The Lamaze Certified Childbirth Educator's Role in Teaching Survivors of Childhood Sexual Abuse

Barbara A. Hotelling, WHNP-BC, CD(DONA), LCCE

ABSTRACT

There is a strong likelihood that at least one participant in any Lamaze childbirth education class has had personal experience with childhood sexual abuse. Using the wisdom of Lamaze Certified Childbirth Educators and respected authors in the field of childhood sexual abuse, this column enlightens the childbirth educator in three ways: understanding the incidence of female and male childhood sexual abuse; understanding the effects of sexual, emotional, physical, and verbal abuse on the pregnant and parenting family; and facilitating classes that are sensitive to the needs of survivors of childhood sexual abuse as well to all expectant parents.

The Journal of Perinatal Education, 21(2), 127–132, <http://dx.doi.org/10.1891/1058-1243.21.2.127>

Keywords: childhood sexual abuse, survivors of childhood sexual abuse, pregnancy, childbirth, parenting, childbirth education

Lamaze Certified Childbirth Educators (LCCE educators) may wonder sometimes if the fear and anxiousness surrounding a woman's impending birth are related to former experiences of sexual, verbal, physical, and emotional abuse or a combination of these forms of abuse. Lamaze class participants who are difficult, hostile, disruptive, or unusually afraid might trigger the question of a participant's past sexual abuse in a knowledgeable and sensitive LCCE educator. It would not be an irrational assumption because the rate of childhood sexual abuse, 25%–40%, has not changed since the 2004 publication of Simkin and Klaus's book, *When Survivors Give Birth* (P. Simkin, personal communication, December 12, 2011). The incidence rate of childhood sexual abuse includes "not only rape or

other forms of penetration, but also fondling, intrusive interest, voyeurism, and other forms" (P. Simkin, personal communication, December 12, 2011).

The rate of abuse of men is equally problematic. According to findings in two studies of male college students (Lisak, Hopper, & Song, 1996; Lisak & Luster, 1994), the rate of abuse among study participants was approximately 17% "for child sexual abuse of males involving physical contact" and more than 25% "when noncontact forms of abuse were included" in the studies' analyses (as cited in Hopper, 2011, "Prevalence: Studies—Review to July 1996," para. 7). Thus, in addition to expectant mothers with a history of abuse, LCCE educators can expect to have expectant fathers in their classes who are living with the effects of abuse.

Simkin and Klaus (2004) report that male or female survivors of early sexual abuse are likely to respond to childbirth classes with boredom, sleepiness, or hostility. The educational tools offered in childbirth classes may not work for them, which may leave the LCCE educator feeling upset, ineffective, and defensive. Simkin and Klaus also note that a rigid, dogmatic educator will be unable to develop learning techniques that benefit everyone and promote empowerment and confidence building. Understanding childhood sexual abuse and its effects on expectant parents can lead to sensitive and empowering teaching that transforms all parents, whether they are survivors of childhood sexual abuse or not.

WHAT EXPERIENCES DEFINE A SURVIVOR?

Simkin, a physical therapist and childbirth educator, and Klaus, a psychotherapist and counselor, began to realize in the 1980s that “women who had been sexually abused during childhood were often especially anxious during pregnancy and frequently went through difficult or even traumatic experiences with birth and early parenting” (Simkin & Klaus, 2004, p. xv). However, it was not until 1992 when journal articles on this subject were published, and, in 1994, the diagnostic criteria for posttraumatic stress disorder were revised and published in the fourth edition of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders*. It was then that a frightening or life-endangering childbirth could meet the new criteria for a traumatic event (Simkin & Klaus, 2004).

There is no universal definition of *childhood sexual abuse*. Simkin and Klaus (2004) offer a broad definition: “Childhood sexual abuse takes place between a child (anyone under 18 years of age) and someone whom the child perceives as more powerful than the child herself” (p. 3). Any activity including physical, psychological, or verbal abuse that causes sexual arousal in the abuser or in someone else is included in Simkin and Klaus’s definition.

Hopper (2011) presents another definition of childhood sexual abuse, as proposed by Lisak and Luster (1994) and by Lisak et al. (1996):

... Lisak and his colleagues (1994, 1996) deliberately chose to weight their definition of sexual abuse in terms of the power differential accompanying significant age differences and the older person’s presumed deliberate sexual use and exploitation of the younger subject. So long as significant differences in age and

power existed, Lisak and his colleagues defined incidents as abusive, regardless of subjects’ emotional appraisal or lasting effects. . . . (“Prevalence: Studies—Review to July 1996,” para. 8)

The power differential is found in most definitions, although the ages vary, and appears to be the baseline for determining abuse.

The American Psychological Association (2011) also considers the power differential “a central characteristic of any abuse” and qualifies this power as “the dominant position of an adult that allows him or her to force or coerce a child into sexual activity” (p. 1). According to the association’s definition,

Child sexual abuse may include fondling a child’s genitals, masturbation, oral–genital contact, digital penetration, and vaginal and anal intercourse. Child sexual abuse is not solely restricted to physical contact; such abuse could include noncontact abuse, such as exposure, voyeurism, and child pornography. Abuse by peers also occurs. (p. 1)

THE EFFECTS OF ABUSE ON PREGNANCY, BIRTH, AND PARENTING

Simkin and Klaus (2004) note that during the abuse, which is often accompanied by violence, a girl or woman experiences physical pain, force, restraint, and terror. Physically, she may also experience breathing difficulties, choking, gagging, helplessness, pressure on her body, severe pain, and genital bleeding. The results in children and adults are confusion, a warped self-image, negative feelings about one’s body, fear, shame, and helplessness (Simkin & Klaus, 2004).

In his overview of research findings and resources that focus on men who experienced childhood sexual abuse, Hopper (2011) cites numerous studies that identify the long-term effects on the abused young male. He especially recommends Lisak’s (1994) study, which found a variety of effects, such as fear, helplessness, and self-blame or guilt. Hopper (2011) lists several other studies that found variations of the following effects: anxiety, depression, dissociation, hostility and anger, impaired relationships, low self-esteem, sexual dysfunction, sleep disturbance, and suicidal ideas and behavior.

E. Sue Blume is the author of *Secret Survivors: Uncovering Incest and Its Aftereffects in Women* (1990). In her foreword to *When Survivors Give Birth* (Simkin & Klaus, 2004), Blume (1990) describes the possible

reactions of childhood sexual abuse survivors to the news that they are pregnant.

Imagine this: You have just found out you're pregnant. You should be filled with joy—after all, this is what you've wanted for so long. But all you can think about is how much you dread every moment of what's to come. You like your birthing professional well enough, but examinations make you feel violated. The thought of so many people seeing you and touching you there is horrifying, as well as things they might do that you don't want them to do, like cutting you. Everything makes you feel powerless. It's as if nothing you want or need matters, as if you have lost all control over what happens to you. They may not even be able to guarantee that the person you have chosen to attend to you is the one who will be there when you give birth. Give birth . . . to your own helpless, dependent child. The thought makes panic flood through you. (Simkin & Klaus, p. xix)

Simkin and Klaus (2004) describe additional effects of childhood sexual abuse, especially on childbearing women. They contend that, as the pregnancy continues, women may feel relieved that their bodies were not permanently damaged by the abuse. For some survivors with an unplanned and unwanted pregnancy, parenthood may represent a kind of punishment by the baby's father, society, or God; the woman may feel she has lost control over her destiny. Some survivors deny or reject the pregnancy, wearing loose clothing, or dieting to avoid gaining weight. Others may go through pregnancy without awareness and give birth without warning. This situation can be especially true in adolescents who have become numb to bodily sensations such as pain, fetal movements, and even contractions (Simkin & Klaus, 2004).

Simkin and Klaus (2004) also note that for some survivors, the common discomforts of pregnancy may become so severe that they become debilitating. Nausea may become emesis gravidarum, requiring hospitalization. Joint pains, backache, and nausea may lead to greater fatigue than is normal and interfere with work and social activities. These mothers may perceive these symptoms as confirmation that their bodies are abnormal or different from other mothers.

Satisfying and empowering birth is less likely to depend on the length of the labor, interventions, or type of birth. Feeling in control, feeling a sense of accomplishment, and feeling well cared for by nurses,

For survivors of childhood sexual abuse, the challenges of labor can be more difficult than usual.

doctors, or midwives is more likely to produce positive birth memories—memories that last a lifetime (Simkin, 1991, 1992). However, for survivors of childhood sexual abuse, the challenges of labor can be more difficult than usual. The woman's sense of control seems unlikely when the birth experience involves such unknowns as how or when labor will start, how long labor will last, and how much pain will be involved, and when the experience contains possibilities of injury to her pelvic floor and problems for the baby (Simkin & Klaus, 2004). Moreover, the woman is in an unknown environment with strangers caring for her in strange clothing with strange equipment, noises, smells, and invasive procedures. She is not allowed to choose her own positions, feed or hydrate herself with her choices, or use comfort measures that she finds useful. Her self-image is low, and now she is in bed with disheveled hair and makeup and looking upward toward caregivers who have clean clothing, have well-kept hair, and are authority figures. Because of increased stress, the woman may interpret the nurses' and others' actions and words as belittling, which validates her low self-image, or she may perceive danger to her and/or her baby when actually there is none. These and other elements of hospital birth can trigger flashbacks, intensify fear and pain, or cause the woman to disassociate from the present. None of these conditions promote empowerment or satisfying birth memories and can reinforce the woman's self-doubts that she can adequately care for and protect her baby.

Male survivors of childhood sexual abuse may find the pregnancy and birth overwhelming. The long-term effects of abuse that Hopper (2011) describes in his research review may interfere with relationships between men and their partners and between fathers and their children. Anxiety, depression, and impaired relationships are not helpful in the transition to parenthood. Low self-esteem will not help the father bond with his child or be supportive of the mother. In Lamaze classes, male survivors may dissociate when there is discussion of sexuality during pregnancy or explicit birth videos. Mothers, fathers, and infants need support during the childbearing year; if one or both parents are survivors, the usual amount of support needed to create a healthy family is multiplied.

Offering a variety of coping strategies and, perhaps, rephrasing and using terms that are cognizant of survivors' sensibilities and needs allow women to choose suitable strategies for themselves.

For a general discussion on the fear of childbirth, read McGrath's article "The Courage to Birth" in this issue of *The Journal of Perinatal Education* (pp. 72–79). Also, for an additional perspective of the fear of childbirth, read Lothian and Grauer's "Navigating the Maze" column in this issue, entitled "Giving Birth: 'We Just Don't Talk About It'" (pp. 123–126).

PEARLS OF WISDOM FOR TEACHING SURVIVORS

The following teaching tips were suggested by LCCE educators when asked to describe their experiences with childhood sexual abuse survivors in Lamaze classes. I asked these educators if they identify survivors attending their classes and, if so, how it is done. I also asked the educators if they provide special services for survivors to aid them in their birth planning. I also gathered information from Simkin and Klaus's (2004) *When Survivors Give Birth* and from Mickey Sperlich, coauthor with Julia Seng of *Survivor Moms* (Sperlich & Seng, 2008). The following suggestions are valid for all class members, not just abuse survivors, and will add to their empowerment and self-determination.

Simkin and Klaus (2004) state that the childbirth educator does not need to know if any class member has a history of abuse, but she does need to know that much of the class content has the potential for triggering anxiety and resistance in learners with abuse issues. The authors also note that "a class taught by someone with awareness of abuse issues can be enlightening, reassuring, and confidence-building" (p. 168).

One of the challenges in teaching in a group setting is that some topics may be emotionally threatening to abuse survivors. According to Simkin and Klaus (2004), topics that may fit in this category are vaginal lacerations and pain, episiotomy, perineal massage, labor complications and interventions, circumcision, breastfeeding, informed consent, sexuality, and childbirth films. The authors also note that practicing comfort measures in childbirth education class may pose problems for abuse survivors when expectant parents lie on the floor among strangers and try to relax under the watchful eye of the teacher who remains upright. Expectant parents enter class with various comfort levels in sexuality, their bodies, and the sights and sounds associated with hospital settings (Simkin & Klaus, 2004). Giving expectant parents control over what they see and hear in class enhances their ability to make and communicate their decisions when they give birth.

Some words or phrases that childbirth educators commonly use to encourage expectant mothers may convey the opposite message to sexual abuse survivors. For example, educators often remind women to "yield," "surrender," "open yourself to the pain," "trust your body," or "do what your body tells you to do" during labor (Simkin & Klaus, 2004, p. 168). Offering various coping strategies and, perhaps, rephrasing and using terms that are cognizant of survivors' sensibilities and needs allow women to choose suitable strategies for themselves. Some women may benefit from strategies such as tuning in, yielding, relaxing into the pain, whereas other women may prefer distraction, focusing outward, and being physically active during painful contractions (Simkin & Klaus, 2004).

Since 1997, Kris Avery, an LCCE educator in Washington State, has given class registrants an opportunity to share any special needs or abuse history in a discreet way. She sends them a confidential form, along with the class registration sheet, asking them to describe how they view birth, their personal learning styles, and anything else they feel is important to share. If they identify a history of abuse, Avery calls them before the class starts, asking how they would like to have their needs met and offering her phone number so they may talk with her outside of class. She can then work with them in birth planning and offer appropriate resources (K. Avery, personal communication, December 4, 2011).

Connie Sultana, an LCCE educator in California, assumes that all women are survivors. When conducting role-playing exercises in class, she gives expectant parents suggestions for feeling more comfortable, such as using bed sheets for privacy in certain laboring positions, facing the foot of the bed so the woman's bottom is not facing the door in the hospital room, and informing providers when they are uncomfortable with pelvic exams. The providers can then place this information regarding the woman's preferences in her chart so that nurses are aware of the need to minimize vaginal exams and touching without permission (C. Sultana, personal communication, December 7, 2011).

Jennifer Joyce Brodie, an LCCE educator in North Carolina, acknowledges that abuse history does not have to dominate birth. She provides expectant parents with handouts and resources to assist them in planning for a birth that does not bring back memories and retraumatize abuse survivors (J. Brodie, personal communication, December 4, 2011). Erin

Luben, another LCCE educator in North Carolina, relies on her lending library and shares copies of Simkin and Klaus's (2004) book, *When Survivors Give Birth*, with expectant parents (E. Luben, personal communication, December 4, 2011).

Mickey Sperlich is a certified professional midwife with nearly 20 years of experience helping women on the journey of pregnancy and birth. She currently coordinates a study on the effects of posttraumatic stress on childbearing at the University of Michigan's Institute for Research on Women and Gender. Sperlich believes the most important thing a childbirth educator can do for survivors of childhood sexual abuse is to let them know they are not alone. She notes that, by the age of 18 years old, 38% of all women have had unwanted sexual contact; consequently, many women entering pregnancy are likely to have a history of abuse (M. Sperlich, personal communication, December 19, 2011). Sperlich warns that although a history of sexual abuse does not mean that there will necessarily be any problems related to the pregnancy or birth, it does mean an increased risk for the following issues: (a) experiencing emotional difficulties caused by the resurfacing of memories of abuse and worrying about becoming a parent; (b) experiencing discomfort with the intimate medical procedures of pregnancy and birth (e.g., internal exams); (c) perceiving the birth itself as traumatic; and (d) experiencing postpartum depression.

Sperlich believes the second most important thing a childbirth educator can do for clients who are survivors of childhood sexual abuse is to assess not what happened in the past but how the past abuse is currently making the clients feel (M. Sperlich, personal communication, December 19, 2011). According to Sperlich, if a client has a history of abuse but was adequately cared for soon after the abuse happened (e.g., received therapy, was believed, was helped), then chances are less likely that she or he will currently need help with past sexual abuse. Assessing the client's current level of distress is important, Sperlich notes, because the educator can be ready to provide the client with a referral to a local trauma-informed therapist, which is probably the best thing the educator can do for the client. However, as Sperlich advises, because not all therapists are trauma-informed, the educator may need to spend extra time finding the best resources for referrals.

Unless the LCCE educator has educated herself and feels ready to help individuals who identify themselves as childhood sexual abuse survivors,

she should not discuss the subject directly in class (Simkin & Klaus, 2004). There are various ways to get the education that is needed to support survivors. Reading books such as *The Courage to Heal* (Bass & Davis, 2008), *When Survivors Give Birth* (Simkin & Klaus, 2004), and *Survivor Moms* (Sperlich & Seng, 2008) is a great start. Beyond that, there are university courses in women's studies, workshops given by rape crisis centers, and workshops by Penny Simkin. For example, Simkin's 1- to 2-day workshop, "Childhood Sexual Abuse and Its Impact on the Woman's Later Childbearing," prepares educators with the tools to assist survivors in birth planning. The goal is to minimize events that may trigger flashbacks or increase stress, making cesarean surgery more likely. Simkin states,

I do feel that mature childbirth educators and doulas as well as nurses and midwives who have the time to give would all be good counselors to help women survivors prepare for birth and get through it without being retraumatized. (P. Simkin, personal communication, December 16, 2011)

LCCE educators themselves may be abuse survivors. Simkin and Klaus (2004) point out that individuals who have successfully resolved or are working on the aftereffects of early sexual abuse can be very empathetic and effective educators; however, their unresolved abuse issues may interfere with parent learning. Traumatic experiences with birth or birth professionals may bring out tendencies to teach parents to be defensive about providers or hospitals and may prevent the LCCE educator from teaching birth in a positive or empowering manner. Simkin and Klaus warn that childbirth class is not the place for the survivor LCCE educator to work through these issues. The authors suggest individual or group work may help the educator to teach painful topics more easily.

Mary Jo Podgurski, an LCCE educator in Pennsylvania, is the president and founder of The Academy for Adolescent Health in Washington, Pennsylvania, and has spent much of her adult life supporting and educating pregnant and parenting teens. She advocates for adolescent mothers by providing in-service programs for hospital staff to make sure the mothers feel safe when laboring, giving birth, and breastfeeding. Podgurski finds the biggest challenge is teaching individuals who interact with adolescents in labor—whether they are abuse

For more information on Penny Simkin's workshop schedule and workshops, including "Childhood Sexual Abuse and Its Impact on the Woman's Later Childbearing," visit her website (www.pennysimkin.com).

survivors or not—what these young women want and what they need. Podgurski tries to change judgments into understanding, and she encourages the hospital staff to take the mother where she is and help the mother get to where she wants to go. She notes, “Every woman should know that each person is a person of worth” (M. J. Podgurski, personal communication, December 18, 2011).

It is wise for all individuals to remember, as Hopper (2011) notes, the following aspects of “the human condition”:

- *All human beings suffer painful experiences and some of these occur in childhood.*
- *All caregivers of children are sometimes unable to protect them from painful experiences.*
- *We all need love and support to deal with the effects of painful experiences.* (“Possible Lasting Effects—Basic Information & Outline,” para. 4)

Hopper (2011) also states, “Child abuse in itself does not ‘doom’ people to lives of horrible suffering” (“Possible Lasting Effects—Basic Information & Outline,” para. 3).

Harriette Hartigan, an internationally known midwife and birth photographer from Ann Arbor, Michigan, empowers childbirth educators with support to share with all women. She suggests, “Share with the women that their uterus is the strongest muscle in the human body. No man has such strength. Encourage women to live this strength of giving birth throughout the rest of their lives” (H. Hartigan, personal communication, December 17, 2011).

REFERENCES

American Psychological Association. (2011). *Understanding child sexual abuse: Education, prevention, and recovery* [Brochure]. Retrieved from <http://www.apa.org/pubs/info/brochures/sex-abuse.aspx>

- Bass, E., & Davis, L. (2008). *The courage to heal: A guide for women survivors of child sexual abuse* (3rd ed.). New York, NY: Collins Living.
- Blume, E. S. (1990). *Secret survivors: Uncovering incest and its aftereffects in women*. New York, NY: Wiley.
- Hopper, J. (2011). *Sexual abuse of males: Prevalence, possible lasting effects, & resources*. Retrieved from <http://www.jimhopper.com/male-ab/>
- Lisak, D. (1994). The psychological impact of sexual abuse: Content analysis of interviews with male survivors. *Journal of Traumatic Stress*, 7(4), 525–548. <http://dx.doi.org/10.1002/jts.2490070403>
- Lisak, D., Hopper, J., & Song, P. (1996). Factors in the cycle of violence: Gender rigidity and emotional constriction. *Journal of Traumatic Stress*, 9(4), 721–743. <http://dx.doi.org/10.1002/jts.2490090405>
- Lisak, D., & Luster, L. (1994). Educational, occupational, and relationship histories of men who were sexually and/or physically abused as children. *Journal of Traumatic Stress*, 7(4), 507–523. <http://dx.doi.org/10.1007/BF02103004>
- Simkin, P. (1991). Just another day in a woman’s life? Women’s long-term perceptions of their first birth experiences. Part I. *Birth*, 18(4), 203–210. <http://dx.doi.org/10.1111/j.1523-536X.1991.tb00103.x>
- Simkin, P. (1992). Just another day in a woman’s life? Part II: Nature and consistency of women’s long-term memories of their first birth experiences. *Birth*, 19(2), 64–81. <http://dx.doi.org/10.1111/j.1523-536X.1992.tb00382.x>
- Simkin, P., & Klaus, P. (2004). *When survivors give birth: Understanding and healing the effects of early sexual abuse on childbearing women*. Seattle, WA: Classic Day Publishing.
- Sperlich, M., & Seng, J. (2008). *Survivor moms: Women’s stories of birthing, mothering and healing after sexual abuse*. Eugene, OR: Motherbaby Press.

BARBARA A. HOTELLING is the perinatal nurse coordinator for the Maternal and Child Health Program and a nurse practitioner in the Department of Family Medicine at the University of North Carolina School of Medicine in Chapel Hill. She has served as the president of Lamaze International and of DONA International, as well as chair of the Coalition for Improving Maternity Services.