South Australian Perinatal Practice Guideline

Sexual Abuse in Childhood

Pregnancy, Birth and Postnatal Care Considerations

Note:
This guideline provides advice of a general nature. This statewide guideline has been prepared to promote and facilitate standardisation and consistency of practice, using a multidisciplinary approach. The guideline is based on a review of published evidence and expert opinion.
Information in this statewide guideline is current at the time of publication.
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Health practitioners in the South Australian public health sector are expected to review specific details of each patient and professionally assess the applicability of the relevant guideline to that clinical situation.
If for good clinical reasons, a decision is made to depart from the guideline, the responsible clinician must document in the patient's medical record, the decision made, by whom, and detailed reasons for the departure from the guideline.
This statewide guideline does not address all the elements of clinical practice and assumes that the individual clinicians are responsible for discussing care with consumers in an environment that is culturally appropriate, and which enables respectful confidential discussion. This includes:

- The use of interpreter services where necessary,
- Advising consumers of their choice and ensuring informed consent is obtained,
- Providing care within scope of practice, meeting all legislative requirements, and maintaining standards of professional conduct, and
- Documenting all care in accordance with mandatory and local requirements

Note: The words woman/women/mother/she/her have been used throughout this guideline as most pregnant and birthing people identify with their birth sex. However, for the purpose of this guideline, these terms include people who do not identify as women or mothers, including those with a non-binary identity. All clinicians should ask the pregnant person what their preferred term is and ensure this is communicated to the healthcare team.

Explanation of the Aboriginal artwork:
The Aboriginal artwork used symbolises the connection to country and the circle shape shows the strong relationships amongst families and the Aboriginal culture. The horseshoe shape design shown in front of the generic statement symbolises a woman and those enclosing a smaller horseshoe shape depicts a pregnant woman. The smaller horseshoe shape in this instance represents the unborn child. The artwork shown before the specific statements within the document symbolises a footprint and demonstrates the need to move forward together in unison.

Australian Aboriginal Culture is the oldest living culture in the world, yet Aboriginal people continue to experience the poorest health outcomes when compared to non-Aboriginal Australians. In South Australia, Aboriginal women are 2–5 times more likely to die in childbirth and their babies are 2-3 times more likely to be of low birth weight. The accumulative effects of stress, low socio-economic status, exposure to violence, historical trauma, culturally unsafe and discriminatory health services, and health systems are all major contributors to the disparities in Aboriginal maternal and birthing outcomes. Despite these unacceptable statistics, the birth of an Aboriginal baby is a celebration of life and an important cultural event bringing family together in celebration, obligation, and responsibility. The diversity between Aboriginal cultures, language and practices differ greatly and so it is imperative that perinatal services prepare to respectfully manage Aboriginal protocol and provide a culturally positive health care experience for Aboriginal people to ensure the best maternal, neonatal and child health outcomes.

Purpose and Scope of PPG

This guideline is intended for use in the identification and support of women who have experienced childhood sexual abuse (CSA) and who are pregnant, giving birth and in the postnatal period.

Government of South Australia
SA Health

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Summary of Practice Recommendations

Health care providers must be aware of Childhood Sexual Abuse (CSA) and the potential implications for pregnant and birthing women.

Screening of pregnant women for CSA is necessary to assess survivors' physical and psychological well-being.

Employing principles of respectful maternity care and continuity of carer is beneficial for the development of trusting, supportive relationships between women and caregivers when they have experienced CSA.

CSA survivors can experience significant trauma when they become pregnant, give birth, and adjust to parenting.

Clinicians are mandated to report to the Department for Child Protection if they have reasonable grounds to suspect that a child or young person is, or may be, at risk of harm.

It is recommended that clinicians employ 'hands off' breast feeding assistance, unless otherwise requested.

Consider Cabergoline for women with extensive trauma, who may find lactogenesis distressing.

Women who have experienced CSA should be offered support. Referral to services relevant to her situation and with her consent is important for her long-term care and transition to parenthood.

Abbreviations

CSA	Childhood Sexual Abuse
GP	General Practitioner
PIMHS	Perinatal and Infant Mental Health Service
PTSD	Post Traumatic Stress Disorder

Definitions

Post Traumatic Stress Disorder	PTSD can follow traumatic events. PTSD can present with the following sequalae: re-experiencing the traumatic event, avoidance, negative emotions and thoughts and hyperarousal following the traumatic event.[1]
Shared decision making	Shared decision making involves discussion and collaboration between a consumer and their healthcare providers. It is about bringing together the consumer's values, goals, and preferences with the best available evidence about benefits, risks and uncertainties of screening, investigations, and treatment, to reach the most appropriate healthcare decisions for that person.
Trauma informed care	Person-centred care organised around an awareness and sensitivity to the possibility that all health consumers, carers, and families may have experienced or be experiencing trauma in their lives. A trauma informed approach accommodates the vulnerabilities of trauma survivors, avoids inadvertent re-traumatisation, and facilitates consumer participation in treatment and care.
Vaginismus	A penetration disorder where any form of vaginal penetration is painful and/or impossible.[2]

Literature Review

Childhood sexual abuse is defined as:

"Any act which exposes a child to, or involves a child in, sexual processes beyond his or her understanding or contrary to accepted community standards. Sexually abusive behaviours can include the fondling of genitals, masturbation, oral sex, vaginal or anal penetration by a penis, finger, or any other object, fondling of breasts, voyeurism, exhibitionism, and exposing the child to or involving the child in pornography. It includes child grooming, which refers to actions deliberately undertaken with the aim of befriending and establishing an emotional connection with a child, to lower the child's inhibitions in preparation for sexual activity with the child."[3]

Each Australian state and territory have their own legal definitions for CSA but every jurisdiction has legislation that criminalises sexual acts involving a child who, at the time of the offence, was below the legal age of consent.[4]

Because of the varying legal definitions, **behavioural** definitions are often used to identify abuse.[4, 5] They can be classified into three types:

1. non-contact sexual abuse (e.g., threats of sexual abuse, verbal sexual harassment, sexual solicitation, indecent exposure, exposing the child to pornography)
2. contact sexual abuse involving sexual intercourse (e.g., sexual assault or rape)
3. contact sexual abuse excluding sexual intercourse but involving other acts such as inappropriate touching, fondling, and kissing.

CSA is perpetrated by an adult or another child (by age or development) who by age or development is in a relationship of responsibility, trust or power and where the abuse satisfies the needs of the other person.[4]

CSA commonly begins with non-physical behaviours commonly known as grooming. Grooming behaviours come in many forms such as psychological, emotional and coersive. CSA will often then become physical once the perpertrator has gained the confidence of the survivor.[5, 6] It may occur on a frequent basis over weeks or even years, as repeated episodes become more invasive over time, and it can also occur on a single occasion.[7]

CSA survivors can experience a range of common feelings that are likely to be triggered or re-experienced during pregnancy, birth and postnatally, these include:

- shame
- humiliation
- helplessness
- loss of control
- feeling "damaged"/ "ruined"
- fear/terror
- anger
- despair.[8, 9]

CSA is a global problem with an estimated prevalence of approximately 12% but these rates are much higher in girls than in boys with rates of 18%.[10, 11] In Australia, one in six women experienced physical or sexual abuse before the age of 15.[12] CSA has long-term negative physical and psychological effects.[13] Health care providers must be aware of CSA and the potential implications for pregnant and birthing women. Respectful maternity care with open communication and individualised care can benefit the woman/healthcare provider relationship and result in women feeling empowered and supported through their transition to motherhood.[14, 15]

Although statistics show that most CSA perpetrators are men, it is essential to acknowledge the presence of female perpetrators, even if they represent a smaller proportion.[4, 16] For this reason, an individualised approach to each woman should be considered.

Impact on Pregnancy, Birth and Parenting

The perinatal period can be particularly stressful for survivors of CSA due to the similarity of bodily sensations experienced during sexual violence and pregnancy, childbirth, and perinatal care.[17] Clinical care may trigger memories of CSA,[18] and for some women, pregnancy, childbirth and early transition to parenting may be significantly traumatic experiences.[8]

Most women who have experienced CSA do not disclose this to healthcare practitioners and may not be easily distinguishable from women who have not experienced abuse.[18] However, their history of CSA can cause significant ongoing distress.[18] Research indicates that women who have experienced CSA exhibit higher levels of fear, stress, and anxiety. They also experience pregnancy complications including pre-term birth at higher rates, compared to women without a history of CSA.[8, 9, 19]

Intrafamilial CSA

Intrafamilial CSA refers to sexual abuse that occurs within the family, typically involving a child and a family member (e.g., parent or sibling) or someone closely related to the family (e.g., uncles, aunts, cousins).[20] Because the abuse is committed by someone the child knows and often trusts, intrafamilial CSA can be especially complex and traumatic, as it involves both the betrayal of trust and the abuse of familial bonds. This type of abuse is often kept secret due to family dynamics, loyalty, fear, or pressure to protect the family unit.[20]

Clinicians should be aware of the impact of intrafamilial CSA on women in terms of the complex family dynamics when CSA has occurred within the home. These women may have limited social support due to complex family dynamics and/or family involvement that is likely to cause distress in the woman.[9]

Respectful Maternity Care

Respectful care principles applied universally to all women, can help minimise the trauma experienced by women who have been exposed to CSA. Continuity of caregiver for women who have experienced CSA can have additional benefits. Continuity of caregiver allows a relationship to develop and can increase the chances that the woman will feel comfortable in expressing her needs. Care for women who have experienced CSA should be individualised, person-centred, culturally sensitive, flexible, compassionate, respectful, trauma informed, and woman led.[17, 21]

Appropriate Medical/Midwifery Responses

Sensitive care throughout pregnancy and childbirth can minimise the potential of further traumatisation for women with a history of CSA.[15] All clinicians should act in a way that empowers the woman to learn more about their body and have control over their physical well-being. Although the following recommendations form a part of routine care they can be very important when caring for women who have experienced CSA:

- Use clear and supportive language:
  - inappropriate language may be a trigger for memories of past abuse
  - use language that describes procedures in equal and adult terms
  - avoid infantilising language, for example ‘good girl’
  - avoid language that encourages shame and/or mistrust in her body, for example, ‘failure to progress’

- ensure a female interpreter is offered if required.

- Avoid authoritative or patriarchal approaches, including what might be perceived to be aggressive posturing (potential to alienate the woman and return her to a vulnerable, childlike state).
- Obtain permission from the woman before any personal or intimate contact.
- Ensure women understand that all procedures depend on their informed consent.
- If women are experiencing flashbacks or dissociating, allow time. When able, encourage the woman to resume eye contact and focus on the clinician's voice (connects woman with the present).
- Obtain permission from the woman before attending any care for her baby.
- Always maintain the woman's privacy. [8, 9]

Antenatal Care

Screening of pregnant women for CSA is necessary to assess survivors' physical and psychological well-being.[8] The first antenatal visit provides clinicians with an opportunity to enquire about a history of CSA. The ANRQ specifically asks about sexual abuse, therefore, checking the response to this question should form part of the screening. Note that a no response to this question does not necessarily mean that CSA has not occurred. Often women will not feel comfortable sharing their experiences and may not respond to a direct question.[22] As trust develops with her health care providers a woman may feel more comfortable disclosing her history of CSA. Health care professionals should be open to conversations about CSA even if at the first antenatal visit the woman says she has no history of CSA. It is important to provide appropriate access to a female caregiver for women whose main spoken language is not English wherever possible.

Identification of Women Who Have Experienced CSA

Sensitive questioning by health care professionals is important and phrases such as the following may be appropriate:

- "Sometimes, the experience of pregnancy and childbirth can trigger past difficult incidents in a woman's life. If you feel anything like this, please feel free to discuss it with me if you feel comfortable or with your general practitioner (GP)."
- "Sometimes, childhood traumas can resurface during pregnancy and childbirth, causing difficult emotions. If you're experiencing feelings like this, talking to a midwife, counsellor, or your GP can be helpful. It's also important for us to understand how we can best support you throughout your pregnancy and childbirth."
- "If you experienced childhood sexual abuse, the physical, emotional, and psychological changes of pregnancy might trigger painful memories. Discussing your history with your doctor or midwife can be helpful."

Women with a history of CSA may present with an extreme fear of the birth and sensitive and trusting relationships with maternity care providers may provide the woman with opportunities to explore her fears. [9, 23] Continuity of care provider can assist women to develop those relationships.

Antenatal Indicators of CSA

The different phases of pregnancy and bodily changes during pregnancy can trigger memories of CSA. Words and physical contact by health care providers can act as triggers.[24]

A combination of the following markers should alert the clinician to a **possible** history of CSA. It is important to be aware that **not all** women who have experienced CSA will exhibit these behaviours and women who **have not** experienced CSA can also experience the following:[24]

- non-attendance
- increased stress, anxiety, depressive symptoms, and suicidal ideation
- concerns over, or declines examinations that require intimate contact for example:
  - abdominal palpation
  - vaginal examinations
  - breast examinations
  - venepuncture
  - ultrasounds.
- difficulties with vaginal examinations or vaginismus
- substance use
- fear of labour/birth
- fear and/or concerns around breastfeeding
- concerns regarding parenting.

Disclosing CSA

- Ensure that you acknowledge the woman's experience and empathise with her.
  - empathy involves listening and understanding the woman's fears and concerns yet still being able to recognise her feelings as distinct from themselves.[25, 26]
- Evaluate her existing social supports.
- In consultation with the woman, determine the need and priority for perinatal mental health and social work involvement in her care.
  - If the woman has existing support services in place, discuss working together to support her through her pregnancy, birth, and postnatal journey.
  - If the woman agrees, contact her support services to develop a collaborative care plan.
- Use non-judgmental language and an open-minded, opinion free approach to communication that relays understanding and empathy in relation to the traumatic effects of the abuse.
- Discuss the potential impact on pregnancy or birth and how you can work together to minimise any potential for trauma or re-abuse.
- Offer information on appropriate support services (e.g. social work, women's health state-wide, perinatal mental health).
- Recommend and facilitate booking for a model of care that offers the woman continuity of caregiver with a caregiver that she is comfortable with.
- Identify if there are any signs of post-traumatic stress disorder (PTSD). Example of symptoms could include, but not limited to:
  - flashbacks
  - intrusive sensory memories
  - repetitive intrusive thoughts
  - nightmares
  - autonomic arousal (e.g. tension, jumpiness, flinching).
    - Arrange a referral (with consent) to the appropriate allied support services (e.g. social work, perinatal mental health nurse, psychiatrist).

Note: *It is not necessary for the health care provider to know the details of the CSA to support her.*

Antenatal Clinical Care Considerations

Any physical contact from the health care provider in the antenatal period can be potentially distressing for the woman who has experienced CSA.[25, 27] Additional trauma can be reduced by ensuring open communication, discussion of rationale, listening to the woman's requests and respecting her wishes if she declines any procedure/intervention or recommendation.

Depending on the woman's symptoms, coping and wishes a formal referral to mental health care may be indicated. Assessment and therapy during pregnancy may significantly reduce or prevent re-triggering of trauma during the birth experience.

Ensure the woman is not rushed to make any decisions about her care. Inform her of the recommended care in pregnancy in advance so she has time to consider aspects of care prior to each presentation. Fear of procedures such as vaginal examination can lead to non-attendance for care.[27, 28]

Mode of birth will be discussed with the woman and her health care providers. When health care professionals can build a positive and safe relationship with the woman, they should discuss the potential that a male health care provider may be involved in her care, particularly in the event of obstetric emergencies. She should be reassured that if she wishes that there is no contact from a male health professional, that staff will attempt to meet her needs.

Explain to women that they do not have to agree to any examination at any time and thoroughly explain the tenets of informed consent and how this can be assured for her pregnancy, birth, and postnatal period.

Vaginal Examinations and Vaginal Ultrasounds

Vaginal examinations and ultrasounds are a frequent trigger for trauma associated with CSA.[24, 27, 28] If a health care provider recommends a vaginal examination or vaginal ultrasound, they should ensure the rationale is explained and informed consent gained and documented.

- Ensure a chaperone and/or support person is present.
- Aim for a quiet environment, with minimal noise and minimal activity outside the room and ensure privacy is maintained.
- Reassure the woman that the examination will stop any time at her request. Pace the procedure to the woman's needs, look for cues that she may be distressed, and always explain actions.
- Ask the woman if she would like to hold/insert the ultrasound probe herself to maintain control.

Intrapartum Care

Women who have experienced CSA may experience fear of the physical process of labour, sense a loss of control. Trauma responses may include:

- dissociation from labour and birth
- flashbacks of abuse
- passive compliance
- childlike behaviour
- fear of pushing
- overly aggressive
- controlling behaviour

Labour and birth can be particularly challenging for women, with feelings of loss of control directly related to: epidurals, contact with many unknown health care professionals, pain, intimate examinations and a process that is somewhat out of the woman's control.[15, 24, 27] Utilising the principles of respectful maternity care and a continuity of care model, it is possible to prevent re-traumatisation of the women in in pregnancy, birth and early parenting.[26] It is essential that clinicians remember the principles of individualised care, and recognise that for some women, vaginal birth might not be possible due to CSA trauma, consider LSCS option where appropriate. Clinicians involved in the birth should also remain vigilant to the vulnerability of the birthing woman; a woman who has experienced CSA is likely to associate danger with vulnerability.

- PTSD responses related to labour and birth can be heightened in women with a history of sexual abuse.
  - Lack of consent for medical procedures may also trigger PTSD symptoms.[29]
- Women who have experienced CSA can experience fear that others will see that she has been sexually abused by the damage to her genitals.
  - This can trigger feelings of shame and humiliation for the woman.
- Being naked and having a male care provider can also contribute to fear and stress for CSA survivors.[15, 27]
  - Health professionals should be receptive to the woman's needs that may include an upright labour and birth and remaining clothed.[29]
- Pain in the vulvo-vaginal region or perineal pressure in second stage can be triggers for flashbacks or other associations to CSA.
  - While most women experience relief from pain with the use of epidural anaesthesia,[29] for some, it may act as a trigger during birth. The associated loss of sensation and confinement to bed can evoke feelings of physical and emotional paralysis reminiscent of their past assault(s).[30] Therefore, individualised care and sensitivity to each woman's unique experiences and preferences are essential when considering epidural use, particularly among women with a history of CSA.
- If the woman is birthing in the hospital, then selection of a birth room is important for some women who do not wish to have their back to the door as they wish to see who is entering the room.[29, 30]
- Clinicians should aim to ensure the birth environment is quiet and calm as the woman is likely to be experiencing a degree of hyperarousal, that could easily intensify with unnecessary commotion and activity.
  - Spotlights on the woman's genitals can also act as a trigger for some women.[29]
  - Women may wish to bath their baby immediately after birth.[29]

Postnatal Care

For women with a history of CSA, the transition to motherhood may provoke fear and anxiety about:[27, 30]

- breastfeeding and skin to skin contact (may trigger memories / flashbacks of abuse)
- their maternal/infant relationship.

After birth women can develop symptoms of distress, such as PTSD, depression and dissociation.[15, 27, 30] If there are signs of these conditions then referral for mental health assessment and treatment should be offered and encouraged, as these conditions are likely to persist and worsen without appropriate treatment. Offer the woman a post birth debrief to explore the impact of the experience on the woman's wellbeing.[29]

Breastfeeding

Generally, women with a history of CSA can move through these memories and breastfeed without problems. For some, the association with the abuse may be too strong and they may decide to artificially feed their babies. Women should be supported in their choices.

Appropriate Support

The clinician should employ 'hands off' breast feeding assistance. Clinicians can use teaching aids such as dolls to facilitate education without the need to touch the woman's breast. If it is necessary for the clinician to use 'hands on' to assist with breast feeding, as with any woman, ask for her permission before touching her breast(s).

If the woman is concerned about breastfeeding, explore her concerns with her and find solutions that are acceptable to the woman. Reassure the woman that her feelings are okay.

Offering alternative feeding methods where appropriate (e.g., when suckling at the breast triggers flashbacks). If the woman opts to artificially feed, ensure this is communicated to other health care providers so the woman does not need to explain her choice again.

Maternal Infant Relationship

Women with a history of CSA may have anxiety/fears about:

- the gender of their baby
- fear of damaging their baby
- fear of loving their baby
- fear of intimate contact with baby (e.g. bathing baby or changing nappy)
- potential risk of postnatal depression or general depression
- the baby's safety (overly concerned)
- a fear of being separated from her baby (if nursery care is required)
- fear of her baby being cared for by strangers that she doesn't know and trust (if nursery care is required).

Appropriate Support

- Explain that daily activities related to the care of baby (e.g. bathing, changing nappies) arise from the baby's hygiene needs and are not related to sexual abuse.
- Reassure the woman that she is not responsible for her history of CSA and affirm her maternal abilities.
- Provide education to the woman about mother-infant bonding, explore and encourage ways to promote bonding. This is especially important for women who have experienced intrafamilial CSA.
- Explain that it is normal to have a short period of sadness that peaks three to five days after birth.
- Facilitate an in-depth conversation around the benefits of breastfeeding for her and her baby. Empower the woman with knowledge but respect her decision to artificially feed her baby.
- Consider suppressing lactation for women with extensive trauma, who may find lactogenesis distressing.
- Explain that the woman's memories of sexual abuse may be reactivated when the child reaches the same age as when her CSA occurred.
- Communicate understanding and sensitivity about how the woman is feeling. Remember she is responding to the effects of being subjected to CSA.
- See *Assessing Parent Infant Relationship PPG* found in the A-to-Z index at www.sahealth.sa.gov.au/perinatal.

Additional Considerations

Health professionals should consider risk and safety for the woman and her baby. Questions to consider include:

- was her abuser prosecuted?
- are they still in her life?
- is her baby at risk?

Concerns about risk for the woman or her baby should be managed depending on the woman's circumstance. If necessary urgent referrals should be made to escalate the level of support offered to the woman and her baby.

Considerations for Health Professionals

Health professionals should be aware of the possibility that the distress the woman experiences can cause distress in the health professional too. They should be careful not to project this onto the woman.

Health professionals may be required to tolerate a high level of distress from the woman at times, they should understand that her feelings cannot be fixed and should not be dismissed or minimised. Offer support and reassurance and wait for distress to pass.

Organise appropriate support and debriefing with colleagues and recognise the emotional strain of caring for a woman who has experienced CSA.

Access staff counselling services as required. The SA Health Employee Assistance Program is available to all employees, providing free, confidential counselling services: SA Health Employee Assistance Program: SA Health

Perinatal Infant Mental Health Service (PIMHS)

Women who have experienced CSA should be offered support and access to specialist assessment and treatment if indicated. Referral to services relevant to her situation and with her consent is important for her long-term care and transition to parenthood.

PIMHS at Metropolitan Hospitals

Flinders Medical Centre: Telephone (08) 8404 2551

Lyell McEwin Hospital: Telephone (08) 8282 0794

Women's and Children's Hospital: Telephone (08) 8161 7227

Useful Contacts/Support Services

Service	About	Contact
Brave Hearts	Provide a coordinated and holistic approach to the prevention and treatment of child sexual abuse, including adult survivor support and education and training.	**1800 272 831** www.bravehearts.org.au
Blue Knot Foundation	Leading national organisation working to improve the lives of adult Australians who have experienced childhood trauma.	**1300 657 380** helpline@blueknot.org.au https://www.blueknot.org.au/
Child and adolescent mental health service (CAMHS)	Free community-based tertiary mental health service provided through the WCHN across South Australia, providing care to infants, children, and young people with severe and/or complex mental health needs. Open 9 am–5 pm, Monday to Friday (except public holidays).	**1300 222 647** www.wchn.sa.gov.au/our-network/camhs
Childhood Sexual Abuse Counselling Service, Uniting Communities	Men, women, children and young people who want to address the effects of CSA in their lives. Appointment required. Fees: Sliding scale according to income. Hours: Mon - Fri 9 am–5 pm	**08 8202 5190**
Helen Mayo House	Provides tertiary level inpatient and outpatient treatment for mothers, their infants, partners, and their families where there are post-natal mental health problems.	**0481 057 744** www.wch.sa.gov.au/hmh
Relationships SA	Adult CSA support available to people over 16 years of age, who were sexually abused as children. Services include counselling, referrals, information, and resources. They also provide support for others affected such as partners and family members. Hours: Monday-Sunday, 9 am–5 pm AEST/ADST	**1300 364 277** www.respondsa.org.au
Regional Mental Health Services/Telepsychiatry	Telepsychiatry is provided to country South Australians through more than 220 video conferencing units across the Digital Telehealth Network.	**(08) 7087 1660**
Yarrow Place	Free and confidential 24-hour crisis response service for rape and sexual assault for people aged 16 years.	**1800 817 421** https://www.wchn.sa.gov.au/our-network/yarrow-place

Resources

Australian Charter of Healthcare Rights: (www.safetyandquality.gov.au)
Australian Charter of Healthcare Rights | Australian Commission on Safety and Quality in Health Care

Australian Government Pregnancy, Birth and Baby: (www.pregnancybirthbaby.org.au)
Pregnancy, Birth and Baby | Pregnancy Birth and Baby (pregnancybirthbaby.org.au)

COPE Perinatal Mental Health Guideline: www.cope.org.au
cope.org.au/wp-content/uploads/2023/06/COPE_2023_Perinatal_Mental_Health_Practice_Guideline.pdf

Medicines Information: (sahealthlibrary.sa.gov.au)
https://sahealthlibrary.sa.gov.au/friendly.php?s=SAPharmacy

SA Health Pregnancy:
Pregnancy | SA Health

SAPPGs Web-based App:
Practice Guidelines (sahealth.sa.gov.au)

Pathology Tests Explained: (https://pathologytestsexplained.org.au/)
Pathology Tests Explained

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When you need more help

If you experience any of the following, please speak with your healthcare provider or general practitioner:

- flashbacks
- crying
- nightmares
- fast heart beat
- sweaty hands
- tension
- jumpiness
- fear of being alone
- thoughts of self-harm

Your doctor or midwife can put you in contact with some additional support.

Support Services

Childhood Sexual Abuse Counselling Service
Uniting Communities

First Floor, 10 Pitt St Adelaide, SA 5000
Telephone: (08) 8202 5190

Blue Knot Foundation

Leading national organisation working to improve the lives of adult Australians who have experienced childhood trauma.
Phone: 1300 657 380
Email: helpline@blueknot.org.au

Relationships SA

Telephone: 1300 364 277
A 24 hours a day crisis support service.

Lifeline

Telephone: 13 11 14

Perinatal and Infant Mental Health Services at Metropolitan Hospitals:

Flinders Medical Centre:
Telephone (08) 8404 2551
Lyell McEwin Hospital:
Telephone (08) 8282 0794
Women's and Children's Hospital: Telephone (08) 8161 7227

Local General Practitioner

(+/- referral to Mental Health Practitioner)

Rural and Remote Telemedicine/ Tele-Psychiatry Unit

Telephone (08) 7087 1660

CAMHS

Telephone: (08) 8161 7198

Helen Mayo House

Provides tertiary level inpatient and outpatient treatment for mothers, their infants, partners and their families where there are postnatal mental health concerns. Requires medical referral.
226 Fullarton Road
Glenside SA 5065
Telephone: (08) 708 71030
www.wch.sa.gov.au/hmh

For more information

Department of Health, South Australia
SA Maternal Neonatal & Gynaecology Community of Practice
Women's and Children's Health Network
Regional Office,
72 King William Road
North Adelaide, SA 5006
www.sahealth.sa.gov.au/perinatal

Interpreter

Government of South Australia
SA Health

Childhood sexual abuse and your pregnancy

Information for women

Government of South Australia
SA Health

Childhood Sexual Abuse

Childhood sexual abuse affects as many as one in six children. It involves physical, emotional and psychological abuse.

Survivors can feel a range of emotions that include:

- Shame
- Humiliation
- Helplessness
- Loss of control
- Feeling damaged /ruined
- Fear/terror
- Anger and despair

Pregnancy, birth and after your baby is born

As you progress through your pregnancy, birth or after your baby is born some of the negative feelings associated with childhood sexual abuse can be triggered or re-experienced. This can be very traumatic for some women.

Care choices

Continuity of caregiver can help you establish a trusting relationship with your doctor or midwife. The support from a known care provider can help you manage your experience the way that you want it to be managed. You may feel safer to talk to your doctor or midwife about the way that you are feeling.

You might find that requesting a female care provider can make you feel safer. If English isn't your first language then an interpreter can be organised for you.

Strategies to help with medical appointments

Childhood sexual abuse survivors can use several strategies to help them through pregnancy, birth and after the baby is born.

You may wish to make sure that you have your partner, a trusted friend or relative with you for all your appointments to help you feel more comfortable.

You are entitled to say no to any procedure that the medical or midwifery staff recommend to you. You may also choose to ask for more time to think about recommendations.

Some women experience extreme fear of procedures such as vaginal (internal) or breast examinations.

During your pregnancy and birth, vaginal examinations may be recommended. These are recommended to monitor the health and wellbeing of yourself and your baby and plan for your care. All procedures are voluntary, and you can change your mind at any stage. Your care provider will be able to answer any questions you may have.

You may also wish to have a friend or family member present for support should you agree to the examination.

Labour and Birth

Labour and birth can be particularly challenging with feelings of vulnerability and a loss of control. This can be because you will meet many unknown health care professionals, experience pain and require examinations which can feel invasive. Being exposed or having an unknown care provider can also contribute to fear and stress for survivors.

If you feel comfortable, talk to your doctor or midwife about how you are feeling. They may be able to use some strategies to make the experience more acceptable to you.

After the birth

You may experience fear and anxiety about breastfeeding or your relationship with your baby. If you are feeling these things talk to your doctor or midwife if you feel comfortable.

It is normal to experience a few days of sadness a few days after birth but if symptoms increase or persist seek assistance.

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Write Group Lead

Dr Angela Brown
Victoria Sutton

Write Group Members

Dr Rebecca Hill
Carly Jones

Major Contributors

Dr Michael McEvoy
Dr Anthia Rallis
Diana Raschella

SAPPG Management Group Members

Dr Michael McEvoy (Chair)
Monica Diaz (SAPPG EO)
Dr Elizabeth Allen
Elise Bell
Elizabeth Bennett
Dr Angela Brown
Marnie Campbell
John Coomblas
Dr Danielle Crosby
Imogen Downard John
Kate Greenlees
Luke Grzeskowiak
Dr Gemma Hardi
Dr Susie Keynes
Catherine Leggett
Dr Angela Mathew
Dr Scott Morris
Dr Amanda Poprzeczny
Dr Anthia Rallis
Amy Rigano
Dr Shruti Tiwari
Allison Waldron

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