic environment of the university, as new students, we were taught that pregnancy was a normal, healthy life event, that midwives were 'practitioners in their own right' and of the great benefits to be gained from supportive, woman-centred care. The reality, I found, was deeply shocking. That I am not alone in this is evidenced by the comments of many others including Davies (1996 p 285) who describes precisely this scenario. Speaking of the reaction of student midwives on qualifying she says:

...many are terrified of practising midwifery and particularly about working on the labour ward. [.....]Because the concept of 'normality' is fundamental to the midwife's identity it causes many students to experience something akin to an identity crisis.

However, it should be pointed out that what these students (and I) feared was not practising midwifery, but obstetric nursing, a job for which they felt unqualified. The situation could be compared to learning all the arts of equestrianism, to then be expected to drive a car with an extremely demanding 'back-seat driver'!

4.4.1 Surveillance and discipline

However, not only was my fear of working on labour ward based on the mismatch between two conflicting definitions of 'normal' (those of medicine and midwifery), but also on the certain knowledge that my definition was the wrong one! Foucault (1975), when discussing the impact of Bentham's Panopticon on the penal institution, asserts that its major effect was '*to induce in the inmate a state of conscious and permanent visibility that assures the automatic functioning of power*' (p 201). I felt that I and my practice were constantly under surveillance, which, although probably a false impression, provided the incentive for me to conform to what was considered by the organisation to be 'the norm'. As Foucault (1975) points out, disciplinary power is usually invisible until it is challenged; a fact which was confirmed to me more than once. On one occasion, having suggested to a registrar that the woman I was caring for was contracting perfectly well and did not require her syntocinon infusion increasing, he proceeded to examine the woman vaginally and promptly decided that she required an operative delivery without discussing his findings or his plan of action with her or me. Having ensconced himself in theatre, when the woman did not duly arrive, he loudly denounced the inefficiency of her midwife and dispatched another midwife to inform me that he was waiting to start the operation. By the simple act of denying me information, he succeeded in discrediting me in front of my colleagues, the woman, and her partner, but in so doing also ensured that I never challenged his authority again. Even more reprehensible, however, is the fact that he deprived the woman and her partner of the information and subsequent support that I could have provided had I known what was happening. I still wonder whether his decision to operate was to some extent motivated by his desire to discredit my opinion that her contractions were adequate.

4.4.2 'Normal' birth

Although a good number of the births I witnessed in hospital were fairly non-interventionist, on looking back, my definition of normality has changed dramatically since becoming independent. When I was working in the NHS,

interventions such as the use of syntometrine and controlled cord traction to deliver the placenta, and the routine administration of vitamin k to infants were invisible to me. I had no other experience or expectations. However, it was the 'deliveries' in which women were pulled down the bed by doctors using excessive force with forceps; in which blood was spattered up the walls and on to the ceiling and the delivery room resembled a slaughterhouse rather than a place of birth; in which women were subjected to multiple vaginal examinations by numerous different people, which made me reluctant to work on labour ward, and to ask myself if this was really what giving birth should be about. Sadly, these experiences are not isolated incidents, as witnessed by some of the interviewees' accounts and also by other literature (Kitzinger, S 1992; Robinson 1999; Moyzakis 2004).

4.4.3 Hegemony and hierarchy

Not only was there a huge discrepancy between reality and the theoretical definitions of 'normality', but I found that my knowledge, my previous life and professional experience were all as nothing in this environment. Bosenquet (2002), who was a student midwife at the time, wrote a very powerful article about her initiation into midwifery, having had a previous profession. Her experience so accurately mirrors mine that the words might have been my own:

I was surprised at the strength of the effect the hospital environment had on my actions and sense of identity. A confident professional woman before I began my training, once I put on my student uniform and became a novice at the bottom of the hierarchical structure, all my confidence, previous knowledge and life experience disappeared. I found myself being 'invisible' referred to as 'this girl', told off by junior doctors (half my age) and blushing at the sight of a consultant. Assertive before, now I put up with being publicly humiliated by some of my seniors, and remained silent when witnessing poor standards of care. (p 302).

I found, like Bosenquet, that I shared the women's position at the bottom of the hierarchy; we were invisible and powerless. The musical concepts of

interpretation, intuition and creativity had no place in this environment which was dominated by technology, rigid policy and rationality. As Kirkham (1999) argues, the culture within the NHS reflects its rootedness in the masculine vision of the world: '*socially coded as separating, controlling, competitive, masterful and hierarchy-orientated*' (p733). Within this culture, not only are female values such as caring and nurturing invisible but attributes such as intuition or interpretation are positively discouraged.

4.4.4 Bullying into submission

Often, circumstances in which individuals feel powerless and undervalued will lead to bullying or 'horizontal violence'. Gould (2002) uses the term 'midwifery cannibalism' to describe the phenomenon. Bullying also features prominently in the reasons why midwives leave the profession (Ball et al 2002, Stephens 2005). During my time as a student I was privileged to be mentored by some fine, caring midwives, but there were also those whose sole intention seemed to be to humiliate me and destroy the miniscule amount of confidence I had. On qualification I soon realised that I was not, as I had hoped, 'a practitioner in my own right', but an obstetric nurse. I was not required to be creative or original, but to keep the organisation running efficiently and be an agent whereby the institution imposed its will upon women. Never before had I encountered such a powerfully androcentric and intransigent organisation, nor had I previously been aware of the huge amount of control the medically oriented system exerted over women and birth. I continue to be amazed at the vehemence with which this stronghold is defended (Katz-Rothman 1982; Savage 1986; Pratten 1990; Wagner 1997; Harcombe 1999; Edwards 2005).

4.4.5 Rehabilitation

Having now left the NHS and set up as an independent midwife, I feel that my balance is finally being redressed. I have a certain degree of autonomy and can use my own clinical judgement, looking to the 'Midwives rules and standards' (NMC 2004) as my yardstick rather than policies formulated in the interests of

organisational efficiency or medical criteria. Being outside of the system, I am now regaining confidence, not only in myself but in the ability of most women to give birth without interference. Furthermore, I am now able to use my 'right brain' feminine attributes, such as intuition, interpretation, creativity and spirituality, alongside my 'evidence based' knowledge and clinical experience. As a consequence, I believe that now I am able to offer myself to women as a more integrated person and therefore care for them in a more holistic manner.

4.5 My philosophy of midwifery

4.5.1 From technomedicine to holism - my place on the continuum.

In order to explain my philosophical position and, therefore, my own impact on the research, I feel it is necessary first of all to 'place' myself as a practising midwife. Davis-Floyd and Mather (2002) speak of three different paradigms of childbirth; the technomedical, humanistic and holistic models. Clearly, these represent different points along a continuum, and individual practitioners could be 'placed' somewhere on the scale according to their own particular beliefs. Within obstetrics and midwifery there are those who would fervently uphold the technomedical model, whereas there are others in both professions who are deeply humanistic. It is probably true to say that there are not many (myself included), who would place themselves at the extreme holistic end of the continuum as defined by Davis-Floyd and Mather:

Many midwives define themselves as holistic and consciously seek to work with what they call 'birth energy'. [.....] Intervening to 'redirect the energies' can ensure that no other type of intervention will be needed [.....] a midwife who has a feel for the power of energy may throw open the window, put on some music, and get the mother up to dance. (p 504).

I would argue that belief in 'birth energy', or, in fact, any specific 'faith', is not prerequisite in order to practise holistically. Throwing open the window, putting on music and getting the woman up to dance could just as well be initiated by a humanistic midwife, but with the same results. For example, Klassen (2001)

quotes the birth story of a woman called 'Eva' with whom she came into contact during her investigation into religion and home birth:

[T]he next thing I know I'm pushing the little one out into my own hands; what utter exhilaration! I lifted him up onto my chest and felt his warm little body curl up in his mother's arms.....The next few moments after the birth were full of exhilaration on my part for this wonderful birth to have produced such a beautiful healthy baby and for [my older son and sister] to have shared in such a miraculous experience... (p 87).

This incredible experience was facilitated by a midwife who merely 'took a back seat' and suggested that the woman should 'catch her own baby'. This selfless act on the midwife's part may have stemmed from a profound humanity, which did not necessarily have any spiritual connotations. However, the end result was that the birth was an intensely personal spiritual experience for the mother, but in no way dependent on the spiritual beliefs of her midwife. It had much more to do with the midwife's personal philosophy of birth.

I would like to think of myself as practising holistically, but not totally within Davis-Floyd and Mather's definition. I do choose to believe in certain truths and my faith is very much a part of my identity. In my dealings with childbearing women, I am wholly present: as a woman, a musician, a mother, a midwife and a Christian. It could be argued that, coming from this point of view, I might be biased in my opinion of what the spiritual nature of birth should be. However, I would argue that my faith helps me to respect the beliefs of others. Knowing that to have faith is '*to be certain of the things we cannot see*' (Hebrews 11: 1 Good News Bible) I am very much aware that spirituality and belief are not based upon anything that can be proven or demonstrated - it is a choice. I have cared for women with a wide spectrum of beliefs, from those with none at all, through those of the 'traditional' faiths, to pagans. To each individual, birth has had a different meaning and significance. I consider myself to be a facilitator, in that the spiritual dimension of birth for each woman lies not in my own personal beliefs, but in their experience. Birth can speak for itself.

4.6 My philosophy in research

4.6.1 From positivism to postmodernism - my place on the continuum

The continuum from technomedicine to holism could be compared with that of the diverse approaches to research, going from positivism, with its belief in the notion that *'one objective and true reality [...] can simply be 'discovered' with rigorous and careful research instruments'* (Mason 1996 p 150), through to the interpretivist or postmodern stance, which acknowledges that no research can be free from bias and that *'knowledge and understanding are contextually and historically grounded, as well as linguistically constituted'* (Mauthner and Doucet 1998 p 122).

Postmodern thought provides a vehicle through which established dominant discourses can be challenged by deconstructing their linguistic organisation in order that other, suppressed discourses may be heard. It rejects the modernist notion that there are universal truths which are immutable and exist independently of society, and draws attention to *'the manner in which the reality we think we know is not essentially 'there' but is merely one of several possibilities that 'could be there'* (Dyson and Brown 2006 p54). It looks *'to the signifier rather than the signified, emphasizing the dynamism and fundamental undecidability of language and meaning'* (Mitchell 1996 p202-3). The fact that it can accommodate many strands of 'truth' or reality, some of which appear to be contradictory, tends to attract criticism from modernist quarters. However, its deconstructive characteristics are also a concern to some and have been called into question. Having discussed the concerns of some feminist writers that deconstruction might mean the disintegration of everything, Edwards (2005) suggests that *'the unease engendered by postmodern uncertainty seemed to be a response to modernity's need for certainty'* (p 50). We, in western society, have been so immersed in modernism since its beginning with the 'Age of Enlightenment' in the 18th century (Mitchell 1996), that it is almost impossible to avoid its influence. It has become so much a part of our thinking and our culture that it is no longer visible.

Like Edwards, I pondered for a long time what my position on postmodernism might be but also where I would place myself on the continuum between it and

positivism. Clearly, I was far from the positivist end of the spectrum but neither could I whole-heartedly embrace postmodernism because I, like others, find its deconstructive characteristics alarming. My initial exposure to postmodernism occurred during my midwifery training at university. Although I would not describe what happened to me as a 'crisis of faith', I was prompted to closely examine my personal beliefs in the light of all the inferences of postmodernism. As a result, my thinking was profoundly influenced, becoming much more flexible and less 'black and white' and my attitude became much less judgemental. However, as Lyon (1999 p 11) states: *'When the restless doubting attitude of modern reason turns on reason itself, nihilism results'*. My fear is nihilism, which lies at the extreme of postmodernism because, to me, the idea of life without faith or belief is at the same time, meaningless and terrifying. Assiter (1996; quoted by Edwards 2005 p 49) astutely points out that *'postmodernists cannot appeal 'to the very values they are rejecting,' by claiming a single truth, that there is no truth'*. I now prefer to think of postmodernism not in terms of the absence of truth, but in terms of the 'happy cohabitation' of many truths. Walsh (2007) sums this up in his assertion: *'the transience of its 'truths' is only a problem if you believe that certainties must define our choices'* (p 19). *'Postmodernism at its best'* say Davis-Floyd and Sargent (1997 p 16) *'entails reflexivity, a refusal to oversimplify multiplicities into misleading dichotomies, and a willingness to turn the critical gaze on oneself even as one strives to interpret the beliefs and behaviours of others'*. I therefore concluded that because the ability to embrace contradictions and diversity is one of the great strengths of postmodernism, it would allow me to retain my own faith, provided that I was prepared to be reflexive and open to other beliefs and modes of thought.

This project, which was designed to examine women's experiences in the arena of the medical hegemony which controls the maternity services, demanded a postmodernist approach. In their seminal treatise on the social construction of reality Berger and Luckman (1966) describe the mechanisms by which institutionalisation occurs, from a commonality in action and habitualisation, to a world in which the resultant institution is experienced as an objective reality. This 'reality' develops an existence outside of, and independent from, those who live and function within it. In order to examine an institution such as that responsible for maternity care, it is necessary to step outside of and deconstruct

that reality, to free oneself from the notion that 'this is how these things are done' (Berger and Luckman (1966 p 77), and to consider other discourses and possibilities that are rendered invisible by the power of the dominant institution. The nature and function of the health services are androcentric and birth, having been subsumed into this model, is now largely defined and controlled by it. The origin of institutionalisation and the industrial process stem from the need for economy of effort, not only physically but psychologically, in that they relieve the individual of the burden of having to choose between a plethora of equal choices (Berger and Luckman 1966). There is therefore every incentive to perpetuate the current institutional model of birth, in order to minimise its expense both in terms of financial and physical expenditure, but also in controlling the rival ideology or paradigm, embodied in women's choice. *'Where the social order is ruled by men, women become the embodiment of an alternative government which must be avoided at all costs'*, says Oakley (2005 p 151). This, she argues, has traditionally been achieved either by separation, in which birth has been given over to women and excluded from the rest of social life, or incorporation, in which women are obliged to surrender their reproductive autonomy and become 'mastered' by the dominant social group; in this case, male dominated medicine.

The dominance of this paradigm has systematically devalued the role and abilities of women and arguably, has scientified the reproductive act to the extent that women are no longer to be trusted with it. As Shildrick (1997 p 167) argues:

The privileging of the so-called higher faculties of reason, intellect, spirit and so on over the material and mundane grounds a two-tier system in which women, tied as they ostensibly are to their bodies, and most particularly to their reproductive bodies, have been deemed largely incapable of autonomous rational thought.

Women, she says, if they are to occupy subject positions, must do so by reclaiming the unity of body and mind and 'affirming embodiment'. This presents a threat to patriarchy, as not only does it contradict dominant discourses and beliefs, but also demands that free choices be offered which are

outside the control of medical dogma.

What postmodernism offers is a means by which to bring to light and validate other truths or realities which would normally be obscured. Its plurality, ambiguity and instability, which strike fear into the hearts of modernist thinkers, are considered by many feminist writers and researchers to be its main strengths. Indeed, Shildrick (1997) states that what is important for feminist postmodernism is that *'there is no singular mode of determination.'* (p174)

Not only, therefore, would postmodernism enable me to scrutinise or deconstruct organisational power structures and question their validity, but also to hear the voices of women whose stories had been obscured or silenced. In addition, the transparency which comes from reflexivity and a willingness to place one's-self in the research would, I hoped, give credibility to the project. However, at the same time, I was aware of the potential for *'hyperreflexivity, paralyzing degrees of abstraction and overattention to textual analysis detached from bodily experience'* against which Davis-Floyd and Sargent (1997 p 16) warn. On a practical level, that would equate with the scenario in which the midwife attending a birthing woman is so focused on her own practice, personality and influence that she loses sight of the woman's needs. As I have explained previously, as a midwife, I see myself as a facilitator or catalyst in relation to birth and it is from this point of view that I approached the interviewees and the research. Inasmuch as it is possible, I wanted the women to speak for themselves.

4.7 Hearing the Women

4.7.1 'Life' Stories

In a study of this nature, looking at the issues surrounding sexual abuse, stories are especially significant. Not only are the women's accounts of what happened to them as children brought to light, and the relevance of that to their childbirth experiences examined, but the ongoing impact of both inevitably crops up.

Our life experience', states Kirkham (1997 p183), *'is constructed as a myriad of linked stories. The construction of these stories renders our experience*

coherent and gives it meaning.

From a child's very earliest days, her understanding of the world, her self-image and ability to cope with life are determined by her stories of what has already happened to her. The importance of infant-mother attachment (Bowlby 1973) has long been acknowledged as central to the psychological and emotional development of children. It is during these early years that children develop an *'inner map of the world'* which *'determines how the child views himself or herself, caregivers, and the way the world works'* (van der Kolk 2003 p 295). This *'personal narrative'* is being continually assembled, added to and interpreted in the light of past experiences. This has a profound impact on the subsequent socialisation, behaviour and psychological health of an individual:

Previous experiences involving safety, comfort and soothing give people a reservoir of pleasurable and safe memories. When they feel threatened and under stress, people with these memories can evoke those feelings and apply them, at least temporarily, to deal with stress at hand. (van der Kolk 2002 p 79).

A child who has received adequate parenting and early care is thereby equipped to cope with future stressful life events. The *'reservoir'* of a child whose early experiences are of abusive, neglectful, violent or excessively unreliable carers will be either empty or unpalatable, leaving him/her vulnerable to overwhelming emotional and psychological distress in the face of difficult circumstances.

The consequences of telling their stories may be particularly costly for survivors of childhood sexual abuse, in terms of psychological and emotional distress. Individuals who have suffered overwhelming experiences such as childhood sexual abuse, may go on to develop post-traumatic stress disorder (PTSD) if they are unable to *'transform and integrate the sensory imprints associated with a trauma...'* (van der Kolk 2002 p58). As an example of this, van der Kolk (2002 p 58) refers to the research of Lee et al (1995) who undertook a longitudinal study on the psychological and physical health of 200 World War II veterans. Forty-five years after their initial interview, it was discovered that those who had

not developed PTSD were those whose accounts had changed significantly, softening the impact of the horror. Those who had developed PTSD had been unable to modify their memories which had remained unchanged throughout the intervening years. Traumatic memories are often retained as acute sensory experiences which can be re-triggered when the individual is confronted by reminders of the original trauma. As van der Kolk (2002 p 66) describes: *'they are imbedded in the experience - they are **having** the experience - but lack the capacity to analyse what is going on in space and time'* (author's emphasis). Unless, or until, traumatic memories become 'defused' by being processed or softened into an acceptable form which then becomes assimilated into the individual's 'story' they continue to act as a threat, somewhat akin to emotional landmines. Several of the women interviewed described their personal minefields in which they could suddenly be precipitated into reliving their abuse by some seemingly insignificant 'trigger'.

4.7.2 From 'life' stories to birth stories

Thus, many women who have survived childhood sexual abuse bring a whole host of 'baggage' with them to their childbearing experiences. Their personal narratives may act as lenses through which they will anticipate or interpret events. Furthermore, there is some evidence that unresolved psychological or emotional issues can have a profound influence upon the progress of labour and birth for any woman (Rose 1992; Kirkham 1997; Tallman and Hering 1998; Walsh 2004 Records and Rice undated). The life story of the sexual abuse (particularly incest) survivor is often one in which she has a very minor role, in which her abuser and his/her desires were central and over whom she had no control or influence. She has learnt from past experience that she is powerless and her body is not her own. Sadly, her experiences of maternity care may confirm this perception, as Kirkham (1997 p 185) observes:

...often women's birth stories have experts as central, active figures and the woman's part in her own story is personally undermining and profoundly disempowering.

Moreover, the secrecy and shame involved in being sexually abused often ensures women's silence and prevents them from telling their stories. They may even have had abortive attempts to disclose, which have served to strengthen their perception that they are helpless (Rouf 2003; also see p155: Kerry's experience). Some will have suffered conflicting and confusing thoughts and emotions regarding their abuse because their abuser denies any wrongdoing, or blames the child for what is happening.

4.7.3 'Official' stories

To some extent this situation is mirrored in the milieu of maternity care by professionals' reliance on written evidence in the form of medical notes, in preference to women's accounts. As Dyson and Brown (2006 p 19) observe:

...social meaning is not automatically located within an object or a situation. It is created by human beings. Moreover, it is created by human beings in their interactions with one another.

Thus, there may be a profound mismatch between a woman's perception of her birth experience and that of her carers. All women approach childbirth with different expectations, according to the personal 'meaning' they have attributed to birth. Maternity workers' expectations or perceptions of the event are often constructed by their interactions with each other in a medically oriented environment, which affords a very different meaning to birth (Mead and Kornbrot 2004). What professionals may perceive as a 'nice normal birth' may have been seen by the woman as a terrifying experience over which she had no control. This situation was, in fact, described by two of the interviewees. Women may emerge from a childbirth experience feeling devastated by it, only to find that their version of events conflicts totally with the 'official' account contained within their notes. Stories have an ephemeral quality about them because, like all verbal accounts, they are subject to change depending on the context or time of their telling. Medical notes appear to be solid and unchanging, and therefore usually seen by professionals as more reliable. Women's stories and experiences may be thereby 'negated' by the authoritative voice of her carers

(Jordan 1997). In the same way, in the past, her disclosures of sexual abuse may have been treated as unreliable and unbelievable by those in positions of authority over her.

Throughout the course of the interviews, I became increasingly aware of the huge risk that some of the women were taking in telling me their stories. In revisiting what had happened to them it was possible that they would encounter triggers that would cause them to relive their traumatic experiences. It was with these thoughts in mind that I determined to find the most effective and least harmful ways of making the women's voices heard above the clamour of the dominant discourses which had had such a profound impact on their lives.

4.8 Grounded Theory

Clearly the objectives of this project, i.e. to discover what the women in question felt about what happened to them, required a qualitative approach. As this is a subject that has received little previous research attention, I considered grounded theory, an approach that is designed to generate new data (Glaser and Strauss 1967), to be appropriate. However, as Bluff (2000) argues, because of the dynamic nature of the research process, it is unlikely that one 'method' will suffice for all the needs of practitioners in the health-care arena, and will therefore require adaptation for use in diverse disciplines. I also shared Edwards' (2001) reluctance to '*condense interviews through coding*' (p 105) and her frustration with the grounded theory approaches to data management which was not gender sensitive. Although Donovan (2000b) argues that '*Methods themselves do not appear to have gender - it is the way they are used and the purpose that they are used for*' (p171), I felt that, although useful to an extent, the effect of coding was to 'dismember' the women, separating them into their constituent parts. Moreover, it seemed to place me in the position of pathologist or surgeon; a clinician who dissects the body in the absence of its occupant, learning something of the impact of disease upon the individual but little about the person and his/her life. 'Stories' observes Graham (1984 p 119) '*are pre-eminently ways of relating individuals and events to social contexts, ways of weaving personal experiences into their social fabric*'. Therefore, in order to gain insight and understanding into the lives and experiences of my interviewees, I

felt it was necessary to engage with them, not only at the time of interviewing, but on an ongoing basis, which meant maintaining the integrity of their stories. In addition, a project such as this, in which the issues of power relationships, dominant discourses and mutedness are examined, requires a deconstructive approach. To an extent, grounded theory methods would provide the means to listen to the women's voices, but in order to make true sense of what they were saying, it was the mechanisms of oppression that had to be 'stripped down', questioned and evaluated, not the women. Grounded theory alone, I felt, would not provide me with the bigger picture in that it would be, to a degree, blind to pre-existing structures and taken-for-granted social beliefs. Furthermore, as Mauthner and Doucet (1998) assert, *'grounded theory seems more concerned with action and interaction and less so with the processes of reflection and decision making'* (p130) and, although effective in researching people's public lives, may be less than satisfactory in examining their 'private' lives. In addition, I wished to place myself within the data, honestly acknowledging my part and subjecting it to scrutiny; a dimension which is lacking in the traditional grounded theory approach. Therefore, I determined that grounded theory would provide me with an 'internal', framework; that is, it would act somewhat similar to the skeleton, which provides structure for the body and enables movement, but is also 'clothed' with flesh which has its own very individual characteristics. What I did not want was for the framework to be 'external' i.e. a prison, which would confine both me and the women. I was particularly conscious that grounded theory had arisen out of the quantitative paradigm and does contain elements which are both interpretive and 'positivist' (Bluff 2000; Lincoln and Guba 2005). I questioned what the marriage between this and postmodernist feminism would look like and whether the match would bring forth fruit. I decided (to continue the analogy of the skeleton), that as long as postmodernist feminism acted as the 'will', or the 'spirit', which provides the impetus and motivation for the actions of the body (and thereby the skeleton), then the partnership would be successful.

4.9 A feminist standpoint

I also chose to approach the research from a feminist standpoint, although, like

Seibold (2000 p 152), I was anxious to avoid becoming tied into a '*single methodological dogma*'. I would agree with Mason (1996) that:

...the great strength of qualitative research is that it cannot be neatly pigeonholed and reduced to a simple and prescriptive set of principles. (p 4).

'*Feminist research....*' says Draper (1997 p 597), '*is about making women and their experiences visible*'. Women are generally considered to be invisible because of their gender, but it could be argued that women who have been subjected to sexual abuse are rendered doubly invisible by those experiences. I wanted to understand, as much as is possible, who these women were and how they felt about what had happened to them, in order to make their voices heard. Oakley (1993) asserts that feminist research should be '*oriented towards the production of knowledge in such a form and in such a way as can be used for women themselves*' (p 245). Wilkinson (1986) cited by Draper (1997 p 597), defines it as '*research on women, for women which leads to the development of theory firmly rooted in women's experience*'. I would add '*by women*' to that definition because of the nature of this kind of research, which places the researcher within the analysis. I partly agree with Walsh (2007) who describes his dilemmas as a male undertaking feminist research when he suggests that a shared humanity, compassion and empathy helped qualify him for the task. However, I would argue that the inclusion of a masculine influence would have a profound impact on the data because the dynamics of woman-to-woman communication are vastly different to female/male interactions. As (Finch 1984 p 75) argues:

... there is an additional dimension when the interviewer is also a woman, because both parties share a subordinate structural position by virtue of their gender.

Furthermore, expecting women to speak openly about a subject such as sexual abuse would be highly problematic with a male interviewer, particularly given that the great majority of survivors have been abused by men.

4.9.1 A partnership of equals

Feminist research is typically characterised by a non-hierarchical relationship between researcher and informant (Oakley 1981) and a rejection of the positivist notion that those undertaking it should, or can do so in an objective and disinterested manner. This is particularly pertinent in the context of interviewing survivors because an authoritarian, paternalistic or disinterested approach could be perceived to mirror that of their abusers. Oakley's (1981) exploration of the masculine 'textbook' model of interviewing drawing on the work of many of the hitherto 'authorities' makes for uncomfortable reading particularly when viewed in the light of the dynamics of childhood sexual abuse:

...interviewing necessitates the manipulation of interviewees as objects of study/sources of data, but this can only be achieved via a certain amount of humane treatment. If the interviewee doesn't believe he/she is being kindly and sympathetically treated by the interviewer, then he/she will not consent to be studied and will not come up with the desired information. A balance must then be struck between the warmth required to generate 'rapport' and the detachment necessary to see the interviewee as an object under surveillance. (Oakley 1981 p33)

This approach would be totally inappropriate for survivors of sexual abuse, several of whom spoke of being manipulated by abusers to comply and submit through 'kindness' or 'love'. As Oakley (1981) argues, it is ultimately depersonalising to both interviewee and interviewer, because:

...while the interviewer must treat the interviewee as an object or data-producing machine which, when handled correctly will function properly, the interviewer herself/himself has the same status from the point of view of the person/people, institution or corporation conducting the research. (p 37)

Thus, any conversation or contact which takes place in the context of the research is governed and regulated by unwritten rules (which are imposed by a remote power) for both participants - a 'pseudo conversation', as Oakley (1981)

puts it. Interestingly, the statement quoted above can easily be transposed to describe the dynamics of the women/midwife relationship in the milieu of the medicalised birth environment. To 'borrow' Oakley's phraseology:

...while the midwife must treat the woman as a baby-producing machine which, when handled correctly (i.e. with the appropriate interventions), will function properly, the midwife herself has the same status from the point of view of the institution responsible for conducting 'the delivery'.

Although the midwife may appear to have power over the woman, and on a certain 'micro' level she has, it is the 'remote power' of the institution which sets the agenda. They are both obliged to dance to the tune of the organisation.

When interviewees are regarded merely as data-producing machines, there is a danger that when they do express honest opinions their evidence may be discounted if their comments cut across the beliefs of the researchers. Dyson and Brown (2006) give a very poignant illustration of this in their description of some transcripts of interviews with mental health patients concerning their treatment. One of the interviewees had described her consultant psychiatrist as a 'paid poisoner'. This, and other ensuing comments, had been edited by the transcriber as *'rambles on endlessly with largely delusional content'* (p166). Thus this woman had been effectively silenced presumably in favour of those who gave the 'correct' responses. Furthermore, as Dyson and Brown (2006) argue, this highlights the fact that researchers, despite believing themselves to be disinterested can, and do, unconsciously bring their own bias into their findings.

4.9.2 Understanding, not proof

The feminist standpoint, with its emphasis on reflexivity, parity between interviewer and interviewee, and acknowledgement of the place of the researcher within the research, not only provided a more honest approach to the project, but, I believe, a more responsible one given the nature of childhood sexual abuse. I would compare it with the concept of 'connected knowing' described by Belenky et al (1986) , which:

...requires intimacy and equality between self and object, not distance and impersonality; its goal is understanding, not proof. (p183)

It is this emphasis on understanding rather than proof which characterises feminist and postmodernist methodology and which formed the bedrock of this research. The spotlight, rather than focusing on the researcher and his/her ability to support a hypothesis, is trained on the respondents in an attempt to understand their lives and experiences. For this reason, this approach may be potentially less exploitative and, consequently, more acceptable to women who may have been disadvantaged and disempowered by abuse. Research dealing with childbirth and pregnancy amongst sexual abuse survivors has been done from a somewhat positivist stance (Robohm and Bittenheim 1996; Cohen 1995) both using control groups and questionnaires, but the findings appear two-dimensional and far removed from the reality of the lives of survivors. Looking at complexities such as women's lives and circumstances and eliciting opinions only from within the researcher's frame of reference, may result in researchers getting *'round answers to their square questions'* (Dyson and Brown 2006 p68). Although these studies provide evidence to suggest that survivors of sexual abuse do experience specific problems, they tell us nothing of how these women feel and what is important to them. The real women remain invisible.

4.10 Common Ground

Despite the fact that I am not, as far as I am aware, a survivor of sexual abuse, I feel that the interviewees and I had several factors in common, which may have helped in fostering equitable and empathetic relationships between them and myself.

4.10.1 Invisible women

Having said earlier that survivors tend to be invisible because of their experiences, it is also true to say that, at the time of their interviews, each individual was at a different stage in her journey to finding a voice and a

presence. The women's positions could be placed on a continuum, from those who remained largely invisible and mute, to those who were able to speak openly about their experiences of abuse; some of whom had become involved in counselling or supporting other survivors. Clearly, all of them had reached a point where they felt able to disclose to me, but several of them maintained a position in which they were invisible to certain organisations or structures. Veronica, who described herself as 'obsessively private' tended to avoid contact with all organisations which she perceived as authoritative, such as Social Services and the medical profession. At the other end of the scale was Kerry, one of the midwives, who had very definitely found her voice and was determined to speak out in her endeavours to improve the lot of survivors and of birthing women in general.

My whole ethos has changed. And I suspect that's changed since I came to know myself and the dirty washing's come out, if you like. Because I feel unafraid of the secrets any more and I can freely question and not be afraid to not be liked all the time... Kerry

However, at the time when they gave birth, all the women had been invisible and muted in some way. Some attempted to make themselves so, as far as the system was concerned, by opting to give birth at home. Others submitted themselves to whatever the organisation had to offer and found ways in which to cope with it. Very few were able to disclose their history or articulate their particular needs. It was these voices that I sought to make audible through the research. I too had been a silenced woman, at the time of my naissance into midwifery, devalued by a system which does not tolerate individuality or recognise any other knowledges apart from its own. I, like the interviewees, was trudging the uphill route towards finding my voice and regaining my equilibrium. When they described instances in which they had felt powerless and humiliated by the treatment they received during their childbirth experiences, I could empathise, knowing the profound effect the organisation had had upon me, both as a woman and a midwife.

As the women who birthed at home had done, I had now placed myself outside of the system as an independent midwife, arguably becoming less visible to *it*,

in order to be more accessible and available to the women in my care. Most of the time during my current working life, I am able to function with the minimum amount of contact with the maternity services. My motivation for avoidance lies largely in the desire to protect women from having their pregnancies consumed by the medicalised, 'one-size-fits-all' ethos, not in any great wish to 'go it alone'. On occasions, I would very much appreciate being able to work collaboratively with the mainstream maternity services but sadly, this is often difficult because of the authoritative and intransigent stance adopted by those who are responsible for them. My reasons for becoming independent to some extent reflected Rhoda's decision to give birth at home. She was, she asserted, no campaigner for home birth but just could not face giving birth in hospital because she knew it would take place on their terms, not hers.

4.10.2 Loss of innocence

As already discussed, one of the major traumatogenic aspects of childhood sexual abuse, according to Finkelhor and Browne (1986), is betrayal. The child suffers abuse at the hands of those to whom she is entitled to, and indeed, does, look to for nurture and protection. Innocence, trust and the carefree-ness of childhood are lost forever. To a very much lesser degree, I suffered my own loss of innocence on my initiation into midwifery. I stated earlier that my expectations of midwifery, of midwives and doctors working collaboratively with women in a warm and encouraging atmosphere, were hopelessly naive. However, why should it be so? Is it not reasonable to expect people to work together in an atmosphere of kindness and respect? I am sure that my own disillusionment with the maternity services came over to the women, as I was honest in my reactions to their criticisms. It could be argued that this introduced bias into the data; however, I would answer that it probably encouraged honesty from the women as they perceived me as someone who understood their reservations and who was not going to dismiss, or attempt to minimise, their concerns. As Oakley (1981 p58), in debunking the notions of detachment promoted by traditional methodology textbooks, argues:

It [feminist methodology] requires further, that the mythology of 'hygienic'

research with its accompanying mystification of the researcher and the researched as objective instruments of data production be replaced by the recognition that personal involvement is more than dangerous bias - it is the condition under which people come to know each other and admit others into their lives.

Furthermore, I feel that it is to underestimate and patronise these women to suggest that their accounts might be influenced negatively by any opinions of mine. These were women who knew what they thought and welcomed the opportunity to make their voices heard through being involved in the research.

4.11 Summary

In this chapter I have described the rationale for the research and how I came to be involved with it. I have discussed how the hegemonic, dominant discourse of medicine, which controls the maternity services, is silencing and subjugating to women users and midwives alike. Issues such as surveillance and bullying have been highlighted as means whereby both groups are kept in a position of powerlessness. I have compared the ways in which my experiences of powerlessness and mutedness within the organisation in the NHS mirrored those of the respondents both as victims of sexual abuse and as users of the maternity services. My reasons for becoming an independent midwife have also been explained, and the impact of my status on myself, my practice and the research. In order to clarify my position, I have placed myself as a midwife on the continuum from technomedicine to holism, with reference to the work of Davis Floyd and Mather (2002) and also on the continuum from positivism to postmodernism with regard to the research.

The importance of 'life' stories to the psychological wellbeing and development of individuals was highlighted, and the potential dangers, for the women, of telling traumatic stories in the context of a research setting. The relevance of stories to the phenomenon of post-traumatic stress disorder was discussed, emphasising the need for traumatic memories to be processed and softened in order to be assimilated into an individual's personal narrative. Memories such as this, that have not been 'digested', have the potential to cause sufferers to be

re-traumatised - an obvious danger for survivors approaching childbirth.

I explained that I chose to undertake the research from a feminist postmodernist stance, since dealing with the impact of the dominant discourse of institutionalised birthing practices on vulnerable women requires a deconstructivist approach. I discussed the inappropriateness of the 'traditional' positivist research stance, particularly in the light of its exploitative characteristics and its claims of objectivity. I felt that the partnership of equals propounded by feminist research and its rejection of objectivity, provided a more responsible and honest approach.

Chapter 5

Method

5.1 Introduction

This chapter describes the way in which the research was carried out, beginning with a discussion on the various ethical issues involved in undertaking a study of this nature. Clearly, eliciting data of such a sensitive character is a delicate task and requires much planning and thought, as there is great potential for it to be perceived as abusive or exploitative by the respondents. I explain how this thought lay behind the conduct of the research, from the recruitment stage, through to the location, timing and structure of the interviews. I reflect on what I perceive to be the impact of the interviews and their transcription on the participants. I then discuss the profound effect that the research has had on me before, in accordance with the principles of feminist research, examining my position and its possible influence on the data. Finally, the rationale for the various methodological approaches is discussed.

5.2 Ethical Issues

A project of this nature, dealing with vulnerable women, is fraught with ethical issues which must be taken into consideration. These issues had a profound impact on the entire study and the way in which it was carried out, from the recruitment of the women, to the place, timing and structure of their interviews, from the feminist standpoint from which I approached it, to the method of data analysis. I feel that almost this entire chapter could come under the heading 'Ethical Issues' but, for the sake of clarity, I shall discuss the more obvious issues first, before moving on to examine others within their contexts.

5.2.1 Ethics clearance

The research proposal for this study was submitted to the University of Sheffield Ethics Committee in 2000 and subsequently given approval. NHS ethics

approval was not sought because recruitment was not through NHS channels and my intention was to interview women who were not pregnant and therefore not currently receiving maternity care.

5.2.2 Clinical supervision

On setting up the study, which she was aware had serious potential to cause the respondents psychological distress, Maggie had contacted a consultant psychologist to advise us on possible problems we might encounter to whom we could refer women if necessary and to provide ongoing guidance. Dr Amanda Gatherer agreed to act as clinical supervisor and her input, particularly in the early stages of the project, was most helpful. She was able to advise us concerning issues such as women regressing or dissociating during interviews.

5.2.3 Consent and confidentiality

Before embarking on each interview, I contacted the women to ensure that they still wanted to go ahead. Only one of the contacts declined at this stage. At the commencement of each meeting, I stressed to the woman that she was free to withhold any information, to ask that the tape be turned off and that she was able to withdraw from the research at any stage. Each respondent was assured that her disclosures would be kept confidential and only made known to my academic supervisor. Any identifying features would be omitted from quotations used in the thesis and their identities would be protected by pseudonyms. My use of actual names as pseudonyms (rather than referring to them as 'Woman 2' or 'Mrs X') was a conscious decision and an attempt to personalise their stories and portray these women as the real people that they are. This approach I considered to be more in accordance with the principles of feminist research.

5.2.4 Power, exploitation and abuse

A *leit motif* running throughout the duration of the study was that of control and powerlessness. The power of the researcher over the researched can be (and

often has been) used exploitatively, which mirrors the relationship between abuser and abused. It is for this reason that I chose to approach the research from a feminist standpoint [see 'Methodology' for discussion on this].

I was acutely aware of trying to avoid what Scott (1998) refers to succinctly as the 'smash and grab' of data collection. This seemed uncomfortably reminiscent of Amanda's (one of the respondents) description of sexual encounters she had experienced during her teenage years:

...it was literally a case of 'wham bam thank you ma'am'. It was very much like that, and then like 'You can piss off now, I've had what I want!'

There has been much debate around the exploitative potential of this type of research (Graham 1984; Stacey 1988). Finch (1984) speaks at length about her concerns for the vulnerability of her female informants because of the easily established trust between herself and them. She puts this down to her identity as a woman and her 'trading' on that. *'I have emerged from interviews with the feeling that the interviewees need to know how to protect themselves from people like me'* she concludes (p79). The possibility that I could have been perceived as yet another abuser was very much in the forefront of my mind particularly in view of my not being a fellow survivor of sexual abuse. The scenario of a complete stranger coming into a woman's home, taking her intimate and painful story to use for her own ends, resounds with echoes of abuse. However, the offering of unlimited time and, by that, respect and acknowledgement of the profundity of their experiences may have gone some way to alleviating the situation. Furthermore, I ensured that they had my contact numbers with an invitation to telephone me if they felt they would like to discuss things further, or had any concerns following the interview. The thought that, ultimately, my research might make these 'women and their experiences visible' (Draper 1997 p 597) helped me not only to avoid seeing myself as an abuser, but provided me with the spur to continue with the project when the subject matter threatened to overwhelm me. Moreover, I felt huge admiration for and a sense of responsibility towards those who had generously entrusted me with such intimate details of their lives, and this served to revive my failing spirit in times of despair.

5.3 Recruitment

Women were initially recruited by Maggie via Survivor's Support Groups, found in the Survivor's Directory (Broadcasting Support Services 1993). This publication, which covers Great Britain and Ireland, is aimed at providing sexual abuse survivors with details of support groups which exist in their localities. These organisations were sent letters giving a small amount of information about the researcher, details of the background and aims of the research and asking that women who felt they would like to take part should contact her. Between 25 and 30 women responded and each was subsequently contacted by post informing her of what to expect. Before receiving her diagnosis, Maggie completed two interviews. However, one she excluded from the study before my involvement with it on the grounds that it was unsuitable; I was never made aware of her reasons. The other failed to record owing to equipment malfunction. I therefore repeated this interview at a later date.

It was from this group of women that the first seven interviewees were taken. The first interview was undertaken jointly by Maggie and myself but thereafter she was prevented from participating owing to her illness. Of these seven women however, five were in their fifties and, although their stories were an incredibly rich source of data, I felt it essential that I also interview women with more recent experience of birth, and therefore, of the maternity services as they are at present ⁵. In addition, several of these interviewees had had no memory of their abuse at the time when they had given birth, their recollections only returning in later life. I was interested to hear from women who had had recall of their childhood experiences when giving birth in order to see how, or if, they viewed their births differently. With this end in mind, I surmised that midwives who were themselves survivors of childhood sexual abuse (CSA), might have a unique insight into the way in which sexually abused women are impacted by

⁵ Another factor which contributed to my decision to re-recruit was that it would be too problematic to attempt to use the list of respondents gleaned by Maggie as there was no way (without contacting them) of ascertaining their ages and whether or not they had had recent birth experiences. The idea of contacting them and then disqualifying them on grounds of age was more uncomfortable to me than merely not following them up.

their birth experiences from the perspective of survivors, mothers and midwives. Furthermore, to my knowledge, research on midwives who were survivors of CSA had not been done before. I duly wrote to the correspondence sections of The British Journal of Midwifery, Midwives (The Royal College of Midwives Journal) and The Practising Midwife, setting out the aims of the research and asking for volunteers. Ten women came forward, all of whom were midwives or student midwives, although not all were practising at that time [see 'Details of interviewees']. Two of them were interviewed via e-mail for reasons of inaccessibility - one was Australian and the other lived in Canada. One other interview took place by e-mail because this woman presented herself very late in the process, when all the other interviews had been completed and transcribed. Dealing with such a sensitive subject, I was acutely aware of the possible emotional impact of my rejecting her disclosure. As it happened, her short birth story yielded some very useful data although, as with the other e-mail interviews, it was lacking the depth and thickness of the personal interviews. Of the two remaining respondents, one was recruited as the result of 'snowballing' and the other, a non-midwife but with very recent childbirth experience, was referred to me by her Health Visitor who had been present at a study day on sexual abuse at which I had spoken.

5.4 The interviews.

5.4.1 Location

The locations of the interviewees represented a wide area of Britain, ranging from southern England to Northumberland. Although findings of this type (and size) of research cannot be generalised, I felt that this diversity was helpful as women's comments about their contact with the maternity services were not limited to the kind of care offered in one particular geographical area.

The interviewees were all given the choice of where their interviews should take place and the majority opted for their own homes. There were two exceptions: the first respondent, who was interviewed at Maggie's home as she was visiting the area and Maggie was, by then, too ill to travel; another woman I interviewed at her local Health Centre because her domestic arrangements were such that she would have been unable to find a space in which we could talk in private.

Interviewing people in their own environments appeared to me to provide a much fuller impression of their lives, relationships and ways of being, which helped to contextualise them and their stories. As the interviews progressed I also increasingly realised the benefits it afforded the women. Home was often spoken of as the place in which they had control, and a relatively high percentage had experienced (or had wanted) home birth. The issue of the power disparity between researcher and researched has provoked much discussion (Draper, 1997; Alldred 1998; Mauthner and Doucet 1998; Seibold 2000) but in examining the lives of sexual abuse survivors it is compounded and takes on a new dimension. These are women who are not only disadvantaged and powerless because of gender but, because of their childhood experiences, avoid deliberately placing themselves in a position of powerlessness. One of the interviewees commented that giving birth at home had empowered her because her carers were obliged to ask her permission in order to meet their own bodily needs, whereas in the hospital, the position would be reversed.

I extrapolated that this, and similar comments from other women, would also include researchers and concluded that from the point of view of minimising the power discrepancy between us, (Moyzakis 2004) home was the ideal place. In addition, although I only began to realise this as the data concerning dissociation and regression emerged, the security and 'every-day-ness' which the home environment provided may have offered some degree of protection to women whose traumatic experiences still had a considerable impact on their lives.

5.4.2 The importance of time

I felt strongly that I should set no particular time limit on the interviews although most of them were completed in 2 hours; the longest being 3 hours and the shortest around 1 ½. However, the time I spent on each meeting was much longer, often taking an entire morning or afternoon. In the vast majority of cases the first part of the meeting took place over a cup of tea while we chatted informally. This had the advantage of establishing a dialogue and a rapport before turning on the tape recorder. The meeting often concluded in the same way; I felt it essential that there should be time after the official interview in

which the woman could 'wind down'. In the first instance I was conscious of the potentially exploitative nature of this type of research (Graham 1984; Finch 1984) and thought that it might take a good deal of time for the women to feel comfortable enough with me to be able to talk openly of their abuse. In the event, this was not usually a problem; like Finch (1984) I was surprised at how easily the women trusted me with intimate details of their lives. However, the importance the women attached to being given apparently unlimited time was soon demonstrated by the data. Some of their birth stories were shot through with instances of 'professionals' who did not have time for them, of feeling pressurised to perform or of being processed by a system whose focus was on efficiency and speed. I began to realise that offering these women time, and my undivided attention, was in some measure, antidotal to these experiences. As I was to discover, this approach to time in which 'the events dictate the time' (Hall 1984) is considered to be 'feminine' as opposed to the masculine 'clock' time which dominates the industrialised world (Helman 2001).

5.4.3 Structure - avoiding the clinical 'gaze'

In a similar vein, I determined that the interviews should be as unstructured as possible. This was aimed at encouraging my informants *'to take on and take over the interview as their own'* (Graham 1984 p 114). This was particularly so in the earlier interviews, because I was taking a grounded theory approach and, consequently, came to the subject with little foreknowledge. I aimed for a largely 'self-structured format' (Graham 1984 p119) associated with research using story telling. Later, as the themes began to take shape, I realised that it was important to avoid becoming too 'directional' because being overly focused on their experiences of abuse could be seen as reminiscent of their accounts of the medical 'gaze' which fixed exclusively on their reproductive systems or genitalia, denying their humanity [see Chapter 3].

5.4.4 Soft focus

As the interviews progressed, I began to include questions, which I hoped would elicit information around the emerging themes. For example, early on in

the research I had little knowledge of dissociation and its various manifestations in the lives of survivors of sexual abuse. My first reaction on interviewing a woman who said she had had no memory of her abuse at the time when she gave birth, was surprise tinged with disappointment. One of the main aims of the research was to explore the experiences of sexually abused women around giving birth. I had expected to hear accounts in which the physical sensations of labour and birth echoed those of abuse. If the women had been unaware of their history at the time, would their experiences differ significantly from those of any other woman? As further interviews were completed, it became clear that the phenomenon of dissociation was a major theme in the emerging data. Therefore, if a woman did not mention it during the course of her interview I would ask her directly if she had ever dissociated. Many women were aware of the term 'dissociation' and understood what was meant by it, but others used phrases such as 'blacking out' or 'leaving my body'. Some described experiences which were clearly dissociative in nature but were not referred to as such. As I studied and pondered the transcripts, the issue of dissociation loomed ever larger. There appeared to be several manifestations of it: long term amnesia surrounding the events of childhood; a short term unconscious reflex action which occurred when the woman was confronted by overwhelming circumstances in which she was powerless to act; and a deliberate moving out of her body when in a traumatic situation, using techniques such as focusing on a flower on the wallpaper. The latter, in contrast to the first two, was often referred to quite positively and was considered to be protective [see Chapter 9]. However, I soon began to realise that dissociation was not only confined to the survivors. Midwives, when presented with situations in which they were powerless to act, often 'escaped' them emotionally, displaying an amazing degree of detachment, apparently rendering them oblivious to the distress of others [see Chapter 9, 'Professional dissociation']. Chu and Dill's (1990) statement that dissociation generally seems to be used '*in the presence of a psychological need to escape overwhelming experiences such as trauma and abuse*' (p887) does not necessarily refer to only personal injury or abuse. As I discovered, several of the midwife interviewees perceived certain incidents they had witnessed on labour ward as abusive and, as a result, 'escaped' by avoiding working in the area. As discussed, dissociation, which has strong links

with post-traumatic stress disorder (van der Kolk 1996; Nijenhuis et al 2001), may occur in any situation in which the person feels helpless and extreme emotions such as fear, terror or horror are evoked.

5.5 How the interviewees responded

5.5.1 Telling Stories

All the respondents appeared to be keen to talk about their experiences and did so in various ways. One woman in particular rehearsed her story almost in one continuous narrative, hardly pausing to take a breath. It was clear that her abusive memories had ossified into a narrative and that she had given this account many times before. Thus telling her story in this way, she was distanced from the original emotional content and protected from further psychological damage; as Jones (1998 p 50) says:

...when people have talked about something a lot, it is as if it has been rehearsed into a story that actually takes a life of its own, somewhat detached from the feelings that were initially involved.

Another woman read extensively from diary accounts concerning the birth of her first child and her subsequent decline into psychiatric illness. Arguably this may have constituted a similar strategy, designed to distance her from the strong emotions associated with her experiences. This woman was much younger however, had recent birth experience and was in the early stages of her second pregnancy. Many of her abusive memories had emerged following the birth of her son. Her emotions were generally nearer the surface and much in evidence during the interview. I felt that she found it necessary to keep our encounter tightly under control, unlike most of the other interviewees, who appeared to be more reciprocal and relaxed. At first I tried to gently steer the conversation in order to elicit certain information but she firmly resisted my attempts, taking the story in her direction, with frequent references to her diary. I quickly realised that I had to abandon any agenda I may have had, as the only information she was going to allow me to take away was that which she had pre-determined.

Reflecting on this 'strategy' later, I felt that it might have been a means of protecting herself from re-traumatisation. Memories that have not been integrated into an individual's personal 'story', according to van der Kolk (2002 p 58), tend to *'lead a relatively independent existence from the remainder of a person's conscious existence...'* It is possible that she considered the account of the woman in the diary to be that of a separate entity, a person who had set down her story and as long as it remained in that form she was immune from its power to traumatise. It may have been the only way she could 'allow' me to have the information, through this 'other woman'. It is interesting to note that this respondent was the only one of the interviewees who admitted to having had, at one time, an 'alter ego' [see Chapter 9].

5.5.2 'Blanking out'

Two of the interviewees described themselves as 'blanking out' (referring to dissociation) during their interviews. This did not appear to happen in response to any particular 'trigger' but during the telling of their stories they became increasingly hesitant and were clearly finding difficulty articulating. Both these women had described how much a part dissociation had played in their lives and that when they felt emotionally overwhelmed or threatened, their automatic reaction was to dissociate. When this occurred during their interviews, the tape recorder was turned off and we engaged in 'everyday' conversation and activities such as tea making to encourage them back into 'reality'. These experiences I found disturbing from the point of view of the immense responsibility it placed upon me as a researcher. Furthermore, these two respondents were both in their fifties and this served as a potent reminder of the long term impact of childhood sexual abuse.

5.6 The transcripts

5.6.1 Translation from the spoken to the written word.

Each interview was tape-recorded and transcribed. I was immediately struck by the difference between the spoken and the written word. I had not previously

realised how powerfully vocal nuances, pitch, silences and all the other elements of which interpersonal communication consists, contribute to meaning and, consequently, understanding. The written word seemed monochromatic in comparison with the 'glorious Technicolor' of speech. In an attempt to contextualise the transcribed words I included indications of 'how' they were said; for example, one of the interviewees, who had been widowed at an early age, was speaking about the fact that she regretted never sharing her fears with her husband:

I will always regret that but I can't do anything about that now, can I? [L: No] I don't know the address (laughs wistfully).

Another dilemma presented itself in the quest to make the transcripts readable. As Standing (1998 p190) observes with reference to transcribing the words of her interviewees, '*We do not speak in grammatically correct sentences.*' One particular interviewee spoke almost continuously, without obvious punctuation. I came to the conclusion (as had Standing, when confronted with the same problem) that I would have to add punctuation in order for it to be understood. As Truss (2003) has amply demonstrated, inappropriate use of punctuation can seriously damage meaning. I therefore used it sparingly, with constant reference to the audiotape, in order to keep to the original meaning as closely as possible. This did, however, in some degree, detract from the 'immediacy' of the interview.

I also pondered over whether to include all the 'ums' and 'errs'. I decided to omit most for the sake of clarity and fluency, but where they appeared to convey a particular meaning or had special significance I included them in the text. I also concluded that, in order to make the transcript more easily readable, I would omit most of my short interjections ('yes', 'mm', 'I see') particularly when they occurred during the woman's narrative.

Many of the women had regional accents and some used 'dialect' words: for instance 'tret', meaning 'treated' and 'on't' for 'on the'. I decided to retain these in the text because I felt to remove them would be to denigrate the respondents by suggesting that their modes of speech were inadequate or unacceptable. Furthermore, as previously explained, I wanted to present these women as the

real people they are. As Edwards and Ribbens (1998 p2) observe:

Ambiguity thus arises when we seek simultaneously to serve an academic audience while also remaining faithful to forms of knowledge gained in domestic, personal and intimate settings.

I did not want my obligations to academia to override my desire to make these women's individual and collective voices heard.

I had decided before commencing transcribing that I would omit text that I considered to be irrelevant to the research. In the event, this proved to be more difficult than I had anticipated. Taking a grounded theory approach meant that analysis was concurrent with data collection and transcription; therefore as the various themes emerged, some portion of text which appeared irrelevant in the early stages might become vital later. I therefore erred on the side of caution and omitted very little, which I sometimes felt made the transcripts rather 'unwieldy' and circuitous.

5.6.2 Field notes and additional information.

Following each interview I made notes, which contained thoughts, impressions and observations, made during the encounter. I documented instances of body language and demeanour which stood out as significant or unusual. For instance, a few of the interviewees appeared to find it difficult to gain or maintain eye contact, which I attributed to feelings of shame or stigmatisation. Indeed, a survivor referred to by Ainscough and Toon (1993) described having such a profound sense of shame and stigmatisation that she would rub pepper into her eyes in order to avoid looking at anyone. Several left me with the impression that they were struggling with suppressed anger, which came dangerously close to the surface during the telling of their stories, although in Judith's case the anger appeared to be directed inwardly. Although all the women were interviewed on their own, I would make notes on how they related to other family members during my visit.

In addition, having transcribed the interview in full, I made a summary of every woman's account, which included information such as: at what age her abuse

took place, what form it took, who had been her abuser/s. It also contained some biographical details (how many children they had, what ages they were, their current domestic situation, a brief life history) as well as any aspects of the woman's story or discourse that seemed to be of particular significance to her. For example Sally's summary, amongst other things, highlights her repeated references to the importance of maternity staff doing their job 'with feeling', her need to wear trousers (for the sake of security) and her perception that she was forced into having epidural anaesthesia which, she felt, caused her to have 'high blood pressure'. I found this served not only as a good '*aide memoire*' but also gave me an overview of each woman's story.

5.6.3 The women's reaction to their transcripts

Every woman was offered a completed transcript of her interview which she could amend or add to as she wished. It is interesting to note that, in the event, several quite definitely declined their transcripts when they were offered. Although they expressed their willingness for the information to be included in the study, they did not want to see it again. I wondered what this might signify. It may have been that the interview had proved cathartic and the rejecting of the transcript marked a degree of 'moving on' or, perhaps more likely, it might have proved too painful or frightening to relive their experiences in print. However, some of the women who accepted and read their transcripts indicated that being interviewed had had a cathartic effect and that the telling and documentation of their stories had been a positive experience. Indeed, one woman, with whom I have continued to have contact, found the experience so powerful that she now feels that she has been liberated from the impact of her past. Finch (1984), described her respondents, often unexpectedly, finding their interviews to be '*a welcome experience*' (p 73). It seems that at this particular stage of her life, this woman was finally ready and able to speak about her experiences, and when the opportunity to do so arose, she took it. I was a stranger, she had complete control over what she disclosed (Porter 1996) and I listened closely and non-judgementally. My identity as researcher meant that I was free from the obligations and constraints (such as time and location) of a counsellor or therapist.

5.6.4 Through the eyes of the beholder

Ultimately, the aim of transcription and documentation is to provide as accurate a record as possible of an encounter between researcher and informant. Clearly, it is not possible to exactly reproduce the event owing to the inadequacy of the written word, the dilemmas of omission or addition, and the 'translation' from a multi-sensual experience to a representation of it by signs and symbols. Furthermore, the interpretation of the data, its analysis, and subsequently, the credibility of the findings, rest on the foundation of documentary evidence. At every stage of the research, this information is subject to the 'lens', or filter, of the researcher's eye. Seibold (2000 p149) observes:

It appeared that in these interviews the balance of power was with the interviewee during the making of the data, but I as the interviewer/researcher had the power of analysis afterwards.

I would argue that much as we may attempt to equalise the power balance during the interview setting, even at this stage the information is subject to 'filtration' or 'refraction' through the researcher in what topics s/he chooses to pursue and those she allows to drop. In addition, and I think this is particularly true in the case of survivors of sexual abuse, the interviewee's desire to please the interviewer and 'do well' may mean that she quickly perceives what interests the researcher and tailors her story accordingly. Consequently the concept of reflexivity is central to the research process, as Kingdon (2005) states:

It [reflexivity] provides a means of dealing with epistemological concerns about how our identities as researchers are multiple, contradictory, partial, strategic and located. (p 623).

Even when we involve our interviewees in reviewing transcripts and commenting on our documentation, the account can never be totally without bias; '*...this is where the integrity of the researcher has to be laid open for scrutiny.*' says Chesney (2001 p 134). Feminist research rejects the positivist

notion that research should, or can ever be objective and without bias (Roberts 1992; Draper 1997; Kingdon 2005). Rather, it is incumbent on the researcher to declare herself, her influence on the research and to expose her methods for examination.

5.7 The impact of the research on me

What I was not prepared for however, was the impact the research was to have upon me. Wise (1998) and Scott (1998), who separately researched both ritual and non-ritual child abuse, both speak of the overwhelming emotional and physical affects this had on them:

...during the weeks of transcription I endured stomach cramps and nausea on a regular basis... Scott (1998 5.14)

...I felt overwhelmed by child abuse: I not only saw it everywhere (in the supermarket, in my neighbours' kids...) but I expected it to happen...

Wise (1998 1.7)

According to Wise (1998 1.6) it is not unusual for female academics working on physical and sexual violence against women and children to experience emotional and physical distress. For the first time in my life I experienced recurrent digestive problems and my mind was dominated by thoughts of sexual abuse. As I transcribed each interview, like Scott (1998), it was as if I was reliving each encounter and account in slow motion. These women and their stories became my constant companions. I felt I had suddenly entered a parallel universe in which different social and physical laws operated and my previous existence now seemed to me somewhat superficial. In the words of Scott (1998 2.2)

...the life-world I had previously shared with friends and colleagues sometimes felt unreal and insignificant.

Etherington (2000), an experienced counsellor, refers to this phenomenon as

'vicarious traumatising' which was first described by McCann and Pearlman (1990). She describes how, whilst undertaking a research study into the experiences of men who had been sexually abused in childhood, she was deeply affected by vivid dreams, intrusive thoughts and images.

For 3 months I listened to 25 men telling me their stories of abuse - day after day I heard graphic descriptions of violence, physical, sexual emotional abuse and neglect. In my role as researcher I felt almost as if I was a passive bystander. As a counsellor I would have been able to use my self, my skills and my understanding to respond actively as I listened - as a researcher I felt powerless. (p 380)

Despite being aware that she needed to talk about her experiences and receive support, she became socially isolated and withdrawn from family, friends and colleagues, and so 'bogged down' that she was unable to think for herself or seek out what she needed. This state of mind she recognised as mirroring the symptoms of post-traumatic stress.

During the interviews I felt there was a huge onus on me not to react to anything that was said in a shocked or judgemental manner. Several of the interviewees described their distress when therapists or counsellors had appeared to react negatively to their disclosures, thereby reinforcing their already keen sense of shame and guilt. Some of the information imparted to me I found extremely shocking but I was also aware of the danger of my succumbing to 'compassion fatigue'⁶. The temptation to dissociate myself was great. How does one expose oneself on a regular basis to such an outpouring of pain and suffering, remain 'present' with the women and yet protect oneself from the potentially crippling emotional consequences? This is a dilemma which Etherington (2000) also encountered in a counselling situation:

⁶ 'Compassion fatigue' is said to occur when the public, having been exposed repeatedly to visual images of suffering by the media, cease to respond to its impact. Initially when reports of the plight of the starving in places such as Biafra appeared on our television screens there was a huge upturn in charitable giving. However, similar images now fail to impress and the public's reaction is often one of apparent indifference. It could be argued that this non-reaction stems from feelings of impotence; the perception that the problem is overwhelming and that one is powerless to act. The conflicting emotions this evokes; that of horror but also of helplessness, requires that, for reasons of self-preservation, a way to distance oneself and 'switch off' must be found. Could this be yet another manifestation of dissociation?

I know now that there were times during their counselling that I wanted to protect myself from the images they needed to share - even whilst I encouraged them to make them concrete and explicit [...] So there was a battle going on inside me - I wanted to encourage their healing work whilst also needing to protect myself from any further exposure. Looking back I think I did manage to do both - but at some considerable cost to myself. (p 380 -1)

I cannot say yet what the long-term consequences of that battle will be for me as it is one in which I am still engaged. Like Judith, (one of the interviewees) I now 'do things with detachment' as if my emotional reserves have been exhausted. I continue to feel myself to be isolated and, to some extent, alienated. I hope that, in years to come, I will be able to look back on the experience from the standpoint of one who is now free from its impact. However, like the women whose lives are indelibly altered by sexual abuse, there will be no return to innocence.

5.8 Myself in the research

5.8.1 My background.

When I first started the research project, I was working as a community midwife for the National Health Service (NHS). However, I was seriously contemplating making the leap from NHS employee to self-employed independent midwife, which I subsequently did in the autumn of 2001. This change came about, as discussed in the previous chapter, because of my increasing frustration with NHS care and the feeling that (in common with many midwives who leave or who become independent - Ball et al 2002, Kacary 2005; Stephens 2005) I was not able to practise midwifery in a way that was acceptable to me. I was serving the institution, not the women. Like the interviewees in Shallow's (2001d) research, I was not happy to be slotted into any area of midwifery practice according to current organisational needs. I, like Kacary (2005), knew that my strengths were in forming ongoing relationships with women and helping them to achieve their goals. My experience of teaching had confirmed that to me. Shallow (2001d p 243) observes that the midwives in her study '*worked best*

where they felt happiest.' I needed to practise midwifery in a way that utilised my particular strengths in order that the women for whom I was responsible should receive the best possible care.

I realised gradually that the institution's fear of birth was beginning to cloud my vision and that I was losing my faith in women to birth their babies safely without intervention. Eventually I came to the realisation that I would have to 'consider whom I should serve'. Gould (2004 p 282) describes exactly the thought process through which I went when she says:

'Eventually the individual has to either abandon their principles and adopt the 'get real' cynicism of the NHS culture, or keep trying to bring about change.

If I remained within the NHS, in order to survive I would have to adjust my personal ideology and accept the medical model of pregnancy and birth and its influence on my clinical practice. For me, remaining within the system and fighting a rearguard action was not an option - I lacked the strength and self-confidence. If I became independent, I would be identifying myself as an 'outsider' and possibly setting myself up as a target for criticism and censure by those within mainstream, 'legitimate' practice. Life would be less secure and certainly less predictable but at least I could live with my conscience. I chose independence. Gradually, my caseload increased until I was attending 2-3 planned home births per month, which left little time for research. However, at last I felt that I was truly practising midwifery. I was no longer hampered by time constraints and I was able to form relationships with each woman and her family. I was able to follow each one through her pregnancy, birth and into the postnatal period. I was privileged to attend births where women were free to follow their own inclinations and birth their babies in the way that was right for them.

5.8.2 From midwifery to research

It was with this background that I came to the research. Where my experience differs from many other researchers is that I did not choose the subject - the focus had already been decided upon and the project initiated by Maggie Smith.

Whereas she had previously undertaken a case study of a survivor of sexual abuse for her midwifery degree dissertation, and therefore was already fairly knowledgeable on the subject, I came to it with very little pre-knowledge. My expectations with regard to what might be revealed in the data were limited to the physical sensations of birth and their commonalities with sexual abuse and the words and phraseology used by carers being reminiscent of those of abusers. I naively thought that from the findings I would be identifying a list of 'do's' and 'don'ts' to help inform midwives and carers dealing with women they knew to be survivors of sexual abuse. What emerged was much more fundamental and rooted in the way that industrialised western nations perceive and, therefore, treat pregnancy, birth and women in general. It turned out that the women's struggles with being processed, dominated and manipulated by the technomedical organisation (Davis-Floyd and Mather 2002) in many ways mirrored my own. It was then that I realised how this could impact on the credibility of my research findings, exposing me to possible accusations of bias or 'going native'; *'adopting the cultural identity of the society being studied'* (Donovan 2000a p138). Consequently, throughout the analysis and writing up of my findings, I was continually aware of maintaining my integrity by personal reflection and seeking advice from my academic supervisor.

'A profound level of self-awareness is required to begin to capture the perspectives through which we view the world; and it is not easy to grasp the 'unconscious' filters through which we experience the world,' state Mauthner and Doucet (1998 p122). Although spending time increasing my self-awareness appeared to me to have connotations of self-indulgence, I felt it was essential from the point of view of transparency and honesty in my dealings with the data.

5.8.3 Positioning

Clearly, the manner in which the interviewer is perceived by the informant can have a profound influence on the orientation, quality and even quantity of the information given. This is amply demonstrated by Finch (1984 p73) who observed an interview between one of her respondents and a local authority housing visitor. The interviewer was *'ploughing her way through a formal*

questionnaire in a rather unconfident manner....' and consequently the woman's responses were 'grudging' and 'stilted'. This was in complete contrast with the relaxed discussion concerning quite private matters which then ensued between Finch and the woman. The question of how to present oneself and the degree of personal revelation one is prepared to make to an interviewee has been the subject of much debate. Mauthner (1998) struggled with ambivalence about maintaining her own privacy whilst expecting others to reveal their private experiences. Eventually, she resolved to speak about herself as a researcher but to make no personal disclosures. Edwards (2001) admits to initially 'having reservations' about sharing certain information about herself, but concluded that, like Finch (1984), *'having a shared experience in common increased trust and commonality'* (p98). Chesney (2001) argues that Lofland and Lofland's (1995) assertion that ethnography requires the researcher to hold back to a certain degree, is of concern because this 'space' is denied to the researched. *'If we as researchers hold back, then it can be expected that the researched will also hold back'* (p 130). I therefore decided that I would not hold back, but determined to tell each respondent before her interview that I was prepared to answer any question about myself or my research. I felt it would be unethical for me to expect these women to reveal intimate details about themselves and their lives, whilst at the same time protecting my own privacy and dignity. In retrospect, I consider this decision was an appropriate one, given the findings concerning the women's desire for relationships with carers and their problems with people who were perceived as cold or distant. One of the respondents later told me that her expectations of 'a researcher' had been the stereotypical objective and aloof individual who shares nothing of herself. One of the factors which she had found most helpful was that I related to her on an equal footing and was prepared to disclose myself to her.

I introduced myself usually as a midwife researcher and often it transpired during the conversation that I was, in fact, an independent midwife. I decided that I would not volunteer information on my reasons for becoming independent unless asked, in order to avoid introducing additional bias. I attempted to present myself however not only as a midwife but also as a woman, mother, grandmother and as a (former) user of the maternity services. This, I believe,

became increasingly so as the project went on.⁷ Furthermore, the fact that I practise outside of the 'system' may have encouraged the women to express their opinions about their experiences of the maternity services more candidly. This may have held true for both categories of respondents (midwives and non-midwives). Finch (1984), in her research on the experience of clergymen's wives found that her respondents became warm and eager to talk after discovering that she also was 'one of them' (p19). My midwife respondents, similarly, appeared to identify with me as someone who had encountered similar experiences, and would understand their frustrations, aspirations and hopes but was removed from the system in which they functioned.

5.9 Handling the data

5.9.1 Using grounded theory

As grounded theory provided the general structure for the research, I did not undertake a detailed review of the relevant literature before embarking on the interviews as I wanted to approach the subject without too many preconceived ideas (Glaser and Strauss 1967, Strauss and Corbin 1998). Literature was reviewed as it became relevant to the emerging themes. For example, I sought literature on dissociation when this phenomenon became prominent. Analysis was concurrent with data collection and transcription and the emerging data informed the conduct of future interviews. Nevertheless, I felt it necessary to combine the use of grounded theory with an additional approach in order to examine the data from as many different perspectives and angles as possible. Acknowledging my own deep involvement with the women and my close identification with them required that I should take an approach in which I could honestly examine my own preconceptions and reactions to the women's stories

⁷ Since becoming independent I feel that my identity as a midwife is integral to who I am. I do not see midwifery in terms of a job or a role but inseparable from all the other facets that constitute 'me'. All my 'identities' are present and involved in my interaction with midwifery clients and I no longer feel the need to maintain a 'professional' persona as when I worked in the NHS. Therefore, I believe that, as time went on, my presence at the interviews became less as the 'midwife' and more as 'me'.

in greater depth, as well as extracting the more subtle meanings from the accounts by systematically reading them with different intent. Using grounded theory alone, I felt, would be like peering closely at a work of art, focusing on the means of execution and its technical excellence whilst remaining oblivious to the whole composition, its meaning, its message, its relationship to other works and its context.

5.9.2 The 'voice-centred relational method'

The voice-centred relational method of doing psychological research⁸ arose from the work done by Gilligan, Brown and colleagues at the Harvard Graduate School of Education (Gilligan 1982; Brown and Gilligan 1993) and was further developed by Mauthner and Doucet (1998). This provided the means by which I could 'keep sight' of the women as whole individuals whilst gaining a more thorough appreciation of their lives, what was important to them, how they felt and what constituted their separate ways of being. It was this approach that provided me with the 'overview' or 'the bigger picture', but also allowed me to extract the *richesse* from each strata of data, which, coupled with some of the elements of grounded theory, made for a more cohesive 'whole'.

It consists of four readings of the text of the transcript:

- Reading 1: This consists of two elements: firstly a reading for the overall plot and subplots, followed by a reading in which the researcher places herself in the text. As Mauthner and Doucet (1998) explain; *'This allows the researcher to examine how and where some of her own assumptions and views [...] might affect her interpretation of the respondent's words, or how she later writes about that person.* (p 127). The second element in this reading I felt to be particularly helpful as I was identifying my own position in the research at an early stage. This highlighted several issues to me. My initial response to many of the accounts was one of anger; towards those who had abused the women, but equally towards the

⁸ Mauthner and Doucet now avoid referring to it as a 'method', preferring instead to see it as 'an approach', thereby freeing it from the overtones of positivism and prescription which are contrary to the ethos of feminist research (Mauthner 2006, personal communication)

individuals providing maternity care whose actions had caused them to re-experience their abuse. I realised that I identified with them because I had encountered similar circumstances and attitudes in the context of working in the maternity services. I too had felt powerless and humiliated. However, having become aware of this, I was prompted to reflect on my approach to the interviewees, endeavouring to recognise that my own frustrations were not necessarily shared by them, or identical to theirs. I avoided using leading questions during the interviews, and in the analysis of the data I tried to avoid placing my own interpretation on the accounts. The acknowledgement of my personal feelings, I believe, enabled me to more clearly recognise and distinguish the women's voices from my own.

- Reading 2: This is a reading for the voice of the 'I', which focuses on how the respondent perceives, speaks about and presents herself. The experience of CSA has a profound impact on women's self-image, their self-esteem and their view of their own position in relation to others. This reading was useful in identifying not only the impact of CSA on these particular women, but also how their experiences of birth had affected them. It also highlighted the power of positive events to change a person's self-concept. Kerry (a midwife) spoke of how, at one time, contact with the medical profession would cause her to adopt the powerless patient role. Since she had disclosed her story and found healing, she had become fearless in speaking up for vulnerable women. Another interviewee, who spoke of her previously difficult relationship with her body, described herself as 'really powerful' as the result of two very positive births.
- Reading 3: In this reading, the researcher listens for how the informant speaks about her interpersonal relationships in order to reveal the woman's social context. In addition to the field observations made at the time of the interviews, this reading helped to provide me with insight into the wider social implications sexual abuse has for women. This brought home to me the long-term consequences of childhood sexual abuse, not

only for individuals but their families. It was helpful in identifying some of the ongoing problems survivors may have relating to their children and how both their experiences of CSA and traumatic birth can impact on their relationships with husbands or partners. Furthermore, it highlighted the sometimes ambiguous relationships abuse victims may have with their abusers, and those within their families whom they perceived to have failed in their role as protectors.

- Reading 4: The purpose of this is to place the woman within a broader context: political, structural and cultural. It was particularly relevant in examining their contact with the maternity services, from the perspective of both users and of midwives. It brought into relief issues such as the impact of authoritative knowledge in discrediting both women and midwives, the discrepancies between women's' concept of choice and that of the maternity services and the effect of the industrialisation of birth on women and midwives. This reading also provided an insight into strategies midwives and other maternity workers employ in order to cope with the inner conflicts of working in such an environment, and the consequences for birthing women.

Each reading requires the use of a different coloured pencil which is used to highlight the particular portion of text which refers to that specific reading. As Mauthner and Doucet found (1998), this procedure is very time consuming and consequently, I was obliged to limit the numbers of transcripts that I submitted to the entire process. However, it had a profound and ongoing impact on the way in which I read and handled all the data.

Both before and after undertaking the voice-relational readings, I broke up the transcripts into themes and 'themes within themes', using 'cut and paste' on the computer (as Mauthner did). I decided that, as the number of my respondents was fairly small, I would not use a computer-based qualitative analysis programme. As I was endeavouring to remain close to the women and their stories, and to maintain the 'structural integrity' of both, I dealt with the data 'manually'. However, this may not have been possible had the number of my interviewees been much greater.

Thus, I attempted to tease out the diverse layers of meaning contained within the data. Employing reflexivity at each stage of the project, from my initial contact with the respondents, through the interviews, to the analysis of the information gained, I endeavoured to make the women's authentic voices heard. I acknowledge that I was, and continue to be, 'emotionally involved' with them and their stories. I would argue that to remain 'objective' and aloof when dealing with such a painful subject would be uncomfortably like the scenario in which the father of one the interviewees regularly watched his small daughter being abused by other men, unmoved by her suffering. Understanding is not gained through detachment and cold observation, but through getting involved with other people's lives. It is in reflecting on my own position and attitudes in relation to the research, that I hoped to recognise and distinguish my own voice from that of the interviewees. It is because of my involvement, not in spite of it, that I am committed to making their voices heard in preference to my own.

5.10 Summary

In this chapter I have discussed the various ethical issues involved in undertaking a study of this nature, particularly the potential for it to be exploitative or perceived as abusive by women who are already vulnerable. I have explained how this influenced the way in which the research was conducted and the impact that doing the research had upon me. The problems of translating the spoken word to the written word were examined and the diverse ways in which stories can be told according to the danger it presents to the teller. I also declared myself and my position in relation to midwifery and research, in accordance with the tenets of feminist research in order that my own part in, and influence on, the data should be clearly seen. I have explained why I chose the methods of data analysis I used and their appropriateness with regard to the subject matter and ability to maintain the integrity of the women and their stories.

The next section gives a short summary of each of the interviewees' details. I decided to place it immediately before the findings rather than in an appendix for ease of reference.

Details of interviewees

(Pseudonyms are used to protect the women's identity)

Claire

Age: 53 **Marital status:** Married **Occupation:** Shop assistant, retired

Children: One son **Age:** 28

Type of birth: Spontaneous vaginal birth in hospital

Perception of birth: traumatic

Abusers: Father and other paedophiles

Age at which abuse occurred: began at around the age of 4 years. Father's abuse continued until the age of 15, paedophile abuse ceased earlier, uncertain when

Memories of abuse: No memories of abuse at time of giving birth. Began to surface in her mid- to late forties.

Trigger to return of memories: Family crisis involving birth and death

Other information: Long term problem with alcohol misuse

Coral

Age: 40 **Marital status:** Married **Occupation:** Voluntary counsellor, survivors of CSA

Children: Two daughters **Ages:** 7 and 5

Types of birth: Both spontaneous vaginal births in consultant units

Perception of births: both traumatic

Abuser: School teacher

Age at which abuse occurred: Began around the age of 15/16 and continued until late teens

Memories of abuse: No amnesia.

Other information: Suffered from severe chronic depression for which she had received hospital treatment.

Jane

Age: 32 **Marital status:** married **Occupation:** Nurse

Children: One son **Age:** 19 months.

Type of birth: spontaneous vaginal birth in consultant unit

Perception of birth: when asked if birth was problematic, said '*Only the treatment [...] the birth bit was lovely [...] the ward was awful*'.

Abusers: 2 men she described as 'grand-dads'.

Age at which abuse occurred: from around the age of 3. Continued for some years (uncertain)

Memories of abuse: No memories of abuse at time of giving birth. Began to surface after birth of son

Trigger to memories returning: Uncertain, may have been linked with birth of son

Other information: Described acute mental health problems following birth but was not hospitalised.

Judith

Age: 52 **Marital status:** separated **Occupation:** Had worked in catering industry. Described current occupation as 'focus play work'

Children: one son, one daughter. **Ages:** 21 and 19

Type of births: Both spontaneous vaginal births in consultant unit

Perception of births: 'enjoyable' owing to absence of pain through dissociation

Abusers: Mother, grandfather, uncles.

Ages at which abuse occurred: mother – early years, starting around 3 years old; Grandfather – around 11 years; Uncles – from early years up to age 11.

Memories of abuse: no memories of abuse at time of giving birth, began to surface during her mid-forties.

Trigger to memories returning: death of mother

Other information: Described having strong aversion to being touched

Lynne

Age: 53 **Marital status:** divorced **Occupation:** Shiatsu practitioner and yoga teacher

Children: two daughters, one son. **Ages:** 19, 21 (daughters) and 23.

Types of birth: 1) spontaneous vaginal birth in hospital; 2) spontaneous vaginal birth at home; 3) spontaneous vaginal birth in hospital.

Perception of births: 1) traumatic; 2) positive; 3) positive

Abusers: Father, mother, brother, molested by more than one stranger

Age at which abuse occurred: Father – from 18 months to 6 years, mother – unspecified; brother – 11 years; other attacks – unspecified.

Memories of abuse: No memories of abuse at time of giving birth, began to surface around the age of 39.

Trigger to return of memories: death of father

Other information: Also subjected to bullying and violence from family as a child

Sally

Age: 22 **Marital status:** stable relationship **Occupation:** full time mother

Children: one son, one daughter. **Ages:** 6 years; 7 months.

Types of birth: Spontaneous vaginal births in consultant unit.

Perception of births: 1) traumatic; 2) more positive

Abuser: step-father

Age at which abuse occurred: From age 6 to 15 years. First child conceived as a result of abuse.

Memories of abuse: no amnesia, but did describe herself 'blocking' memories from her mind.

Veronica

Age: 58 **Marital status:** widow **Occupation:** had worked in administration, currently working voluntarily in a charity shop.

Children: one daughter, one son. **Ages:** 36 and 31

Types of birth: 1) vaginal, but unable to recall whether instrumental; 2) vaginal, probably by forceps. Both in consultant unit.

Perception of births: both traumatic

Abusers: father and father's friend

Age at which abuse occurred: from age 6 to 15 years.

Memories of abuse: described having 'blocked out' memories at time of giving birth. Uncertain when they surfaced.

Trigger to memories returning: uncertain

Other information: Severe mental health problems following son's birth. Hospitalised and treated with electro-convulsive therapy.

Wanda

Age: 56 **Marital status:** married **Occupation:** voluntary counsellor for CSA survivor organisation

Children: two sons. **Ages:** 34 and 23

Types of birth: 1) Spontaneous vaginal birth at home; 2) spontaneous vaginal birth in consultant unit

Perception of births: Both non-traumatic, but described birth as *'the most revolting thing that's ever happened to me'*.

Abuser: father

Age at which abuse occurred: probably started at around 5 years old and continued for some years.

Memories of abuse: No memories of abuse at time of giving birth, began to surface when her second son was about 8 months old

Triggers to memories returning: uncertain, may have been birth of second son.

Other information: Suffered severe mental health problems after the birth of her children; also had Hirschsprung's disease for which she had received hospital treatment as a child.

Midwives

Amanda (student midwife)

Age: 33 **Marital status:** stable relationship

Children: two daughters **Ages:** 10 and 6

Types of birth: 1) Spontaneous vaginal birth in consultant unit; 2) spontaneous vaginal birth at home.

Perception of births: 1) traumatic; 2) positive

Abusers: older brothers and step father

Age at which abuse occurred: Brothers – from age 6 for several years; step-father – from age 15

Memories of abuse: no amnesia

Brenda (hospital midwife in Canada)

Age: not disclosed * **Marital status:** separated

Children: two daughters **Ages:** unknown *

Types of birth: 1) Spontaneous vaginal birth in consultant unit; 2) spontaneous vaginal birth at home.

Perception of births: 1) traumatic; 2) positive

Abuser: older brother

Age at which abuse occurred: from age 8 to 11

Memories of abuse: no amnesia

Jo (student midwife)

Age: 39 **Marital status:** married

Children: 2 daughters, 1 son. **Ages:** daughters -14 and 9, son 13.

Types of birth: 1) Spontaneous vaginal birth in consultant unit;
2) spontaneous birth in consultant unit; 3) home birth

Perception of births: 1) traumatic; 2) non-traumatic; 3) positive

Abusers: neighbour, and one-off attack by a stranger

Age at which abuse occurred: Did not specify what age but implied that it continued for some years

Memories of abuse: no amnesia

Jenny (hospital midwife in Australia)

Age: not disclosed* **Marital status:** married

Children: One son **Age:** just over 6 months

Type of birth: ventouse birth in consultant unit after transferring from birthing centre.

Perception of birth: traumatic

Abuser: male acquaintance

Age at which abuse occurred: one-off rape age 17

Memories of abuse: no amnesia

Other information: Reported that she linked the sensation of the ventouse birth with the rape

Kerry (community midwife)

Age: 46 **Marital status:** married

Children: one daughter **Age:** 21

Type of birth: footling breech birth by forceps in consultant unit

Perception of birth: traumatic

Abuser: father

Age at which abuse occurred: between the ages of 3 and 17.

Memories of abuse: Did not have total amnesia but did speak of blocking the memories of it as 'putting the dirty washing in the bottom drawer'.

Other information: Reported severe postnatal depression but was not hospitalised.

Louise (hospital midwife)

Age: not disclosed * **Marital status:** stable relationship

Children: one son, one daughter **Ages:** 7 years; 6 weeks

Types of birth: 1) emergency caesarean section during induced labour for postmaturity; 2) vaginal birth following induction of labour for postmaturity in consultant unit.

Perception of births: 1) traumatic; 2) non-traumatic, but many issues around doctors' reluctance to honour her request to keep vaginal examinations to a minimum. Midwives she described as following hospital procedures and she was unable to find the voice to say no, thus felt out of control.

Abusers: not specified *

Ages at which abuse occurred: not disclosed *

Memories of abuse: no amnesia

Rhoda (hospital midwife)

Age: 35 **Marital status:** stable relationship

Children: one son and one daughter **Ages:** 5 and 2

Type of birth: 1) spontaneous vaginal birth at home; 2) spontaneous vaginal birth in consultant unit.

Perception of births: Both positive

Abuser: Grandfather

Age at which abuse occurred: unsure – early childhood.

Memories of abuse: memories had been submerged but began to surface when she was 25 years old and beginning her midwifery training. This was before she gave birth.

Triggers to return of memories: unknown

Other information: Her memories were only fragmentary at the time of the interview

Rosie (hospital midwife)

Age: 31 **Marital status:** Married

Children: one son, one daughter **Ages:** 12 and 9

Types of birth: 1) vaginal birth after augmentation of labour with syntocinon, in consultant unit; 2) spontaneous vaginal birth at home

Perceptions of births: 1) traumatic; 2) positive 'absolutely perfect'

Abusers: uncle and one-off attack by stranger

Ages at which abuse occurred: not specified

Memories of abuse: no amnesia

Ruth (had been hospital midwife, was not practising at the time)

Age: 31 **Marital status:** married

Children: one son, one daughter. **Ages:** 7 and 5

Type of birth: Both spontaneous vaginal births at home.

Perception of births: both positive. Midwives were aware of her history.

Abuser: School teacher

Age at which abuse occurred: started when she was 11, continued for some years.

Memories of abuse: no amnesia

Other information: At the time of her interview was awaiting the trial of her abuser.

Sharon (hospital midwife)

Age: 32 **Marital status:** stable relationship

Children: one son, one daughter. **Ages:** 7 years; 6 months

Type of birth: both spontaneous vaginal births at home.

Perceptions of births: 1) positive; 2) traumatic

Abusers: Male friend of the family; one-off rape by stranger

Age at which abuse occurred: 1) around 3-4 years; 2) in teens

Memories of abuse: no amnesia

Susannah (hospital midwife)

Age: 37 **Marital status:** stable relationship

Children: two sons, one daughter. **Ages:** 18 and 16 years (sons); 13 years (daughter)

Types of birth: all spontaneous vaginal births in consultant unit.

Perception of births: 1) traumatic; 2) unspecified; 3) unspecified.

Abuser: Step father

Age at which abuse occurred: between the ages of 12 and 17 years

Memories of abuse: no amnesia

Vickie (community midwife)

Age: 44 **Marital status:** married

Children: three sons **Ages:** 17, 15 and 9 years

Types of birth: 1) vaginal birth, complicated by pre-eclampsia, and intrapartum haemorrhage during induced labour; 2) spontaneous vaginal birth; 3) spontaneous vaginal birth. All in consultant units.

Perception of births: 1) remembers little of it – described herself as 'detached'; 2) positive; 3) non-traumatic

Abuser: elder brother

Age at which abuse occurred: from early age to 16 years.

Memories of abuse: no amnesia

Other information: Abuse centred on breasts, therefore found breastfeeding problematic.

* These interviewees contacted me by internet and did not disclose these details. I have subsequently been unable to contact them.

Chapter 6

The sequelae of CSA in the lives of these women

6.1 Introduction

The purpose of this chapter is to explore what the interviewees said about the impact that childhood sexual abuse (CSA) had upon them and their everyday lives in order to more fully understand the problems they brought with them to their childbearing experiences. It starts with an examination of the impact of the women's traumatic history on their memories of the events because a substantial number reported having had no memory of their abuse at the time when they gave birth. This will include discussion on memory retrieval and the role of everyday events not only in triggering new memories, but also in causing the women to re-live previous traumatic experiences. This will be followed by discussion of the findings using Finkelhor and Browne's traumagenic model (1986) as a framework in order to highlight the uniqueness of trauma arising from CSA, as opposed to other types of trauma. The chapter ends with discussion on the resultant vulnerability of these women and the many ways in which this influenced their lives, laying them open to re-traumatisation in circumstances which mimicked their abuse.

6.2 The far-reaching effects of CSA

It became obvious to me during the project just how relevant their previous history was to their perceptions of birth, parenting and all that involves. Much of the data supports the findings of previous research on the sequelae of childhood sexual abuse, but I feel it is pertinent to re-iterate them in order to provide the context for later discussion on the women's childbearing experiences and contact with the maternity services. I quote freely from the transcripts out of a strong desire to make their stories heard in order that the reader should be enabled, like me, to become acquainted with the women as individuals, and consequently, care about what happened to them. To approach this project from the point of view of objective observer, as I explained in

Chapter 4 (Methodology), would be to subject these women to yet another form of abuse.

The data from the interviews confirmed what is already known about the long-term psycho-social sequelae of sexual abuse. Several of the interviewees reported that they had engaged in diverse forms of self-harm at some time during their lives. This included self-biting, cutting, head butting, ironing arms and deliberately breaking limbs. Some women reported having made suicide attempts, which mostly consisted of overdosing. One woman described this as a cry for help, whereas another explained that it was an attempt to numb the severe emotional pain she was feeling. One interviewee had tried to hang herself when the pain associated with her memories of abuse became overwhelming during a period in which she was receiving counselling. Four of the women described struggling with various eating disorders such as anorexia nervosa, bulimia and compulsive eating. These are all behaviours which are recognised as sequelae of past traumatic events and are commonly reported by survivors of CSA (Browne and Finkelhor 1986; van der Kolk 1996; Heritage 1998; Seng et al 2002; Hobbins 2004; Hanan 2006).

Several of the women had suffered from mental health problems such as severe, chronic depression and some of those who had previously had submerged memories of their abuse reported having experienced psychological crises around the time that they regained their memories. From their experience of working with survivors of CSA Simkin and Klaus (2004 chapter 2) suggest that this is not uncommon. Depression in adult life has been strongly linked with the experience of CSA (Bachmann et al 1988; Browne and Finkelhor 1986; Bifulco et al 1991; Briere and Elliott 1994; Benedict et al 1999) and the work of Buist and Barnett (1995) and Buist (1998) suggests that women who have experienced CSA are at higher risk of developing postnatal depression. Two of the women reported suffering from profound depression following the birth of their children but both felt that this was partly a result of their traumatic birth experiences. This will be discussed further in Chapter 7.

Several interviewees suffered from chronic ill health such as genito-uninary, gynaecological and bowel problems, all complaints which have been associated with CSA (Arnold et al 1990; ACOG 2001; Stenson et al 2003).

What was clear from their accounts was that for most of these women,

childhood sexual abuse was not just a distant memory, an unpleasant episode in their lives, but something which had an ongoing impact on their daily lives:

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

The 'ever-present-ness' of their identity as survivors and the far reaching nature of what had happened to them as children was striking. The effect of CSA on their subsequent lives was evident in the minutiae of everyday living, having an influence on seemingly insignificant decisions such as choice of clothing or how to stand in a queue.

6.2.1 Trauma and memory

Trauma of any kind is known to have a profound impact on memory (van der Kolk 2002) and this constituted a major theme in the research. Not only did women report having had amnesia surrounding traumatic events from childhood, but also that life events could unexpectedly trigger memories to return or cause flashbacks to situations within their conscious memories, as if they were actually experiencing the trauma. Chapter 9 will consist of a fuller discussion on the phenomenon of dissociation and traumatic amnesia but at this point it is useful to examine the role that they had in contributing to the general and wide-ranging sense of vulnerability in the interviewees.

People who suffer from post-traumatic stress disorder (and many survivors of sexual abuse are affected by PTSD, or are partially symptomatic) are unable to assimilate and integrate their memories, causing them to relive the trauma when faced with certain triggers and, subsequently, to behave in a manner out of all proportion to their current situation (van der Kolk 2002). This is caused by a neurobiological response to the sensation, emotions or feelings that were present during their original traumatic experience. This, in turn, activates a motor response to threat which would have been appropriate to the original trauma but fails to relieve the distressing emotions. This may serve to

perpetuate and enhance feelings of loss of control and helplessness. These 'foundations' have a permanent and lasting impact on the lives of abuse victims and will dictate the way in which they react to and perceive things throughout their lives.

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

In some ways, at the time of interview, these women resembled the categories of survivors identified by Seng et al (2002) – those who were well on the road to recovery, those whose trauma was ongoing, and those who were not yet ready to know. Although it could be argued that all these women were ready to know, in that they were willing to talk about their experiences with me, it was clear that they were all at different points in the process of dealing with what had happened to them. Some had only fragmentary or limited sensory memories of what had occurred. For others, abusive memories continued to surface in response to seemingly insignificant triggers, which could have a devastating effect on their social interactions. Many continued to experience dissociation in situations in which they felt overwhelmed emotionally or which were reminiscent of abuse. Some, like the women in Seng and colleagues' research (2002) who were well on in their healing, were able to take the initiative and manage circumstances better in order to ensure that their needs were met.

6.2.2 Amnesia and the recovery of 'lost' memories

Several of the interviewees reported experiencing long-term amnesia concerning the events of their childhood, with memories only surfacing in adult life, some as late as middle age.

Amnesia or 'delayed recall' is a phenomenon which is well supported by research in the area of childhood sexual abuse (Herman and Schatzow 1987; Williams 1994; Elliott and Briere 1995; Elliott 1997; Widom and Morris 1997). Research also suggests that the trauma of childhood sexual abuse is more likely to result in complete memory loss than any other type of trauma (Elliott 1997). It is believed that traumatic memories differ from non-traumatic

memories in that they cannot be processed in the normal way and are initially stored as sensory fragments with no semantic or linguistic components. They are therefore not assimilated into an individual's personal narrative and consequently, remain in their 'undigested' state (van der Kolk and Fisler 1995). As a result, memories do not return in complete narrative form but are usually experienced as sensory or emotional fragments. Participants in van der Kolk and Fisler's study (1995) all reported that their traumatic memories had initially surfaced in the form of somatosensory or emotional flashbacks, which is supported by other research findings (Brewin and Andrews 1998). Memories are often triggered by events which bear a resemblance to the original trauma or have a trauma-specific significance to the individual (Herman and Harvey 1997).

Some women reported that their memories had begun to return in response to momentous events such as birth and death. In several cases, memories were triggered by the death of the perpetrator. This was so in Judith's case, as the death of her mother prompted her memories to surface in the form of vivid flashbacks in which she would lose touch with reality. This had a profound impact not only on her psycho-social functioning but also had physical repercussions which affected her everyday life:

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

Judith

Lynne's memories of childhood abuse also began to surface after the death of her abuser (father) causing a psychological crisis:

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

It is interesting that she describes herself as 'releasing' the memories. This appears to support the idea that memories may return when the survivor feels she has reached a stage in life when it is safe for them to do so (Rose 1992; Terr 1994; Simkin and Klaus 2004 chapter 2).

Although Kerry had retained memories of her abuse, she dealt with them by blocking them or, as she described it - '*putting the dirty washing in the bottom drawer*'. Like Lynne, shortly after the death of her father, she suffered an emotional collapse which appeared to be linked with the release of abusive memories:

And my father died 6 years ago, so the year after was when my life, if you like, collapsed in a sense about what I'd been carrying around with me...

Kerry

Claire's memories suddenly returned in the form of vivid flashbacks two days after her niece gave birth to twins, one of whom died, while the other lived but was seriously ill.

6.2.3 Intrusive re-experiencing of traumatic memories

As increasingly more memories are retrieved, they are ascribed a personal narrative by the traumatised individual in order to 'explain' what happened to them. However, this does not appear to 'defuse' them as research indicates that individuals may continue to be affected by intrusive sensations related to their trauma (van der Kolk and Fisler 1995; van der Kolk, van der Hart and Marmar 1996: Chapter 13).

Some of these women reported experiencing intrusive memories of their CSA on an ongoing basis. This took the form of flashbacks to abusive scenarios and could be triggered unexpectedly by situations which contained elements associated with the original event. Memory triggers are often apparently innocuous, everyday events but which hold particular significance to a traumatised person. For example, Ehlers et al (2004) describe a woman who had been attacked by a bull experiencing a flashback on seeing a car number plate containing the letters MOO.

Similarly, some of the women in this study continued to find that their everyday lives were deeply affected by their childhood experiences. Several described events and occurrences in their daily lives which would trigger traumatic memories, often quite unexpectedly. Some lived from day to day never knowing when they were going to be propelled into a flashback by some apparently insignificant trigger. These could be almost anything that had the power, because of association, to arouse traumatic memories: smells, colours, touch, words or phrases, certain days or time of year. For instance, Judith reported having had flashbacks triggered by bluebells.

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

It seems that since her memories of abuse had surfaced, many and varied life events had the power to induce vivid flashbacks, all of which made for an extremely frightening and anxiety-invoking existence:

...the sort of early flashbacks were quite a shock because it was as if...I couldn't separate what was here and now and what was then. I would get...the slightest little thing could hook me into being in that place which is where for me, links in with, you know, the midwifery part, because from my perspective (thank goodness) I was dissociated enough that that didn't happen, but it does now. If I have to have...sort of medical or dental treatment now, then it cuts across. But the slightest thing could move me back into that space of time and I wasn't as aware then that I am now, sort of thing. It was as if I was whichever child part and I have, I still do, when I have new flashbacks. I have the physical sort of pain. It can be associated with smell as well and it's – it is – very much as if ...you know, whatever happened then is actually happening now. Judith

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

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

Kerry

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

6.2.4 'Predictable' triggers

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

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

Many of the women found that invasive or intimate medical examinations or procedures, especially when they were carried out by men, mirrored their abusive experiences and could cause them to have flashbacks or to dissociate in response [see Chapter 9]. Claire found that intimate medical examinations had the potential to cause her to re-live events related to the paedophile ring, just as if it were happening again:

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

Lynne also found that certain procedures had the ability to cause her to flashback or dissociate. She described how feelings of dehumanisation engendered by a routine mammogram examination could constitute a trigger:

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

Several of the interviewees found going to the dentist problematic as a result of their childhood experiences, partly because of the connotations with oral sex, but also because of the feelings of vulnerability it engendered. Arguably, most people without a history of abuse find it uncomfortable to be in the situation in which they are obliged to lie back whilst allowing abnormally close physical contact by a relative stranger. Survivors undergoing this kind of procedure must put themselves in a position of extreme vulnerability requiring a degree of trust which they simply may not have.

Judith explained how a recent trip to the dentist found her struggling with dissociative flashbacks in a situation which strongly mirrored an abuse scenario:

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

Rosie, whose memories had surfaced relatively recently and consisted entirely of sensory fragments suggesting oral sex, recalled a very similar situation involving a trip to her dentist:

At one point when I was – this was obviously before I knew [about the abuse] when I was a young teenager, I was supposed to have a brace fitted and um...they sort of make a cast of your mouth, obviously, and it involves putting a sort of hard plastic thing in your mouth with some gooey stuff in so you can

make a cast of your mouth. I just remember him just sort of pushing it into my mouth and not being able to breathe and gagging on it and just feeling just like really frightened. I mean I guess it probably would have been frightening anyway, but it was ... there was something more than just fear, and that was pretty dreadful. Rosie

The link between abuse involving oral sex and fear of dental treatment is fairly predictable and has been demonstrated by the work of Willumsen (2001), who found that women reporting sexual abuse in the form of oral penetration, experienced significantly higher levels of dental fear than women who had been subject to other forms of sexual abuse. Furthermore, a study by the same researcher some years later (Willumsen 2004) linked feelings of loss of control with dental fear in CSA survivors. Significantly, the data suggested that women with a history of CSA find interpersonal factors such as communication, trust, fear of negative information and lack of control more fear evoking than women with dental fear but without a CSA history.

6.2.5 The media

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

J: ...at one stage, early on, I couldn't – just to see the word "sex" written down was like, you know...and television was an absolute nightmare...

E: What sort of things on the television? Programmes about sex or sex-scenes or...?

J: Anything. It was...it was really quite random

E: Would that flip you back into a scenario thing?

J: Yes. It would flip me back into a scenario or it would flip me back into what I used to call the "black hole" because it was like everything in there was black except for this tiny chink. That would be just sort of focused on what was in my immediate view then. I would cut everything else out. Judith

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

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

Ruth recounted feeling utterly devastated on the occasion when she felt compelled to watch a television programme on paedophilia; arguably, an example of a traumatised individual feeling compelled to repeat the trauma (van der Kolk 1989):

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

It is interesting to note that Elliott (1997) reports that the most commonly cited trigger to trauma recall amongst her 724 traumatised respondents was some form of media presentation. However, van der Kolk, Hopper and Osterman (2001) report that Pitman, (personal communication with the researchers July 1996) attempted to simulate a traumatic stressor by showing college students a film which consisted of actual footage of human and animal deaths and mutilations. Despite its horrific nature, it failed to produce post-traumatic symptoms in these non-traumatised individuals. Clearly, the students had no history which would predispose them to trauma, and presumably were in a situation in which they had a) volunteered for and consented to the experiment;

and b) would have had the choice to opt out during the film if it had proved overwhelming. In other words they had choice and control over the event. The nature of trauma is the fact that it is uncontrollable, overwhelming and unavoidable.

6.3 The uniqueness of trauma resulting from CSA

Unlike most other traumas, however, CSA occurs at a time when an individual's emotional and psychological development are incomplete. Parental abuse has a profound and deleterious impact on the child/parent attachment bonds which, in turn, affects an individual's ability to integrate sensory, emotional and cognitive information into a cohesive whole. This effects how people process subsequent stressful information throughout their lives, therefore making them forever vulnerable to extreme stress reactions (van der Kolk 2003).

Carter (2000 p54) refers to the long-term impact of CSA in terms of 'role-locked' relationships; i.e. those which are formed in unfavourable environments (such as abusive ones), demanding a certain type of response consequently causing roles to become fixed in a particular pattern:

The shape which early interactive reciprocal role relationships take will lay the foundation for later adaptive or maladaptive patterns of relating to oneself, others and the world.

Particularly in the case of those who had been incestuously abused from an early age, it could be seen that the interviewees' childhood experiences had shaped their personal locus of control, their way of being and self-image. From early on in their lives they had known themselves to be powerless as their physical and emotional integrity was repeatedly violated. Because of this, it seems that distorted images and skewed emotional processes were built into their psyches like faulty foundations into a structure. No matter how expert subsequent building work was, the foundations had been laid and would continue to influence the structure as long as it stood. That is not to say that these women saw themselves as victims - far from it. All of them had overcome the legacy of their past to some extent and had gone on to lead relatively

normal lives, held responsible jobs, formed meaningful relationships, had children and found varying degrees of healing. Undeniably however, to some extent, their abusers still influenced their thought patterns, their beliefs and actions. It was as if they viewed life through a distorting lens.

Finkelhor and Browne (1986) suggest that the conjunction of the four traumagenic dynamics described in their 'traumagenic model' (betrayal, stigmatisation, traumatic sexualisation, and powerlessness) is what makes sexual abuse unique as opposed to other kinds of childhood trauma like parents' divorce or physical violence. They state:

These dynamics, when present, alter the child's cognitive and emotional orientation to the world, and create trauma by distorting a child's self-concept, worldview, and affective capacities. (p180)

Their traumagenic model provides a useful framework within which to discuss the data resulting from the interviews.

6.4 Betrayal

At the heart of sexual abuse is betrayal of trust. A child's natural proclivity for, and need to, trust is abused and manipulated by those who are in the position of caretaker or guardian. The enormity of this will have an ongoing impact on the child's capacity to trust (Davies and Frawley 1994).

Trust in others over whom we have no control is a prerequisite in almost every area of life – we trust that other road users will be driving on the left, that when we visit our GP, he or she will act for our good, that the food we buy will not poison us – but survivors may find themselves unable to function in situations which demand their trust and involve loss of personal control. Betrayal occurs when a child realises that someone whom they love and depend on, has harmed, manipulated, or lied to them. In some cases, the sense of betrayal extends beyond their abusers to include those who failed to act protectively and put a stop to their suffering. The issues of trust and betrayal were recurring themes throughout the interviews, influencing lives in many subtle and diverse ways, including personal relationships, social interactions, contact with health

professionals and organisations - a testimony to the wide-ranging and lasting impact of childhood abuse.

A deep sense of betrayal was very evident in Claire's interview. Her father not only abused her himself but also hired her 'services' to a paedophile ring, and the feeling of betrayal at his hands screams relentlessly out of her words. She described him passively watching, casually smoking a cigarette whilst the abuse was taking place, apparently unconcerned by her suffering. During her interview she referred to this scenario three times in almost identical words:

But he also used to take me and we used to go into the house and there would be ten or eleven other men and he would lounge up a wall, smoking a cigarette

Claire

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

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

Claire

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

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

In adult life, after reacting in an uncharacteristically violent manner towards a

man with whom she was falling in love, she felt obliged to end the relationship because she did not want to risk losing control of herself in this way again. Not only had her abuse affected her ability to trust others, but this unexpected reaction on her part profoundly influenced her ability to trust herself.

Kerry was betrayed by her father, who had continuously abused her from before the age of three until she was 17 years old, but this was exacerbated by the fact that, ironically, after she eventually disclosed, they were both expected to attend the same location for counselling. The implications of this incongruous situation made it difficult for her to trust the therapy and receive any benefit from it.

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

Kerry

She went on to say how, in adult life, the fact that she had been able to build up a relationship of trust with her General Practitioner (GP) meant that she would be unwilling to consider moving to another geographical area if that meant changing her GP.

6.4.1 Tacitly collusive other carers

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

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

Veronica was the second youngest child in a family of 8 children and remembers her mother appearing 'defeated' and tired with little time for her. She felt that her mother was almost certainly aware of what was happening, but poverty and hopelessness made her reluctant to acknowledge the situation.

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

Wanda was convinced that her mother was aware that her father was abusing her, but failed to act protectively towards her, perceiving her as a threat.

6.4.2 Betrayal by those in authority

Some of the survivors felt that they had been betrayed by individuals or organisations who had the ability to put a stop to their abuse. Claire revealed that the men involved with the paedophile ring who abused her on a regular basis held respected, professional positions in the community. She described being vaginally examined by a doctor at the house where her abuse took place, and his advice to her abusers to '*leave her alone for one or two weeks*' because of the injuries she had sustained. This continued to have repercussions later in life, as she explained:

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

In Susannah's case, after she had left home, there was a police investigation into her stepfather's abusive activities with her younger sister. Unfortunately, this merely resulted in fine and two years' probation, whilst her sister was placed in residential care - the very fear that had kept Susannah silent about his abuse. She expressed an entirely understandable sense of betrayal towards those whose role it was to protect them.

Some of the women felt frustrated and bewildered by what they felt were missed opportunities to get the help and support they desperately needed. Most of the interviewees in this study did not disclose their abuse at the time when it was ongoing. However, similar to the interviewee in Burian's study (1995) [see p62] who wanted her doctor to ask her why she was experiencing pelvic pain, they felt that they displayed certain symptoms which ought to have alerted the

appropriate bodies to suspect abuse. They often questioned why those people had not picked up on the clues that were there to see. Arguably, some of these signs or symptoms may not have been as obvious to others as the women imagined, and their feelings of stigmatisation may have led them to believe that they were displaying clear signals. Moreover, at the time when most of the interviewees' abuse occurred, the frequency and indicators of sexual abuse had yet to be widely recognised and therefore it was not usually suspected as a possible cause. On the other hand, anecdotally, there was, and may still be, a general reluctance by society to acknowledge the existence of sexual abuse.

When, as a teenager, Amanda found herself subject to abuse by her stepfather, she quickly went from being a model student to a poor achiever who regularly truanted from school. Unfortunately, her dramatic decline went un-investigated and unquestioned, depriving her of the opportunity to find help:

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

From a young age Wanda remembers being taken regularly to Great Ormond Street Children's Hospital by her father because she suffered from Hirschsprung's disease⁹. She thinks that staff there may have suspected that she was an abused child but it was never followed up.

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

⁹ Hirschsprung's disease is a congenital disorder most commonly affecting the lower bowel. It is caused by an absence of nerve cells in the large intestine which stimulate the rhythmic contractions which move faecal matter through the gut. Consequently, the bowel becomes obstructed, causing constipation, abdominal distension and discomfort. This may be treated with regular enemas, which parents of children with the condition are taught to administer. (www.ich.ucl.ac.uk/factsheets/families/F000225)

When I was 8 at school, I did say once on the dinner table that my Dad did things to me that I didn't like, and I was told by one of the teachers 'we don't talk about those things at dinner'. Kerry

She explained that her teacher's reaction left her with the conviction that she was at fault, thereby introducing the elements of blame and shame which (as discussed in Chapter 3) are often responsible for survivors' reluctance to disclose (Summit 1983; Hobbins 2004).

6.4.3 Abusive mothers

Until recently, the sexual abuse of children has been considered an almost exclusively male behaviour and society has been reluctant to recognise the possibility that abusers may be female (Squire 2003). However, Longdon (1993) reports that children may indeed be subject to brutal sexual abuse by women, contrary to the popular belief that female abuse tends to be an extension of maternal activities such as fondling or kissing.

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

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

Judith had suffered sexual abuse by her mother, grandfather and uncles, but not her father. Although she did not describe what form her mother's abuse

took, her account strongly suggests that it was far from the stereotypical view of female sexual abuse.

As was seen in the accounts of women who developed post-traumatic symptoms following birth, [see Chapter 1] the sense of betrayal largely arises out of an individual's unmet expectation of care from someone who could be expected to behave in a nurturing and sympathetic manner. Arguably, the general expectation that mothers should be nurturing and protective, led to an even more acute sense of betrayal in these women.

6.5 Stigmatisation

As previously discussed, because childhood sexual abuse occurs at an age when the child's emotional and psychological development is at an early stage, her perception of herself and the world around her are shaped by her experiences. Among the long-term effects of CSA are poor self-esteem and stigmatisation (Bachmann et al 1988; Holz 1994). Finkelhor and Browne (1986) describe stigmatisation as:

...the negative connotations – for example, badness, shame, and guilt – that are communicated to the child about the experiences and that then become incorporated into the child's self-image. (p 184)

Many of the interviewees described their perceptions of themselves as shameful or guilty, which often prevented them from disclosing their abuse. Some of them saw themselves as stigmatised in the original sense of the word, marked out because of their experiences. Even though many of them did not verbalise this belief *per se*, it was very much in evidence as a theme running through the interviews. Two of the women described experiencing a particularly acute sense of stigmatisation around the time that their memories surfaced

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

Wanda

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

Veronica describes similarly feeling that others could see what was going on inside her head when, during sex education classes at school, she finally realised the significance of what her father was doing to her. She had kept silent about her abuse for most of her life, never even revealing her secret to her husband, who had died some 25 years earlier. The impression gained throughout the interview was of someone who had an acute sense of 'otherness' because of her '*cold dark dungeon of secrets*' as she described it. Lynne also felt this sense of isolation:

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

Furthermore, two of the interviewees expressed feelings of stigmatisation associated with receiving psychiatric treatment as a result of their CSA:

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

Although it may be argued that the stigma attached to psychiatric illness is less nowadays than in previously, it continues to be viewed with suspicion and a general lack of understanding. Ruth's description of her mother's concern that she should not disclose her psychiatric history to her work colleagues (she was

a midwife) because of the connotations of Beverley Allitt¹⁰, is typical of the anxiety surrounding mental illness. For survivors of sexual abuse who have sought psychiatric help for their symptoms, this perception may serve to increase their sense of shame and stigmatisation. Ruth's assertion that having to go to her psychiatric nurse seemed like a punishment appears to support this.

6.5.1 Poor self image / esteem

Poor self-esteem was much in evidence in the majority of the interviewees and had an impact on many areas of their lives. As Kitzinger, J (1997) points out, survivors often reflect the attitude their abusers have towards them. Susannah, whose stepfather had taunted her with being 'fat', 'ugly' and unlovable, described how she *'always felt dirty and disgusted, [...] meaningless and no self-esteem....'* which she disguised by displaying anger and aggression linked to the death of her biological parents.

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

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

Furthermore, her opinion of herself had been profoundly coloured by the assertion, by the organiser of the paedophile ring, that she was to blame for their actions because she was so pretty, and that she enjoyed what they did to her. Despite the fact that she was only a small child when the abuse occurred, she had been unable to free herself from the perception that she was responsible, and his words continued to cause self-loathing and shame:

C:...he [the organiser of the paedophile ring] was always very nice...very quietly spoken, very gentle, and if I wasn't being very compliant with them in the circle, he would always come into the middle and talk me round. But by saying he

¹⁰ Beverley Allitt was a nurse who, in 1993, was found guilty of murdering 4 children in her care.

knew it was what I wanted to do, that I enjoyed it.

E: Oh, right. So it was your fault?

C: *Oh yes. Always my fault. If I wasn't as pretty as I was, they wouldn't want to touch me - I hate myself! I utterly and completely hate myself!*

E: Still?

C: *Oh yes. Sometimes I'm a bit better but most of the time I absolutely hate myself and you get counsellors saying "Stand in front of the mirror every morning and say 'I'm alright. I'm good, I'm nice'" and I can't do that. When I get up in the morning I stand in front of the mirror, I brush my hair and I go away....*

Claire

Wanda described herself as always knowing that she was 'wicked' although before the memories returned, she was not aware of why this was:

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

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

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

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

Low self-esteem is a common sequelae of CSA and the anecdotal accounts of survivors clearly highlight this. Many women feel that they are to blame for what happened to them, that somehow there was something they might have done to prevent it. Hanan (2006) speaks of her feelings of self-loathing and her lack of self-respect as resulting from her anger at 'allowing' the abuse to take place. Similarly, Heritage (1994) describes herself as feeling to blame for her childhood experiences. Tilley (2000), a victim of a violent sex attack in

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

6.5.2 Dirty bodies

As discussed in Chapter 3, the body is the battle-site of abuse, and consequently many survivors of CSA have distorted ideas about their bodies. Wanda's feelings about her body, particularly her genitals and reproductive functions, were profoundly influenced by her abuse. She explained that her father (abuser) had been treated for a sexually transmitted disease and described how, when her memories surfaced, she had felt compelled to cut out her genitals to stop the feelings of being infected and dirty.

The action of cutting genitals was also described by one of the interviewees in Kitzinger J's study (1997), who cut her labia with scissors because they 'never looked right' (p 91). She recalled this perception as stemming from her abuser's fascination with her genitals, which started as soon as she grew pubic hair.

Some survivors of sexual abuse perceive themselves and their bodies to be 'dirty'. Tilley (2000) recalled showering until the water ran out because she felt so dirty after being sexually attacked. Phoenix (undated) described herself as '*too dirty to defend myself, like I've been caught doing something wrong*' (p 28-29), on becoming pregnant.

Similarly, Kerry perceived that her body was dirty as a result of the many years of CSA she had suffered. When, in early pregnancy, she experienced vomiting and bleeding, she interpreted it as her body rejecting the pregnancy for this reason:

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

Jane too felt that her body was ruined, not only because of the abuse, but also as a result of the bulimia she had suffered from since the age of eleven. The perception that the body is ruined, dirty or evil is not uncommon in sexual abuse survivors and is a recurring theme in anecdotal literature (Kitzinger, J 1997; Blume 2004; Rouf 2003; Phoenix undated).

6.6 Traumatic sexualisation

'Children who have been traumatically sexualised,' state Finkelhor and Browne (1986 p182), *'emerge from their experiences with inappropriate repertoires of sexual behaviour, with confusions and misconceptions about their sexual self-concepts, and with unusual emotional associations to sexual activities.'*

Not surprisingly, many of the women interviewed reported experiencing severe long-term sexual problems which revealed themselves in diverse ways and behaviours ranging from aversion to sex to promiscuity. It was clearly an area in which their abuse still had a considerable impact, resulting in the confusions and misconceptions described by Finkelhor and Browne. Even when they were in good supportive relationships, it seemed that a silent, but immensely powerful, third party was present.

Several of the interviewees used strikingly similar phraseology when describing their surprise on achieving a pregnancy given their reluctance to have sexual contact:

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

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

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

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

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

Coral explained that she found it easier to go through IVF (in vitro fertilisation) treatment than to have sex with her husband. Judith described how, before her memories of abuse emerged, she would avoid having sex with her husband by delaying going to bed. As the memories of her abuse began to surface in the form of flashbacks, she developed a severe aversion to being touched, which made any kind of sexual contact impossible placing a further strain on their already shaky relationship.

Wanda's description of her first experience of sex with the man who was to become her husband clearly had resonance with her CSA although it occurred at a time before her memories had surfaced:

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

Jane described how during psychosexual counselling she had to reveal to her husband for the first time that *'sex was like being raped every time and had been the whole time we'd been together. I'd just been making the right noises and going through the motions.'* **Jane**

She recounted that during love-making she would often have terrifying flashbacks to her childhood abuse which would cause her to dissociate to such an extent that she felt she had left her body and was *'floating about on the ceiling'*. She also reported behaving violently towards her husband on occasions when engaged in sexual activity. Significantly, Lynne's unexpectedly violent reaction towards her partner also occurred in a sexual context.

Kerry described how the revelation of the extent of her father's sexual abuse nearly caused her marriage to fail because of the huge impact it had on her husband. Although she had travelled a long way down the road to healing, she could not see her attitude to sex changing and her words reflect a deep sense of powerlessness:

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

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

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

As previously stated, engaging in high-risk sexual activities has also been observed in survivors of CSA. In Hanan's account (2006) she described herself in her teenage years as drinking heavily to numb the pain and having 'one night stands' whilst in a spiral of self-loathing and disrespect. Smith's interviewee (1998b) recalled becoming promiscuous in her early teens, perceiving sex as a means of having some control over a relationship. Some of the interviewees in this study explained that they had been promiscuous earlier in their lives as a result of the beliefs and feelings about themselves resulting from CSA. Lynne had been able to engage in purely sexual relationships, but love was never part of the equation.

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

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

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

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

6.7 Powerlessness

6.7.1 Compliance and silence

Childhood sexual abuse relies on the fact that children are vulnerable, dependent and therefore not in a position to refuse what is done to them. The interviewees' stories confirmed the literature on sexual abuse, that abusers use many different means to control their victims including threats, physical violence, coercion and promises of special treatment (Rose 1992; Sanford 1991; Smith 1998b; Hobbins 2004; Rouf 2003; Simkin and Klaus 2004 chapter 2) Many of the women interviewed recalled being powerless against their abusers owing to their physical size and young age. For example, Claire described how she would try to run away from her father each time he took her to the house where the paedophiles met:

I started seeing them when I was about 4, because I can remember the coat that I wore, and after the first couple of visits, I used to try, when we walked down this particular road, I used to try and run away...unsuccessfully, because I mean, children of 4 can't really outpace their parents and if you'd got a great big pixie hood up the back, and Dad just used to hold on and pull me back. It was quite easy. **Claire**

Lynne believed that her abuse started when she was only around 18 months old when, clearly, she was in no position to resist, and in an abusive household such as hers there was little hope of anyone else putting a stop to it.

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

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

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

Susannah's story demonstrates several different means by which her stepfather controlled her and her siblings. Her biological father had died when she was 9 years old leaving her and her two sisters with no-one but their mother in whom they could confide. A year after her stepfather started abusing her, her mother died, ostensibly from a drug overdose, but Susannah suspects that he may have been responsible for her death after she had caught him abusing her older sister. Having previously secured custody of the children by adoption, he then had complete control over their lives and the abuse continued unchecked despite the fact that other family members had their suspicions. Suspecting his involvement in her mother's death, Susannah was convinced that the threat to her own life was not something she could ignore. In addition to the physical

threat he posed to her, he set about subjugating and isolating her psychologically and emotionally.

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

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

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

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

This was 'Daddy loves you' and 'special', and all that crap. [...] And I worshipped my father when I was a child. I mean, he spoilt me rotten.
Wanda

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

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

Although some of the women were kept silent by various threats made by the

perpetrators of their abuse, others failed to disclose because of the expectation that it would have caused the breakdown of highly valued relationships and/or the possible disintegration of their families. Amanda chose not to confide in her mother regarding her stepfather's abuse in order to protect her and their relationship. Sally's close relationship with her mother was also her reason for non-disclosure despite becoming pregnant with her stepfather's child.

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

Sally

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

'She's all I've got'....'cause by this time my own family, my Nan and granddad and my aunt and uncle, we had no contact with...I mean I should never have denied it...looking back with hindsight now, but at the time I did, because I thought well... 'they'll put me in a home...it'll happen to me with somebody else', 'cause this is all the things he told me....he'll kill me... Susannah

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

6.7.2 Disclosure did not mean empowerment

Many of the women had eventually disclosed their abuse, some much later in life when their memories had surfaced. For some, the cost of disclosure was huge in terms of the impact it had on other members of their family and the resultant guilt and shame which they experienced.

Kerry's story demonstrates the impact that disclosure of sexual abuse can have

on a family from the perspective of both a survivor and the mother of a victim. It also illustrates their sense of impotence and betrayal when care agencies fail to act appropriately. Kerry was always aware that her father had abused her as a child but later discovered that he had also abused two of her sisters and, even more disturbingly, her own daughter:

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

Kerry

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

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

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

6.8 Vulnerability – the end result

Trauma, of any nature, brings with it vulnerability, and consequently, the women's lives and daily activities were profoundly influenced by their need to

avoid situations in which they would feel out of control or powerless, and thereby risk re-experiencing their trauma. The impact of this was evident even in the apparently mundane areas of daily existence.

6.8.1 Vulnerability and everyday life

6.8.1.1 Sleep

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

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

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

Kerry also explained that any physical contact, when she was in a vulnerable position such as this, was very likely to be misconstrued as abusive:

I've worked to a level that we accept is ok for us and ...we've [she and her husband] got a good relationship in other ways but that's the thing that stays with you, is that every time someone makes contact with you when you're vulnerable in bed asleep and you're having a nightmare, or you're having a flashback, that it's not your abuser, it's your husband. So the reactions that he gets initially are; it's the abuser and not your husband. **Kerry**

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

go to sleep before settling to sleep herself:

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

Judith

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

Nightmares and sleep disturbances are commonly reported by people who have suffered traumas such as CSA (Heritage 1998; ACOG 2001; Squire 2003), and these women were no exceptions. Both Claire and Jo continued to suffer from nightmares concerning their abusive experiences as children. Wanda's sleep was often disturbed by terrifying dreams and, during her first pregnancy, Ruth recalled having had nightmares about breastfeeding because her abuse had focused mainly on her breasts. Sadly, since the birth of her first child, 15 years previously, Jo's nightmares had also included that of having her perineum sutured.

6.8.1.2 Other aspects of daily life

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

It's to do with security. [...] I can't even stand pull-up trousers because they're too easy to get down and that, so I'm always in trousers with button and zip and it used to be always with a belt, which I found very hard when I was pregnant with my son, to find a belt that would do up...So I had to stop wearing a belt which made me feel very insecure... **Sally**

I used to think 'Well, I'll put a belt on with me trousers so he can't get down me

trousers and he can't get...I'll put tights on' and, you know, all sorts of things to try and deter him but nothing really ever...[...].nothing did really. Ruth

Susannah described how even the most mundane activities in her life are influenced by her feelings of vulnerability.

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

Susannah

Like the birth-traumatised respondent in Beck's (2004a) study, it was as if these women's souls had been damaged. Clearly, this would have the potential to impact hugely on their perception of childbearing and institutionalised maternity care which will be discussed in the following chapter.

6.8.2 Vulnerability and Authority

One of the major areas in which the women were vulnerable was that of contact with authority, whether individuals or organisations. It is not unexpected that survivors of sexual abuse experience difficulties with figures of authority, given the fact that for the majority, their abuse will have been perpetrated by someone who was, or whom they perceived to be, in a position of authority over them. Furthermore, abusers often hold highly respected positions in their community as this provides them with the opportunity and power to carry on their activities. Clearly, this is highly relevant to women's contact with authority as personified in the medicalised organisation which provides maternity care.

Some of the interviewees described their continuing struggle with the issue of authority. This encompassed having contact with various professions and organisations ranging from healthcare workers to the police and many felt that, certainly in the earlier stages of their lives, they would have been unable to refuse anyone in authority.

Kerry explained that she continued to find some people in authority problematic because their 'bullying' behaviours were reminiscent of her father who was a well respected, churchgoing member of the community:

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

Lynne described how her history of abuse would cause her to 'become' the abused and defenceless three-year-old child again in the presence of an authority figure:

And yes, it's people in authority that – not so much now – but it used to be I was immediately 3 years old with no defences at all and had to do whatever was asked of me. Lynne

Throughout her life, she had carried an image of herself as helpless and unable to protect herself. As an example, she recounted an episode from her twenties when she had been sexually abused by a dentist whilst under the influence of a general anaesthetic.

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

At the time of her interview she was in her fifties, had just moved house to a rural area to live alone for the first time, and continued to struggle with feelings of helplessness. She gave a vivid account of a recent incident in which an encounter with authority had great resonance with her abusive experiences, leaving her devastated:

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

This scenario, which would probably have caused a certain amount of anxiety in someone without a history of CSA, had a devastating impact on a survivor because it not only resembled a possible abuse scenario, but also replicated the power differentials present in an act of abuse. Some women described their reluctance to become involved with large authoritative and paternalistic institutions such as the health and welfare services, because it replicated feelings associated with abuse. Veronica was particularly vociferous in her anger towards what she felt was the intrusive and threatening nature of authority represented by these organisations:

*...Because the least attention I get the better it is for me. That's why I won't have Social Services involved or anything. I don't need them....And I suppose part of it is because I want to be in control of what happens to me....and I said to them even if I find things difficult, I wouldn't tell them, 'cos I don't want them interfering. I just tell them. I just say they are nosey-parkering busy bodies. **Veronica***

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

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

E: Oh dear. No privacy then?

V: So they said 'Well we don't have to do it.' I said – 'Look - I'm not too fat and I'm not too thin, and you can see how tall I am. Will that do?' [...] It makes me so angry...that they do these things and they don't really know why they do them, do they? It's red tape. Veronica

Unfortunately, most people passing through the health services do so with little or no questioning of the rationale behind the routines to which they are subject. Individuals who react in this way are usually labelled 'difficult' and can consequently be dismissed, thus avoiding the need to evaluate or consider their comments. As a result, the system continues unchanged. Often the only alternative for those who do not 'fit', both employees and users, is to avoid contact. Veronica's experience of being 'processed' in this way finally resulted in her absenting herself altogether which she felt was the only option available to her. As a self confessed obsessively private person, she clearly felt that it presented too much of a violation of her privacy and of her personal integrity. She was powerless to change the system, but could protect herself from its perceived threat by avoiding it:

So we left it and then I got another appointment sent through to me, something to do with neuro-physical tests or something and it said on it - 'Please be aware that you may be required to give a urine sample.' I never kept the appointment,

so it doesn't matter. I rang them up and cancelled it. It's all this 'Big Brother' business. 'We know what we're doing.' And I don't think they do. Veronica

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

But she also had to set definite limits on where she could be touched:

J: *...he [consultant] sent me round the curtain and I thought, 'I'm not getting on that bed'. So I was standing there and he said, 'Come on, you're going to have to get up there for me to examine you!'*

E: Oh dear! How did you do it in the end? You obviously managed to do it.

J: *I allowed him about that much actual contact area and that was it (gestures to a very small area of her body)* **Judith**

Her consultant enabled her to cope with the examination because he wisely kept to the limits she had set, thus giving her more control over the procedure.

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

Unfortunately however, healthcare workers are often 'blind' to the potential impact their apparently 'routine' procedures might have. During her interview, Susannah (a midwife), described a recent appointment with the urodynamics

clinic in the hospital in which she worked. Staff appeared to be totally oblivious to her need for privacy in these circumstances:

*So he [consultant] sat there eating his cheese and onion and there was the urodynamics nurse and the auxiliary [...] and they were standing there and there was the bed, and there was the toilet and the machine. And I looked at them and I thought, and I looked at him and I said, 'If you think for one minute that I am going to sit on there and have a wee while you're sat there eating a packet of cheese and onion, you can think again!' He said, 'Do you want me to leave the room?' I said, 'Well, I'm not doing it in front of you!' And he went, 'Oh, for goodness' sake!' light-hearted. I said, 'Alright then – you wee in it first!' I said, 'and then we'll see how fast you can wee!' And he went, 'Okay, point taken. I'm going.' And then she, I looked at the nurse, and she said, 'Oh, do you want us to leave as well?' I said, 'Yes, I bloody well do. Would you want to wee in front of people? Get out!' And I had to do it very jovial because I could feel the anger rising, and I thought I'm going to lose it, I'm just going to walk out and I knew I needed this problem sorted. **Susannah***

Fortunately, on this occasion, Susannah felt confident enough to challenge the status quo. However, many women, particularly survivors of CSA, would not have been able to resist and consequently have risked being re-traumatised. This scenario gives a shocking demonstration of the unquestioned, and invisible, power differentials at work between health care workers and their patients. It is disturbing that even after Susannah had tackled the consultant, the nurse and auxiliary still expected to stay and had to be asked to leave. Arguably, most people would not have defended their right to privacy as tenaciously as Susannah, and would have either subjected themselves to (at the least) a highly embarrassing experience or, as she was tempted to do, walked out.

When Lynne was asked how she felt intimate procedures and examinations could be handled more appropriately, she gave the example of a recent visit she had made to the Practice Nurse for a cervical smear test:

I think the nature of the person, like the nurse I saw last week before my scan.

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

As her comment suggests, and the experiences of Judith and Claire demonstrate, a significant factor in either triggering or avoiding flashbacks, is the manner in which the procedure is undertaken. The women described coping well, or adequately, with procedures which had the potential to emphasise their vulnerability and cause distress when they felt more in control, in which they were treated with kindness, respect and consideration. It appears that feelings of powerlessness, loss of control or objectification (all feelings strongly associated with sexual abuse) had a far greater potential to cause flashbacks and retraumatisation than the procedures alone.

What also emerged in the data concerning medical procedures was that there was no single formula or 'magic bullet' that could be applied to each situation for all survivors. For instance, when asked if Claire's strategy (holding the clinician's arm when performing an intimate examination) would be useful to her, Lynne reacted very negatively.

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

Wanda felt that the presence of a chaperone for such a procedure would be essential whereas to Veronica, the presence of another person would be totally unacceptable.

6.9 Summary

Trauma has a profound impact upon memory and many traumatised individuals (including survivors of CSA) will suffer from long-term amnesia concerning the

event or events. Several of these interviewees reported that, for a long period in their lives, they had had no recollections of what had happened to them in childhood although they were usually aware that all was not well. Memory retrieval occurred often as an ongoing process and seemingly insignificant triggers could be encountered unexpectedly, releasing new, as yet unassimilated, fragments of memory. Other 'known' triggers, which had trauma-specific significance to the individual, could be predicted to cause a flashback to a particular event.

The data demonstrated the far-reaching and long lasting consequences of CSA and the resultant vulnerability this engenders. Because CSA occurs at an early stage in an individual's development it has the power to significantly influence their perceptions of themselves and the world around them. The impact of CSA is very evident in the building blocks which form personality and in a survivor's response to stressful events throughout life, because it interferes with the child/parent bonds which are central to the child's subsequent security and ability to trust. Finkelhor and Browne's traumagenic model (1986) provides a useful insight into the factors which, in conjunction, make CSA uniquely traumatising.

The result of CSA and its consequent trauma is extreme vulnerability. Many of these women's accounts reflected the way in which this, to some extent, controlled their lives, from the position in which they slept, to what they chose to wear, and how they related to others. Particularly relevant to this study was their contact with individuals or bodies in authority because the power disparity in the interaction is highly reminiscent of that embodied in the abuser/victim relationship. Situations in which the women felt out of control or helpless had the power to cause flashbacks to abusive scenarios and re-traumatisation. Many of the interviewees found ways in which they could minimise the possibility of this occurring, some avoiding contact with authority as far as they could, while others formed coping strategies which would enable them to retain some measure of control. In the arena of healthcare, the women found the impersonal, dehumanising effect of the 'assembly line' unacceptable and expressed the need to be treated as individuals and as people. It was reported that when practitioners took a collaborative, respectful approach, the women were enabled to cope adequately.

Chapter 7

The women's experiences of childbearing

7.1 Introduction

This chapter starts with a brief look at how the interviewees approached pregnancy in order to understand some of the anxieties and perceptions that coloured their expectations of the process. This is followed by an examination of their experiences of birth and how this impacted upon them. Firstly, their negative accounts are discussed in the context of the three major themes which emerged from the data: powerlessness, betrayal and humiliation. Following this, there is an examination of what the women said they wanted from maternity care, after which is a discussion on the data concerning their positive experiences. This includes the accounts of home birth, because an unusually high percentage of interviewees birthed at home.

7.2 How the women approached pregnancy

To all women, becoming pregnant requires a leap of faith into the unknown, but to survivors of CSA the journey into motherhood can be fraught with unexpected pitfalls and traumas. The majority of the interviewees described their pregnancies as planned although some recalled having had mixed feelings about pregnancy and birth. As referred to previously, several of them expressed surprise that they had been able to conceive given their unwillingness to engage in sexual contact, or because they were convinced that their bodies must have been ruined by the abuse. Some women may perceive pregnancy itself as an invasion of their bodies over which they have no control (Seng et al 2004). Despite having planned their pregnancies, some interviewees described feeling invaded by their growing fetuses:

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

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

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

Jo expressed very similar sentiments regarding her expectations of hospital birth:

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

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

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

Clearly, these women perceived that they would not be offered choice about what was done to them and that they would be powerless to refuse. Lynne explained that hospital represented an environment in which control would be taken away and in which she would be unable to make her needs known. It appears that the women's fears centred on the loss of control involved in placing themselves in situations which would mimic their experiences of abuse.

As has been pointed out, women who have a history of CSA come to childbearing with much 'baggage' rendering them vulnerable to re-traumatisation. Their early experiences of betrayal, violation and powerlessness have a huge impact on their anticipation of the event and on their expectations of carers. Some women may perceive their bodies as dirty and view themselves with shame or self-loathing. As previously stated, all these factors may make them particularly vulnerable to perceiving their birth experiences as traumatic (Soet et al 2003).

7.3 The impact of maternity care on the women

As discussed in Chapter 1, the provision of maternity care is embodied within a system based upon the philosophy that birth is a medical event, which is unpredictable, risky and dangerous. It is expressed through an organisation which has been heavily influenced by the ideologies underpinning industrialisation: efficiency, calculability, predictability and control. In addition, the delivery of maternity care is increasingly dominated by the management, and avoidance, of all risk. This means that the focus of care is predominantly on the needs of the institution, rather than on those of the women it ostensibly serves. Birth has now become defined by medical criteria and, to a large extent, controlled by obstetrics and the organisation providing maternity care. These two symbiotic powers are, to some extent, united in their drive to make birth less risky and more predictable, thereby avoiding expensive legal action. Consequently, policies, protocols and 'guidelines' are formulated in an attempt to standardise practice; ostensibly on grounds of safety, but also for financial reasons [see discussion on risk in Chapter 1]. Furthermore, obstetrics now promotes itself as the exclusive authority on childbearing and increasingly perceives its role as that of 'fetal champion'. The model of the body as a machine is central to medical ideology as is the long-standing idea that women's bodies are flawed and in need of medical assistance to give birth. This provides a 'legitimate' basis for the intense scrutiny to which women are subject during pregnancy and birth and forms the rationale for numerous interventions. As previously pointed out, control is strongly linked with the existence of true choice, but in a milieu permeated with this mindset, the idea of

allowing women to make free choices and have control over their birthing is extremely threatening; not only to the concept of safety, but also to the authority of the organisation.

These interviewees had relatively little to say about the purely physical process of giving birth. Their accounts were full, however, of the impact that maternity care had upon their perceptions of birth and, in some cases, the effect this had on their relationship with their baby.

The experiences of the older women revealed the assembly line ethos of the maternity services at its zenith, particularly in the area of antenatal care. They described being processed and objectified in environments that were unfriendly, uncomfortable and impersonal:

It was in a Nissen hut. You were given a grotty old dressing gown to put on. I waited 4 ½ hours. The place was packed with other pregnant women and loads of kids. Wanda

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

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

The impact of this environment, on occasions, proved too much for some of them to bear, and both Wanda and Veronica described themselves running out of the clinic and going home – Veronica often leaving her underwear behind in her haste to escape.

The younger women had mainly received their antenatal care in the community from their community midwives or GPs. Consequently, there were no comments regarding the physical environment in which antenatal care was provided. In this respect, it appears that antenatal care has improved since the time of the older women's pregnancies.

In some ways, the medical and midwifery staff described by the older women were more overtly dictatorial. Following her flight from the antenatal clinic, Wanda recounted how her GP had turned up on her doorstep an hour later and had 'gone bananas'. Veronica described being treated 'like a criminal' because of her stated intention to bottle feed her baby, and 'made' to breastfeed by midwives in the hospital. Lynne reported broaching the subject of a home birth with her GP during her first pregnancy but being told that it was not an option for a first birth and that she was 'too old' (aged 29 years). This is in contrast to the accounts of Rosie and Rhoda, (referring to pregnancies 9 and 2 years previously) who, on requesting home births, were confronted with the concept of risk by caregivers, rather than outright denial.

Furthermore, in the accounts of the older women, there were more reports of staff being openly rude, unkind or unpleasant. This was observed in scenarios such as that in which Claire's labour attendants told her to 'shut up and get on with it' and in the callous attitude of the female doctor suturing Wanda's perineum:

I was exhausted after the birth [...] I said, 'I feel ever so weepy.' 'Oh, don't start that off!' she said, 'I'm not going to be 5 minutes!' I mean, she was a cow. She really was awful! Wanda

Veronica also recalls maternity staff 'bullying' her and telling her it was ridiculous when her labour was not progressing well.

However, despite the outward changes in care provision over the years, the accounts of the younger women revealed that maternity care could still be dehumanising, disempowering and inhumane, but usually in more subtle ways. It is unthinkable that a scenario like that recounted by Claire [see p 202] would occur nowadays because the giving of enemas has ceased to be a routine part of labour care. However, women with more recent birth experiences reported being dehumanised in other ways: care providers focusing exclusively on their genitals, a lack of respect for their privacy or dignity, staff walking in and out of rooms or bed-spaces uninvited, or, in Coral's case, being treated like a naughty child.

Both Sally and Susannah's first pregnancies occurred when they were teenagers. Susannah's firstborn was 18 years old at the time of her interview and Sally's son was 6 years. The judgemental attitude of some staff towards teenaged mothers appeared to have changed little in the intervening years:

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

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

Sally

The power of the system over the women appears to have remained largely unchanged, but in most of the more recent cases was expressed in more covert ways. Rosie, who was also a teenager during her first pregnancy, recounted a birth in which she experienced loss of control through her labour being taken over by the medical agenda, in which her birth plan was all but ignored. Others recalled being given pain relief without their consent, sutured by unknown male doctors who pressed on regardless of their obvious distress, or being attended by staff who appeared intent on following protocol rather than consulting them. Their trauma often stemmed from a lack of communication on the part of carers, or attendants who were focused on hospital routines, causing them to be ignored, rather than the overt rudeness or dictatorial attitudes seen in the older women's caregivers.

It could be suggested that the mechanisms involved with the disempowerment and dehumanisation of these women in their contact with the maternity services are very similar to those at work in sexual abuse. As discussed in the previous chapter, Finkelhor and Browne's traumagenic model (1986) provides a useful framework within which the trauma-inducing factors concerned with CSA could be discussed. Powerlessness and betrayal, two of the traumagenic factors, also featured prominently in the literature concerning traumatic childbirth. In these women's birth stories, once again, the themes of powerlessness and betrayal

were highly visible. However, there was another prominent theme, that of 'humiliation'. It is in the context of these three themes (powerlessness, betrayal and humiliation) that I will discuss the women's experiences.

7.4 Powerlessness

7.4.1 Absent mothers

One of the striking features about some of the women's accounts of hospital maternity care was the perception that, to a large extent, they were absent. Their stories were full of what was done to them, but contained little about what they did. The routines, rituals and procedures which form such an integral part of maternity care today, overshadow and obscure their role in childbearing.

Despite their fears concerning giving birth, none of the women in this study opted for an elective caesarean section as some tocophobic women are reported to do (Hofberg and Brockington 2000; Beech 2007). It appears that most wanted to be actively involved in giving birth.

Jo's description of her first labour (in hospital) reflects the findings of Soet et al (2003), whose respondents reported that they were unable to mobilise and use their own pain management strategies because they were confined to bed by electronic fetal heart monitors. Their expectations of being active birth-givers were sacrificed for medical dictates:

...I can remember trying to at one point, trying to get on all fours and rocking, because that seemed to help, but the leads wouldn't stretch and they were wrapped round me and things were....because I had got one round my leg and that was coming off, and then, there was no contact. It was just horrible, really horrible. Jo

Lynne described her distress when attached to a fetal heart monitor which was not registering her contractions:

... and they wired me up to the machine that registers the contractions [...] and they said, 'Oh, nothing's happening...', you know, 'it'll be a long time yet – more

of this.' And I was in absolute agony and I thought 'well, if it gets worse than this I'm just not going to be able to cope with it!' Then they found out the machine wasn't working! Lynne

This scenario demonstrates some health professionals' reliance on the 'authority' of technology, which excludes the woman's knowledge. Lynne's opinion was not sought but she was informed by the 'experts' (on the basis of their 'scientific knowledge') that she was not in labour. This situation is a vivid reflection of the dissonance of her childhood, when, she explained:

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

As discussed in Chapter 6, survivors of CSA have a pre-existing vulnerability and may perceive themselves to be helpless, particularly in circumstances in which they encounter authority. This makes it difficult for them to refuse what is done to them or make their needs known:

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

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

...I was scared. I could hear other women screaming, obviously they were screaming because they were labouring too. But I didn't scream, I just swallowed all the sobs and cries because that was the way...I...did, as a child, swallowed all the sobs, the cries, when I was being abused. I was afraid, I was in pain, um...I had a mask over my face and my husband kept trying to put it on to my face which was again, you know, hands over your mouth, when you were being abused as a child to stop you shouting for help. So the whole experience

was like being thrust back as an adult but still feeling like that helpless child in the dark and being so afraid and alone. Kerry

Women who are already disempowered by their childhood experiences are, as previously pointed out, more at risk of perceiving giving birth as traumatic (Soet et al 2003). As this account of Kerry demonstrates, they can be precipitated into flashbacks of abusive scenarios when faced with situations which are reminiscent of abuse.

Kerry's description of her daughter's birth by forceps is interesting in the way in which it is worded in that it was strongly reminiscent of the comment of the woman quoted earlier who spoke of having her baby 'taken out' [see p43]:

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

Kerry is a very articulate woman who chooses her words carefully. Arguably, most women would have said 'my little girl was born' or 'I gave birth'. Her choice of words paints a vivid picture of birth in which the mother is absent as an active participant. The wordage is more suggestive of surgery in which the unconscious patient has a body part removed.

Jenny, who had planned a waterbirth in a low-risk unit within a large hospital, described how her labour became increasingly medicalised as she 'failed' to make sufficient progress. Having been transferred to delivery suite, her identity as an active birth-giver is inexorably altered to that of passive patient with resultant feelings of powerlessness:

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

As referred to earlier, psychological morbidity following birth has been linked with high levels of obstetrical intervention (Ryding et al 1997; Green et al 1998;

Creedy et al 2000) and this scenario may provide an insight into what lies behind this. Jenny's problems with medicalised labour stem from a loss of control over what was done to her and not being listened to. She has become invisible. Interestingly, Jenny was the only woman to directly link the physical sensations of giving birth with her experience of sexual abuse. However, she explained that the feeling of being powerless played the biggest part in reminding her of what had happened.

Jo described a scenario which occurred during the early stages of her first pregnancy, in which she was vaginally examined by consultant with medical students in attendance.

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

Clearly Jo felt that because this constituted part of what was perceived as 'routine' care and, therefore, what was expected of pregnant women, she had no grounds on which to object. Any woman who has a history of CSA will find it difficult to question the authority of the practitioner or the organisation in which s/he functions and for Jo, who had a fear of authority, this was particularly problematic.

7.4.2 Mothers absenting themselves

As well as finding themselves absent through the medical and institutional management of their births, many of the women absented themselves by dissociating when they felt overwhelmed or out of control. Several of them spoke of this as a well-used coping strategy which they had developed during their childhood. When asked how she dealt with intimate procedures Kerry said:

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

Kerry

Dissociation, however, did not confer power but merely served to minimise the negative impact of being powerless:

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

Judith described herself doing things 'with detachment', referring to dissociation:

... because I didn't view myself as having any right to say no to anything ... that they wanted to do. **Judith**

Dissociation then, constituted a means of coping with circumstances in which the women perceived themselves to be powerless. It was more often than not mentioned in the context of maternity care and what was done to them by health professionals. This response is very much in evidence in other qualitative research and survivor's accounts (Parratt 1994; Rhodes and Hutchinson 1994; Robohm and Bутtenheim 1996; Kitzinger, J 1997; Seng et al 2004)

7.4.3 Absent fathers

Several of the interviewees described how they were deprived of the support of husbands or partners when they were not allowed to stay with them during early labour. Apart from being denied the known benefits of continuous labour support, (Tarkka and Paunonen 1996; Yogev 2004) this deprived them of, in some cases, the only person whom they could trust and who might be expected to act as an advocate on their behalf:

They were telling me what to do, and what I couldn't do and ...I can remember saying that I felt (you know, the pains were really bad because I went to the hospital and they sent my husband home because I was obviously in early labour) and um ... and I was completely on my own through the night, wandering around corridors ... trying to keep quiet because people were trying to sleep ... **Jo**

Lynne's husband was sent home on her admission to hospital after being told

by a doctor that labour was only in the early stages. Her husband complied, and as a consequence, missed the birth of their son. Claire recalls being angry with her husband for missing the birth of their baby after he was dispatched home by the sister in charge of labour ward.

Jane described her feelings of vulnerability when deserted by her husband whom she needed to advocate for her. He, however, probably felt unable to challenge the midwife's dismissal, causing Jane to react angrily:

I got really bad pain about 9 o'clock and I wanted G to stay, so I asked the midwife and she examined me and said, no, nothing was happening, so he should go home till the morning, and I was really mad at him because I wanted him to say, 'no, I want to stay', but I just couldn't be assertive then. So he went and I hated him...for going, and I was in a lot of pain... **Jane**

Ironically, having sent the women's supporters away, maternity carers were in no position to provide one-to-one support for them. Most large maternity hospitals appear not to recognise the importance of early labour support and this is reflected in the staff/client ratio. Antenatal wards are not set up to accommodate overnight stays by birth partners and neither can labour wards be populated by women who are not yet in active labour as this impedes throughput and threatens efficiency. Thereby, the organisation effectively deprives women of a potential source of empowerment, separating them from those who could provide moral support, make their wishes known and act protectively.

7.4.4 Vaginal examinations and intimate procedures

As discussed, one of the major areas in which the theme of powerlessness was in evidence was that of what was done to the women by maternity carers. Intimate or invasive procedures could be predicted to constitute problems for women whose bodily integrity had been violated as children. However, the data showed that *how* a procedure was undertaken was far more significant in terms of the women's perception of it, than simply the procedure itself. Procedures such as vaginal examinations (V.Es) and abdominal palpations, which are very

much an integral part of routine, medicalised maternity care, tend to reinforce the message that caregivers have power over women (Bergstrom et al 1992). Furthermore, as these authors point out, the V.E has become highly ritualised and consequently, dehumanising, in an attempt to make it into a socially acceptable act. Stewart (2005) suggests that the ritual washing which aims to sanitise the procedure may serve to convey the message that the woman's body is contaminated or polluted. This may strengthen a survivor's pre-existing belief that she and/or her body is dirty or ruined.

Susannah's account of a vaginal examination that took place during her first pregnancy contains many of these elements:

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

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

From their observations, Bergstrom et al (1992) argue that practitioners develop strategies such as 'personal disembodiment' in order to cope with intimate contact with clients in the clinical area. This, as the authors suggest, acts to protect the professional from empathising with the client, an emotion which would seriously impede their ability to function in an environment in which such procedures are routine. However, it dehumanises the woman. This was observed in accounts the women gave of intimate procedures and was clearly a source of great distress to them, being strongly reminiscent of their abusive experiences:

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

In this scenario are embodied several different elements which could be predicted to be problematic from a survivor's point of view and were obviously significant to Amanda; the restraint of her legs in stirrups, exposure of her genital area, pain, a male doctor who had close physical contact with and was focused upon her genitals. Jo's account was remarkably similar and also involved perineal suturing:

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

This comment is comparable to the account of a birth-traumatised respondent of Kitzinger, S (1992) who referred to being depersonalised by a doctor who 'never even looked at the top half' of her. She described herself being reduced to a vessel whose contents were to be offloaded. Some of the women in this research spoke of their feelings in similar terms:

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

I was just a body that was carrying this baby and was going to have it, and

that's how I felt all along. **Sally**

According to van der Kolk (2002) human beings, as primates, are '*programmed to seek out others for the soothing and regulation that they cannot provide for themselves*' (p 63). Both Amanda and Jo report that they were crying, and clearly expected this to elicit a sympathetic response from their carers. The fact that their distress went un-remarked and unacknowledged confirmed to them that they were indeed powerless.

The accounts of Amanda, Susannah and Kerry all contain references to the stirrups which are used to hold the women's legs in the lithotomy position for procedures such as suturing. Clearly, these items of medical equipment, which go unnoticed by clinicians, may have deeply significant connotations for survivors of CSA:

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

This reflects comments made by women in other qualitative research who were reminded of their abuse when confined and immobilised by medical equipment, whilst being subjected to intimate procedures (Kitzinger, J 1992; Rhodes and Hutchinson 1994; Smith 1998b).

Sadly, the women's expectations that birth in hospital would mean loss of control through routines such as vaginal examinations were realised in many cases. Even when women did express their wishes to caregivers, they were largely ignored. Louise explained that she had devised a birth plan stating that V.Es should be kept to a minimum but found that:

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

Rosie had also formulated an 'extensive birth plan' during her first pregnancy in

order to maintain some control over what happened to her in labour, but commented:

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

It appears that the women's strategies to avoid loss of control were ineffective because the demands of the institution took precedence over their need for control. Furthermore, it has been suggested that birth plans may be perceived as a threat to the organisation's authority and therefore elicit a negative and defensive response from some caregivers (Kitzinger, S 2006a).

Interestingly, both Vickie and Judith had relatively recently acknowledged that they had the right to refuse medical procedures and since that time had found them much more difficult to tolerate:

I've put off having a smear this time. It's very strange isn't it, but I think maybe it's because you've given it the importance ... that it deserves, whereas before, to deal with it you just, you know, locked it away and got on with your life and did what you thought you should... Vickie

It would appear that an acknowledgement of her own value and worth lies at the heart of her refusal. She was no longer constrained to deny her own needs in preference to others'.

7.4.5 Controlling pain: controlling women?

The issue of pain and its management in labour was definitely associated with perceptions of powerlessness and loss of control in the minds of some of the interviewees. This was far more profound than mere dislike of the physical sensations of drowsiness and disorientation caused by narcotics. The connotations of being passive recipients of care rather than active participants in labour were strongly suggestive of sexual abuse. It seems that, in some cases, a power struggle took place between the women and their carers. This is clearly seen in Brenda's account:

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

As already discussed, the perception of control and mastery for some women is strongly linked with giving birth without the influence of narcotic drugs. Brenda clearly saw the avoidance of pain relief as her strategy to maintain a sense of control during labour. By submitting herself to it she felt subjugated by her carers and consequently, powerless:

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

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

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

She blamed the epidural for the subsequent sharp rise in her blood pressure, which resulted in her being re-admitted to hospital postnatally.

Similar to the respondent in Waymire's research (1997) [see p32], Rosie described how her feelings of loss of control, owing to lack of suitable support and effective communication by her carers during her first birth led, to her

requesting an epidural which was not what she had planned:

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

Some of the interviewees reported being given Pethidine without their consent. Jo described her experience which occurred during her first birth:

... and then this awful midwife came on with a student. I don't remember their names, that's how out of it I was ... and they were all ... she gave me some Pethidine. I don't remember them asking me if I wanted it because I know from being a nurse that I didn't want – I don't want anything like that because I've seen what it's like and that was ... I can't remember what happened then for about 2 hours, it was just ... It completely knocked me out. **Jo**

Kerry explained that the issue of being given pain relief without her consent was one of the major factors in causing her to experience loss of control in labour. Amanda described herself as 'fighting the contractions' and being given Pethidine in order to be examined.

It appears that, in these cases, the motivation for the administration of pharmaceutical pain relief arose from carers' rather than the women's need – 'woman control' as opposed to pain control. This reflects the experience of the woman in the scenario with which this thesis begins.

Truly supporting a woman through the process of labour is costly, not only in terms of staffing and resources but, on a personal level, it is exhausting and emotionally draining for the individual midwife. In an environment where multifarious demands and pressures are constantly tugging at the sleeves of carers, pharmaceutical pain relief may act as 'midwife relief', a coping strategy for hard-pressed staff. Additionally, it represents a means by which women can

be made more acquiescent to medical and institutional demands.

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

7.5 Betrayal

As was seen in Chapter 2, one of the major determinants of women's perception of control and mastery in childbirth is strongly associated with their perception of their birth attendants (Halldorsdottir and Karlsdottir 1996a; 1996b; Tarkka and Paunonen 1996; Berg and Dalberg 1998; Waldenstrom et al 2006). Halldorsdottir and Karlsdottir (1998a) identified three main categories of need in birthing women; caring and understanding; security and trust; and control of self and circumstances. At the heart of good supportive relationships, and implicit within all these categories, is trust. As previously discussed, women need to trust their carers in order to abandon mind control and give themselves over to the process of labour and to access their inner strengths and resources. They need to trust that their attendants will act in their interests and protect them and that inner space. Unfortunately, as has been pointed out, betrayal of trust lies at the heart of sexual abuse and is, according to Finkelhor and Browne (1986), one of its major trauma-invoking factors. Consequently, many survivors of CSA, having been betrayed as children, will have a pre-existing propensity to distrust

other people, particularly those in positions of authority. Many of the women in this study spoke of their difficulties with trust brought about by their childhood experiences of betrayal. Sadly, they also had much to say about their feelings of betrayal by maternity carers.

Most, if not all, women approach childbirth with expectations of how they would like their birth to take place including how they will be supported as they negotiate the event. As was seen in the words of Weaver's interviewee (1998) [see p28], most women realise that they have minimal control over the physical manifestations of the birth process, but they do have expectations of how they will be helped to cope with them. They do expect carers to 'get into the boat with them' to provide comfort, encouragement, guidance and protection. The characteristics that women look for in their attendants are very much human qualities such as warmth, good communication, empathy, connection and understanding. Halldorsdottir and Karlsdottir (1996a) coined the phrase 'professional intimacy' to describe the functioning of these attributes in birth attendants.

The accounts in which the women's sense of betrayal is prominent are all lacking in these human qualities. The interviewees, it appears, generally had realistic expectations of the physical sensations of labour and birth. What they were not prepared for was the absence of humanity and compassion that could be expected from persons in a so called 'caring profession'.

Claire, as has been previously discussed, had an acute sense of betrayal by her father whom she described looking on passively whilst her abuse was taking place. She described the care she received from male doctors thus:

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

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

...the sister said, 'Open your legs!' and sort of parted my vaginal lips and just

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

As a result of this cruel and callous treatment, Claire, like the interviewee quoted in Halldorsdottir and Karlsdottir's (1996b) [see p23] study on caring and uncaring encounters with birth attendants, decided that she would never go through childbirth again. Her birth was uncomplicated, quick and apparently required no interventions. Her decision was based entirely on the conduct of her 'carers'.

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

This comment reveals two of her expectations concerning the experience; firstly, that birth would be painful, but also that she would be treated with humanity and given the emotional support that she needed to endure. As in the scenarios in which Jo and Amanda described themselves crying but being ignored, the result is utter powerlessness. Amanda's comment about her perineal suturing experience similarly reveals a deep sense of betrayal at treatment that was dehumanising and reduced her to a mere 'body part'.

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

A particularly recurrent theme in Sally's interview was the manner in which she felt dehumanised by carers' lack of compassion, which she referred to as the 'no care attitude'. This was strongly reminiscent of the attitude of her abuser, and clearly caused her a good deal of distress. Her words strongly resemble Claire's comment about her carers:

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

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

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

Some women revealed their sense of betrayal at carers' lack of communication and discussion with them. Both Lynne and Amanda described their midwives talking amongst themselves but failing to communicate with them. This behaviour was also reported by the birth-traumatised women in Beck's study (2004a), one describing how staff even discussed and argued about the possible death of her baby in front of her as if she were invisible.

Kerry was separated from her daughter immediately after the birth for 12 hours when she was admitted to the Special Care Baby Unit. However, she was given no information on her daughter's condition leading her to believe that she would not survive:

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

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

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

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

Some of the interviewees recounted scenarios in which the actions of professional carers left them feeling exploited or abused. Kerry, a midwife, described her feelings of exploitation and betrayal when, having endured a complicated and frightening birth experience, she was 'invited' to help with the daily chores on the ward by a work colleague:

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

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

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

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

Many of these accounts strongly reflect those given in other qualitative research on traumatic or negative birth experiences. The 'soul hurt' described by one of Beck's respondents (2004a) was very much in evidence in these women as were feelings of insecurity, fear, hurt, bitterness and anger displayed by the women who encountered uncaring midwives in Halldorsdottir and Karlsdottir's research (1996b). Women going through the process of childbirth clearly need attendants who are emotionally available to them, who are warm, caring and understanding. When their expectations are met with coldness, indifference and

a lack of empathy, the result is betrayal. As seen in the literature concerning traumatic childbirth, this is damaging for any woman. For survivors of sexual abuse, it may constitute a re-enactment of their abuse.

7.6 Humiliation

Humiliation, shame and self-blame are frequently associated with sexual abuse; victims often feeling to blame for what has happened to them, but also confusion or shame concerning their bodies. Giving birth, therefore, represents a situation in which these negative emotions can be re-experienced and reinforced. The humiliation experienced by some of these women, resulting from the treatment they received during childbirth, contributed significantly to their ongoing perception of the event. It was strongly associated with the 'conveyor belt' of hospital routine coupled with the unspoken assumption that women's bodies and babies are the property of the institution.

One of the most shocking accounts of 'ritual humiliation' was given by Claire:

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

It is interesting to note that Claire recognised that both she and the nurse were equally powerless in these circumstances which provide an extreme example of the dehumanising impact of industrialisation on both clients and workers. Claire commented that the humiliation of this scenario plus her attendants' coldness

and indifference to her distress were the most painful and damaging factors of her birth experience.

Both Jo and Lynne reported that their contractions ceased during the second stage of labour. This is a possible example of 'stalled labour' (Tallman and Hering 1998) which, as previously mentioned, may be linked with a history of CSA. Lynne, whose fear that in hospital things would be 'taken out her hands', found that her fears were realised when she was obliged to rely on her carers to tell her when to push. In Jo's case, she recalled staff being impatient for her to give birth but being unable to comply:

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

Giving birth 'against the clock' is problematic to many women and is what now defines many births as 'abnormal'. In neither of these instances was there a suggestion of fetal distress, the women simply failed to comply with arbitrary limits placed upon their labours. Consequently, they were left feeling humiliated and inadequate, that their bodies had failed them, requiring them to rely on others at this crucial time.

Several of the women described humiliation in the context of perineal suturing and their stories bear great similarity. For some women, this procedure was the most traumatic event associated with giving birth because it was especially potent in replicating sensations and feelings they associated with being abused:

I was definitely reliving lots of things with my brothers [abusers]. Because they're not gentle, are they? [...] They're sticking great tampons, they're swabbing blood, and I've seen it done [...] It was humiliating. It was

embarrassing. It was painful. It was frightening. I was going through this whole gamut of feelings and emotions, and I just felt absolutely destroyed, and I thought, 'I'll never have another baby. I'll never go through this again. I will never do this again!' **Amanda**

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

Kerry's experience is somewhat similar to Amanda's and reveals a lamentable disregard for human dignity. It appears that practitioners' single-minded focus on the procedure blinded them to Kerry's needs and prevented them from empathising with her:

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

At the time, Kerry's response to the situation was to blame herself for not coping with it:

This is the system, you know, and the system obviously is like this and why do I feel so vulnerable and upset about this because this probably happens to so many other women? **Kerry**

She clearly felt she had no right to question the system and just as she had stifled her cries for help as an abused child, she suffered in silence. The perception that they were at fault for not coping with the routines and rituals of the system was also reflected in the comments of other women.

The issues of privacy and dignity were of great importance to all the women and

failure on the part of staff to respect these was a great source of distress. Sally described her feelings of acute embarrassment and shame when, in order to carry out procedures and observations, midwives and others would enter her bed space without her permission. Jo lamented the lack of privacy afforded to her while she was undergoing perineal suturing:

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

Coral's humiliation occurred as a result of the paternalistic and prescriptive attitude of her carers. She spoke of being 'made' to have a bath during labour, and being sent back to it 'like a naughty child' when she got out before the prescribed 45 minutes had elapsed.

So it sort of felt like I was being punished... Coral

Whatever the rationale for a 45-minute bath might be, it was clearly not for Coral's benefit and served to reinforce her sense of shame and powerlessness. Some of the women described their humiliation at the paternalistic and insensitive actions of staff providing breastfeeding 'support' which, in some cases, actually resulted in them deciding to formula feed. Breastfeeding is a sensitive subject for some survivors and several of these interviewees found the concept of it problematic because their abuse had been centred on their breasts. During my time as a hospital midwife I, like Tilley (2000), saw many breasts 'grappled with' in the name of breastfeeding 'support' and many babies 'shoved' unceremoniously screaming on to poised and waiting nipples. These women's accounts confirmed Simkin and Klaus's (2004 p 98) observation about women's first experience of breastfeeding and illustrated professionals' lack of respect not only for their bodily integrity but also for their status as mothers. Furthermore, they illustrate the disempowering nature of the 'expert' model in relation to yet another area of childbearing.

Susannah was averse to breastfeeding but decided that she would do it in order to avoid coming under pressure from midwives on the postnatal ward. Her

description of the 'assistance' she received from a midwife is more reminiscent of a sexual attack:

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

Susannah

Her reaction: *I couldn't say, 'Please don't do that'*, is reminiscent of that in the account she gave of her vaginal examination by a junior doctor early in her pregnancy. On this occasion, however, she did manage to resist to a certain extent, but the midwife, possibly intent upon carrying out her 'breastfeeding support function', was clearly undeterred:

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

Rosie's account is similar. She describes midwives coming into her room, grasping her nipple, squeezing it and 'shoving' her baby onto the breast and then walking away. Jo recalled that as she was gently encouraging her baby daughter to wake up and breastfeed she was assailed by a nursery nurse:

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

What is striking about all the accounts of breastfeeding 'help' is the sheer brutality of it, not only for the women but also for the unfortunate babies. In Jo's account, the rough and 'authoritative' approach of the healthcare professional contrasts starkly with her tender and gentle handling of her baby.

These breastfeeding scenarios reflect somewhat the findings of Stapleton et al (2002a) on the language of health professionals in antenatal consultations. They observe that midwives frequently used the word 'discuss' in relation to their giving of verbal information, when the woman had neither been asked her opinion or given an opportunity to voice her own concerns. It appears that this kind of 'breastfeeding support' is also something which is 'done' to the woman and does not involve working with her or asking her opinion. Arguably, in this way, the health professional can feel that she has discharged her responsibility and the routine is completed with the minimum amount of effort or personal engagement.

In many of these accounts, the elements of powerlessness, betrayal and humiliation, are all present. Betrayal occurs when a person's expectations that they will be helped, nurtured and valued by someone in a caring role are frustrated. It is particularly poignant when there is a large disparity in power between them and one is highly vulnerable. Humiliation does not automatically arise out of powerlessness, but, as is seen from these accounts, does form the 'medium' in which it can occur. Arguably, humiliation is far more damaging than powerlessness alone because it robs an individual of dignity and humanity and has connotations of shame. Furthermore, it is highly visible in situations involving torture, violation and abuse and research suggests that interpersonal traumas carry a higher risk for the development of extreme stress disorders than accidents or disasters (van der Kolk, van der Hart and Marmar 1996; Roth et al 1997).

7.7 The ongoing impact

Some of the women described having difficult relationships with their children and in most cases, this was very much associated with their history of abuse. As has been discussed, women who have experienced CSA are more at risk of perceiving their births as traumatic, which, in turn may have a negative impact on their parenting (Ballard et al 1995; Reynolds 1997; Kitzinger, S 2006a).

Rosie, whose first birth was a negative experience in hospital which was followed by a very positive home birth for her second child, contrasted the ease with which she bonded with her daughter (second child) with how she felt about

her firstborn. She linked the differences to the circumstances surrounding their births:

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

Veronica, who described her first birth as 'a nightmare' in which she 'felt raped over and over again', recalled that she had great difficulty bonding with her daughter for the year following her birth. Kerry suffered from severe depression for nine months after her daughter's birth, which she attributed, partly, to the traumatic nature of the event.

It is very likely that the women's early parenting problems stemmed from a combination of their abusive histories and their traumatic birth experiences and it would be impossible to isolate the impact that each factor had upon them.

7.8 What did the women want?

Having discussed the women's negative experiences, it would be helpful to examine what they perceived to be important and helpful as survivors of CSA in a birth situation.

7.8.1 Female carers

We have seen that women's perception of their birth experiences is hugely influenced by the manner in which they are cared for, the attitudes and actions of their attendants. Many of the women in this study also indicated that the gender of their carers was important to them, and most felt they preferred to be cared for by women. In situations in which they felt vulnerable, male carers could cause them to experience flashbacks to abusive scenarios:

When a man's examining you internally, there comes a point when it could be

any man doing it. You can lose sight of the fact that that is a doctor. That could be your abuser. **Wanda**

All the interviewees had been abused by men and therefore perceived them as potentially abusive. As a result of their early experiences most felt unable to refuse demands made upon them by males. Consequently, they were obliged to endure intimate and invasive procedures by male practitioners; some taking refuge in dissociation, others finding themselves reliving their abuse.

7.8.2 Relational care

The issues of control, relational care, security, trust and good communication were very much in evidence, reflecting the findings of previously discussed research on birthing women's needs (Halldorsdottir and Karlsdottir 1996a; 1996b; Lazarus 1997; Berg and Dalberg 1998; Green et al 1998). All the interviewees stressed the importance of the human qualities of their carers. They wanted to be cared for as individuals, by individuals who engaged with them and worked with understanding, compassion, humour and all the other attributes that constitute good relationships. What they found difficult was the feeling that they were being processed by a system which neither knew nor valued them as individuals; as Lynne so eloquently put it, being treated like '*an object on a conveyor belt of vaginas*'.

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

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

Claire

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

...I think just someone sort of ... just being there and being a bit more understanding. **Coral**

Sally's repeated reference to her attendants' 'no-care' attitude testified to her

need for human warmth and understanding. She spoke highly of a student midwife, who in contrast to some of the older, qualified staff, made herself emotionally available:

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

Sally

This comment is very reminiscent of those made by some of the Icelandic women, (Halldorsdottir and Karlsdottir 1996b) whose perception that midwives understood what they were going through helped them to achieve 'successful' births.

7.8.3 Continuity

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

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

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

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

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

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

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

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

I think each time the antenatal that I went to, each antenatal clinic that I went to you saw a different doctor - I don't think I saw the same one twice. [...] but it would have been much nicer if you could have built up some form of relationship with one or even two. If you saw two, because one wasn't there sometimes, that would have been much better because then you know who you're going to see. **Clare**

As has been seen, one of the major impacts of sexual abuse on a child is the destruction of trust and many survivors find that they distrust health professionals and people whom they perceive to be in a position of authority. Continuity of carer provides the opportunity to build up trusting relationships, as

Judith observed:

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

Kerry's account, on the other hand, provides an excellent example of the benefits of continuity. She explained that owing to her chronic health problems and her abusive history, she had no trust in doctors:

... all they ever did was cut me open, take things out of me. **Kerry**

However, latterly she had been able to build up a trusting relationship with her General Practitioner who had consistently counselled and supported her through turbulent times. Consequently, she had been able to recover some of the trust she had lost not only as an abused child but also in the context of medical treatment.

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

Clearly, to be successful, continuity of carer must be with the right person. As Lynne astutely observed, survivors, not wanting to rock the boat, might not feel able to express dissatisfaction with a carer and consequently persist with an arrangement which was detrimental to them.

Rhoda's account of her first pregnancy, on the other hand, is an example of the great benefits to be had from a good ongoing relationship between a woman and her midwife. It is very significant that Rhoda trusted her midwife to the extent that it was not necessary to disclose her abusive history. She received the consistency and quality of care she needed without having to identify herself as someone with 'special needs' (Kitzinger, J 1997). When asked if she thought it would have made any difference if her midwife had been aware of her history,

she said:

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

This comment is noteworthy, because it suggests that continuity of carer, in which the woman and her midwife are able to develop a good, trusting relationship, may, in some cases, negate the need for disclosure. It could be argued that if this were the case across the board, then fewer women would be coming away from childbirth traumatised and broken. However, although the concept of continuity is promoted by maternity providers, it is rarely realised to any great extent.

7.8.4 Good communication and the offering of genuine choice

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

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

This experience contrasts starkly with the care she received from her GP, who treated her very much as an individual, kept her informed, and encouraged her to make choices. As a consequence of this, she felt in control:

He gives me time, he tells me to book the appointment last on the list if that's possible, he gives me options too. If there's a problem that I go along with he'll say, 'Well, there are probably three things we can do about this Kerry. There's this, there's this and there's this. Which do you feel you would like to do?' So he

gives me control all the time. **Kerry**

Clearly, Kerry's perception of control was strongly associated with the giving of information and choice. Similarly, Judith felt that her experience of maternity care would have been better if staff had exercised good communication skills:

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

As seen earlier in this chapter, many of the women's accounts illustrate a lamentable lack of communication and information giving on the part of carers. Some, like Rosie, found themselves being subjected to various unwanted interventions, with little explanation of what was going on, others were given pain relief without their consent, some were kept ignorant of their sick baby's condition following the birth. All these factors were a cause of great anxiety and the perception of loss of control for the women.

Some of the interviewees commented on the importance they attached to being able to call a halt to a procedure at any time if it was proving too stressful. As with the woman encountered by Smith (1998a), although they may have the desire to cooperate, survivors often find that their bodies respond in unconsciously defensive ways:

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

As Judith implied, busy-ness and pressure of work are the factors which often cause carers to push on regardless:

I know on the one hand people are busy and pushed for time but at the same time just a little bit more time explaining what's going to happen and being prepared to stop. **Judith**

Sadly, as seen in the scenario recounted by Burian (1995) [see p62], in situations in which the woman is perceived to be uncooperative or demanding, professionals may react by becoming more forceful and authoritarian, which is

counterproductive for both parties. Judith gave an example of this when describing her friend's difficulty with allowing a doctor to perform an internal examination. Because of her apparent non-cooperation, he became impatient and attempted to force the issue:

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

It is highly significant that both Claire and Judith had been enabled to cope with intimate procedures by male consultants who were prepared to work collaboratively with them and respect their limitations [see Chapter 6]. Despite the fact that intimate examinations by males were a potential cause of trauma to these women, the sympathetic and respectful attitude of their carers helped them to endure the procedures and emerge from them without long-term psychological damage.

7.9 Good experiences

7.9.1 Carers who 'got into the boat'

Despite the fact that the vast majority of negative accounts concerned hospital births, there were several which contained examples of positive birth in hospital. Without exception, these were associated with good, supportive and sensitive care by health professionals. These findings supported those of other qualitative research into what birthing women want (Halldorsdottir and Karlsdottir 1996a; Tarkka and Paunonun 1996; Berg and Dalberg 1998; Waldenstrom et al 2006) and highlight the importance of the midwife/mother relationship.

Vickie recalled being cared for by a 'wonderful' student midwife during her second birth, whom she remembers as trying to be an advocate for her:

...and they wanted to break my waters [...] and I said to her I didn't want my waters broken [...] [she] kept going out and saying, 'no, she doesn't want her waters broken!' and I can remember feeling awful that I was putting her on the

spot, and they wanted me to be monitored, and I didn't want to be and ... Anyway, eventually I said yes, they could break my waters – so they did...

Vickie

This scenario illustrates the conflict between a woman's wishes and the institutional drive to keep control of birth. Unfortunately, in this instance, the dictates of the 'system' prevailed probably because Vickie felt the need to protect the sympathetic student who was valiantly trying to protect her. However, she did go on to have what she described as a 'wonderful normal birth' causing her to feel pride and elation. Despite the fact that her advocate was not able to protect her entirely from unwanted interventions, the fact that this student respected her wishes and stood with her gave her the perception of being in control, resulting in a 'redemptive birth' (Reynolds 1997).

Other women spoke warmly of hospital midwives who had treated them with respect and consideration. Sally, who had criticised the insensitivity of some professionals who would enter her bed space without asking permission when her curtains were closed, spoke highly of the younger, more recently trained midwives who showed respect for her need for privacy. Louise, whose body bore the marks of self-harm praised her midwife for the sensitive way in which she kept her covered and 'jumped in' to examine her before the doctors could, in order to protect her from her greatest fear, the exposure of the scars. Lynne described her third birth in hospital as 'a good birth' partly because it was quick, but also on account of the two 'nurses' who admitted her and cared for her, placing the baby on her chest as soon as she was born. Wanda, despite having feelings of disgust about birth, appeared to link the fact that her second birth (in hospital) was 'fine', with 'wonderful' staff.

Despite the fact that she had been manipulated into choosing a hospital birth for her second child by her unsupportive and unsympathetic community midwife, Rhoda described this birth in very positive terms. In order to minimise the possibility of losing control in the hospital environment, she had arranged for a midwife friend to care for her for the majority of her labour at home, transferring into hospital in the later stages. She attributed her positive perception of the experience to being 'with somebody I wanted to be with'. When asked how this midwife made the experience good, she said:

... she just let me get on with it really, ... yeah, she just let me get on with it, but was there when I needed her. **Rhoda**

This description of her midwife echoes the comments of Halldorsdottir and Karsdottir's respondents (1996a) about midwives who were supportive but not controlling, whom these authors describe as showing 'professional intimacy'.

All of these accounts show that it is possible for women, including survivors of sexual abuse, to have very positive experiences of birth in hospital. The satisfaction that these women felt was strongly linked with the attitudes and actions of those caring for them. However, as is demonstrated in my scenario, the hospital environment is one in which women's needs and wants often collide with those of the medicalised institution. Consequently, the way in which their birth unfolds often depends very much on the philosophy of the individuals caring for them and whether they are willing (or able) to act protectively towards them against the dictates of the system (Gould et al 2005).

7.9.2 Intimate procedures: It's not what you do, but the way that you do it!

As mentioned previously, women who have been subject to CSA may find invasive and intimate procedures traumatic, or at the least, difficult. The data from these interviewees indicated that any kind of procedure, intimate or otherwise, could be perceived as traumatic or abusive depending on how it was done and the attitude of the practitioner doing it. Some of the women reported having totally opposite reactions to similar procedures and it is very revealing to compare their accounts.

Amanda, whose experiences of vaginal examinations and perineal suturing with her first birth were clearly traumatic [see p192], described having a very different reaction to a vaginal examination during her second pregnancy:

... and she [midwife] said, 'May I examine you?' And I let her examine me as well. [...] She asked my permission first and said, 'this is what I can do' and I gave her my permission, and she went ahead and did that. She was very, very gentle, she was lovely. **Amanda**

Susannah, one of the respondents who had found perineal suturing traumatic following her first birth [see p 193] recalled coping well with the procedure after a subsequent birth. It was performed by the midwife who had attended her during labour and birth whom she described as 'very courteous'. When asked why she perceived this procedure so differently, she said:

They asked my permission. 'Is that ok?' [...] That was the difference, yes. It wasn't, 'We're going to suture you, put your legs in these stirrups and...' you know. **Susannah**

It is clear, comparing these accounts with those of their first births, that being given genuine choice by respectful, caring midwives determined their perception of the procedures. Furthermore, in Susannah's case, the fact that her midwife did not require her to be restrained in stirrups was a great relief to her.

Claire, whose only birth experience was so traumatic that she never became pregnant again, recounted a single positive experience of an intimate procedure during the perinatal period, which stood out to her because it involved kindness and honesty:

I think I might have had one [midwife] twice who was exceptionally nice because I had to have stitches and they said they'd put the self-dissolving one in and they hadn't and when she came one time [...] I couldn't stand up straight, let alone walk! And she just said, 'These stitches haven't gone' [...] She had to take them out and that was very painful but she was – I can remember her being extremely nice. She said, 'It's going to hurt because I've got to pull because the skin's growing over them.' But she was as gentle as she could be and was very nice to me... **Claire**

The accounts of these women demonstrate the immense difference that humanity on the part of carers can make. These midwives showed genuine concern for their clients, asked their permission, gave them choice and tried to be gentle. Consequently, the women were enabled to cope with the procedures

without reliving their past or finding them traumatic.

7.10 Home birth – a different world

As we have seen, it is possible for women to have positive and empowering births in hospital, but the medical and institutional ethos in which hospital maternity care is enshrined makes it uncertain. To a large extent, women's experiences depend on their individual attendants' birth philosophy and ability to withstand the pressures from the system. It seems that several of the interviewees felt that the only certain way to achieve the birth experience that they wanted, was to avoid exposing themselves to the hospital environment. Sadly, in some cases, this was only after a traumatic first birth experience in hospital. Of the 20 women interviewed, 9 had home births for at least one of their children, which reflects the findings of Parratt's research (1994) who also found a high number of home births among survivors. Others said that they would have liked a home birth but for various reasons did not achieve it. There was only one negative report associated with home birth and this was from Sharon, who found her second home birth traumatic partly because she was unable to dissociate, a coping strategy she had used during her first birth [see pp 251-2]. In addition, it was very painful and quick leading to a perceived loss of control because she felt her carers did not keep her sufficiently informed. None of her problems occurred as a result of birthing in the home environment but rather as a combination of the failure of her personal coping strategy and poor communication by her carers.

7.10.1 Why home birth?

In almost all the interviews, the rationale given for choosing to give birth at home was based predominantly on avoiding the loss of control hospital birth would have entailed. This thinking is also much in evidence in the rationale for many non-survivors planning home births (Ogden 1998; Edwards 2005) and many of the women who book my services as an independent midwife give similar reasons for their choices. One of my clients stated that she would 'rather give birth in a field full of sheep than go back to the hospital' and another that

she would 'rather die than have another caesarean'. These were women who had suffered traumatic experiences with their first births in hospital and felt that the only way to avoid a recurrence of the situation was to give birth at home where they would be in control. Certainly, the motivation underlying most interviewees' choices appeared to stem from the need to avoid hospital, rather than a positive belief in home birth *per se*.

Several of the interviewees described their decisions as stemming from the need to be in control and clearly associated the hospital with feelings of powerlessness. Amanda and Jo saw avoidance of the hospital as crucial if they were to avoid repeating their traumatic experiences of perineal suturing, both using the same phrase, '*no way in a million years*' to emphasise their determination.

Some spoke about their aversion to the dehumanising effect of the 'conveyor belt':

...patients lose their identity, more or less on arrival to labour ward. You know, 'Pop that on!' 'Put that gown on, jump up!' [...] I think you stop looking at the person as an individual and what need she might have, you're just on a conveyor belt. **Ruth**

I didn't want to be part of the conveyor belt system, so I decided I was going to have a home birth. **Rhoda**

Rosie's highly medicalised first birth had a negative impact on her, but interestingly, it was not until she had witnessed the impact of the 'cascade of intervention' (Inch 1984) on a friend's birth at which she had been present during her second pregnancy, that she decided to plan a home birth:

... observing her going in and kind of the whole routines around that and then her ending up with a ventouse delivery for this tiny little baby that - you know, having an epidural. The whole lot, the whole cascade happening and watching that from the outside, I just walked out of the hospital and said to myself, 'I am not having my baby in hospital!' **Rosie**

In each of the women's accounts the reasons given for choosing to give birth at home were concerned with their need to remain in control, or at least, not lose control over what was done to them by health professionals. Hospital was viewed as an environment in which loss of control would be inevitable and where their autonomy would not be respected.

7.10.2 The women's perception of home birth

It was a wonderful, wonderful experience. I felt it really set me up for, you know, being a first time mum. **Rhoda**

The comments about their experiences of home birth were, with one exception referred to above, very positive. Choosing to give birth at home enabled the women to free themselves from the system, to strip away all other influences which would inevitably impact on them in the hospital environment. Consequently, they were able to give their energies to coping with the natural, physiological sensations of birth, rather than finding strategies to endure whatever was demanded of them by the production line. Furthermore, home birth gave the women access to many of the factors they felt were necessary for a good birth experience: continuity of carer, one-to-one care and the opportunity to form a relationship with their midwives.

The issue of control was the most highly visible theme in the interviews along with good supportive relationships with carers. As has been seen, a good relationship with supportive carers is a prerequisite for the perception of control. The end result of these needs being met was empowerment, which could have a lasting positive impact on the women's self-esteem and ability to parent their offspring. Opting for a home birth afforded the women control in many ways. Firstly, being on their own territory to some extent put them in a position of power over their carers, reversing the balance of power which could be expected in the hospital environment:

... those midwives were guests in my home, you know, that was my house. If they wanted to go to the loo, if they wanted a drink, you know, we provided it for them. So I felt that we were in control - well I was in control of the situation,

which benefited me, because I needed to feel that I was in control. **Ruth**

Birth at home gave them the ability to choose who and how many would be present. They had control over their environment, there would be no strangers walking in and out of their room at will. Consequently, their needs for privacy were met. Furthermore, they saw home as the place where they could labour in their own time, free of the constraints that would be placed upon them in hospital:

... it was quite long, it was very painful,...it took me two hours to push him out and I think to this day, if I'd been in hospital, there's no way I would have had a normal vaginal birth...It would have been a forceps or some - I'm sure it would've been. **Rhoda**

All the women spoke of being attended by caring and sympathetic midwives, who listened and provided the security and emotional support necessary for birth:

I laboured and birthed at home. The midwives were wonderful. Respectful, kind and gentle. They let me make ALL the decisions. Including whether my ex would be there. They took care of my needs not only clinically but emotionally. They heard me when I spoke and I felt loved and nourished by them. **Brenda**

Amanda contrasted her first birth in hospital with her second, a home birth:

A:... It was hellishly painful again, but I didn't do any screaming, I didn't have the fear.

E: So, it's not the pain that's the problem really?

A: No, it's not the pain, it's the actually, for me, it was the way they were in your face. They were in my bits. They were there and they were so aggressive and so my second delivery couldn't be any more different from the first. It was so very different. But because I took control of it and I think it helped that I had a really good relationship with the midwife. **Amanda**

Clearly, she found birth very painful, but this, as she said, was not the issue. As the women quoted in the Icelandic research found (Halldorsdottir and Karlsdottir 1996a), the support of her 'gentle' and sensitive midwife enabled her to cope. Rhoda described the impact her positive experience of birth had on her ability to parent her child:

... and he was born under water ... and it was lovely. It was a wonderful, wonderful experience. I felt it really set me up for, you know, being a first time mum [...] You sort of have this romantic view of that it's going to be like and of course it's not, it's hard work, but I had such a positive experience of the birth that I really felt ... set up and really strong. It was really excellent. Rhoda

Furthermore, her birth had a 'redemptive' impact on her previously poor relationship with her body:

I felt ... like I'd lost control over my body when I was small and I don't think I ever really felt much in control of it after that [...] I've certainly never liked my body but once I'd had, you know, it had sort of served me well after these two births and I thought, 'God ... actually, it's a pretty good body!' you know, 'It's done two wonderful things', and I felt really powerful. Rhoda

Rosie's comment summed up the advantages the women gained from home birth over a hospital birth:

*And it was lovely! Absolutely perfect! Exactly what I wanted. [...] I felt like I was, it was me, and everybody was fitting around me, was that birth. It was what I wanted and the other birth it was like I went into hospital and fitted around them. [...] I wouldn't do it **any** other way ... I really wouldn't. [...] It was all about control ... and me feeling that I was being listened to and that I was doing it. You know, my first birth I kind of felt like ... they were doing it ... you know, they were getting the baby out of me ... or they were managing my labour, whereas the second time I felt very much like ... very ... I was convinced my body could do it and I could do it and at the end of it I felt this huge sense of achievement that I'd done it. Whereas, I think with the first baby it was – 'We did it. The baby's here.'*

It wasn't so much, 'I did something great.' **Rosie**

The comparison between these stories and many of the hospital birth accounts is startling. Women who birth at home are very much present at and centre stage of their birth experiences. Their attendants play a supporting role thus enabling them to give birth in their own way and time. The travail and pain of labour are accepted as a normal and inevitable part of the process through which it is necessary to pass on the journey into motherhood and not as something to be controlled. The needs and wishes of the women take precedence. They are listened to, valued and respected and consequently, emerge triumphant.

7.11 Summary

Some of these survivors approached pregnancy with deep-rooted fears, not only about what was happening in their bodies, but concerning their contact with the maternity services. Several expressed anxieties over the expectation that they would be obliged to submit themselves to routine vaginal examinations and other invasive procedures which form an integral part of hospital maternity care. Unfortunately, many of their fears were realised.

The women had little to say about the purely physical sensations of giving birth, their accounts being mostly concerned with the way in which their births were managed, the attitudes of carers and the impact this had on them. Three themes emerged from the data associated with negative experiences, powerlessness, betrayal and humiliation, which are also factors prominent in the traumatising mechanisms of CSA.

The women's positive experiences were almost always associated with the perception that carers had been supportive, respectful and offered genuine choice. A high proportion of the interviewees chose to give birth at home mainly because hospital was associated with loss of control and powerlessness. Many of the factors that the women wanted, such as continuity, relationships with midwives and individualised care, were gained through birthing at home. Home also provided the women with an environment in which they were largely free from the constraints imposed by medicine and the institution, enabling them to

give birth in their own ways and times. The women's accounts demonstrate that birth trauma is not inevitable for survivors of CSA and that a good birth experience can be hugely empowering, enhancing a woman's self-esteem and ability to parent.

Chapter 8

How did a history of CSA impact on the practice of the midwives?

8.1 Introduction

This chapter will examine what the interviewees who were midwives said about how their history of childhood sexual abuse informed their practice. Eight of the interviewees were practising midwives at the time of their interview, two were students, one had practised and was waiting to start a 'Return to Midwifery' course and one was on maternity leave. Six had been practising midwives at the time when they gave birth. Their comments are invaluable because they were able to view the maternity services from the dual perspective of both users and health-care professionals.

The issues that the midwives felt constituted good practice involved giving women choice and control, good communication, treating women as individuals and acting as advocates on women's behalf. However, the medically dominated process-driven environment in which maternity care is delivered militates against this and these midwives were obliged to find ways in which they could try to free women from its impact. Some found subtle ways to support women's choices whilst other more assertive characters took a more confrontational stance and could subsequently find themselves being censured by colleagues.

8.2 Awareness of the potential for abuse in maternity care

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

I'm sure she had a failed ventouse delivery, 'cos I can remember the cap

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

Rhoda described her aversion to working on labour ward which stemmed from the need to distance herself from what she described as 'ritualised abuse':

... I find it almost impossible to work on labour ward. I work on a bank contract so I can work where I want to, and I avoid delivery suite like the plague really, because I just don't want to be involved in that ... ritualised abuse really. You know, when I think how birth can be and when I think how birth is for the majority of women now, I just don't want to be involved in that at all. Rhoda

The reluctance to work in the labour ward environment was also highlighted by Vickie, who commented on other midwives whom she had observed avoiding it, describing what occurred there daily as 'brutality'.

8.3 Using their experiences positively

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

8.4 What did the midwife survivors consider to be good practice?

8.4.1 Offering choice and control

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

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

The midwives approached these strongly linked issues with an understanding of women's need to feel in control which was informed by their own experiences:

I wouldn't want to do something to somebody that I wouldn't allow to happen to me. **Susannah**

The importance of truly informed consent, described by Vickie as *'the proper sort of consent. Not just that they've said yes'*, was highlighted by many of the midwife interviewees. In some cases this was couched in terms of 'asking' or 'asking permission' which suggests a very different client-practitioner relationship than that implied in the term 'gaining consent'. It could be argued that 'gaining consent' is often seen as part of undertaking a procedure or an intervention rather than a precursor which actually determines whether or not the procedure takes place.

As referred to previously, one of the particularly sensitive areas in maternity care in which the issues of power and control are highly significant, is that of intimate and invasive procedures and this subject came up repeatedly in the interviews. Several of the midwives described their strong dislike of performing vaginal examinations (V.Es) and two reported struggling with the perception that

they themselves were acting abusively when engaged in performing V.Es. However, most were reluctant to carry out the procedure on a routine basis in normal labour because they felt invasive procedures should be kept to a minimum. Some described their willingness to employ other methods of monitoring progress of labour such as observing the woman's behaviour. Kerry clearly started from the premise that vaginal examinations were a part of her practice, but offered the women some degree of choice over the frequency at which they would occur:

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

It could be argued however, that this approach has limitations as it fails to take into account those who are averse to any intimate procedures.

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

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

As Smith (1998a) found, women may give their consent to a procedure in theory, but find themselves unable to tolerate it in actuality (described in the introduction to the thesis). Some of the midwives explained that informing the woman before undertaking the examination that she could ask for a procedure to be stopped, formed part of their regular practice. However, stopping a procedure relies on the woman being able to voice her needs and, as discussed, some are unable to do this. Unfortunately, some clinicians assume

that once the woman has given her consent they are entitled to press on regardless.

Several of the midwives also described their willingness to be flexible in their approach to how and where to perform vaginal examinations. Some expressed the opinion that lying flat on a bed might be distressing for survivors of CSA and would therefore suggest alternatives that might be more acceptable:

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

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

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

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

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

As discussed in Chapter 7, the trappings of medicalised birth which have

become largely invisible to practitioners, may represent a powerful threat to women who have suffered sexual abuse:

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

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

8.4.2 Good communication

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

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

Arguably, most midwives would consider talking women through invasive procedures to be good practice. However, Kerry's revelation that this could be construed as abusive by some women, is a timely reminder of the importance of avoiding the 'standard approach' by taking the lead from the woman.

Good communication was generally perceived to be far wider than mere verbal interaction, but in terms of relating to women as fellow human beings. Kerry

defined this as being a '*professional with a human face*'. The value of self-disclosure was highlighted by some of the interviewees. This was not necessarily in the context of revealing their history of CSA, (although one midwife described disclosing her history to a client) but in sharing something of themselves and their experiences as women. Susannah's story of her encounter with a woman who was struggling to learn self-catheterisation, is a lovely example of a midwife who, by sharing something of herself, was able to encourage another:

I actually went in and spoke to this woman and I, I don't often say to women, 'this happened to me', but that ... was um ... a classic instance where she needed to hear that the professional looking after her had been through the same thing. And that's what I did, and she said that it helped her tremendously. I showed her how to do it, not literally showed her, but I explained it, and I said, 'the best, the easiest way I did ...', I said 'the first time I did it I sat on the edge of the bath, fell in the bath, hurt my back, cried buckets, um, threw the catheters across the room, screamed at my children, for trying to knock on the door to see what was, the big crash was, you know, wee all over the carpet and everything,' and, because I'd, you know, and I did do that, and I said to her 'I'm not lying that is ...', then she said 'I can just imagine you sitting there doing that', and then we laughed. She cried, I cried, then we laughed. **Susannah**

Communication then, was perceived to be a dialogue and a means whereby the midwives could gain an understanding of their clients' needs and consequently, empower them. This is, arguably, the converse of the organisation's belief that communication enables women to understand the clinician's intentions and consequently, comply.

8.4.3 Treating women as individuals

The comments of the midwife interviewees revealed an awareness of the potential for women to become depersonalised by the production-line ethos of institutional maternity care. When asked how care for women might be improved, one suggested '*not to treat everyone ... as ... a protocol*' (Sharon)

and another spoke about the importance of women retaining their identity by wearing their own clothes rather than being obliged to wear a hospital gown. Interestingly, none of the midwife interviewees said that they treated women as they wished to be treated themselves. This approach, which superficially appears to be an acceptable premise on which to base practice, represents just another manifestation of the standardisation of the delivery of care which has its focus on the caregiver rather than the receiver. These midwives emphasised their commitment to identifying the needs of individuals and tailoring their care accordingly:

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

In the context of procedures they attempted to remove the ritualistic element, which has been identified as depersonalising to both practitioner and client (Bergstrom et al 1992), by eliciting the women's opinions on how the event should be conducted.

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

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

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

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

some people don't want it all loose like that ... **Vickie**

This demonstrates the frequently paradoxical nature of the midwife's role and the importance of being constantly alert to the needs of individuals. Lynne pointed out in her interview that there is no specific approach which is appropriate for all survivors of abuse:

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

It would appear then, that the most useful guide to caring for a woman with a history of abuse, and indeed any women, is the woman herself.

8.4.4 Continuity of carer

All of the issues discussed above are only truly effective in the context of continuity of carer. Several of the midwife survivors referred to it specifically, but in other accounts it was implied. The interviewees who expressed an opinion on giving women the opportunity to disclose a history of CSA felt that one continuous carer was a prerequisite. Kerry described the feelings she experienced on making a disclosure in terms of losing control of her secret:

The secret doesn't, if you like, belong to you quite as much as it did. **Kerry**

Providing survivors of CSA with a continuous carer would help to minimise the feelings of loss of control by confining the information within strict limits.

The impression given by the midwife survivors was that they believed that good quality maternity provision was embodied in one-to-one care, which enabled midwives to fulfil their role of supporting and protecting women. Amanda, drawing on her own traumatic experience, expressed the need for all midwives to be competent in suturing in order to avoid the situation (which occurred in

several cases referred to in Chapter 7) in which a stranger is required to perform a potentially traumatic procedure:

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

This comment makes a strong case for continuity of carer to be provided for all childbearing women because, as previously discussed, many survivors of CSA do not wish, or are unable, to disclose their history and are therefore not identified as such. A one-to-one relationship could provide a context in which disclosure might be a possibility, or even, as in Rhoda's case [see pp 212-3], make disclosure unnecessary.

8.4.5 Advocating/protecting

It was clear from their accounts of working with women that these midwives placed great importance on their role as advocates. Several recounted scenarios in which they fought to protect women from the ever-present threat of medicalisation. However, their attempts to practise in a manner which they felt was appropriate often cut across what was regarded as appropriate by the organisation in which they worked. Supporting women and giving choice sometimes required midwives to place themselves in the firing line.

Rosie recounted on one occasion caring for a young woman whose baby was lying in the occipito posterior position (in which the baby's back lies to the mother's back and often results in a long, painful labour). Labour had been long and arduous but the baby had shown no signs of distress; therefore, Rosie had given the woman more time than is usually "allowed" in order to afford her every opportunity of giving birth spontaneously. The woman eventually became exhausted however, and seemed too tired to make the final effort to birth her baby. The medical team became involved, informing the woman that they were going to 'give her a hand'. Rosie then explained to the woman exactly what the options were and asked her what she wanted. This was not well received by the

doctor:

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

This scenario provides an illustration of the incompatibility between the two diverse philosophies - the medical 'expert' model and the woman-centred midwifery ideal (Arney 1982). Rosie was one of the more assertive midwives who felt more able to confront authority than many of the other interviewees and consequently, often found herself 'hailed over the coals' as a result. She had been working as a midwife for two years at that particular hospital but was aware that she might not be able to continue fighting indefinitely:

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

Susannah also described a scenario in which she defended a labouring woman against a doctor who would not accept that she had refused to be examined by him. He appeared unable (or unwilling) to comprehend her difficulty:

I said 'she really does not want to be examined by you, because you're a man', he said, 'go back in there, and tell her I'm a doctor.' Susannah

Having been refused as a man, he repeats the request, this time as 'a doctor' - someone in authority over the woman. In asserting his position as a medical professional, he is also declaring his authority over the midwife, whom he perceives as subservient. Susannah stood her ground despite continued pressure until, fortunately, the woman birthed spontaneously without the examination.

8.5 The pressure to conform

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

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

Vickie

Many midwives, myself included, would be able to give similar accounts of succumbing to the pressures exerted by the organisation to the detriment of women. It seems that the task of the hospital midwife, who truly wants to provide individualised and woman-centred care, has suffered a sea change, from supporting normal birth to continually repelling boarding parties intent on bringing birth and women under their control. Unfortunately, many midwives do not feel strong enough to resist, and those who have a history of CSA are especially disadvantaged.

Several of the interviewees did not find it easy to confront authority. Consequently, they superficially surrendered to the system whilst quietly working to support women behind closed labour ward doors. Sharon, who had qualified relatively recently, explained that she used her junior status and inexperience in order to avoid compliance with hospital policies when she felt they contradicted the women's wishes. Jo, a student at the time of her interview, would encourage the woman to follow her body's cues only when her mentor was out of the room. She was reluctant to take a confrontational stance because of her inability to challenge authority; consequently, she found a non-confrontational strategy to achieve her ends. Clearly, Jo felt it was not possible to represent the woman's interests at the same time as meeting the demands of the system and was therefore obliged to practise 'undercover' midwifery. There is much anecdotal evidence that midwives resort to some kind of subterfuge in order to support and protect women from having their births hijacked by the medical model in the hospital environment (Russell 2007). Vickie provided a

good example of 'documentary poetic licence' when recounting caring for a colleague during her labour:

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

It is also well known in midwifery circles that cervical dilatation is deliberately underestimated, and full dilatation rarely diagnosed, in order to give woman more time within a system that uses time criteria to define the parameters of normality.

Midwives who want to provide care suited to individuals rather than performing standardised routines, however, may find themselves isolated from colleagues in the protocol-infested waters of the hospital environment¹¹ (Walsh et al 2004; Edwards 2005). Most of the midwives expressed their reluctance to comply with the routines and rituals associated with institutional maternity care, at the same time knowing that they would be disapproved of. Some spoke of their perception that their practice was continually being scrutinised or discussed by others:

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

¹¹ Guidelines are ostensibly formulated with the intention of protecting the public from risk by providing practitioners with a framework in which to work. Sadly, they quickly become ossified, forming policies, the adherence to which is viewed as the epitome of good practice. 'Risk strategies are underpinned by particular concepts of evidence. Guidelines based on this view of evidence are believed to ensure less-risky practice. Whether overtly or subtly, clinicians are required to adhere to such guidelines in order to minimise adverse events for the patient, clinician and organisation', state Walsh et al (2004 p 104). Despite the fact that Dimond (2004) says 'Guidelines, procedures and protocols will never remove the personal and professional responsibility of the midwife to use her professional discretion in the care of her patients', it would be a very brave (or foolhardy) midwife who was prepared to use her professional discretion in a situation for which there was a relevant hospital policy. As society becomes increasingly concerned with risk avoidance, the demand for professional guidelines multiplies until practice comes to resemble swimming in shark-infested waters.

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

Sharon

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

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

Midwives learn from their earliest contact with the clinical environment that it is more comfortable to comply with the status quo than to challenge it. Acquiescence is a habit which is particularly difficult to break and is not only disempowering for the midwife concerned but also conveys to the women in her care that they too are powerless (Kirkham 1996).

8.6 Care which respects all women

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

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

From the accounts of the midwives, it appears that the key ingredients of maternity care which is appropriate for any woman, regardless of whether or not she is a survivor of CSA, are respect, good communication (with the emphasis

on listening), a willingness to treat her as an individual and to facilitate and support her choices. In the 'process-driven' environment of the large consultant unit this is a particularly tall order. Practising in this way demands that practitioners be free from arbitrary time limits, the demands of institutional 'routines', and the mentality which sees women's choices as threatening to the authority of the technomedical organisation.

8.7 Summary

The midwife interviewees were acutely aware of the potential for maternity care to be perceived as abusive by women who had a history of CSA. They felt that their experiences helped heighten their sensitivity to women's needs and their understanding of the problems of birthing survivors. Although their practice was informed and guided by their knowledge of their own needs as survivors, they appeared to recognise the need to treat each woman as an individual.

From the midwives' accounts it would seem that the factors which they perceived to define good practice often conflicted with the requirements of the organisation through which maternity care is provided. They endeavoured to protect their clients from medical and institutional constraints, using good communication skills, taking time explaining things, offering choice and individualising care; but trying to practise woman-centred midwifery in a milieu which has other foci was not an easy task. Midwives who were prepared to fight found that they risked being castigated by colleagues. Those who felt unable to openly challenge the status quo, sought other, less confrontational ways of supporting the women, often practising 'undercover midwifery'.

Chapter 9

Dissociation

9.1 Introduction

Dissociation was first identified by Pierre Janet, a French physician, psychiatrist and philosopher, in the latter part of the nineteenth century. It is based on the doctrine of 'association', the belief that memories are brought to consciousness by an association of ideas and occurs when memories of a traumatic event are unavailable to be associated (Braun 1988). The concept fell out of favour for several decades owing to the influence of Sigmund Freud and his psychoanalytic theories which emphasised repression¹² in preference to dissociation (Mollon 2000). Today, however, the phenomenon of dissociation is widely recognised within the fields of psychology and psychiatry and has recently attracted a good deal of research interest.

Dissociation is believed by most theorists to be a defensive mechanism in which an individual develops the capacity to separate him/herself from physical or psychological pain associated with traumatic events (Briere et al 2005). Chu and Dill (1990 p887) state that *'dissociative defences in general seem to be used in the presence of a psychological need to escape overwhelming experiences such as trauma and abuse.'* Sanford (1991 p26) refers to it as *'walling off what cannot be accommodated'*.

According to Dissociation in the UK, an organisation which exists to provide training and information for professionals as well as treatment (www.dissociation.co.uk accessed 2004 p1), *'dissociation exists along a continuum from normal everyday experiences to disorders that interfere with everyday functioning.'* At one end of the scale are activities considered to be normal such as becoming 'lost' in a good book or performing everyday actions

¹² Repression (which formed the cornerstone of Freud's psychoanalytical theory) describes the belief that forgetting is motivated and that traumatic memories, or those associated with extreme negative emotions are actively, albeit unconsciously, pushed out of consciousness (Gross 2001). Freud argued that the memory disturbances linked with the experience of trauma do not occur as a result of the failure to integrate the event into the individual's personal narrative, but arise from the active repression of sexual and aggressive impulses (van der Kolk; Weisaeth, van der Hart 1996).

involving a simultaneous multiplicity of tasks without having a reflective awareness of one or more of them (Speigl and Cardena 1991). At the other end of the continuum are out of body experiences and dissociative disorders. A small percentage of traumatised individuals also develop the syndrome of dissociative identity disorder (formerly multiple personality disorder) (van der Kolk, van der Hart and Marmar 1996). In its more extreme forms, dissociation is known to be linked with the experience of some kind of trauma and is believed by many authorities to be highly predictive of the development of post-traumatic stress disorder (Marmar et al 1994; Weiss et al 1995; Shalev et al 1996; Putnam 1997; Ursano et al 1999; Olde et al 2005).

When faced with a highly stressful event, in order to protect ourselves from being overwhelmed, we distance ourselves from it at the time, thereafter gradually integrating the experience until it becomes part of our consciousness and incorporated into memory. However, failure to integrate the memory on a semantic or linguistic level can lead to long term psychological morbidity in the form of dissociative disorders, intrusive re-experiencing of the event/s and fragmentary memories (van der Kolk and Fisler 1995; Harvey and Bryant 1999).

9.2 Types of dissociation

According to van der Kolk, van der Hart and Marmar (1996) psychiatry recognises three distinct but related mental conditions within the scope of 'dissociation' referred to as primary, secondary and tertiary. Primary dissociation may occur when an individual is unable to integrate what has happened into consciousness, when the experience is split into its individual somatosensory components without integration into personal narrative. It manifests itself in flashbacks, intrusive distressing memories and nightmares although the sufferer may also experience long-term amnesia concerning the event.

Secondary dissociation occurs when the person, in a traumatic state of mind, experiences a separation of mind and body. They may describe leaving their body during a traumatic episode and viewing the scene from a distance. Thus the individual is able to carry on as if nothing had happened because s/he is

'anaesthetised' from the strong emotions that would normally arise from such a situation. Many survivors of CSA will have been repeatedly subjected to trauma and, as a result, continue to experience dissociative responses into adulthood when faced with distressing life events or situations which engender similar emotions to the original trauma.

Tertiary dissociation refers to the development of distinct ego states or personalities which may contain elements of the emotions associated with the traumatic events. Other ego states within the individual may remain completely unaware of the trauma and therefore carry on with the routine functions of everyday life. It is this that is described by the term 'dissociative identity disorder'.

Dissociation is not a phenomenon confined only to survivors of childhood sexual abuse but is commonly reported among those suffering from post-traumatic stress disorder of whatever origin, including war, accidents and natural disasters (Weiss et al 1995; Shalev et al 1996; Ursano et al 1999; Nijenhuis 2000). However, van der Kolk (2003) maintains that interpersonal traumas, such as sexual abuse or incest, are likely to have more profound and complicated effects than impersonal ones, because children are at a critical and impressionable stage in their social and psychological development. This not only affects psychological or social development, but can result in developmental delays in cognitive, language and motor skills, and a whole range of behavioural problems from learning disabilities to aggression against self and others.

9.2.1 Detachment and Emotional numbing

Severe trauma frequently results in emotional numbing, derealisation (the sense that the world is not real) and depersonalisation, in which an individual experiences a sense of detachment from their physical or psychological being (Braun 1988; Spiegel and Cardena 1991; Livingstone 2002). It is thought that hyper-arousal experienced by victims of trauma exhausts the biological and psychological resources required to experience a wide variety of emotions, including pleasurable ones (van der Kolk and McFarlane 1996). Although dissociation can be an effective way to continue functioning while the situation

is ongoing, its continuation once the trauma has past, often engenders 'a subjective sense of 'deadness' and a sense of disconnection from others' (van der Kolk 1996, p 192), which interferes with everyday life.

It is interesting to note that this psychological defence mechanism can also have a profound impact upon an individual's perception of physical pain. Emotional numbness has often been associated with self-injury and van der Kolk (1996) suggests that some people are motivated to self-mutilate in order to find relief from emotional numbness. He reports on an unpublished research project in which he 'collaborated' with eight self-harming individuals, measuring their responses to painful stimuli during times when they felt a strong urge to cut themselves. Six of the eight participants registered no pain response to any stimulus that could be 'applied within ethical limits'. From this he postulated that these individuals had '*developed a conditioned analgesic response to an environmental stressor*' (p 189).

Judith described herself as experiencing a profound degree of emotional numbness, and engaging in self-harm '*because it was almost like I could almost feel that....*'. Interestingly, she was the only interviewee to report giving birth painlessly owing to dissociation.

9.3 Normal life events and dissociation

A lesser degree of dissociation may be experienced by perfectly healthy individuals to cope with stressful, but not traumatic, everyday events (Morgan et al 2001). Sanford (1991) describes how, following a fall in a restaurant, rather than feeling the expected emotions of embarrassment, pain or fright, she became obsessed with retrieving the shoe she had lost. Unable, for that moment to comprehend what had happened, she became focused on an irrelevant detail. It was not until a few days later that she was able to '*find some meaning in the event*' (p26).

Although birth could not be described as an everyday event, it is within the realms of normal expected human experience. It could be suggested that the increasingly popular technique of self-hypnosis, now being promoted as a method of pain management during childbirth, (Mongan 1998; Reid 2002; Spencer 2005), is an example of the positive use of a dissociative technique.

Mongan (1998), a practitioner of hypnobirthing, describes it in these terms: *'similar to the daydreaming or focusing that occurs when you are engrossed in a book or staring at a fire - when you lose track of what's going on around you'* (p 12). The woman is encouraged to enter a state of deep relaxation and use visualisation in order to dissociate herself from the physical sensations surrounding labour. This not only helps the woman to deal with the pain of labour but also gives her the perception of control by placing a coping strategy at her disposal. One hypnotherapist describes her own labour experience thus:

I wasn't sleeping, I was in a very deep state of relaxation, and when you're relaxed you can't feel fear, tension and pain – all the things usually associated with childbirth. As the contractions came, I was having a wonderful time. In my mind, I was off to all the fantastic places I have seen on my travels around the world. (Howells 2003)

Women using self-hypnosis for childbirth have even reported 'out of body experiences' describing how they watched themselves giving birth from another part of the room (DeSouza 2003 personal communication). Clearly, the degree and type of dissociation achieved using these techniques can be very positive and helpful when under the control of the individual and used appropriately.

However, survivors may find that which began as a way of providing an escape route from an unacceptable reality, can persist throughout their lives and may come into play (sometimes inappropriately) when feelings or circumstances arise which are similar to those surrounding their abuse. For example, three of the interviewees reported dissociating when having consenting sex with their husbands.

9.4 What caused the women to dissociate?

Many of the survivors interviewed referred to their ability to 'switch off' when confronted by situations in which they felt threatened, in pain or out of control. Two of the interviewees found themselves beginning to dissociate during their interviews, presumably because the telling of their stories elicited the emotions linked with their abuse. Several of the women had also experienced traumatic

amnesia and for many years had no conscious memory of their abuse.

The most common triggers for dissociation (cited by eight of the eleven women who dissociated) were intimate examinations and invasive procedures particularly when they were performed by males. Interestingly, not all the women mentioned dissociation in relation to their childhood abuse. A possible explanation for this could be that some still had submerged memories at the time of their interview. This would seem likely as it is common for long term amnesia to follow severe trauma (van der Hart et al 1993; Devor 1994; van der Kolk and Fisler 1995; Carolusson and Karilampi 1996; Livingston 2002). For example, Rhoda's memories began to emerge as she started her midwifery training at the age of 25. At the time of her interview (aged 35) she knew that she had been abused by her maternal grandfather but her memories were not properly formed into a narrative or even pictorially, but consisted of sensations. She found herself dissociating whenever she thought about herself being the subject of abuse.

Five of the interviewees clearly recalled dissociating during the birth of at least one of their children and three others may have done, but their accounts were ambiguous in that their seemingly dissociated states could be attributed to their being under the influence of Pethidine or Entonox at the time. Of these three, Jane recalled that during labour she spoke with a 'deep psychotic voice' which she believed to be her brother's. Arguably this may have been an example of tertiary dissociation i.e. dissociative identity disorder, which lies at the extreme end of the spectrum of dissociative responses. She also reported that for some time in her past life she had had an alter ego of whom she was unaware until 'Jenny' had 'died':

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

This account was the only example of possible tertiary dissociation among the interviews.

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

9.4.1 Coping with the inescapable

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

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

The intentional use of dissociation was also seen in the account of one of Parratt's interviewees (1994) [see p68] who described making a conscious decision to dissociate during labour:

I just made my mind up, that was it, I was going. (p35)

Accounts of survivors of childhood sexual abuse often contain references to the use of coping strategies such as counting flowers on wallpaper, focusing on an object in the room and disappearing into it, separating mind from body in order to cope with abuse (Smith 1998b; Simkin and Klaus 2004 pp 12-14). This could be described as an attempt to maintain emotional integrity while their physical self was being violated. The survivors in this study also reported using similar coping strategies:

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

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

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

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

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

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

It is interesting to compare this account with that of Parratt's (1994) interviewee [see p68] whose dissociated state appeared to have a harmful effect on her baby's heart rate during labour. Although Kerry's account of dissociating on having her blood pressure taken suggests that this response was not under her conscious control, the interviewee in Parratt's research, once she realised that her baby might be in danger, managed to bring herself round.

9.5 Dissociation during the birth process

As previously stated, five of the interviewees reported dissociating to a certain degree at some time during the birth process. Despite having had no memory of her abuse until after the births of her children, Judith explained that dissociation helped her to enjoy giving birth because, as previously stated, she felt no pain. Sharon also found that dissociation formed an effective coping strategy during her first birth experience (a home birth), which she described as 'positive' and 'affirming':

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

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

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

This is reminiscent of Rose's birth account (1992) in which her dissociated state interfered with her ability to birth her infant. Similarly, Lynne also reported feeling traumatised by her first birth, which took place in hospital. When asked if the actual act of giving birth had caused her any problems she said

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

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

9.6 Which women were most likely to dissociate?

Although it is difficult to draw conclusions from such a small sample, generally the women who dissociated tended to have been; a) abused from a younger age, b) suffered for a longer period of time and c) have more extreme abuse histories. This finding is supported by other research (Strick and Wilcoxon 1991; Boon and Draijer 1993; Carolusson and Karilampi 1993; Gast et al 2001; Livingston 2002).

One of the respondents, although she had been subjected to repeated rape by her stepfather for four to five years, had never dissociated either during the assaults or in any other situation. Neither did she suffer amnesia surrounding the events. There seems to be little to account for this except that her abuse started when she was 12 years old, later than most of the women who dissociated. Furthermore, the evidence suggests that the response to trauma is highly individual, and influenced by diverse factors such as personality type, beliefs, family circumstances and the degree to which they feel supported (van der Kolk and McFarlane 1996; Seng 2002b; Soet et al 2003).

Interestingly, although Claire reported being severely abused incestuously and by a paedophile ring from the age of around four years, she did not mention ever using secondary dissociation as a coping strategy. She did, however, describe having vivid flashbacks to the abuse, precipitated by any kind of intimate examination (primary dissociation). It is impossible to say why Claire had not developed dissociation as a strategy during the horrendous abuse that she suffered but it is interesting to note that soon after the abuse ceased she started to drink heavily and went on to become an alcoholic. Claire's traumatic memories remained buried until she was in her mid forties and it is quite possible that she used alcohol as a means of coping with the resultant negative emotions (van der Kolk 1996 Chapter 9). One of the behaviours linked with post-traumatic stress disorder is that of avoidance, in which situations or people that might act as triggers for memories of the trauma are avoided (Crompton 1996a; Gold-Beck-Wood 1996; van der Kolk and McFarlane 1996 p12; Charles 1997; Robinson 1999; Creedy et al 2000; Robinson 2001b; Seng 2002a; Seng 2002b; Beck 2004b; Seng et al 2004). Arguably, Claire's decision to have no more pregnancies following the birth of her son is an example of an avoidance

strategy. Being deeply traumatised by the experience, and having no other psychological coping strategy at her disposal, she thereafter avoided placing herself in similar situations. Most of the other women, even though some had been traumatised by their first birth, went on to have other children and found alternative ways to avoid retraumatisation.

Jenny, the woman who had suffered a single episode of abuse, a rape when in her teens, appeared not to have experienced dissociation or amnesia in relation to her attack. However, during her instrumental birth, she appears to have had flashbacks to the sensory and emotional aspects of the event.

9.7 Dissociation and home birth

Two of the women who gave birth at home reported dissociating during the birth. Ruth, who had two very positive home births, said that she coped with them using the same strategy that she had used during her abuse – focusing on a crack in the ceiling and disappearing into it. She felt that she was very much in control of her birth experience and being able to use her own coping mechanism contributed to that perception.

Sharon, the other woman who dissociated during birth at home, also reported a high degree of satisfaction with her first birth. When asked about how she had coped with procedures such as palpations, vaginal examinations and blood pressure taking, she said:

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

However, despite her second home birth being uncomplicated and quick, her memories of it were of feeling out of control and in extreme pain. At the time of her interview, her baby was 6 months old and she reported having ongoing flashbacks to the event, was experiencing psychosexual problems and emotional distress as a result. She felt that this stemmed from her inability to effectively use her dissociative coping strategy during this birth:

... there was nothing really that should have been traumatic but actually, it was. But I think that ... I've worked quite hard to stop dissociating with my partner you know, and he's been very supportive about all the things that have happened to me and I felt that it was really unfair to do that when I was with him in any way, emotional, or when we were having sex and I'd worked really hard to stop doing that and then when I was in labour I couldn't do it I don't think, or certainly not to any decent extent... **Sharon**

This suggests that for some survivors of CSA, dissociation may have a protective effect and is associated with the perception of control. This supports the findings of other qualitative literature (Parratt 1994; Rhodes and Hutchinson 1994; Kitzinger, J 1997). It could also be argued that the relinquishment of mind control referred to in Chapter 1, describes a degree of non-pathological dissociation which is a normal response to the intense sensations of labour.

9.8 Where the power lies

It would seem then, that positive reports of dissociation were usually associated with the woman being able to use her coping strategy to deal with the physical sensations of labour and birth, which fall within the boundaries of expected normal human experience. Negative accounts were nearly always linked with feelings of powerlessness and the perception that control lay in the hands of others who were perceived as unsympathetic and uncaring. Arguably, this lies outside the realm of expected human experience. It appears that the issue which determines whether dissociation is perceived positively or negatively is that of who has control. It can be used as an effective coping strategy when in the hands of the woman; conversely it can be an involuntary response to overwhelming feelings of powerlessness as a defence against '*even more catastrophic states of helplessness and terror*' (van der Kolk, van der Hart and Marmar 1996 p 314). It is this type of experience which is strongly linked to post-traumatic stress disorder (American Psychiatric Association 1980; van der Hart et al 1993; Olde et al 2005) and for many of these women, birth scenarios in which they felt helpless and out of control constituted a re-enactment of their childhood abuse, [see section on PTSD, Chapter 2].

9.8.1 An avoidance strategy

Harvey and Bryant (1999) conclude from their qualitative investigation into the organisation of traumatic memories, that:

...dissociation and disorganisation can be conceptualised as forms of avoidance that may be used by trauma survivors to cut from and manage traumatic memories. (p 404-5).

Dissociation constituted just one of the strategies by which the survivors attempted to avoid losing control over what happened to them. Other avoidance strategies included giving birth at home, delaying admission to hospital until labour was well advanced and, as discussed, in Claire's case, avoiding pregnancy. These women felt unable to challenge the way in which 'institutional' maternity care was delivered, but found ways to avoid contact with the organisation or minimise its impact. It could be argued then that dissociation is an 'avoidance' strategy and occurs when literal avoidance is not possible. As previously discussed, avoidance is one of the core criteria in the diagnosis of post-traumatic stress disorder (American Psychiatric Association 1994) and the women interviewed in this study demonstrated both manifestations of it; a) physically avoiding situations in which they would lose control, and b) dissociating in inescapable circumstances which they found overwhelming.

9.9 Control and Labour 'styles'

As discussed in Chapter 3, Rhodes and Hutchinson (1994) identified four 'labour styles' of sexually abused women; 'fighting, taking control, surrendering and retreating', dissociation forming part of the latter two [see p59]. They suggest that these 'styles' might alert carers to the possibility that the woman they are attending may have a history of sexual abuse. The authors state that these 'styles' are not mutually exclusive and women could display different behaviours during the same labour. However, as previously pointed out, it appears that in the majority of cases, the particular style of behaviour was manifested in connection with various aspects of labour management rather

than the 'normal' sensations of labour itself. Certainly this was the case for these women. Some of the interviewees recounted displaying what could be described as 'fighting' and 'taking control' behaviours but the majority coped using passive, non-confrontational strategies of which dissociation was one.

It is a cause for great concern that there is an increasing body of evidence that women who have no apparent history of sexual abuse are experiencing dissociation and suffering from post-traumatic stress disorder following childbirth (Creedy et al 2000; Beck 2004b; Olde et al 2005) [see section on PTSD, Chapter 2]. Given that post-traumatic stress disorder and post-traumatic stress symptoms are brought about by *"vehement emotional reactions during or shortly after the trauma such as intense fear, helplessness, loss of control and horror..."* (Olde et al 2005 p128) it is highly disturbing that women should be experiencing emotions of this type and magnitude during a process which could be described as a normal life event.

9.10 'Professional dissociation'

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

9.10.1 'Professionalism'

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

caused by the ongoing staffing crisis in many areas (Charlton 2001; Ashcroft et al 2003; Kacary 2003; Walsh 2003a; Walsh 2003b). The dominant medical or 'technocratic' model (Davis-Floyd and Mather 2002) which dominates today's maternity services, militates against 'relational' care, which is, arguably, what attracts most women to enter the profession of midwifery. It would seem that both midwives and their clients have similar struggles with the nature of the maternity services and that midwives as well as women feel powerless, betrayed and dehumanised.

...the midwife as machine is expected to perform all her tasks and function fully at all times, regardless of her complex inner world – which is of no interest to those who run the service.....In this model the body is a machine: it does not feel emotions and is not subject to hunger and thirst, does not have menstrual cycles and does not get tired. It performs at a set standard all the time, regardless if it is the first or the sixth night duty in a row. The midwife in this model is told off for getting 'too involved'; she is expected to separate her emotions from her work, since to involve her emotions is 'not professional'. (Anderson 2005)

Professionalism, in this milieu, is equated with male orientated qualities such as efficiency, objectivity and detachment. Midwives are required to fit the model despite the fact that the essence of midwifery is relational, and feminine qualities lie at its core. They may well have entered the profession prompted by the desire to be 'with woman' but soon discover that, instead, they are required to be 'with CTG', 'with notes', 'with doctor'. As Shallow (2001a-d) discovered, midwives are expected to function equally well in all areas of maternity care, regardless of their own particular preferences or strengths. There is little or no support for those who find this difficult or who encounter distressing or traumatic events in their work situation.

Kerry, an experienced community midwife, recounted an anecdote from her clinical practice which illustrates this. She was called out to a house in the early hours of the morning to find a seriously ill young woman who had just given birth to a dead, macerated baby, which was lying on the landing, just in her eye line as she reached the top of the stairs. Despite the seriousness of the

situation, she was unable to access any help, nor did she receive any practical or emotional support from colleagues in the hospital.

... my supervisor didn't come out to me, to assist me and I couldn't get the GP to respond to me. I actually had to deal with five shocked and distressed people. That included the two ambulance men. [...] I took her into hospital, wrote an initial report, handed over. No-one said to me 'Go home, go home!' I actually carried on working the whole of that day and continued working and then took 'til December (that was in the September. The December was when I actually went off sick and collapsed). **Kerry**

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

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

The concept of 'professionalism' described here is clearly that of a coping strategy, a way in which personal distress can be 'switched off' or blocked in order to continue functioning. Because the midwife is expected to perform perfectly at all times regardless of the circumstances, she may be obliged to assume a 'professional persona' for use at work which protects her from her own and others' distress. Hunter (2000), drawing on the work of Hochschild (1983) on emotional labour, quotes a midwife who described herself as 'putting on a professional mask' as she changed into her uniform. This enabled her to '*leave behind her personal self and function in the way that would be expected of her as a midwife*' (p 34). It could be argued that this has echoes of the alter ego seen in dissociative identity disorder referred to as 'tertiary dissociation' (van der Kolk; van der Hart and Marmar 1996). This persona is unaware of the trauma, and consequently, the individual is enabled to continue in her

professional capacity unencumbered by personal feelings.

9.10.2 Avoiding personal conflict

It appears that for many midwives who want to remain working within the organisation but do not feel able to spend their time fighting, there is little choice other than submitting to its demands, regardless of their own personal philosophy of birth. Unfortunately, this may produce cognitive dissonance, as Jo, a student midwife at the time of her interview, indicated:

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

In order to cope with this a choice may be made (consciously or unconsciously) between continually swimming against the tide, or dissociating from clients, which involves focusing on the demands of the system rather than on the needs of women. Just as secondary dissociation provides survivors with a means of coping with the unthinkable, this serves to minimise the emotional impact on the midwife and enables her to continue functioning. Instead of disappearing into a crack in the ceiling or a stain on the wallpaper, the midwife focuses on rules, routines and rituals and thus disappears into the system.

In effect, midwives may align themselves with the organisation and consequently dissociate from women to protect themselves from internal or external conflicts which might arise from the disparity between clients' wishes and the dictates of the system. This may be more comfortable than supporting women in choices which are not endorsed by the organisation and which, if allowed, could make the midwife vulnerable to ostracism.

9.10.3 Focus on routine and ritual

Practitioners' focus on routines and procedures is an issue which cropped up frequently in the accounts of the women. Bergstrom et al's study (1992) on the conduct of vaginal examinations in the second stage of labour identified two major themes: the VE as a healthcare 'ritual', and the personal disembodiment

of the caregiver. The ritualistic aspect, they assert, allows the intimate aspects of the procedure to be ignored by all participants, who become *'role players instead of authentic persons'* (p 16). The disembodiment of caregivers enables them to *'dissociate a subjective response from an objective, technical procedure that may inflict pain'* (p16). Not only do these mechanisms protect caregivers from the full emotional impact of what they are doing, but they also provide a means of avoiding the need to question their efficacy or desirability.

As discussed in Chapter 7, several of the women gave accounts in which, despite their obvious distress, caregivers persisted in completing procedures. It appears that carers' focus on routines apparently protected them from the emotional impact of the situation. Again, this has echoes of the abused child focusing on a crack on the wall or a flower on the wallpaper in order to 'escape' the reality of what is happening in her body.

9.10.4 Focus on risk

As birth has become increasingly medicalised and issues of risk and litigation ever more prominent, the autonomy of the midwife has been gradually but relentlessly eroded. Midwives working within today's maternity services are acutely aware of the pressure on them to conform to policies, protocols and 'guidelines' intended to eradicate all risk from the birth process but in which, as Anderson observes, they have little or no input:

Clinical midwifery policies (enforced as non-negotiable) are written by senior obstetricians who, in practice, are given the authority to 'allow' what will or will not happen to their patients. Midwives who try to challenge this authority are often bullied into submission, or leave on the grounds that they have little clinical autonomy. (Anderson 2005 p 472)

Rhoda explained how her community midwife effectively denied her request for a home birth by threatening her with the death of her infant. By focusing on the concept of risk, she could effectively justify her actions by believing that she had acted in her client's interest by protecting her from harm. From the medical perspective, she had acted professionally and responsibly in warning her of the

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

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

9.10.5 'Professional' detachment and emotional numbing

Midwifery is a profession which involves a high level of direct contact with people, often in highly emotional or stressful situations. Consequently, midwives are particularly susceptible to 'burnout syndrome' in which physical and emotional exhaustion leads to low morale, a loss of concern, empathy and job satisfaction. Burnout, argues Sandall (1995) is often exacerbated by lack of support and understanding from colleagues and is correlated with:

...role ambiguity at work and unrealistic work policies resulting in an inability to achieve work goals, large case-load size and isolation at work (p 247).

She interviewed midwives who had been providing continuity of carer for several years and reported that people in this position often coped by '*...distancing themselves in a way that was harmful both to their clients and to themselves, psychologically*' (p 247), which is highly reminiscent of the

'emotional numbing' and 'detachment' manifestations of dissociation discussed earlier.

In today's maternity services, pressure is exerted on midwives from all sides, not only by the medical and legal constraints of their position, but also by organisational and managerial requirements. In addition to that, a strong culture of self-sacrifice pervades midwifery causing many individuals to place unrealistic expectations on themselves (Kirkham 1999). Consequently, emotional numbing and distancing may not only occur as a result of these pressures but also act as a coping strategy enabling individuals to continue to function in this environment. This emotional distance and apparent lack of interest in the women as individuals was deeply distressing to some of the interviewees, who linked it with their experiences of abuse:

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

'Professional dissociation' is the antithesis of 'professional intimacy' described by Halldorsdottir and Karlsdottir (1996b) which the researchers define as a combination of closeness and distance, which '*creates space for the receiver of care and yet allows for connection*' (p 368). It combines clinical competence with the human qualities of caring, warmth, good communication and genuine concern for women. This was particularly observed in both Rhoda's birth accounts. She described her first midwife as '*a lovely woman and a lovely midwife*', implying that they related first and foremost as women. The midwife who attended her second birth, she described as '*supportive [...] but not in my face*', which, it seems, is the epitome of 'professional intimacy'. Consequently, her perception of childbirth was a very positive one: '*I felt really powerful.*' Conversely, as was seen in the accounts of other survivors, birthing women attended by dissociated, uncaring midwives often find their birth experiences disempowering and frightening.

9.11 Summary

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

There were many reports of dissociation from the women interviewed. Some described dissociating in order to cope with their abuse as children, using strategies such as focusing on something other than what was happening to them physically. Several interviewees reported using this coping mechanism to deal with the sensations of labour. Interestingly, this type of dissociation was used in the context of home birth and was considered by the women to be protective. Others described experiencing flashbacks and reliving abusive scenarios when they encountered 'triggers' or situations which reminded them of their abuse. The issue of who had control determined whether they viewed dissociation positively or negatively. Dissociation also appeared to be an avoidance strategy, acting to limit the emotional damage incurred when literal avoidance was not possible.

The evidence suggests that midwives also use a degree of dissociation in order to cope with working in an environment in which there are many potential conflicts. 'Professional dissociation' could be described as a survival strategy which acts to protect the individual from the emotional and psychological consequences of powerlessness. It is the antithesis of professional intimacy and is ultimately harmful to women, midwives and midwifery.

Chapter 10

What is problematic about institutionalised birth?

10.1 Introduction

As I stated in Chapter 5, when I began the research I initially thought that I would be identifying a list of 'do's' and 'don'ts' to help inform midwives and carers dealing with women they knew to be survivors of sexual abuse. The expected accounts, of how the physical sensations of giving birth mimicked those of sexual abuse and the words of caregivers mirrored those of abusers, largely failed to materialise. However, as time went on, it gradually dawned on me that, for these women, much of the problem lay with the system through which maternity care is delivered, rather than with the physical attributes of giving birth. It appeared that what the women struggled to cope with was the medically controlled 'production-line' ethos of the large consultant unit. I therefore found myself increasingly questioning the need for, and desirability of, much of what is considered to be routine maternity care. In the majority of cases, the women appeared to have had realistic expectations of the birth process and it was mainly after experiencing a traumatic first birth in hospital that the idea of giving birth became problematic. Of the forty births represented in the data, twenty-nine were hospital births. Of these, seventeen women perceived some aspect of their maternity care to have been either traumatic or deeply distressing. Eleven births occurred at home and five of these were planned as a direct result of a negative first birth experience in hospital. This chapter will therefore discuss the issues associated with institutionalised birth which could be described as contributing to women's negative experiences.

In Chapter 7 we saw that the women's negative perceptions of birth were characterised by three factors; powerlessness, betrayal and humiliation. All three were linked with 'routine' care in the hospital environment and the powerful influence which medicalisation, coupled with institutionalisation, has upon the delivery of maternity care. The loss of control women experienced was associated to a large extent with the technocratic model of birth (Davis-Floyd 1992) with its technology, routines and rituals, as well as the constraints placed

upon them by the organisation which deprived them of social support. Betrayal resulted when the women's expectations of caring and empathy from their attendants were met with coldness and a lack of concern. Humiliation was associated with carers' lack of respect for women's dignity and privacy and, it could be argued, resulted from a combination of maternity workers' single-minded focus on the needs of the organisation coupled with unsympathetic attitudes.

As we have seen from the literature and the data, birthing women, including those who have a history of CSA, place great value on the humanistic characteristics of the midwife's role. All women expect their midwives to be competent and knowledgeable but place equal importance on being cared for by individuals who show respect, communicate well, offer choice and relate to them with genuine warmth (Berg et al 1996; Halldorsdottir and Karlsdottir 1996a, Halldorsdottir and Karlsdottir 1996b; El Nemer et al 2006). When this relationship functions well and women feel nurtured, supported and valued, the result can be truly empowering. However, the impact of the medicalisation and institutionalisation of birth has been to disempower both midwives and women. Having identified institutionalised birth as problematic for survivors of sexual abuse, and, indeed, as a source of trauma for other women without histories of CSA, this chapter will discuss the issues which may be at the heart of women's disempowerment and consequent traumatisation. It will start with a brief discussion on the potential limitations of this study, which will be followed by another look at the scenario referred to in Chapter 1, as this embodies many of the issues which impact on birthing women and their midwives. This will be followed by a discussion on the factors which are instrumental in disempowering midwives, whose role has suffered a radical transformation from facilitators of normal birth to obstetric nurses. The next section will examine the role of risk in controlling women and midwives, after which will be a discussion on the factors which have separated midwives from their client group. The impact of placing time constraints on birth will then be explored, followed by a discussion on how control is removed from women by the tecnomedical model of birth. The chapter will conclude with an exploration of the alternatives to the current industrialised and medicalised model such as home birth, Midwife Led Units and Free Standing Birth Centres, case load midwifery and independent

midwifery care.

10.2 The limitations of the study.

As discussed previously in chapter 5, early on in the research process I identified a potential limitation when I realised that most of the participants were in late middle-age and therefore had no recent experience of maternity care. Furthermore, several explained that they had suffered long-term amnesia as a result of their abuse, which was still affecting them at the time when they gave birth. In order to have relevance for maternity caregivers today, it was necessary to elicit the opinions of women who had given birth more recently, within a system which reflects more accurately maternity care as it is today. The recruitment of the midwife survivors of CSA provided me with the opportunity to interview women who had not only been recent users of the services, but who also had current, or very recent, experience of maternity care as midwives.

However, I believe that the potential weakness of this study actually became one of its strengths in that it highlighted several issues: 1) the long-term damage that can result from CSA; 2) the long-lasting impact of traumatic birth; 3) the potential for modern, as well as 'old fashioned', maternity care to traumatise; 4) the continuing power of the institution and the medical profession over women, despite the recent emphasis on choice and control.

Furthermore, interviewing women who did not suffer from long-term amnesia, provided me with a comparison group. There appeared to be no protective effect for the women with no memories of their abuse at the time when they gave birth. One the whole, both groups of women had the potential to find their birth experiences traumatic when overwhelmed by feelings associated with their abuse such as powerlessness and loss of control.

10.3 A retrospective

Before beginning the discussion, I feel that it is appropriate to refer back to the scenario in which I was involved, which is documented in Chapter 1. I believe it sets the scene for, and gives context to, subsequent discussion as so many of the factors involved in the disempowerment of women and midwives are

contained within it. Having heard the accounts of the interviewees and become familiar with the various influences to which birth, women and midwives are subject in the hospital birthing environment, when I encountered it for myself during the writing up of this thesis, the women's words took on an immediacy and a new relevance. Having left the NHS some years ago and therefore being somewhat uncertain about the current state of affairs, this scenario confirmed to me that very little had changed in the intervening years. Despite the emphasis on communication skills and psychological aspects of care (in both midwifery and medical training), institutionalised maternity care continues to have the potential to disempower and dehumanise. The aspects of childbirth care which the interviewees found to be distressing were still present; the power and control vested in the medical profession, the pressures of protocols and policies and the concept of risk, the dehumanising effect of routines and rituals which characterise conveyor belt care.

Had I not been present with the woman, she would almost certainly have been subjected to more unwanted vaginal examinations, may have been pressured into having an epidural (possibly resulting in a repeat caesarean section or instrumental delivery) and consequently emerged from the experience re-traumatised and distressed. I do not say this in any way to boost my own ego, but as a statement of fact. My position, outside the organisation's control, enabled me to support her and stand with her. Her hospital midwife, although kind and pleasant, was encumbered by the dictates of medical staff and hospital policy. I could afford to make myself unpopular; she would be at work in the same environment the next day. As it was, the woman felt triumphant and proud that she had successfully birthed her baby in her way. Part of her elation also stemmed from the perception that she had managed to escape most of what the organisation was intent on doing to her.

The scenario not only demonstrated the powerful influences which are exerted upon the birthing woman, but their impact on midwives, including myself. I remember consciously debating whether to defend her right to refuse another V.E, or to 'support' her by helping her to cope with it. I know that the latter is the action I would have taken as a hospital midwife, and having done so, felt content in the knowledge that I had effectively carried out my 'with woman' role. To do that, however, I knew that my focus would have to change from the

woman's needs to those of the organisation, effectively protecting myself from the emotional impact of allowing the woman to be violated.

10.4 How did the Devil come? When first attack?...

...Time, bring back

The rapturous ignorance of long ago,

The peace, before the dreadful daylight starts

Of unkept promises and broken hearts. (John Betjeman 'Norfolk')

As has been discussed, most women long to form relationships with their midwives. Not only is this expedient on grounds of physical safety but for reasons of maternal satisfaction and good psychological outcomes (Flint 1991; Berg et al 1996; Halldorsdottir and Karlsdottir 1996a; 1996b; Berg and Dahlberg 1998; Page et al 2001; Rosser 2003). Midwifery is, in essence, a relational vocation, which should enrich the lives of both women and midwives¹³. Nowadays, it can amount to little more than speed dating. The role of the midwife, particularly in the hospital environment, has been subsumed into the medical model of birth, and her autonomy, even within the realm of normality, has been seriously eroded. The destiny of women and midwives is inextricably bound together, and consequently, when midwives become powerless and invisible, the women for whom they care suffer the same fate.

¹³ Unlike obstetrics, which is based on managing a process, true midwifery has at its heart the relationship between two women. The concept of relational care is equally important to both mothers and midwives and is its own reward for both parties: the woman receives strength and self belief in order to safely birth her baby; her midwife the satisfaction of being her travel companion on the journey into motherhood. Edwards (2005 p 160) states '*Relationships between women and their midwives were one of the most significant determining factors on how women experienced planning and having home births or transferring to hospital.*' Conversely, many of the midwives interviewed by Ball et al (2002) were prompted to leave the profession because they felt the opportunity to form relationships with their clients had either declined or ceased to exist altogether. Midwifery without relationship holds as little meaning as marriage without relationship.

To many midwives midwifery is a vocation in the literal sense - a calling. I have heard many midwives say that they were 'born' to be midwives and that is all they have ever wanted to do. Indeed, Maggie Smith was one of them. Interviewees in a study by Williams (2006) on why women choose midwifery, described their decision to become midwives in terms of 'having' to do it or of feeling it was what they were 'supposed' to do. Rosie, one of the interviewees in this research, put it this way: '*....I had my second baby and I thought 'No, I definitely need to be a midwife.' [...] I couldn't imagine doing anything else.*' Edna Beguia (2005), a Filipino midwife, explained her feelings about midwifery thus: '*It is a calling to be of service to mothers who are instruments of life, to the children and to the community as a whole. It is a call for service to life.*'

10.5 The disempowerment of midwives

10.5.1 The medicalisation of birth

Clearly medicalisation has redefined birth but it has also brought about a radical change in the identity of the midwife and the devaluation of her role as was demonstrated by the accounts of the midwife survivors. Anderson (1999) observed the impact of this on women entering midwifery without a background in nursing. Because they have never been socialised into the hospital environment, their initial exposure to the paraphernalia surrounding medicalised birth can be profoundly disturbing:

...many students become stressed and confused, as their community experience fades and they struggle to reconcile their own developing philosophy of what a midwife is. (p 4)

As discussed in Chapter 4, Davies (1996) also makes a similar point. She argues that the definition of 'normality' in childbirth has been reconstructed in such a way that student midwives may suffer an identity crisis upon becoming qualified. Having been inculcated during their training with notions of birth as a 'normal life event', the discrepancy between theory and practice generates acute anxiety in those who are based in medicalised units to the extent that some are 'terrified' of working on labour ward. It is noteworthy that midwives in Shallow's (2001d) research also used the word 'terrified' in the same context. This also reflects the comments made by some of the midwife interviewees about this environment [see section 8.2]. Jenny, the Australian midwife, wrote:

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

Several of the British midwives also referred to what went on in the labour ward

using words such as 'brutality', 'assault' or 'abusive'. Sharon reported witnessing scenarios on labour ward (as a student midwife) in which she described feeling that women had been 'raped'. Interestingly, she said that since qualifying she had not encountered a similar situation. It is to be hoped that this was due to improvements in care in her particular unit rather than her becoming socialised into hospital culture and consequently blind to its impact. Labour ward is one of the environments in which the ethos of technomedicine is most keenly felt, and the perceived need to be actively managing birth conflicts strongly with the midwifery philosophy of watchful inaction. Rosie described her frustration with the lack of knowledge displayed by some doctors in her unit regarding the nature of 'normal' birth:

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

Despite the fact that midwifery has learned much from obstetrics, this has not been reciprocated. In the hospital environment particularly, midwifery knowledge is marginalised and rendered almost invisible (Shallow 2001c) by the dominant discourse of medicine. Midwives are required to become competent in, and rely on, medical technology rather than on the 'tricks of the trade' previous generations of midwives employed to facilitate normal birth (Stuart 2003).

Medicine has taught us basic processes about normal childbearing and a great deal about the abnormal. It has also taught us important things about what to do when things go wrong. Medicine, however, whilst deeply involved with how actively to adjust deviations from the parameters it has established, has little study of the extent of normality and how normality can be retained. Kirkham (1996 p182).

Arguably, it is not in the interest of medicine to support normality because this would be to undermine its own position of power. Furthermore, having the ability to define the boundaries of normality ensures that its hegemony is perpetuated.

The dominance of the technomedical model of birth has meant that many of the traditional midwifery skills have fallen into disuse as the identity of hospital-based midwifery has largely changed to that of 'obstetric nursing' (Donnison 1988; Thomas 2003) which has had far-reaching consequences for women. Weston (2005) describes how her community midwives, who had been '*confident and competent professionals*' when caring for her at home, '*became invisible under the bright hospital lights*'. Invisible midwives result in invisible women.

10.5.2 The demands of the organisation

Recent research reveals the immense pressure under which midwives work and the demoralising effect the organisation's demands have on their self-esteem. As was seen from the accounts of the midwives, working in the hospital environment was a continuous struggle to protect women from the influences of the production-line and medicalisation. Rhoda explained how the pressures of the low staffing levels in her unit impacted upon her practice, causing her to feel she was failing in her responsibility to the women, which was one of the reasons she avoided the labour ward environment:

It's just the level of the work, you know, you get thrown at you when you're down there [labour ward] so you end up looking after 2 or 3 women [...] a woman comes in perhaps quite frightened and ... needing some support and I felt able to give it for a certain amount of time and then I've been called away because something else is happening somewhere else and by the time I've gone back, they've just lost it really and I don't feel I can get them back on ... and you know, even if I did, it probably wouldn't last that long before I had to go again... Rhoda

Many of the midwives interviewed by Ball et al (2002) reported their frustration as their own needs for continuity, autonomy and respect were being constantly sacrificed on the altar of 'service needs':

The fact that I was working in an unfamiliar situation with no recent experience

did not seem to matter. I would still be castigated for not knowing. This totally undermines one's confidence, which is never high in a new and strange situation. In all my years as a midwife I had never felt so demoralised. I drove home sobbing, and felt I never wanted to set foot in that place again. (p 73)

They expected you to constantly rotate from ante, postnatal, community and labour ward, leaving you feeling continually disorientated. It all felt so chaotic and stressful. (p 61)

Kacary (2003), a midwife working in the NHS, highlights the impact this has upon midwives and the service they provide:

To attempt to make us all expert at everything is insanity. It will result only in nothing being very good and those of us who strive for excellence feeling dejected, frustrated and ultimately leaving a profession we entered with such high aspirations and idealism. But perhaps mediocrity is what the NHS does best.

At the time she wrote this, she was practising as a community midwife, but by 2004 she had left the NHS to become independent. Clearly, the move to independence was costly for her, but possible. Others who are unwilling or unable to take this option may find other ways in which to cope, such as seeking non-clinical posts or courses in further education (Ball et al 2002). Those remaining must either continue to 'fight their corner' daily, or, to some extent, submit to the demands of the institution and compromise.

Shallow's (2001d) paper on midwives' 'Confidence and competence' in the context of integration identified similar feelings in her interviewees. Midwives were obliged to alter their practice in order to be able to work in any area of maternity care at any time. This led to a lack of confidence which engendered fear and anxiety:

Where midwives had felt they had expertise before integration, they felt devalued and disempowered by the process. (Shallow 2001d p 238)

Anderson (2005) likens the practice of institutional midwifery to being a chess piece on a chessboard. As discussed earlier, the industrialised organisation actually requires the objectification of its workers in order to function most efficiently. This model fails to take into account the human need for companionship, collaboration and social interaction. Coping with change is acknowledged as hugely stressful (Schott 1996), but midwives working within this environment may be encountering it on an almost daily basis. The evidence shows that without the support provided by ongoing collegial relationships and the confidence which comes from working in a safe, familiar environment, they become demoralised and disempowered (Shallow 2001a-d; Ball et al 2002). Consequently, they will be in no position to empower the women in their care.

10.5.3 'Continuous midwife monitoring'

Just as surveillance and screening of pregnant women is focused on 'foreseeing pathology', so 'midwife monitoring' is designed to identify those who are not conforming with 'normality' thus ensuring that remedial action can be taken before the situation becomes unmanageable. As previously discussed, this was very much in evidence in the accounts of the midwives, who described themselves and their practice being scrutinised or criticised by colleagues. Kirkham's (1999) paper on the culture of midwifery in the National Health Service found that midwives felt that they were being 'policed' by their colleagues. Indeed, one of the respondents' accounts appeared to support this:

...she was brought in to be kept an eye on ... We were all told she was in for observation ... it was quite horrible for her ... we were meant to report her if we saw anything wrong with her practice ... I think she was brought in to be judged, not supported ... and it was expected, as her colleagues, that we would sneak on her... (p 736)

Worryingly, not only does this impact on the delivery of care in hospital but the effects are also being felt in the area of home birth. Rosie described how the hospital's policy on rupture of membranes to delivery time affected her home birth. Having not gone into active labour after spontaneously rupturing her

membranes she was warned that she would have to be admitted if she had not delivered within a certain time limit:

I felt slightly stressed that even in my home, the hospital managed to come in and ... dictate things. **Rosie**

Robinson (1997), reports that in her capacity as Honorary Research Officer of AIMS, she is aware of a rising number of complaints about the quality of care women receive at home, some women describing their experiences of home birth in terms of 'bad hospital birth at home'. She says:

We suspect that the midwife – probably rightly – feels that she is most likely going to be clobbered if she deviates from hospital norms, and this prevents her from providing the kind of care she and the woman would prefer...

Midwives and others, (for example, Savage 1986) who act as a thorn in the flesh of the organisation, are swiftly brought under control. As the midwife interviewees described, those who question the status quo or undermine the dominant culture may be censured and isolated by their peers or immediate superiors (Kirkham 1999; Ball et al 2002; Gould 2004; Hastie 2006). This acts as a deterrent to other would-be renegades. '*...it is the tall poppies who get their heads chopped off first*', observes Robinson (1998). '*Once they have disappeared, their colleagues scuttle into the shadows.*'

Horizontal violence and workplace bullying have been the subject of much debate and discussion in recent years (O'Driscoll 2000; Gould 2004; Leivers 2004; Mander 2004; Hastie 2006). According to Mander (2004) bullying thrives in large, 'caring' organisations and serves to prevent innovative and imaginative practice by ensuring that departures from the norm are quickly stifled. The devastating impact that workplace bullying has upon the lives of midwives cannot be underestimated. Midwives leave the profession (Ball et al 2002), suffer from depression and other psychiatric illnesses and even, as in the case of Jodie Wright, commit suicide (Hastie 2006).

On a larger scale, 'rogue' midwives are also brought to book and made examples of by more senior midwifery managers and those in the higher

echelons of the maternity service structure. As the ultimate threat to a pregnant woman is the loss of, or damage to, her unborn child, so is the threat of suspension to the midwife. Disciplinary action in the form of suspension not only means loss of reputation and identity but, to many midwives, their livelihood. Flint (2004) refers to the case of Deborah Hughes, a midwife who, unaware that the maternity unit had been closed, was suspended for assisting at the birth of a woman who was brought to a London hospital by ambulance in advanced labour. As Flint points out:

... she was suspended – just as she would have been if she had folded her arms and looked on while the woman struggled by herself.

Flint (2004) also refers to Paul Beland, a community midwife who suffered the same punishment when he attended a woman birthing at home after the local Health Authority had suspended their home birth service. Richards (1997) also gives an account of two midwives who were suspended for failing to adhere to trust policy when the woman they were attending at home refused to leave the birthing pool for the birth of her child. There was no suggestion of malpractice, the mother was happy with her care and her baby was born in good condition. It seems that disciplinary action in these cases may not have been solely about protecting the public, but about bringing wayward midwives to heel and thereby sending a clear message to other would-be renegades.

10.6 Risk and woman management

The concept of risk avoidance has also provided the organisation with a powerful means of controlling both women and midwives. The current focus on the fetus as a 'patient' in its own right has been facilitated by the invention and widespread use of fetal surveillance technology such as electronic fetal monitoring and ultrasonography. Consequently, in addition to protecting women from death, obstetrics has expanded its remit to become 'fetal champion' and now sees its role as '*defending the interests of the fetus against the interests of the mother*' (Bassett et al 2000 p 529).

As Hewson (2004) observes, the rhetoric used by maternity providers may be

that of choice and empowerment, but the measures deployed are increasingly authoritarian in nature. As seen in the opening scenario, women who attempt to stray beyond the borders of institutionally defined safety may be seen, and treated, as deviant or irresponsible. Healthcare professionals then feel justified in using 'worst case scenarios' to warn them of the consequences of their actions. In many cases however, the information consists only of the 'bad news', there is no attempt to balance the argument. Rosie (who was not a midwife at the time) describes meeting with a hospital doctor in order to request a home birth:

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

As Levy (1999 p 697) argues, information giving can be used as a '*strategy for behaviour modification*' rather than empowerment. This is often observed when women request home births. As referred to previously, Rhoda (one of the midwife interviewees) describes being effectively denied a home birth for her second child by her community midwife's threat that '*if you have this baby at home and it dies, it'll be your fault!*'

One woman in Edwards' (2005) study was first told by her midwives that she could not have a home birth because there were already two other women booked for home births in the month her baby was due. When she failed to concede, they then told her that she was ill informed and irresponsible. Finally, having exhausted their arsenal of small arms, they launched the ultimate deterrent and informed her that: '*her child might die and that she might bleed to death before help could arrive*' (p 20). That this is not an isolated incident is demonstrated in Howells' (2005) account of planning a home birth in Glasgow in which she was repeatedly cajoled, threatened and hampered in her attempts by midwives and managers who focused on the perceived risks of waterbirth. Howells reports that she is not alone in experiencing these problems in Glasgow as she is now being contacted regularly by women facing similar difficulties.

However, as Edwards (2005 p80) observes:

There are criticisms of risk as a concept, as well as criticisms about how obstetrics defines risk and what it omits to mention.

Certain risks tend to be emphasised while others may be minimised or ignored, depending on the standpoint of the professional. In my experience, women requesting vaginal birth at home after a previous caesarean section are invariably warned of the risk of uterine rupture whilst the higher risk of postpartum haemorrhage, to which all women are subject, is often not mentioned. Neither have I encountered any woman who was warned of the risks she might face when having a VBAC (vaginal birth after caesarean) in hospital: immobility through being connected to a fetal heart monitor, potential infection from a cannula site or from repeated vaginal examinations, not to mention the psychological sequelae. For women planning medically managed births the risk of iatrogenesis is rarely mooted. Abbott (2004) wryly puts forward suggestions for a written checklist on the risks and drawbacks of hospital births to be given to all women in the same way that women planning home births are regaled with precautionary information on their choice. AIMS (see Abbott 2004) comments on this:

We have yet to come across anyone who has been fully, or even partially, informed of the risks of a hospital birth.

Interestingly, Lowden (2007) comments that the recent RCOG guideline on 'Birth after caesarean' reveals their continuing doubts about the safety of vaginal birth following a caesarean section, despite evidence to the contrary. Whilst examining the document, she realised that 'trial of VBAC' was, in fact, seen as an intervention while a repeat elective caesarean section was considered to be the norm. Despite claims that practice is informed by, and based on, scientific evidence, some practitioners seem reluctant to accept findings which contradict long-held beliefs.

As was seen in the midwife interviewees' accounts, midwives working within the system are frequently faced with the impossible choice between compliance with the organisation and its treatment of birth as a risk-laden event, or the

betrayal of women and their own ideals. As Davies (1996) concludes, neither path leads to happiness:

When institutions embody fear of birth, and midwives working within these institutions try their best to cling onto a philosophy of birth as normal, a cruel division of loyalties results: the midwife as employee versus the midwife as supporter of women. It is too simplistic in this situation to blame individual midwives for not being more assertive. Which midwife working in a consultant unit has not experienced this conflict of split loyalty, where she has ended up feeling she has betrayed the woman for whom she was 'caring?' (p 286)

The threat of risk has proved to be greatly enhancing to the power of the organisation and obstetrics, by investing them with the role of 'fetal champions', depriving women of responsibility for their bodies and babies. Not only has it provided another focus away from the needs of women, but also an effective tool by which the organisation can bring about the compliance of women and midwives.

10.7 The separation of midwives and women

10.7.1 The assembly line

Much has been written of the negative impact industrialisation has had on the provision of healthcare, including the maternity services (Walsh 2007, Ritzer 1996; Wagner 1994). Davis-Floyd (1992) describes the hospital as 'a highly technocratic factory' (p55) and commentators have referred to the 'conveyor belt' or the 'process mentality' of large consultant units (Kirkham 2003; Kirkham 2005; Walsh 2007). As Taylor's words suggest (cited in Ritzer 1996), the system works best when served by workers possessing an ox-like mentality. The women's accounts indicated that individualised care was very important for them as survivors of CSA and as midwives. However, the effective functioning of the organisation based on the industrial model is threatened by users who demand individual treatment and workers who are innovative or act as individuals. Consequently, midwives who want to support women on their terms

rather than those of the organisation may, as referred to previously, be perceived as threatening and find themselves censured and isolated (Leap 1997; Hadikin and O'Driscoll 2000; Hastie 2006). As Stapleton et al (2002b) point out, it is much easier to 'go with the flow'.

The adoption of the industrial model by the healthcare services has brought about fragmentation. Whereas, in the past, one midwife would be responsible for one woman with whom she could form a relationship, today's maternity provision relies on care being provided by numerous individuals each responsible for their part on the conveyor belt. This paradigm has proved unpopular with both women and midwives (Ball et al 2002; Hunter 2005). After the publication of Changing Childbirth (Department of Health 1993) the problem of continuity in maternity care was ostensibly 'addressed' in many areas by the setting up of midwifery teams¹⁴. This however, has proved to be yet another example of the institution responding to women's needs on its own terms. The consensus of the respondents in Edward's research (1998) was that being cared for by a number of midwives does not in fact provide continuity and that merely meeting midwives does not equate with knowing them. Research suggests that women actually define continuity in terms of getting to know their midwives and the quality of their relationships (Edwards 1998; Tinkler and Quinney 1998; Farquhar et al 2000; Green et al 2000; Hindley 2005). The data from this study indicates that a one-to-one relationship with a carer is

¹⁴ Team midwifery was implemented as a response by maternity service managers to the aims of Changing Childbirth (Department of Health 1993). 'Traditional' community midwifery provided continuity during the antenatal and postnatal periods, but women were usually cared for by an unknown midwife during labour and birth in hospital. The Team Midwifery model was heavily influenced by the 'Know Your Midwife Scheme' (Flint 1991) and consisted of groups of midwives working together in both the community and hospital settings. This was intended to improve maternal satisfaction by providing continuity of care, (as opposed to carer) throughout pregnancy and birth. Thus it was hoped that the Changing Childbirth objective, that at least 75% of women should know the midwife attending their birth, (Department of Health 1993 p 17) would be achieved. Usually, women were assigned a named midwife but their care was shared between the members of the team. Some teams consisted of 6-8 midwives, but others were much larger and sometimes, hospital based (Page, Cooke and Percival 2000). However, the concept of 'knowing' the midwife was more often than not equated with merely having *met* her before.

considered a prerequisite for the building of trust destroyed by abuse and the minimising of the potential for re-traumatisation.

Unfortunately, it appears that the centrality of continuity of carer to the provision of maternity care has often gone unacknowledged and some initiatives designed with the aim of providing continuity have been discontinued (Page 1997). It could be suggested that the organisation is not wholeheartedly in favour of midwives forming relationships with women because women's needs then become the primary focus of care in preference to its own (Kirkham 2000).

10.7.2 Professionalisation of midwifery

The professionalisation of midwifery has had a profound impact on the relationship between midwives and women and although it implies autonomy and equity with other professions, in practice this is not the case (Kirkham 1996; Symon 1996; O'Connor 2001). As Kirkham (1996) observes, the relationship of midwifery with medicine has been enabling only for doctors. Furthermore, it has to some extent contributed to the separation of midwives and women, further enhancing the control of the organisation and medicine (Edwards 2005).

At the heart of midwifery lie feminine concepts concerned with relationship, reciprocity, 'being with', empathy and caring (Fleming 1996; Browne 2003) but, in order to survive, it has acquiesced to the medical profession and become subject to its domination (Donnison 1988). Sadly, the impact of being subsumed into a system which super-values objectivity, rationality and positivism, has been to place midwives in a confusing and frustrating position (Kirkham 1996; Kirkham 2000). Midwifery has failed to make its own definition of what professional midwifery might look like, and consequently has espoused itself to the medical paradigm. This, observes Wilkins (2000), is indicative of a person who is *'in possession of specialist abstract knowledge and thereby stands in privileged relation to his or her clients (p 30)*. Clearly this ethos has the effect of separating professionals from their clients and therefore hinders the midwife carrying out her traditional 'with woman' role (Kirkham 1996). Kerry, one of the midwife interviewees highlighted the impact of this when she said:

...professionalism for some midwives, obstetricians, means coldness, sticking

to the clinical aspects and not mixing in the personal and humanistic aspects of dealing with women. **Kerry**

This attitude was observed in the cold and unsympathetic attitudes of midwives and caregivers in some interviewees' accounts, often prompting them to find ways to avoid placing themselves in similar situations on subsequent occasions. The superior position expected of the professional in this model is incompatible with that of the traditional, egalitarian relationship between women and midwives (Symon 1996).

Woodward (1997) draws attention to the dichotomy involved in the concept of 'professional' caring and the tendency for 'instrumental' care (what is done by the practitioner) to be emphasised at the expense of 'expressive' care (the way in which it is done, which includes an emotional element). This imbalance was observed frequently in the accounts of the interviewees and resulted in the objectification of the individual in receipt of care. Sharon's interview was interesting in that it clearly demonstrated a dichotomy between her desire, as a midwife, to meet women's needs and her personal wish to 'get on' in midwifery. At the time of her interview she was fairly newly qualified and described how she used her junior status in order to avoid *'joining in that obstetric routine'*. When asked if she found it difficult to be part of the system she said:

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

It is interesting that she perceives 'the job' (i.e. her 'professional' responsibility) and providing care for the woman as separate issues. It could be argued from this that the scales were already tipping in favour of the 'needs of the job'. However, she was beginning to realise that, as she wanted to ascend the career ladder, her strategy to avoid compliance would have to be abandoned. Furthermore, she had discovered (to her surprise) that she enjoyed working in emergency situations on labour ward. When asked to specify exactly what she found enjoyable, she said:

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

It appears that these emergency situations may be directing her focus away from women's needs and possibly providing a 'legitimate' reason not to engage with clients. Her account demonstrates the powerful influence the medical and institutional paradigm has on midwifery practice and the ease with which women's needs may be eclipsed by other considerations.

10.7.3 The straightjacket of time constraints.

One of the most important aspects upon which effective midwifery care and 'successful' birth depend, is time. Traditionally, midwives saw their role as one in which they waited and watched with the birthing woman, supporting her through the twists and turns of labour until (usually) nature took its course. Birth was not seen as something to be interfered with and was never defined in terms of time. Women who have experienced normal childbirth often express surprise because their perception of time is altered during labour. This kind of time is defined as 'polychronic' by Hall (1984; quoted in Helman 2001 p23), in which *'personal relationships and interactions take precedence over the rigid schedules of the calendar and the clock. Time is not experienced as a line, but as a point at which relationships or events converge'*. This is expressed in the naturally altered state of consciousness which labouring women enter when not under the influence of anaesthesia and may also be associated with 'time distortion' spoken of by proponents of 'hypnobirthing' (Mongan 1998).

Birth, however, having become defined by obstetrics and confined by the institution, is now subject to monochronic (clock) time, in which time dictates the event. This kind of time is, according to Helman (2001 p23), *'a form of external social organization imposed on people, and is essential for the smooth functioning of industrial society'*. In the western world, it is a dominant feature of almost all medical institutions which, Helman suggests, may be the reason why

some patients perceive health care to be inhumane and impersonal. *'They and their families may see it as a way [of] avoiding human contact, of not dealing with their illness and the emotional reality of their situation'* (Helman 2001 p23).

Parkins (2004) in her article on the significance of time in the practice of slow living with reference to the Slow Food movement,¹⁵ observes: *'....having time for something means investing it with significance through attention and deliberation'* (p 364). Conversely, it could be argued that not having time or placing the emphasis on the temporal rather than the event is to take away its significance. Parkins draws attention to the centrality of 'care', (both caring for and caring about) to the meaning of 'attention'. By its emphasis on time and efficiency, the organisation gives little opportunity for true caring to take place, and has consequently stripped the act of giving birth of its significance.

The issue of time was prominent in the accounts the survivor midwives gave when speaking about what they felt was good practice. Time formed the 'growing medium' in which good care, women, and midwives could blossom and flourish. Information giving, explanations, doing procedures slowly and carefully and being prepared to stop are all time consuming. Forming a relationship with women and their partners in order to understand what is important to them is time consuming. Building up damaged trust takes time. Midwives and women spending time together and getting to know one another is at the heart of women's satisfaction with maternity provision which provides continuity of carer (Tinkler and Quinney 1998; Walsh 1999; Green et al 2000; Pairman 2000; Rosser 2003).

Time, or lack of it, is one of the major reasons why midwives are leaving clinical midwifery because they feel that they are prevented from giving women the support they need (Ball et al 2002). Midwives are expressing their frustration and distress because they feel they are failing women and not living up to their own ideals. Tellier (2003) describes her reasons for leaving midwifery after practising for only two years:

¹⁵ The Slow Food movement, which is based in Italy, was formed in 1986 in response to McDonald's plans to open an outlet in Rome. It provides financial support for small local growers and artisans around the world to encourage the preservation and maintenance of traditional foods and promotes slowness as a critical response to the globalised culture of fast food.

We had the same worries as any midwife: looking after two women on labour ward if you are lucky, or it's three and 'take that APH' as well. You feel that you are putting people's lives at risk. [...] I wanted to stay in there and do my best but I didn't feel I was good enough. (p 4)

Wells (2003) in her article entitled 'Leaving the Conveyor Belt' explains that, despite the fact that she was 'passionate about midwifery', because of the excessive demands placed upon her she was prevented from providing families with the kind of midwifery care she wanted to give and which they deserved. She described herself leaving the hospital at the end of each shift '*feeling drained, dehydrated, and hoping that something vital hasn't been forgotten*'.

Sadly, this situation is being played out in over-stretched consultant units across the country on a daily basis. Midwives, and others at the lower end of the organisational hierarchy, have minimal control over their time and workload and consequently, are severely limited in the way in which they can practise.

Practising as a midwife has changed from spending an appropriate amount of time to give the best possible care to the individual mother and her baby, to running from one woman to the next, whilst thinking about the one after. No time for building relationships and giving the care necessary in real midwifery, rather than just cost effective care.

E grade hospital midwife (Ball et al 2002 p59)

It is clear that many midwives working in this way are unhappy with this state of affairs but spend their time at work just trying to survive. My own experience strongly reflects those quoted above. I would personally compare my time working in a large consultant unit with being held underwater and breaking the surface occasionally just long enough to snatch enough air to carry on. As Parkins (2004) points out, '*The more time one has available to think, reflect and evaluate, the greater the possibility for either more fully committing to one's tasks or, more likely, changing one's practices habits and ideas.*' (p 376)

It could be argued that maintaining a high level of activity is advantageous to the organisation because workers consequently have no opportunity or inclination to question or pose a threat. The system is more comfortable with the

automaton than with the autonomous.

As pointed out in Chapter 8, midwives who continue to work within the system struggle to find ways in which they can 'manipulate' time constraints to prevent labouring women from becoming subject to obstetric 'attention'. This was also discussed by one of Russell's (2007) midwife interviewees who said:

Unofficially I do fight my corner virtually every day because everybody is nine centimetres for a couple of hours because there is always a bit of an anterior lip to be found somewhere. (p 129)

Both the industrialised hospital system and the medical culture within it function in 'monochronic' or linear time. Birth exists in a different time continuum altogether. This situation is best demonstrated by the modern cinematographic technique in which the subject is 'freeze framed' whilst its surroundings are moving at speed. The incompatibility between the two has resulted in damage to women, midwives and the ancient art of midwifery.

10.8 The disempowerment of women

10.8.1 Separation from social context

As discussed in Chapter 1, birth has been removed from its original context; the home and the heart of the community of women, and now takes place, largely, in the isolation of hospital. Consequently, birthing women have ceased to be at the centre of the event, in an environment where they are familiar with the social structure and function, and are thrust into an alien culture characterised by very different social norms. The sense of being in an alien environment emerged strongly from the women's accounts of traumatic birth in hospital, even from those who were midwives. I asked Kerry whether she felt her familiarity with and pre-knowledge of the hospital system had empowered her as a birthing woman. She replied:

It disempowered me, because I was the bed-maker, because I was a member of staff so denied even the cup of tea in the bed that the other women got. No, it

didn't help me. [...] Probably, my shame and my re-abuse is the way I term that experience, was impacted more upon by being, um ... being in a place that I didn't feel I could trust. **Kerry**

It seems that, despite her familiarity with the hospital, she did not consider it to be a place of safety. Furthermore, it appears that her status as a midwife in her own hospital blinded her colleagues to the fact that she was a new mother in need of care and comfort.

Women birthing in the institutional environment are separated from familiar surroundings, family, and social support and disempowered by virtue of being on someone else's territory where others make the rules and are conversant with the functioning of the organisation (Richards 1978; Kirkham 1989). This was seen in the reaction of the husband of the woman whom I transferred to hospital in labour [see Chapter 1].

Hospitals often place strict limits on the number of birth partners who can attend at any one time (Warren 2006) and in certain cases women may even be separated from their husbands/partners (as were several of the interviewees in this study). They are thereby deprived of those who might act in the capacity of advocate and pose a challenge to organisational authority. This may have resonance for the survivor of sexual abuse who, during the period in which the abuse was taking place, may have found herself powerless, separated from those who were in a position to act protectively.

10.8.2 Negation of women's knowledge

As discussed in Chapter 1, the Enlightenment brought about a radical change in thinking and men became increasingly concerned with the mastery of the natural world, perceiving that this would give them control over their own destiny. Childbirth, under the auspices of the institution and the medical profession, has been stripped of its former spiritual, social and mystical properties. All other influences having been removed, obstetrics now claims to have the 'authoritative voice' in the realm of childbearing. Jordan (1997) points out that:

A consequence of the legitimisation of one kind of knowing as authoritative is the devaluation, often the dismissal, of all other kinds of knowing. Those who espouse alternative knowledge systems then tend to be seen as backward, ignorant, and naive, or worse simply as troublemakers. (p 56)

Clearly, this applies to both midwifery and women's knowledge, which being enshrined in feminine ideals and ways of thinking, are alien to the prevailing Cartesian mode of thought. The concept of technomedicine (Davis-Floyd and Mather 2002), which now characterises maternity care, assumes that the woman has:

...nothing useful to tell about her body or the birth and that only the machines and medical gatekeepers have the knowledge necessary to produce a healthy baby... (Trevathan 1997 p83).

This assumption clearly lay behind the reactions of the hospital doctor towards my client and myself (described in the reflection), as well as in scenarios such as that recounted by Lynne whose labour pains were discounted in favour of the 'scientific' data produced by a non-functioning tocograph. Georges (1997), in her research into fetal ultrasound imaging in Greece, highlights the role that ultrasonography has in facilitating the production and enactment of authoritative knowledge. She recounts a scenario in which a doctor uses the ultrasound machine to discredit the information given by a pregnant woman, substituting his own, 'machine-derived knowledge' thus enabling him to:

reinforce her place in the broader system of patriarchal and hierarchical social relations within which the medical encounter is embedded. (p104).

As was demonstrated in Rosie's and Susannah's anecdotes [see section 8.4.5], the biomedical model of birth relies on the 'expert', (i.e. the practitioner), rather than the woman, to 'diagnose' and legitimise not only pregnancy itself but also the various stages of labour (Katz-Rothman 1996). It places a strong emphasis on the role of the professional as decision-maker and action-taker, whereas the woman is expected to be passive and accepting (Jordan 1997; Shildrick 1997).

Jordan (1997) gives a fascinating insight into this in her description of a birth that took place in a highly technological US hospital. The woman's labour was being videotaped and Jordan was present as an observer taking part in a large research project on the dynamics of care during the second stage of labour. She describes how the woman makes it clear to her carer (a 'nurse technician') that she has the urge to push. However, protocol dictates that a doctor must confirm that she is ready to push and then perform the delivery, but he does not appear despite being paged several times. The woman becomes increasingly distressed but is not allowed to follow her body's urgent promptings without being given 'permission' by the doctor. Both her knowledge, and that of her carer, count for nothing in an environment where medical knowledge is the only authority.

To some extent, the maternity carer's response may be somewhat predictable, being in the United States where midwives have even less autonomy than in Britain. However, a similar scenario is described by a British woman during her first birth, in hospital (Weston 2005):

All of a sudden, at the darkest hour I felt it....it was like a pop inside, my contraction felt different and I felt that maybe this baby was going to be born! The midwife was summoned. 'I think I want to push,' I told her. I was examined. 'You are 10 cms, but let a doctor check you.' I was surprised but asked: 'where is the doctor? When will he be here?' 'About 15 minutes', came the reply. I said to the midwife, 'I have waited 24 hours to have this baby. I am not waiting any longer. You are a midwife! Do your job!' (p 6)

Fortunately, despite being in the vulnerable position of labour, Weston was able to assert herself and make her needs known. Arguably, most labouring women would not feel able to challenge their caregivers in this way, particularly if they have been subjected to sexual abuse.

The medical expert model usually ensures that the authoritative voice of the medical profession goes un-challenged, and the efficacy of its practice is often taken for granted. However, Wagner (1997) recounts how a perinatal study group he set up to evaluate maternity services in Europe discovered a large gap between science and practice. They then recruited a scientist from outside their

group to survey routine obstetric practices, who drew the staggering conclusion from her research that only around 10 percent of all routine obstetrical procedures had adequate scientific basis (Fraser 1983, cited in Wagner 1997). This, and other findings, says Wagner (1997 p370) *'... went a long way to disenchant me not only with 'authoritative knowledge' but with authoritative practice as well.'*

Arguably, to some extent, this problem has been addressed by the issuing of National Institute for Clinical Excellence (NICE) guidelines, which have been somewhat of a mixed blessing, but do at least provide some evidence on which to base practice. However, Walsh (2001) points out that the first draft of the clinical guidelines for electronic fetal monitoring commissioned by NICE failed to endorse intermittent auscultation for monitoring low risk women in labour because: *'it was felt that midwives had become so deskilled that it would be too expensive to retrain them again!'* (p 54). It appears that NICE guidelines may be increasingly influenced by financial concerns, rather than clinical efficacy alone.

10.8.3 Medically controlled birth

The picture of birth in hospital today is a very different one from that which was the norm throughout most of history. Gone are the gossips and the female attendants with their birth stories providing comfort and encouragement to the woman, to be replaced by a 'gaggle' of guidelines. These may provide comfort and encouragement to the medical profession, but frequently cause anxiety and discouragement to women. In this environment birthing women are provided with pharmaceutical pain relief, medical technology and a midwife who, (as recounted by Rhoda – see p 269 section 10.5.2) sometimes may have to share her time between several other women. In the current climate of staff shortages, fragmentation and emphasis on time/resource management, it is almost impossible for the lone midwife to provide the degree of emotional support women in normal physiological labour may require. It is therefore not surprising that midwives may *'take the analgesia/anaesthetic approach'* (Hughes 2003), and this was demonstrated in some of the interviewees' accounts; two reporting being given Pethidine without their consent and two being pressurised to consent to epidural anaesthesia. The impact of medicalised birth was

particularly in evidence in Rosie's account of her first birth [see pp 195-6]. No-one took the time, on admission, to explain to her the usual timescale of a first labour, she was consequently given diamorphine too early, which, she explained, had the effect of slowing labour; because labour was progressing slowly she requested an epidural in order to sleep. This further impeded progress which was then countered by the siting of a syntocinon infusion. The end result was an experience in which one of her few memories was feeling *'completely out of control'*.

Arguably, the epidural provides a very effective form of control for the organisation and is an example of the symbiotic relationship between the medical profession and the institution. Medical science provides the required technology which enhances the efficiency of the organisation. Epidural anaesthesia not only separates the woman from experiencing the natural sensations of labour, but effectively frees the organisation from many of the 'painful' manifestations of the event which might hinder the smooth running of the machine. It also prevents the woman receiving the messages her body is conveying concerning the birth process. Instead, the progress of labour is recorded and monitored by machines which hinder her mobility. Consequently, medical science provides synthetic hormones in order to 'enhance' the contractions weakened by immobility. The urge to push her baby out of the birth canal may also be compromised, if not absent. Obstetrics treats this deficiency with a ventouse machine or forceps.

Under the influence of the epidural, a birthing woman is obliged to rely on others. It could, perhaps, be described as medically induced dissociation for both the woman and her carers. Just as the sexually abused child is enabled to cope by separating mind and body, so the labouring woman becomes unaware of what is taking place in her body and can therefore continue functioning as if nothing were happening. Her carers are spared the unruly and emotionally demanding nature of birth. The midwife can 'do her job' unhindered by the need to expend emotional energy supporting her client. She may even be able to take responsibility for more than one woman, therefore increasing efficiency. This is a far cry from the concept of the lone sailor navigating her way through untameable seas, her midwife alongside her providing encouragement, support and comfort. The technomedical model of birth reduces the woman to the status

of a passenger, which is greatly beneficial to the smooth running of the system, and therefore, highly desirable to those responsible for it.

Data from this study suggests that, on occasions, epidurals and pharmaceutical forms of pain relief may be actively promoted by caregivers in conflict with women's own wishes; this is also supported by other anecdotal evidence (Kitzinger, S 1992; Arms 1994). Although there is no denying the usefulness of the epidural in certain circumstances, this study, and other research (Kitzinger, S 2006a), indicates that women affected by CSA may find that the feelings of powerlessness they experience associated with epidural anaesthesia and the resultant medicalisation of their birth, can reflect their experiences of abuse.

10.8.4 Depersonalisation

As was seen in several of the accounts, the concept of being subjected to medical scrutiny may be particularly distressing for survivors of CSA as it has connotations of voyeurism. Lynne referred to the objectification of being 'stared at' in a medical context as likely to trigger memories of her abuse [see p146].

Lopez-Dawson (1999) and Kitzinger, J (1992) both make the link between the 'watching' and 'observing' elements of maternity care and voyeurism.

Being watched by a crowd of medical students who are never introduced or being examined by a doctor who never even looks at her face can remind a woman of voyeuristic elements of abuse. Kitzinger, J (1992 p219).

This scenario is very similar to Jo's account of an incident in her first pregnancy when she was given a vaginal examination by a consultant surrounded by medical students. Watching, in this context, implies scientific or educational interest, in which the individual has little or no significance. It is consequently dehumanising and reminiscent of the abuser/victim relationship. This was also highlighted by the accounts of the interviewees in this study who, as referred to in Chapter 7, described attendants focusing on their genitalia whilst at the same time ignoring them. They were unanimous in their opinion that it was this type of objectification which caused them to perceive their treatment as abusive. Intimate procedures undertaken by carers who showed kindness, respect and

consideration were not problematic. This is supported by other literature on maternity care for survivors of sexual abuse (Rose 1992; Chalfen 1993; Tidy 1996; Waymire 1997; Aldcroft 2001; Rouf 2003; Scalzo 2003; Hobbins 2004; Weinstein and Verny 2004)

The impact of the medically led and process-driven hospital environment can be to render maternity workers impervious to women's needs for privacy and dignity. The interviewees' accounts of staff wandering in and out of the room whilst their damaged perineae were 'on display'; Kerry's 'final humiliation' [see pp204]; Sally's recollections of caregivers entering her bed space without permission; maternity workers grabbing women's breasts, are a testimony to this. As discussed in Chapter 7, humiliation is prominent in situations of torture, violation and abuse. For women who have suffered the shame and humiliation of CSA this may be devastating. For women who have not, it may be a traumagenic factor resulting in birth-related PTSD.

10.9 Institutionalised childbirth and sexual abuse

***'... sexual abuse is all about power, not sex.'* Susannah**

As discussed in chapter 1, there has been much talk recently of improving the delivery of maternity care and the issue of offering more choice to birthing women is highly visible. There has also been some emphasis on making cosmetic changes to the hospital environment, rendering it less clinical and more homely (Edwards 2003b). In recent years antenatal care has been made more accessible by placing it predominantly in the community. However, as was pointed out in chapter 7, [section 7.3], despite some changes for the better, it appears, comparing the more recent birth accounts with those of 20 or 30 years ago, that the power of the institution and medicine over women and birth remains largely unaltered. It is merely expressed in different ways.

Clearly, giving birth in an environment in which she is stripped of power, dignity and her personal identity can have deep resonance for a woman who has suffered CSA. There are direct parallels between sexual abuse and the 'processing' of women in today's highly technocratic maternity services. Consequently, many of the interviewees found themselves re-experiencing their

abuse in the hands of the 'system'. Midwives, who might be expected to provide support, nurture and protection for them have become increasingly powerless, dominated by the medical paradigm and the organisation in which the majority of them work. From both groups of women there is a tangible sense of betrayal. The message which emerged strongly from the accounts of survivors is that they need to be treated as individuals, involved in decision-making, and to form relationships with their caregivers. They expected practitioners to be competent clinically but equally, expected them to show warmth, good communication skills and genuine interest in them. Unfortunately, this takes time and effort on the part of clinicians who, especially when under pressure to maintain throughput, may not have the time or the inclination. Rhodes and Hutchinson (1994) report that they elicited the opinions of several midwives and a physician when proposing to undertake their research into the labour experiences of survivors of CSA. When asked how being well informed about sexual abuse would change labour 'management', one elaborated:

I really don't have time to open this can of worms. It takes long enough to get through a prenatal visit without taking on the job of social worker. (p 219)

This comment reveals a task-oriented and institutionalised attitude to care provision, in which the psychological and emotional needs of clients are seen as largely irrelevant. Clearly, this person (the researchers do not specify whether this was a midwife or the physician) feels that taking individual needs into consideration is not part of his/her role. This would appear to reflect the attitude of the doctor in my vignette who, despite being in possession of information that should have influenced his practice, appeared unwilling to allow it to alter his behaviour. It is far easier to rely on following protocols and policies, enacting routines and rituals, than to engage with people as individuals. Furthermore, it enables the professional to retain their position of power. It is likely that the majority of survivors who pass through the NHS system are either unwilling or unable to disclose their history. Consequently, health carers with this mind-set, encountering women who react unexpectedly or who appear excessively demanding, may dismiss them as merely being awkward, as did some of the midwives in the scenario which first aroused Maggie Smith's interest in the plight of survivors giving birth. This may result in the perpetration of 'childbirth

abuse’.

10.10 Everywoman

To Page’s (1997) observation that what is best for midwives is also best for women, I would add, *‘what is best for midwives and women, is also best for survivors’*. Survivors should not be perceived as an alien race requiring special treatment and making unreasonable demands. They are normal women, who have been subject to abnormal experiences leaving them vulnerable to psychological harm and emotional difficulties. Their response to trauma is only that which could be expected of any other human being in similar circumstances. Maternity care provision should be such that it is appropriate for any woman; regardless of her background, circumstances or history, as Gutteridge (2001) suggests:

*The service provision for child-bearing women needs to be sensitive to the fragility of the unseen ‘layers’ that are part of every woman. **The system must assume to treat every woman as though she has some emotional trauma.** If this were the case, those women who are living in fear of undisclosed sexual abuse may be saved some of those feelings that might catapult them back to that helpless child.* (p 315, my emphasis)

If all childbearing women were treated with respect, dignity, kindness and consideration, then the issues around disclosure might be irrelevant, and far fewer women would be coming away from childbirth emotionally scarred and traumatised.

10.11 What are the alternatives?

As we have seen, the industrialised hierarchical model on which institutional maternity provision is based is unhelpful to women and midwives. There are, however, alternatives to the ‘traditional’ hospital maternity care model such as Midwife-Led Units (MLUs) and Free Standing Birthing Units (FSBCs), caseload midwifery, Independent Midwifery care, and birth at home. As discussed in

Chapter 7, the interviewees in this study found an alternative in home birth in order to avoid the aspects of hospital care which they found unacceptable.

10.11.1 Home birth

It would appear that the social context of birth is very important to survivors of sexual abuse, as demonstrated by the number of home births experienced by the interviewees. Edwards (2005), in her study on women planning home birth observed that for them, *'Home was a metaphor for control and connection and hospital a metaphor for loss of control and separation'* (p17). Similarly, the most frequently cited reason for the interviewees in this study to choose home birth was that of control. Here they would be able to remain connected to their own social support networks, surrounded by all that was familiar and helpful to them. Home was a place of safety where they would have the power to decide what was done to them and their attendants would be in the position of guests on their territory. Ogden et al (1997) in their research on the impact of home birth on women also identify 'control' as playing an important part in women's memories of the event. One of their respondents closely echoed Ruth's opinion [see pp 221-2]:

...the fact that it is in your home is very important because it is your environment and the people who are there come into your home so they are not in control. (Ogden et al 1997 p 210)

Many women, however, continue to encounter difficulties achieving home birth under NHS care. The recent NMC document 8-2006 (NMC 2006), identified the most common barriers to women accessing home birth as: confidence and competence of midwives; perceived conflict between risk and a woman's choice; and lack of resources. Despite the fact that women's right to choose home birth has been repeatedly prominent in government documents (Department of Health 1993; Department of Health 2004) and although midwives have a duty of care towards women birthing at home, it appears that obstacles are frequently placed in the way of women who plan home birth. This was borne out by some of the interviewees' accounts in this study, as well as

the work of Edwards (2005) and also by the stories of women who responded to a request by AIMS (Association for Improvements in the Maternity Services) for descriptions of the various 'challenges' they had encountered when booking a home birth. The difficulties they experienced ranged from being restricted to a certain narrow time frame, through being accused of selfishly putting undue strain on overworked midwives, to the woman who was told, when she went into labour, that there was no midwife to attend her at home (AIMS 2006). Many of my clients come to me having fought long and hard to procure an NHS home birth, jumped through innumerable hoops, been bombarded with stern warnings from numerous health professionals but not having achieved their aim.

10.11.2 Midwife-led units and free-standing birth centres

Home birth however, is not appropriate or desirable for all women, and there are alternative birthing environments which offer a holistic approach to care and promote equitable relationships between client and clinician. Although none of the interviewees had experience of these (they either gave birth in consultant units or at home), it is important, in the light of the findings of this study, that they should be discussed.

Some midwife-led units may share the same premises as an obstetrically-led unit and are often in close proximity within the hospital. Free-standing birth centres are midwife-led units that are geographically remote from the consultant unit to which they are usually linked. Both have been set up with the intention of providing a midwife-led model of care as distinct from the type of midwifery care which is delivered within the framework of the technocratic institution. According to Hodnett et al (2005) in their systematic review, MLUs are associated with a reduction in medical interventions and increased maternal satisfaction.

There is some debate around what actually defines midwife-led care and as Hughes and Deery (2002) point out, much of the literature on the subject focuses on policies, protocols, booking and exclusion criteria, or neonatal and maternal outcomes rather than a description of the characteristics of this model of care. Walsh (1997) provides an operational definition, discussing issues such as midwives taking responsibility for assessing risk of newly booked women and the importance of the relationship between midwives and obstetricians. Hatem

et al (2004) however, define it as being *'based on a philosophy of pregnancy and birth as normal physiological processes. Its focus is on the promotion of normality and psychosocial support'* (p1-2). It is this that forms the bedrock upon which the midwife-led model of care is founded, and the outworking of this was observed in many ways by Walsh (2007) in his study on an FSBC. He describes how his pre-conditioned notions of maternity care were profoundly challenged by a model that was not based on the 'process mentality'. Very early on in his study he wrote in his diary:

I can see already that the quality of the interactions among the staff, and between the staff and the the women, is different but I just feel it's not fair that they can do this and other midwives can't. Should they just increase the throughput a bit so that there is more stuff to do? (p52)

He also identified that an absence of hierarchy characterised this birthing environment. Fairtlough (2005) poses a very pertinent question when discussing the effectiveness of the heirarchical model of management:

Would you rather have the plant operated by trained professionals, for whom pride in safe working is part of their personal identity, or by people who only work safely because they are afraid of the boss? The identification of discipline with hierarchy is a mistake - a dangerous mistake. Actually it's the professionalism of the workforce that matters. (p 18)

As this comment implies, environments which encourage this kind of ownership and personal responsibility for good practice are framed within a structure which is non-hierarchical and empowering to the individuals working within it. The result is a workforce that functions safely, efficiently and takes pride in providing a good service.

Reading Walsh's (2007) thought-provoking book, one is struck by the passionate degree of ownership clearly felt by the staff. If a room needed decorating, members of staff would hunt for bargains which they could use in the project. Midwives converted a disused storeroom into a complementary therapy room in a single day and would bring in their own items in order to

make the centre more homely for the women. In this environment birth was, in Walsh's words, 'taken off the assembly line', each woman treated as an individual, each labour acknowledged as unique. One particularly striking anecdote concerns a woman who, having been admitted during labour, decided to go out with her husband to the local rugby club 'do':

She says 'I think I would just rather go and be with him' so she went and sat with him at the rugby club do. He's doing the DJing and she is at the back, sitting down and while all that's going on she is obviously quietly labouring because when she comes back at 12.30 am, she delivers, so she's fully dilated when she gets back into the unit after being out there with her hubby. (p55)

This story, which would probably cause apoplexy in obstetric and risk management circles, serves to demonstrate the huge gulf which exists between the midwifery and technomedical philosophies of birth. As Walsh (2007) points out, it has important implications about trust: for the woman, that she will accurately interpret her body's signals; and between the woman and her caregivers. Furthermore, it indicates the midwives' willingness to place control into the hands of the woman with the acknowledgement that she is the expert when it comes to her labour and her body.

There is a good deal of evidence to say that midwives function best and are happiest when able to work autonomously and provide woman-centred care (Hundley et al 1995). The MLU and FSBC have, for many years, provided midwives with an opportunity to work in this way and offered women the chance to give birth in an environment which is focused on their needs. The evidence suggests that both women and midwives greatly value maternity care delivered in this way (Dunlop 2001; Rosser 2001; Kirkham 2003; Robotham and Hunt 2006). This type of birth environment, which promotes individualised care by empowered and motivated midwives and encourages equitable relationships, would appear to be eminently suitable for survivors of sexual abuse.

10.11.3 Case load, or one-to-one midwifery

This model enables midwives to provide women with continuity of carer

throughout pregnancy, birth and the postnatal period by carrying their own case load. Midwives often work in partnerships, usually within groups of 6-8 individuals, and are commonly responsible for around 40 high- and low-risk clients per year, attending births at home or in hospital as appropriate. It is an approach which enables care to be woman-centred and individualised, whilst giving midwives a good deal of flexibility in their working patterns. *'In case load practice'*, observe Stevens and McCourt (2002a), *'the parameters are defined by the actual case load, not the institution...'* (p 46)

In their evaluation of midwives' perceptions of the first one-to-one scheme to be set up, in response to the recommendations of Changing Childbirth (Department of Health 1993), they found that clinicians appreciated this way of working because they experienced a high degree of autonomy, and were enabled to practise what they described as 'real midwifery' (Stevens and McCourt 2001; Stevens and McCourt 2002 a-c).

Page et al (2001) in their study comparing the clinical outcomes of this one-to-one scheme with those of 'standard' care found a reduced level of caesarean section and assisted deliveries, lower uptake of epidural anaesthesia and a reduction in the numbers of episiotomies amongst the women cared for by one-to-one midwives. According to Andrews et al (2006), in their review of case load midwifery, these findings have been replicated repeatedly by other research.

In their review of the evidence regarding women's opinion about continuity of carer Green et al (2000) found that women generally gave having a 'known' intrapartum carer a low priority, placing the emphasis on consistent caregivers whom they could trust. Walsh (1999), in his study of women who had experienced both 'standard' care and one-to-one midwifery, found that women placed great value on being cared for by a known midwife, with whom they had developed a trusting relationship. Furthermore, Sandall et al (2001) report that women cared for by the Albany Midwifery Practice (AMP), rated their midwives as 'kinder, warmer and less rushed' than other practice midwives (p 3). Women giving birth under AMP care also experienced fewer interventions, assisted and operative births than those receiving standard care. Neonatal outcomes were comparable in both groups but AMP care proved to be more efficient in terms of bed occupancy as these women had fewer antenatal admissions and were discharged earlier postnatally (Sandall et al 2001). Bearing in mind what the

interviewees in this study said about individualised relational care and continuity of carer, it would appear that case load midwifery would be welcomed by survivors of CSA.

10.11.4 Alternatives, but not available to all women

MLUs, FSBCs and one-to-one midwifery schemes however, do not exist in all areas of the country and despite their popularity, many have been terminated along with other apparently successful midwife-led initiatives (Page 1997; Lee 2001; Walsh 2002; Bones 2005; Gould 2006; Robotham and Hunt 2006). Ostensibly, the reason given is financial, and undoubtedly, this does have a huge influence, but Page (1997) argues that often the reluctance to continue with innovative practices stems from the 'fear of excellence'. Because these schemes are seen to create a situation of inequity in the service, it is considered preferable to return to the mediocre *status quo* rather than attempting to raise the general standard for all women. Regardless of the evidence which demonstrates the success of these small practices (Rosser 2003), and despite public support, many MLUs have already closed and the majority of those remaining are continually under threat. As Robotham and Hunt (2006 p376) comment:

It's [closure of MLUs] allowed to happen because it occurs in isolation [...] there is no one authority with real power protecting MLUs as a whole, despite the overwhelming evidence and continual government edicts that say MLUs are a good thing.

Furthermore, despite all the recent rhetoric about choice and the benefits of small midwife-led units, in September 2006 the new Chief executive for the NHS, David Nicholson, caused anger and disbelief in midwifery circles by announcing that he planned to 'redesign' and 'improve' healthcare by concentrating key services into fewer hospitals. There would be up to sixty 'reconfigurations' scheduled to take place before the next general election which would mean a wave of closures of smaller maternity units as well as Accident and Emergency Departments (Carvel 2006). Moves such as these are

generally welcomed by the medical profession because they enhance its already dominant position (Gould 2006).

The Royal College of Midwives has also warned recently that the government's failure to increase midwife numbers demonstrates that midwives are no longer seen as a priority (Royal College of Midwives 2006). Furthermore, the fact that the government has declined to back the 'One Mother One Midwife' campaign at a national level (AIMS 2007), suggests that this is not considered sufficiently important.

Inevitably, dwindling midwife numbers and centralisation will lead to women having even less choice and control over where and how they give birth and will bring midwives further under medical and institutional control. Midwives are leaving their profession because they no longer feel they can practise in today's medically controlled, financially driven maternity services (Ball et al 2002). Sadly, the ability to 'opt out' of the system is not open to the majority of pregnant and birthing women and the current plans for centralisation means alternatives are becoming rarer.

10.11.5 Independent midwifery

Independent midwifery practice is characterised by case loading and the provision of one-to-one care, but is practised by midwives who have stepped outside of the NHS. They may work as individuals, pairs or small groups. Some women may choose to 'opt out' of the system by booking the services of an independent midwife (IM). However, this option is not, in practice, available to all women, partly because of the financial considerations involved, but also because of the scarcity of IMs in some areas. Furthermore, at the time of writing, the future of independent midwifery is uncertain owing to the government's decision to make indemnity insurance mandatory (details on www.saveindependentmidwifery.org)¹⁶. Moreover, because it offers an alternative to both women and midwives, and is to some extent outside the control of local authority NHS maternity providers, it is perceived as a threat by

¹⁶ Even despite this, IM numbers are increasing dramatically in some areas as more midwives are leaving the NHS in order to be able to practise more autonomously and give the quality of care that they are unable to provide under the auspices of the mainstream maternity services.

some obstetricians and senior managers. Consequently, individual midwives have been subject to apparently unwarranted disciplinary action. Several have been suspended and obliged to fight lengthy and expensive legal battles in order to survive (Beech and Thomas 1999; Kitzinger, S 1999; Mander and Fleming 2002; AIMS 2004).

From a global perspective, Wagner (1995) describes the 'witch hunt' against home birth midwives and those who have a non-conformist involvement in birth as, *'part of a global struggle for control of maternity services, the key issues being money, power, sex, and choice'*. He states that in the previous 10 years he had been asked to consult or testify in twenty cases across the globe at investigations into the practice of health professionals. Alarming, 70% were midwives and 85% were women. It appears that the struggle which began in the seventeenth century with the advent of male midwifery is set to continue while women and midwives strive to assert their right to unadulterated birth.

10.12 Summary

It appears that the industrialised and medicalised ethos of the maternity services (particularly embodied in large consultant units) militates against women experiencing birth as an empowering and positive experience. Women with, and without, histories of CSA may emerge from their experience of birth in this environment traumatised and suffer long-term psychological problems. This chapter has focused on the reasons which may lie behind this.

The responsibility for birth has been claimed by obstetrics, which has redefined it in terms of a medical event and the role of the midwife under the dominance of the medical profession has become that of obstetric nurse. Midwives are further disempowered by working within an environment which is strongly influenced by the industrial model, in which they are expected to work like cogs in a machine, or the ox described by Taylor (cited in Ritzer 1996).

The medical and organisational emphasis on risk avoidance also proves to be a means by which both women and midwives are controlled and brought into line. Information concerning risk is often delivered in a threatening manner and may be based on practitioners' personal beliefs rather than solid research evidence. Women and midwives have become separated both by the fragmented nature

of care and the professionalisation of midwifery. Rather than defining professionalism in midwifery terms, it has, to some extent, accepted the male oriented model of medical professionalism with its emphasis on the 'expert' with his/her superior knowledge and position.

The institution has also defined and confined birth in terms of linear time, thus stripping it, and birthing women, of their significance. Spending time with women lies at the heart of good midwifery practice and is particularly pertinent in providing care for survivors of sexual abuse.

Institutionalised birth has also disempowered women by removing them from their social context, negating their knowledge by the 'authoritative knowledge' of medicine, and 'managing' the process of reproduction using medical technology. Moreover, women and their bodies are subjected to intense scrutiny during pregnancy and birth, which can be perceived as depersonalising and voyeuristic. Furthermore, the process-driven hospital environment may cause women to suffer a loss of privacy and dignity.

Alternatives do exist, but, despite the rhetoric concerning women's right to choose where and how they give birth, many are either under threat or not accessible to all women.

Chapter 11

Conclusions and recommendations

11.1 Introduction

This chapter will briefly re-iterate the findings of the study, and drawing from the discussion in Chapter 10, will highlight the reasons why industrialised maternity provision (i.e. the large medicalised institution) is inappropriate for survivors of CSA and arguably, for the majority of birthing women. After this, there will be a short discussion on the issues surrounding the dissemination of the findings of a study of this nature. This is followed by suggestions for further research arising out of this work.

It will then make recommendations referring to:

- The role of Free Standing Birth Centres, Midwife-Led Units and home birth in freeing women and midwives from the production line and the technomedical model.
- Ways by which women and midwives would be enabled to form relationships, such as caseload midwifery and the community midwifery model (van der Kooy 2005)
- The need for midwifery to formulate its own definition of professionalism, based on feminine ideals and values.
- The need for ongoing staff training, support and referral structures
- The importance of offering women a choice over mode of delivery

11.2 Conclusions

The data from this study revealed that feelings of betrayal, powerlessness and humiliation were associated with women's negative experiences of birth. As referred to in Chapter 10 [see p 262], a significant number of the women having hospital births found some aspect of their experience traumatic or emotionally distressing. This was strongly linked with 'institution led' care, epitomised by attendants who were 'dissociated' and whose focus was on the needs of the

organisation rather than the women. The interviewees' positive experiences were frequently associated with carers who were emotionally 'present', showed compassion, warmth and treated them as individuals. The accounts confirmed the great importance women attach to feeling in control during the birth process. Their perceptions of control were linked with good communication skills and information giving by caregivers, being involved in decision-making, control over their environment, respect for privacy and dignity and genuine informed consent. These particular women did not appear to expect that they should have control over the physiological sensations of birth.

The work of Halldorsdottir and Karlsdottir (1996a; 1996b) and others indicates that what birthing women find helpful is carers who are clinically capable but who also engage with them, showing genuine interest and warmth, thereby creating a birthing environment in which they feel secure and protected. The data from this research suggests that the needs of survivors of CSA are identical, but also that they may be predisposed to perceive their births as traumatic because of their histories.

This research demonstrates the ongoing damage which can result from the marring of the midwife-woman relationship which is at the heart of 'successful' and empowering birth experiences for many women, including those affected by CSA. Midwives have become disempowered by their loss of identity following the redefinition of birth by obstetrics coupled with the dehumanising and controlling nature of institutionalised maternity care provision, influenced by the industrial model. Women and midwives have also been separated to some extent through the professionalisation of midwifery which has taken for its model that of the medical expert rather than its former, egalitarian, 'with woman' identity. Obstetrics, coming from a standpoint of risk, has enhanced its control over the birth process by imposing strict time limits upon it, which is beneficial both to itself (by increasing the need for medical involvement) and to the organisation's need for efficiency and throughput. This was seen both in the accounts of the women who gave birth and in the midwives' anecdotes.

The women birthing in a process-driven hospital environment were often disempowered by being separated from their social context and support network, a disregard for their needs for privacy and dignity, the negation of their own knowledge by the authoritative knowledge of medicine and the impact of

the technocratic model of maternity care (Davis-Floyd 1992) on the birth process.

11.3 Dissemination of the findings

It is important that the findings of this research should be disseminated in the arena of maternity care provision, in order that caregivers should be made aware of the difficulties survivors of CSA may face and how they can avoid causing further distress. However, the dissemination of information of this nature requires careful handling not only because of the sensitive subject matter which it covers, but also because of its potential to cause readers to feel criticised and consequently, defensive of their practice.

Whether in the writing of a book or in speaking about the findings at midwifery conferences or study days (I plan to do both), I feel that the key to effective dissemination lies in the telling of the women's stories. If readers or hearers can be enabled to see the realities of maternity care through survivors' eyes, they might be prompted to take a fresh look at how care is delivered and be challenged to make changes to practice.

Page (1996), when she was Director of Midwifery for a large, busy maternity service, made the observation that the organisation itself was made up of *'well-intentioned, naturally kind people'*, but concluded that: *'it was the system, which had become a chain rather than a support, that prevented professionals, both midwives and doctors, exerting the most human and compassionate side of their nature, and using their knowledge and skills to the full'*. (p 530)

The findings of this study must be communicated in a way that is compassionate both towards survivors of CSA and maternity workers, acknowledging the fact that the vast majority are doing their best to provide good care in a situation which, in many ways, and for many reasons, works against this. Midwives, who struggle with the 'blame culture' of the healthcare environment every day of their working lives, must not feel 'blamed' for the shortcomings in care identified in this research. Moreover, I am at pains to point out that although this thesis raises questions about the appropriateness of the medical paradigm controlling normal birth, it is not intended to be a diatribe against medicine or medical practitioners.

11.4 Further research

One of the prominent findings of this study was that amongst women who have suffered CSA there is a much higher incidence of home birth than for the general population. As discussed previously, this replicates the findings of Parratt (1994). As both these studies only involve small numbers of women, further research, involving large numbers would be useful in order to ascertain whether this holds true for the general population of survivors. Furthermore, as far as I am aware, there has as yet been no research specifically examining the experiences of survivors who give birth in alternative birthing settings such as Midwife Led Units (MLUs) or Free Standing Birth Centres (FSBCs). A large scale study comparing the experiences of survivors who choose these options with those who birth in large consultant units, might prove to be a very useful tool when considering the most appropriate maternity provision for these women. Outcomes such as women's psychological health, relationship with their infants, breastfeeding rates and adaptation to parenthood could be examined. The research could combine the use of a questionnaire with a semi-structured interview, aimed at identifying not only the sequelae of birthing in these environments, but also what the women felt about their experiences.

11.5 Recommendations

As pointed out previously, this study did not include any women who had given birth in MLUs or FSBCs and, until such time as research on survivors birthing in these environments is done, we cannot say for certain whether or not they do provide a better experience of birth for these women. My recommendations concerning MLUs and FSBCs are based upon the data which indicates what aspects of 'typical' maternity care that they found problematical: 'conveyor belt care', powerlessness, and fragmentation of care; and what they said they wanted from the maternity services: to form trusting relationships with staff, to be free from time constraints and to be given choice and control over what was done to them. Clearly, that kind of care is more feasible in an environment where hierarchy is minimal, midwives have more autonomy and are less

pressurised by hospital routines and birth is 'taken off the assembly line' (Walsh 2007).

We have seen how the marginalisation of women's knowledge and the midwifery model of birth leaves women exposed and vulnerable to 'childbirth abuse'. The empowerment of midwives and the promotion of birth as a healthy life event would do much to empower women. There are alternative ways of working which have already proved their worth not only from the point of view of midwife job satisfaction, but which are highly valued by women as well as being financially sound.

11.5.1 Free-standing birth centres and midwife-led units

The evidence shows that midwives enjoy working in these environments in which they experience a far greater degree of autonomy (Saunders et al 2000; Walsh 2007). The fact that women value this kind of maternity care is often demonstrated, ironically, by the fervent support often shown by women and their families when one of these units is threatened with closure (Robotham and Hunt 2006; Walsh 2007). The evidence also suggests that birth centres are financially good value (Rosser 2001; Bones 2005) and achieve outcomes which compare very favourably with 'standard' hospital care (Rooks et al 1992; Waldenstrom and Nilsson 1997; Hodnett et al 2005), particularly in the promotion of normal birth and maternal satisfaction. The emphasis on the psychosocial aspects of birth which characterises the midwife-led model (Hattem et al 2004) would appear to respond to the needs of women who have been made psychologically vulnerable by their experiences of CSA.

11.5.2 Caseload midwifery

Caseload midwifery has also proved popular with both women and midwives (Walsh 1999; Beake et al 2001; Sandall et al 2001). For midwives, it offers the opportunity to work more autonomously and to utilise their midwifery skills to the full. It allows clients and midwives to form trusting relationships, which is beneficial to both.

Furthermore, the Independent Midwives Association (IMA) has devised and

proposed an NHS Community Midwifery Model inspired partly by the AMP paradigm which would enable more midwives to work in this way (van der Kooy 2005). Under this scheme, women would not only be able to receive continuity of carer, but also choose their own midwives thus benefiting from an increased variety of choices. Moreover, because this would be financed by the NHS, it would potentially improve care for all women, (unlike Independent Midwifery care for which clients are required to pay) including those who are vulnerable or disadvantaged. It would also, to an extent, remove the current emphasis on geographical boundaries, placing the onus on the needs of individuals.

11.5.3 Home birth

As discussed in Chapter 7, it appears that the incidence of home birth among survivors of CSA may be higher than that of the general population. There is also evidence that some women may consider giving birth unattended at home if they are unable to find support to do so within the NHS (Barnes and Stenson 2007). It is important therefore, that the rhetoric surrounding the choice of home birth should become a reality. The promotion of caseload midwifery, because it gives midwives the opportunity to develop confidence and competence, would pave the way for home birth to become more readily available.

11.5.4 A midwifery definition of professionalism

As discussed, the professionalisation of midwifery has done nothing to enhance the relationship between midwives and women, being heavily influenced by the male-oriented medical model of professionalism which places the emphasis on the professional as expert. There is an urgent need for midwifery to return to its roots, and to reaffirm its commitment to being 'with woman', rather than 'with institution' or 'with women' (Hunter 2005), which describe the current way of working. Halldorsdottir and Karlsdottir's (1996b) phrase 'professional intimacy' could provide a useful foundation upon which to base a definition of midwifery for the 21st century. The concept of being 'professional' denotes the midwife's competence and confidence in her own skills to support women to give birth successfully, while the concept of 'intimacy' signifies the manner in which care

is delivered. It implies finding the delicate balance between suffocating closeness and aloofness, between practice based merely on 'clinical evidence' and that solely guided by human qualities such as intuition, common sense and empathy.

Midwifery must free itself from the technomedical notion that successful birth is measured only in terms of fetal outcomes and reassert its commitment to care for women and their offspring holistically. As discussed previously, women place great value on the quality of the experience as well as on the birth of a healthy infant, and their perceptions are determined to a large extent by the quality of the emotional support they receive. A professional model for midwifery which re-affirms and celebrates the traditional values of the vocation, along with knowledge gained from sound research and practical experience, would go a long way towards improving midwifery for midwives and care for women.

11.5.5 Staff training, support and referral structures

As the scenario of Maggie Smith's coffee room demonstrates, the issue of attending women with a history of CSA is one which sparks a number of different reactions in midwives. Some may feel unprepared or perplexed as to how they can provide appropriate care, whilst others may be unwilling to acknowledge the existence of CSA. In June 2002 'Sanctum for Midwives' was founded with the aim of helping *'those working through child sexual abuse issues that impact on their midwifery practice'* and to create *'a national programme of awareness, training and implementation'* (Gutteridge 2005 p 7). At its inception many midwives contacted Sanctum to share their personal experiences of caring for survivors which suggests that practitioners may feel that there is a lack of appropriate support and training in their workplace.' *It emerged*', says Gutteridge, *'there is a deficit in knowledge and awareness about this very sensitive issue within health care, and particularly in midwifery, where the intimate is particularly personal'* (p 7).

It is therefore of vital importance that all health care professionals (including medical staff) working with women should be informed and receive appropriate training in providing care for survivors. This should include teaching concerning the signs and symptoms that might suggest a history of sexual abuse;

strategies to help women maintain the perception of control; communication skills (including the avoidance of words and phrases which might act as memory triggers); and how to avoid scenarios which might be perceived as abusive. Consequently, even though women may not disclose their history, caregivers may be able to understand if they encounter certain responses such as dissociation and know how to respond appropriately.

The creation of the position of consultant midwife in recent years has been beneficial in promoting good midwifery practice and providing clinical leadership (Shallow 2004). Consultant midwives, with the remit of providing and promoting good care for vulnerable women (including survivors of CSA), could act as a resource and information base and be responsible for organising in-service training around the issues of abuse and childbearing. As well as working in the clinical arena, they could also act in an advisory capacity for midwives who feel they need support in caring for a survivor or to whom women could be referred if necessary. This would relieve the burden of responsibility on the individual midwife, who may feel out of her depth in caring for certain women, and from the woman's point of view, provide specialist care if she has particular problems as a result of her experiences

Furthermore, as this study demonstrates, there are midwives who themselves have histories of sexual abuse, which can have a profound influence on their practice, and, in certain circumstances, cause them a good deal of psychological distress. It is important therefore, that all midwives should be enabled to better understand their own emotional responses to this issue as well as gaining an insight into the needs of women with such a history.

Raphael-Leff (2000) speaks of the value of promoting psychodynamic understanding of emotional processes amongst maternity care workers in order that they should become more aware of their own and their clients' needs. Deery (2005) highlights the need for psychotherapeutic concepts and group work theory to be used in enabling midwives to cope with the demanding emotional nature of their work, particularly in the arena of midwifery education. She also refers to the work of Progress Theatre (Pollock 2003), which provides participative and interactive theatrical presentations on sensitive topics such as bullying and sexual abuse, enabling midwives to jointly explore their own responses to these issues (Deery 2003). I have been involved with Progress

Theatre on several occasions, both as a student midwife in a learning situation, and also at study days as a speaker on sexual abuse. I can testify to the invaluable impact that it has had on my understanding of these important issues and on my own self-awareness. The use of resources such as Progress Theatre, not only in the training of student midwives, but in the ongoing education of maternity caregivers could do much to enhance the emotional care for survivors of CSA. Qualitative research aimed at evaluating the effectiveness of such a tool would also be useful.

11.5.6 Offering women true choice concerning mode of delivery.

As we have seen, several of the women in this study, having experienced a traumatic first birth, expressed deep fears concerning future pregnancies, one interviewee subsequently avoiding pregnancy altogether. For this, and other reasons, some women may request elective caesarean sections. While some may be enabled to cope with vaginal birth given the appropriate, sensitive care, others may not. It is therefore essential that these women should be able to give birth by elective caesarean section if that is their choice. It is well known that some obstetricians actively promote caesarean sections but midwives can be equally guilty of promoting their favoured mode of delivery, the vaginal birth, in the belief that this is best for all women. The findings of Hofberg and Brockington (2000), [see p 44], that tocophobic women who were denied their requests for caesarean section suffered higher rates of psychological morbidity than those whose wishes for operative birth were achieved, demonstrates the psychological damage that can occur when clinicians decide what is best for women on the basis of their own preferences.

11.6 Caring for, or caring about?

The common thread running through the entirety of this thesis is that of women's need for 'care' in its widest sense. Arguably, the concept of 'care' within the industrialised maternity services has been reduced to a process which is perceived to 'guarantee' a healthy product with optimum efficiency and minimum risk. Several of the interviewees described traumatic experiences in

which they were 'cared for' in this definition. It seems that the heart-cry of birthing women is not merely to be 'cared *for*', but to be 'cared *about*'. Van der Kolk, van der Hart and Marmar (1996) make this very interesting statement:

*As long as people are able to imagine some way of staving off the inevitable, or as long as they **feel taken care of by someone stronger than themselves**, psychological and biological systems seem to be protected against becoming overwhelmed. (p 303, my emphasis)*

The protective power of individualised, sensitive care for women is largely ignored in our industrialised, depersonalised, maternity services. Arguably, the system finds this too simple a concept to take seriously; it prefers to take a more 'scientific approach'. Thus, the cries of women for human contact and comfort are met by medical science with epidurals, pharmaceuticals, active management of labour and a host of technological 'advances'. The organisation responds with team midwifery, integration of hospital and community midwives and centralisation. Sadly, rather than meeting women's needs, these factors are often instrumental in creating more trauma, betrayal and disillusionment. Whether they are survivors of CSA or not, it appears that childbearing women who feel they have been well cared for and had their needs met by compassionate, sensitive people do not find birth traumatic.

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