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Article

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(Re)activation of survival strategies during pregnancy and childbirth following experiences of childhood sexual abuse

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ABSTRACT

Objectives: To explore the pregnancy and childbearing experiences of women-survivors of childhood sexual abuse [CSA]. We aimed to generate a theory explaining those experiences for this population (women), this phenomenon (pregnancy and childbirth), and this context (those who have survived CSA).

Method: Participants (N=6) were recruited to semi-structured interviews about their experiences of CSA and subsequent pregnancy and childbirth. Data saturated early, and were analysed using Grounded Theory (appropriate to cross-disciplinary health research). Coding was inductive and iterative, to ensure rigour and achieve thematic saturation.

Results: Open and focused coding led to the generation of super-categories, which in-turn were collapsed into three distinct, but related themes. These themes were: Chronicity of Childhood (Sexual) Abuse; Pregnancy and Childbirth as Paradoxically (Un)safe Experiences; Enduring Nature of Survival Strategies. The relationship between these themes was explained as the theory of: (Re) activation of Survival Strategies during Pregnancy and Childbirth following Experiences of Childhood Sexual Abuse.

Conclusion: Pregnancy and childbirth can be triggering for women-survivors of CSA. Survival strategies learnt during experiences of CSA can be (re)activated as a way of not only coping, but surviving (the sometimes unconsented) procedures, such as monitoring and physical examinations, as well as the feelings of lack of control and bodily agency.

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Childhood sexual abuse; women's mental health; birth trauma; bodily agency; childbirth; maternity care

Introduction

Pregnancy and childbirth can be a vulnerable time for women who have previously experienced childhood sexual abuse [CSA]. For many, CSA can be chronic (Pereda et al., 2016), the effects of which are long-term (Beitchman et al., 1992), both psychologically (Byrne et al., 2017; Wajid et al., 2020) and physically (Irish et al., 2010; Olsen, 2018). Throughout this paper we refer to women who have experienced CSA as 'women-survivors'. In this study, 'survivor' *did*

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resonate with women who participated in interviews. The term 'women-survivors' is useful shorthand, but we recognise not all women who have experienced CSA find this a relevant or helpful term.

Healthcare professionals [HCPs] are often challenged when caring for women-survivors of CSA, as disclosure is rare (Cawson et al., 2000; Morrison et al., 2018), often due to fear of judgment (MacIntosh et al., 2016); or not being believed (Stiller & Hellmann, 2017). In studies of maternity care, lack of CSA disclosure has been linked to having incomplete or no memory of the abuse (Garratt, 2011), difficulty in asking for help or trusting others (Gerber, 2019; Seng et al., 2002), or simply not wishing to disclose due to feelings of shame or embarrassment (Coles & Jones, 2009).

Interactions between HCPs and women through the course of pregnancy, involve frequent intimate examinations, physical contact, and at times women's immobilisation as they labour. These experiences can be perceived as threatening (Rhodes & Hutchinson, 1994), sometimes intrusive and unconsented (Coles & Jones, 2009). They may cause women-survivors of CSA to experience flashbacks to their traumatic abuse and/or dissociation (Garratt, 2011), thus, the journey to childbirth may feel paradoxically unsafe (Burian, 1995).

To regain a feeling of safety, women-survivors of CSA may seek a means to control the situation and therefore cope with feelings of threat or disempowerment during their maternity care. Although the literature-base is small (Montgomery, 2013), scholars have written regarding women's experiences of childbearing after CSA and how they cope during times of distress when engaging with maternity care services (Gaudard e Silva de Oliveira et al., 2016; Leeners et al., 2016). These ways of coping are crucial to maintaining a sense of control in situations in which they feel they have none (Byrne et al., 2017; Montgomery et al., 2015b).

Though CSA is often cited as problematising women's experiences of pregnancy and birth, the transition to parenthood can be a time of healing. For some, pregnancy and birth empowers women to take control of their own bodies and challenges the memory of the abuse by focusing on the body as a site of growth, rather than of abuse. Further, it may supplant negative memories with ones of pride in their creation (Chamberlain et al., 2019; LoGiudice & Beck, 2016). Research suggests pre-emptive work can be undertaken to improve labour (Gerber, 2019; Sperlich et al., 2017), such as: creating birth plans (Rhodes & Hutchinson, 1994), prioritising trusting relationships with HCPs (Florian, 2018; Montgomery, 2013), and respecting privacy (Parratt, 1994). These preparatory aspects of maternity care can promote women's empowerment and sense of safety, and in turn, may work to limit triggers of past CSA (Leeners et al., 2016).

The effect of CSA on future pregnancy and childbirth remains relatively under-researched with no clear agreement about experiences; therefore, this study aims to explore the experiences of pregnancy and childbirth for women-survivors of CSA, and develop a theory using grounded theory analysis. Grounded theory is an analytical methodology, which aims to generate new theories about specific phenomena, experienced by specific populations, in specific contexts (Glaser, 2006; Glaser & Strauss, 1967; Silverio et al., 2019). The theory which is developed, can then be used, not only to inform future research and clinical practice about this devastating phenomenon, but can also be 'tested' by changing either one of the population, phenomenon, or context (Corbin &

Strauss, 1990). Furthermore, our study aims to provide a platform on which this much under-researched population (Silverio et al., 2020) can voice their lifecourse narrative (Silverio, 2021; Silverio et al., 2021).

Materials and methods

Semi-structured interviews were undertaken with women (N = 6) who had previously experienced CSA (participant details in Table 1). We aimed to understand their pregnancy and childbirth experiences. Women were recruited from the UK via word-of-mouth, to The *S*exual *A*buse, Pre*G*nancy, & *E*xperiences of Childbirth [SAGE] Studies. Data were collected between July and September 2019 (eligibility criteria in Table 2.) Interviews were face-to-face (n = 1), telephone (n = 4), or video-calls (n = 1).

The study was designed as a piece of lifecourse research (Wainrib, 1992), whereby the experience of CSA and the experiences of pregnancy and childbirth present as ruptures across a woman's lifecourse, and it is these ruptures which offer sites of empirical inquiry (Silverio, 2021). Therefore, and in-line with previous CSA research (Byrne et al., 2017; Montgomery et al., 2015a, 2015b), so not as to ask directly about abuse, interviews in this study began with a broad opening question of: *'Could you tell me about the experiences which led to you taking part in this research?'*. This was followed by a brief semi-structured interview schedule (see *Appendix 1*), which was broad enough to allow the researcher flexibility to follow-up on interesting points made by the participants, but ensured common lines of inquiry across all participants. Interviews lasted 30–60 minutes, ending by asking whether they had any advice to share with women in similar circumstances. Data were found to be saturated early in the recruitment process (n = 5), where no new concepts were occurring with the addition of the fifth interview (see also Silverio et al., 2019). This is not uncommon for studies of specific phenomena (Guest et al., 2006), however, a further

Table 1. Participant demographics.

Name	Age at Time of Interview	Age (in years) CSA Started	Age (in years) CSA Ended	Number of Children
Hope	32	12	14	2
Nita	41	12	14	2
Chloé	50	1	14	1
Opal	54	7	14	3
Cora	70	1	6	3
Zoë	71	8	11	2

Table 2. Eligibility criteria [a].

Inclusion Criteria [b]	Exclusion Criteria [b]
• Participant was ≥18-years of age at time of interview. • Sexual abuse occurred in childhood (<18-years of age). • Participant had given birth at any time since the last incidence of CSA. • Last incidence of CSA was ≥5-years prior to the date of the interview. [c]	• Participant was engaged in legal action against the perpetrator of their abuse at time of interview • Participant was experiencing current/ongoing abuse. • Participant had diagnosis of severe mental illness. • Participant had learning difficulties.

[a]All women, eligible or not, received a leaflet documenting support resources and contact details for appropriate charities.
[b]Participants had to meet all of the inclusion criteria AND not meet any of the exclusion criteria to be eligible.
[c]This length of time was chosen so there was enough time between the CSA and the interview for it to not be recently traumatic, and was longer than most recent similar studies (Montgomery et al., 2015b).

interview was conducted to confirm this assumption of data saturation. Inductive and iterative coding ensured rigour and aided eventual thematic saturation (i.e. where themes were sufficiently supported by data in order to generate a theory).

Interviews were audio recorded, transcribed verbatim, and hand-coded, using a Grounded Theory approach, appropriate to cross-disciplinary health research (Silverio et al., 2019). It is a hybrid, Classical Grounded Theory approach (Glaser & Strauss, 1967), using inductive methodical processes from Glaser (1992), and practices of framing the theory within wider literature from Strauss (1987). The study therefore drew upon a post-positivist paradigm (Levers, 2013) encompassing a critical realist ontology and an objectivist epistemology (Annells, 1996), meaning participants' recounted stories were accepted as true reflections of their experiences and any pre-conceptions were actively excluded (or 'bracketed'; Gearing, 2004) from analysis (Sands & Krumer-Nevo, 2006; Silverio, 2018).

Results

Analysis began with lower-order ('open') coding whereby data were coded line-by-line using words from the transcript, followed by a higher-order coding where open codes were grouped together, and the data were re-coded using these more 'focused' codes. From here several related super-categories were developed (Figure 1) which were then collapsed, merged, or split into three distinct, but inter-relating themes: Chronicity of Childhood (Sexual) Abuse; Pregnancy and Childbirth as Paradoxically (Un)safe Experiences; Enduring Nature of Survival Strategies (Figure 2). Analysis is presented below with the most illustrative quotations presented for each theme, accompanied by each participant's pseudonym.

Chronicity of childhood (sexual) abuse

All women experienced chronic (daily/weekly) CSA. For some, this started as early as a year old, which for Cora, was by her aunt:

> "*It was something that happened I suppose twice a week when she came to visit and it involved her giving me a bath and things which developed from that and then putting me to bed, which took pressure off my mother who had a new baby, but was an ideal opportunity for a predator, so to speak.*" (Cora)

Sexual abuse was sometimes concurrent with physical and/or emotional abuse. Here, Opal discussed the fear her father instilled in her from age seven:

> "*Now for years it went on, but I was so scared. . . I used to ask friends did their daddies do it to them, not letting them know . . . . . I didn't know if they were lying because their daddy told them to be quiet.*" (Opal)

Not all abuse was perpetrated by relatives. Chloé spoke of her first instance of abuse happening in care when she was very young and had no memory of it until aged twenty-eight, when in therapy:

> "*I was three, maybe two, three and it was by an older boy in the children's home who was about nineteen and I remember it because I had a physical manifestation of it one day after I had been having psychotherapy and I had the feeling of it happening to me, so somebody had their hand over my mouth and their parts inside of my vagina.*" (Chloé)

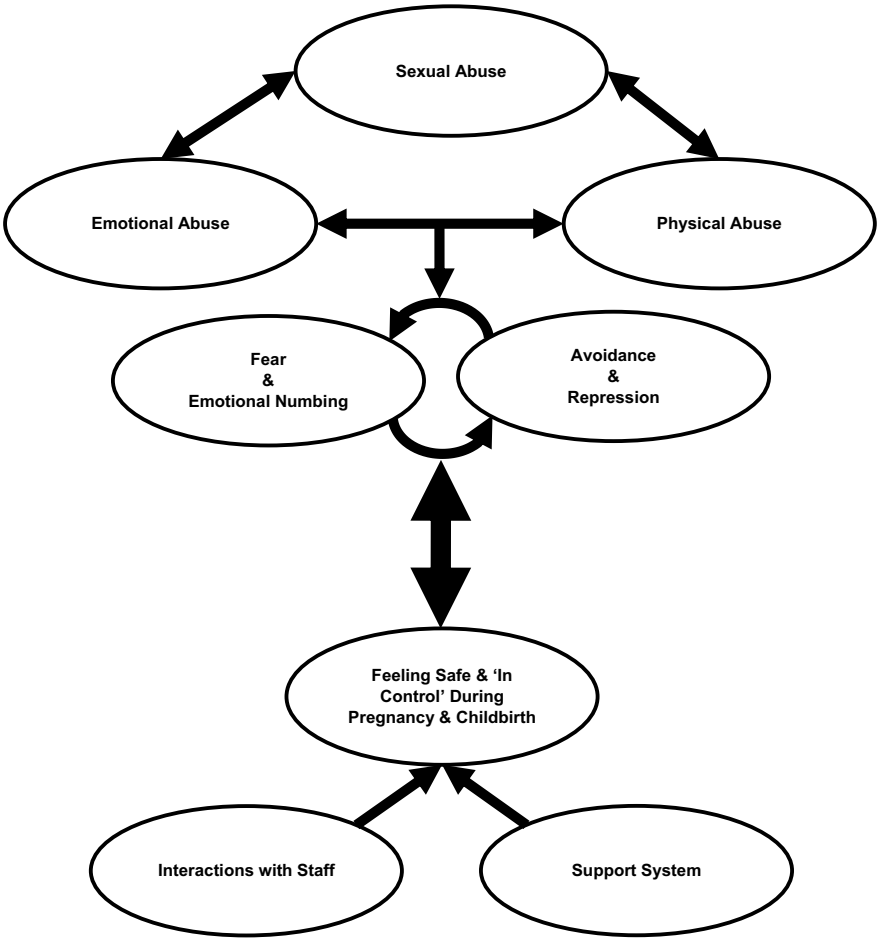

Figure 1. Thematic diagram of super-categories.

Likewise, Hope shared of an enduring abusive 'relationship' with a much older man, something which has been discussed in previous work (Harner, 2016):

> "*It was a sort of relationship with someone who was much older, so thirty-ish, over a period of about two-years. At the time I thought it was a boyfriend relationship, but obviously in hindsight it wasn't, but it was quite a kind of silent relationship.*" (Hope)

This theme documents the chronic nature of CSA which women in this study previously experienced. Though all women endured at least two years of CSA, incidences varied, with some women reporting daily abuse. Also captured in this theme was that perpetrators were not always the same person, but could be multiple people over an expanse of time. Further, women in this study reported perpetrators could also be female; something which Kramer and Bowman (2011) state is rare, and often 'invisible' in narratives of CSA. Women discussed how the chronicity of abuse they suffered impacted their mental health and psychological wellbeing, as well as their ability to trust.

Pregnancy and childbirth as paradoxically (un)safe experiences

Though some women were able to begin to heal and trust again, this was challenged over their lifecourse, such as in future sexual intercourse and conception:

> "*It [CSA] was done without permission. . . it started without my permission and it ended without my permission. . . maybe the same with my pregnancy because my pregnancy happened without my permission.*" (Nita)

Some women discussed how they found themselves disconnected from the physicality of carrying and/or birth:

> *"I've had three children and one miscarriage. The first child was born when I was a student at university. . . in 1970 and due to the circumstances at the time he was adopted at 10 days old . . . . . I think I really had more of the attitude of a surrogate and all the way through the pregnancy it was this was somebody else's child, and this is the process which will happen. . . "* (Cora)

Pregnancy examinations and labour were also challenging times, as exemplified by the contrasting accounts from Opal, who felt the need to protect herself from the attending medical staff:

> *"And she [mother] kept saying, "What's wrong love? Why?" I said, "I don't want them looking at me down there. She said, "It's okay, they're doctors." I just went crazy, ripped all the wires off . . . . . I was in hard core last stages of labour, and I locked myself in the loo because I thought, "They are going to see that I've been sexually abused or be able to tell.""* (Opal)

And from Chloé, who described her thirty-two-hour labour as an almost silent, fear-evoking catatonia:

> *"I was very quiet during childbirth and I wonder, thinking about it. . . I wonder if there was a connection between being [covers mouth-referencing sexual assault] and if you felt more liberated you would just make a lot more noise because you can. . . "* (Chloé)

This theme clearly demonstrates the paradox women experienced during pregnancy and birth. On the one hand, the people around them were there to deliver their child safely, but on the other, these interactions could evoke the same fears they carried over from their history of CSA. This often rendered them disempowered, scared, and in some cases, re-traumatised.

Enduring nature of survival strategies

How women reacted to pregnancy and childbirth, depended on the nature of their recovery from chronic CSA and how they had learned to cope when under threat from human stressors – either during their abuse or subsequently. This led to the final theme in which women discussed how these 'survival strategies' had been learnt, were lifelong, and helped women (re)gain control when they felt under threat:

> "*I don't think I'm exaggerating here. . . I felt very little for the next four years [after abuse]. I was completely knocked out emotionally and didn't really come to until I was about ten-ish . . . . . I think I developed this capacity to cut things off. . . batten down the hatches. . . put the lid on the volcano. . . all those metaphors that one uses. . . "* (Cora)

With regards, specifically to pregnancy, some participants discussed this feeling of emotional numbing, as coping via a more intense psychological dissociation:

> "*From my perspective of what I know now but I didn't know at the time, I think when I was actually physically giving birth that I was actually using the dissociation coping to deal with the pain of birth because I found both births relatively easy.*" (Zoë)

Whilst internal control was discussed by some participants, having a voice, controlling the narrative, and deciding who found out about the CSA was important, and something which was echoed as an issue in pregnancy and childbirth:

> "*. . .my voice not really being heard and you feel quite out of control . . . . . you are physically trapped and tied to a bed, as it were, with nobody listening to you and that's a really strange experience where you are meant to be at the centre of things but actually you are the person with the smallest voice in the room . . . . . I mean, it's a kind of theme through life. I struggle in situations where I am not in control and where I have no voice. It creates a bigger feeling of panic in me.*" (Hope)

When internalised coping was not working, and control was seen as being lost, a common survival strategy discussed across interviews was 'defiance'. Chloé recounted physically and verbally fighting back against her abuser, but also reflected on how she experienced similarly violent reactions to her attending obstetric staff many years later:

> "*. . .I pretty much got violent back with the last boy. . . he used to come back to the children's home and then he did it one more time and by that time I was like, "You can fuck off right now". I remember punching him in the ear and saying: "If you ever touch me again, I'm going to kill you!" . . . . . I reckon I was, yes maybe thirteen, fourteen, something like that. Then I became quite sexually active quite quickly after. . . "* (Chloé)

> "*. . .the lady was like "If he doesn't come out, we're going to have to cut you" . . . . . they had to bring in a lot of doctors when he was stuck, but I don't really remember too much about that. . . I thought "Fuck that! You ain't going near me. . . it's coming out, you are not touching me!"* (Chloé)

Survival strategies in this context refer to the way women who previously experienced CSA cope with said abuse. These survival strategies become a way of surviving threatening situations long into their future, and are sensitive to being (re)activated, not only in times when memories of the abuse are triggered, but in any situation where they feel unsafe, distressed, trapped, or powerless. In this study, common survival strategies included defiance; compliance; 'shutting down', dissociating, emotional numbing or suppression; and avoidance (Leclerc et al., 2011; Montgomery et al., 2015a). (Re)activation is not linear and can involve a combination of responses, when – as Kitzinger (1978) states – women are expected to perform the 'perfect patient' role, in what are often, less than perfect conditions.

Discussion

Interpretation of theory

Grounded theory analysis elicited three main themes in relation to women's experiences of pregnancy and childbirth, having previously experienced CSA. The theory itself – *(Re) Activation of Survival Strategies during Pregnancy and Childbirth following Experiences of Childhood Sexual Abuse* – is derived from the way in which the themes inter-relate

(Figure 2). Here, themes are processional (Silverio et al., 2019), whereby experiences of chronic CSA (Theme 1), lead to the development of enduring survival strategies (Theme 3), which are in turn, (re)activated when experiencing threat or distress during pregnancy and childbirth (Theme 2).

Analysis demonstrated women-survivors of CSA develop a means of surviving traumatic situations as children, and when found to 'work', will continue to use the same strategy in situations they experience as similarly threatening (such as during pregnancy and childbirth). It is important to recognise it is not necessarily a specific medical examination or procedure or a particular gender of HCP, but the perceived lack of control, agency, or consent to said procedure which mirrors their experiences during CSA. Pregnancy itself can lead to women-survivors not feeling in control of their own bodies, feelings which can be amplified when they feel their concerns go unheard. These perceptions can lead to feelings of vulnerability, distress, or threat, which are overcome by (re)activating survival strategies. We see here (re)activation of survival strategies is crucial to women's ability not only to cope, but to survive otherwise routine examinations which they, due to their history of CSA, may find traumatic.

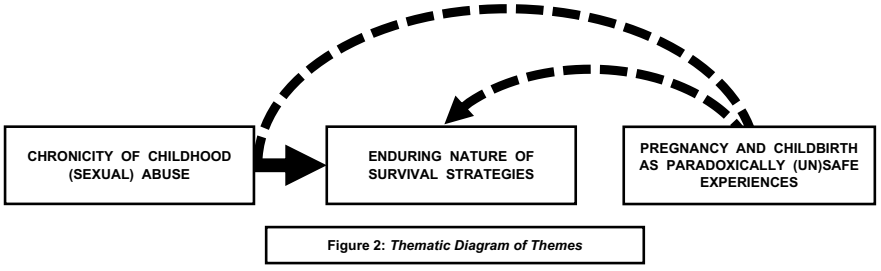

Figure 2. Thematic diagram of themes.

Framing the theory

These data are consistent with previous research citing the lasting impact of CSA trauma on the way individuals interpret and protect themselves in perceived unsafe situations (Van der Kolk, 2014). Part of this longstanding impact is that the CSA itself was chronic (i.e. occurring more than once and over a long period of time) for all of the women in this study. Chronicity has been noted by several other scholars in their research on organised paedophilia (Salter, 2019), children who experience CSA in foster care (Steenbakkers et al., 2018), and intra-familial CSA (McClain & Amar, 2013). Participants in the study did not receive any psychological support as children. This is neither unusual given the trauma they endured (McClain & Amar, 2013), nor surprising as many children struggle to recognise or articulate CSA (Longfield, 2015). Specific reasoning for disclosure rates remaining low is widely debated (Cawson et al., 2000; Leclerc & Wortley, 2015), but could point to the low levels of engagement many women-survivors of CSA have with psychological support services (Steenbakkers et al., 2018), especially when CSA is chronic (Morrison et al., 2018). Women in this study were often despondent about disclosing CSA due to repeated disclosures being disbelieved (Stiller & Hellmann, 2017).

The present study echoes previous research which has found pregnancy and childbirth to not always be perceived as safe (Coles & Jones, 2009; Montgomery, 2013), and indeed can be deemed threatening (Montgomery et al., 2015b). For women in this study, pregnancy and

childbirth represented a paradoxically unsafe time in their adult life, in which survival strategies learnt during CSA were (re)activated. 'Survival strategy', here, is used to differentiate it from the more generic idea of consciously 'coping'. We locate 'survival strategy' as a more sub-conscious mechanism, implying strategies are developed to engender a sense of control. These responses are involuntarily called upon long after the abuse has stopped, should present-day situations be perceived as threatening or disempowering (Garratt, 2011; Parratt, 1994).

The originality of this grounded theory is the aspect of (re)activating survival strategies learnt during CSA whilst receiving maternity care. (Re)activation is not simply recalling traumatic events when feeling threatened, nor is it pre-empting and mitigating situations which could render women disempowered or not in control. Rather (re)activation is involuntarily enacted as a mechanism to survive situations and restore bodily agency, and become ingrained as a way of reacting to the world. Different survival strategies act like a map which women follow, to ensure safety when perceiving threat. Notably, it was not known which or why one survival strategy was utilised over another at any given time, and (re)activation of particular survival strategies varied.

Strengths, limitations, and future research

Strengths lie in the rigorous methodology employed to analyse these data. Grounded theory enabled a rich analysis with a small number of participants. Secondly, the demographics are varied in this study (broad age range; mixed numbers of children; range of CSA duration from 2–13 years), however we recognise due to the small number and withholding other demographic characteristics such as ethnicity and interval since last birth experience (due to potential identifiability) could limit the potential utility of our findings. We also recognise the length of time which had lapsed between the last incident of abuse and the time of the interviews, may be interpreted as a limitation, however, we argue a lifecourse rupture such as CSA is significant enough such that recall memory can be relied upon (Van der Kolk, 2014). Furthermore, telephone interviews, whilst pragmatic, may have led to slightly shorter interviews (Sturges & Hanrahan, 2004) than if we had adopted the 'gold standard' of face-to-face interviews for all participants. Future work should also address the minor limitation of being a study bounded by geography, and should recruit women who have lived and given birth outside the UK to see whether experiences of maternity differ, which can be achieved by 'testing' the theory we have generated. The theory developed in this study could also be 'tested' in women-survivors of adult sexual abuse/assault who have experience of pregnancy and birth (i.e. changing the context), in women-survivors of CSA about their experiences of gynaecological procedures/examinations (i.e. changing the phenomenon), or in male-survivors of CSA who go onto become parents (i.e. changing the population) to see whether differences exist between them and the women-survivors of CSA.

Conclusion

Within the scope of this study, sensitive care, open communication, and an awareness and understanding of more subtle trauma responses appear to have the potential to alleviate the necessity for the (re)activation of survival strategies, by ensuring women are empowered, feel agentic and in control, which in turn, contributes to the feeling of threat being reduced. Better understanding of CSA amongst maternity professionals –

no matter their gender – may therefore positively impact women's experience of antenatal care and birth, meaning women are more comfortable accessing maternity services. From this study, it is important to recognise women's behaviour in reaction to seemingly routine monitoring or physical examination, can be a result of feeling threatened. Reactions, therefore, may in fact be (re)activations of survival strategies learnt during CSA, which are involuntarily enacted to survive a situation in their maternity care, which they have perceived to be threatening.

Acknowledgments

We would like to thank all the women who took part in this study. Sharing your experiences has not only made this research possible, but has allowed us to call for positive changes in maternity care settings.

Authors' contributions

CR conceptualised the study with SAS and YR. SAS and CR prepared documents required for ethical approval. CR and SAS recruited participants. CR collected all data and led on data analysis and interpretation with SAS. CR and SAS led on writing of manuscript with contribution from EM and YR. All authors read and approved final draft of manuscript.

Consent to participate

All participants provided fully informed consent before interviews commenced.

Consent for publication

All consenting participants also consented for anonymised data to be used in future publications.

Disclosure statement

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Declarations

Ethics approval

Ethical approvals were sought and granted by the UCL Research Ethics Committee (project ID: 14915/001).

Availability of data and material

Given the sensitive nature of the data produced by this study, the interview transcripts will not be made publicly accessible.

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