Breastfeeding and Maternal Touch after Childhood Sexual Assault

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Abstract

Introduction:
The study is a qualitative exploration of breastfeeding and maternal touch with new mothers who are survivors of childhood sexual assault (CSA) by a family member.

Objectives:
The objective of this study is to explore the experience of breastfeeding in mothers with a past history of CSA perpetrated by a family member.

Methods:
Using an interpretive framework, eleven women were interviewed with an in-depth semi-structured method and the transcripts coded and analysed by themes. All participants were new mothers who volunteered in response to a community based advertisement. Each woman self-identified as being sexually abused as a child by a family member.

Results:
Significant themes that emerged about breastfeeding were the importance of breastfeeding to the maternal-infant relationship and infant development. Other more challenging themes included detachment and dissociation, exposure and control, lack of pleasure, and splitting of the roles of the breasts into maternal or sexual objects.

During the course of the study maternal-infant touch was raised as an important theme associated with body boundaries between the mother and her child and related to the mother’s past CSA experience. Baths and nappy changes were two areas in which some mothers encountered difficulties associated directly with their CSA.

Some participants encountered difficulties associated with their healthcare. These were largely associated with the participants’ lack of control in the professional encounter and intimate examinations. Baby
examination was also problematic with women reporting being concerned about their ability to protect their children within the professional encounter.

Conclusion:
Many participants described breastfeeding as a positive experience which enhanced their bonding to their babies. They faced challenges as CSA survivors due to the duality of the breasts as sexual and maternal objects. Touch and maternal-infant boundaries emerged as important themes after CSA.
Declaration

This is to certify that

1) the thesis comprises only my original work towards the PhD,
2) due acknowledgement has been made in the text to all other material used,
3) the thesis is less than 100,000 words in length, exclusive of tables, maps, bibliographies and appendices.

Student Signature
Dedication

For mothers, sisters, and daughters

In Memory of Max.
Acknowledgements

First and foremost my thanks to the women who participated in this study. You trusted me with your stories and this thesis is in honour of you.

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[Signature]
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Chapter 1

Introduction

We have lost each other for so long. My name means nothing to you. My memory is dust. This is not your fault or mine. The chain connecting mother to daughter was broken and the word passed into the keeping of men, who had no way of knowing (Diamant, 1998 p.3).

This thesis is an exploration of early mothering and breastfeeding with women who are survivors of child sexual abuse (CSA).¹ It examines the experience of breastfeeding from the participant perspective; how women survivors understand mothering and their breastfeeding bodies in relation to their experience of CSA by a family member.

I use a biopsychosocial framework to argue that CSA affects early mothering.

I began this thesis because of Meg², a young mother who attended my general practice with her baby. She had been breastfeeding when her son smiled at her. She was terrified. She came into my clinic. She couldn’t stop crying and as she entered the room, she placed her son as far away as possible. She had just recalled her rape by her father for the first time. She sought to understand why breastfeeding had triggered her memory.

¹ Child sexual assault and child sexual abuse are both terms that are commonly used for unwanted sexual activity between children and adults or peers in a position of power. Child sexual abuse emphasises the chronic nature of the sexual abuse in children, while child sexual assault emphasises the criminal nature of the act. The women who participated in this study self-reported child sexual abuse rather than assault and I have chosen to use the term the participants identified with throughout most of the thesis. See Chapter Two pp.20-21 for further discussion.

² Pseudonyms are used throughout the thesis.
She asked me for answers; I didn’t have them and could find little information to give her. I began to read, to study, and my research had begun.

**Reflections**

At the outset I must state that I have worked as a clinical medical practitioner for twenty five years. All my adult life has been spent being or training to be a medical practitioner. It is part of the very essence of who I am, so I acknowledge that I may not be as far removed from the ‘clinic’\(^3\) while I write this thesis as I wish to be. Being a general practitioner (GP) and responding to my patients brought me to research. I want the findings of my research to reach women like those who participated in this study. I want to influence and change the primary medical care that survivors receive.

However, being a researcher has challenged the ‘doctor’.\(^4\) In researching long-term impacts of CSA on early breastfeeding, I began to better understand the complex interactions between mothering, breastfeeding, CSA experiences, and the medical and social worlds. This is research that does not fit neatly into a single theoretical or methodological tradition. In trying to understand the women I saw in the clinic, I have moved beyond clinical medical practice. I have done this physically by leaving my practice, returning to academic study at a University and by taking an academic appointment in a medical school. I have returned to the very

\(^3\) French philosopher and historian Michel Foucault uses ‘clinic’ as a metaphor for medical perception and the construction of medical knowledge. My medical training and life as a clinician colour the way I research and think. This is both a strength and a weakness as the effect of power in the research interview and the ‘othering’ of the participant may go unrecognised by me in my work as a researcher. Reference: M. Foucault, 1994. *The Birth of the Clinic: An Archaeology of Medical Perception*, Vintage Books.

\(^4\) Here I use doctor in keeping with *The Australian Concise Oxford Dictionary* definition ‘a qualified practitioner of medicine; a physician.’
place that taught me to think like a ‘doctor’. In my quest to better understand women and their experience, I returned to a medical school within a university. I returned from clinical practice with a different set of tools. Having spent twenty five years listening to women’s experiences and being a female GP, I have used emotion and intuition to hone and improve the interview techniques that I was taught at medical school. With the women I interviewed I am creating new knowledge based in their experience. I have moved in the way I think about the world and illness. I no longer think in solely positivist terms, as this study has taught me alternative ‘ways of knowing’ and creating knowledge based on a social constructivist model.

As I read and reread this work I am conscious of two voices contained within—both are mine. The clinical voice, often speaking in third person, detached and objectifying, if not objective: the research voice, in first person, is an integral part of the interviews, their analysis, and the results. I am as much within the study as my participants. I have made a deliberate choice to leave both voices within my thesis. Without being a GP, I doubt the study would have occurred as it did in response to women I saw in clinical practice. I would not have had the privilege of women sharing their experiences of CSA and its consequences for them as mothers. The exchange\(^5\) between the participants and me would have been different if I had not been a clinician. For some, the interview was an exchange. I was able to answer questions they had been unable to ask others and so the interviews became an interaction. My professional experience was important in demonstrating my fitness to undertake this

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\(^5\) Exchange is used in preference to ‘discussion’ to emphasise that the interviews involved both verbal discussion and non verbal communication: an exchange of multiple communications.
research with a vulnerable population and for gaining ethics approval to do the research.

Situated Research

In explaining and reflecting on my role as a researcher I am starting with a myth of Indian origin as a metaphor for research. Figure One is a visual representation of the following story. I deliberately placed the image before the story to illustrate the different experience between seeing the picture and reading the story:

Figure One. The Elephant and the Six Blind Men Doing “Research”


*Once upon a time, there lived six blind men in a village. One day the villagers told them, “There is an elephant in the village today.” All of them went to the elephant to find out what an elephant was like.*

“The elephant is a pillar,” said the first blind man who touched the elephant’s leg.

“Oh no, it is like a rope,” said the second blind man who touched the elephant’s tail.
“Oh no, it is like a branch of a tree,” said the third blind man who touched the elephant’s trunk.
“It’s like a big fan,” said the fourth blind man who touched the ear of the elephant.
“It’s like a huge wall,” said the fifth blind man who touched the belly of the elephant.
“It is like a solid pipe,” said the sixth blind man who touched the elephant’s tusk.

They began to argue about the elephant and each one of them insisted that they were right. A wise man saw them arguing as he passed by. “What is wrong?” he asked. The blind men answered “We cannot agree what an elephant is like.” Each of them then told him what the elephant was like. The wise man explained to them “All of you are right. The reason each of you is telling it differently is because you each touched a different part of the elephant. The elephant has all the features you have described” (Jainworld.com, 2004).

Each ‘researcher’ and the ‘wise man’ in this story collected data or told a story based on part of the elephant, how and where he conducted his research based on his situation and previous knowledge. He examined or explained his experience of the elephant using the methods available to him. No one reflected on the limitations of their reach, sight, methods of research they used, their pre-existing knowledge or the interpretations they made. The wise man did not consider the extra knowledge that the blind men gained from touch⁶, for him his vision told him the story and he was as limited in his telling as the men without sight. While the shape and form he saw was generalisable to all elephants, he could not see the scars and marks that told of the elephant’s life experience. None asked

⁶The privileging of vision over touch in western thought dates back to Plato’s Allegory of the Cave. The elephant metaphor is doubly relevant to this research because it demonstrates of the privileging of one sense (vision) over another (touch). Touch was particularly important to the CSA survivors in this study, as they breastfed and cared for their babies. Intrusive touch was a theme in baby care and professional examination. These themes are discussed in Chapters Six and Seven. Similarly, one research method (quantitative) can be given a higher status than another (qualitative). Finally, within the interview, the spoken work (transcript) can be given more weight than the emotional interaction between researcher and participant. The interview interaction is discussed in detail in Chapter Five.
the elephant about being or feeling like an elephant—after all, the elephant was not considered important in the experience, it was not a recognised ‘knower’. The data was collected with perhaps the best of intentions, as accurately as possible given the so-called “blindness” of the six and the “vision” of the one, but omitted considering the limitations of the researcher and his standpoint as observer/researcher. Each observer then interpreted the data, but without reflection on the limitations of his perceptions or interpretations, or an understanding of the complexity of being an elephant at that time or in that place. The Hindus use this story to promote tolerance of other viewpoints; it is called the Theory of Manifold Predictions (Jainworld.com, 2004). I use it here as a metaphor for my research, to appreciate the value of using in-depth qualitative methods in understanding a complexity of mothering after CSA.

All knowledge is partial and situated, as was demonstrated by the elephant ‘researchers’ above. The researcher always affects the data collected and so no research is truly objective and therefore all research is limited (Malterud, 2001, Oakley, 2000). The metaphor used above assists me to explain that while I agree with Oakely and Malterud, each of the seven Indian men contributed important information about the elephant in spite of the limitations. Similarly, the research presented in the following chapters contributes to understanding the experience and process of breastfeeding for eleven women who are survivors of CSA. The detail provided by each woman, while unique to her and her experience, is a strength rather than a weakness of the research presented. Rather than did she or didn’t she breastfeed, each woman explains why breastfeeding was important to her, the challenges she faced as a breastfeeding survivor of CSA. In telling her story to me, she explores the physical and emotional
components of the experience through the research: the pleasure, the pain, and how it felt to mother her baby.

A postmodern perspective argues that simple summaries or recipes are not good explanations of the world as it is made up of complex, contradictory and even competing understandings. I have presented the participant viewpoint deliberately throughout much of the thesis. However, it must be recognised that the participants’ words are coloured by how they work within my writing. The quotes presented within this work are not chosen randomly: they reflect my argument, my interpretation and analysis and my underlying theoretical framework. Denzin (1997 p.xiii) succinctly argued this point: “… the worlds we study are created, in part, through the texts that we write and perform about them”. He goes on to describe the four forms of text commonly used in research: speech, transcriptions, written interpretations, and the performances of the texts. Denzin identifies that the performance and the work of text is quite different for each form of text. For example the emphasis and work of the spoken words of an interview are changed when the same words are written and used in a transcript, a journal article or a thesis.

I Speak
I speak as a woman who is a mother: my understandings of mothers are coloured by my own experience. My children taught me new ways of attending to the world. For example, successful breastfeeding is far more complex than promoting ‘breast as best’. It was something that was done to and with my body. It was an emotional, physical and sensual
experience for me, the complexity of which I understood poorly before my experiences as a mother.

It had been hard in medical school to give medical professionalisation preference over caring. I fought and resisted, but gained sufficient medical ‘professional gloss’ to pass. As a young mother, my understandings were being challenged again. The depth of my connection with my children altered the way I thought and felt. My experience was similar to that of Sara Ruddick: caring, emotion and feeling became critically important to my thinking. Ruddick (1984) describes how her experiences reading and writing about Virginia Woolf shaped her thinking:

I seemed to learn new ways of attending the natural world and to people, especially to children. This kind of attending was intimately concerned with caring [...]. The more I attended the more deeply I cared. The domination of feeling by thought, which I had worked so hard to achieve, was breaking down. Instead of developing arguments that could bring my feelings to heel, I allowed them to inform my most abstract thinking (Ruddick, 1984 pp.150-151).

In my case it was my clinical and maternal experiences that acted in a similar fashion, challenging a medical training where thought dominated feeling and resulted in a deeper understanding of the complexity of mothering. It allowed me to acknowledge the emotional components within the research interview and incorporate it into the analysis and reporting of the research.

I speak as a white, middle class, tertiary educated woman, part of the privileged, dominant culture. My life has always been lived within these boundaries, impacting on and limiting the way I think of medicine,
mothering and breastfeeding. It further places boundaries on my conceptualisation of the research process and valid academic work.

I speak as a GP. My education and my clinical work have been based in and limited by a scientific paradigm. I have been thinking about CSA and its impact on young mothers since I became aware of a number of CSA survivors who came to my clinical practice with difficulties breastfeeding and mothering their children. My medical education, knowledge and training were inadequate to deal with the problems these women encountered. I sought information using the time honoured medical technique of ‘when in doubt, look it up’. I went first to textbooks, then to journals and finally to Breastfeeding Australia’s Lactation Resource Centre (LRC) and Melbourne’s Domestic Violence and Incest Resource Centre (DVIRC) in the community seeking information. I found that women-centred stories about birth and breastfeeding after CSA were missing. I was unable to find the information I was seeking to assist me to understand and counsel the mothers who attended my practice.

**I Seek**
The research had a long conception—starting in the early 1990s—and when fully developed, as I thought, was further delayed by a twelve month long journey through two University of Melbourne Ethics Committees. The ethics committees were concerned about the safety of participants, as well as the risks and benefits for them. In fulfilling their ethical role protecting participants the committees assisted me to assess the risks and benefits to research participants in greater detail. The benefits were that I rethought and redesigned my original research plan. The study was smaller and based in what I needed to know rather than
what information might be useful. The protection process was risky as well, because the approval process was difficult and long. Someone less dedicated to the research topic may have given up and sought a topic that was less sensitive. The women’s stories contained within this thesis would not have been heard. It was during this time that one of my clinic patients reminded me of the importance of the proposed research to her: “If you [as a doctor] are silenced, what hope have we”?

The idea for this research arose in my clinical practice when I was a GP in the south eastern suburbs of Melbourne. I saw many young mothers who were having problems with breastfeeding and early mothering. Meg, one of these mothers, told me of her difficulties feeding her baby and of her past history of sexual assault. I had not thought to ask but she told me her story. In spite (or perhaps because) of my training, I had no knowledge of the impact of sexual abuse and violence on the new mother.

Meg’s story, mentioned in the introduction of this chapter, began when she was breastfeeding and her son’s smile triggered her memories of incest. Meg told the story of her injury caused long ago by the CSA perpetrated by her father. Her childhood abuse was replayed across a generation. Her story was powerful, making me pay attention to her story amongst so many illness stories. As I reflect on that consultation now, I think it was the intensity of her fear and distress which alerted me to the importance of her experiences. The contrast between our two breastfeeding and mothering experiences added another layer of meaning, making her story resonate deeply with me. Her story had particular meaning for me as the listener. Frank (1995 p.xii) in *The Wounded Storyteller* argues that it is through their stories that the ill and injured
create empathetic bonds with the listener, assisting their healing and widening the circle of shared experience as the story is retold.

**Finding Voice**
Writing my doctoral thesis gives voice to some of the experiences of the women who participated in the research and the women I saw as patients. As I wrote, retelling their story, I rediscovered my voice within medicine.

Thirty years ago, as a medical student, I was silenced. As medical students we were expected to participate in peer examinations by our teachers and the discomfort and embarrassment of students was largely ignored and sometimes openly mocked. Examining each other was regarded as uncontroversial and practical. While the effect varied for each student, inherent in the process was a loss of control over our own bodies, to whom we exposed them, and by whom and how we were touched. It was the beginning of a process of detachment and powerlessness that continued through medical school and for me, culminated in fifth year with the forced digital examination of a patient who refused to let students examine her. The examination took place in a large Melbourne teaching hospital in 1978. It involved me, my ward round group and a clinician/tutor. Two of us were told by our tutor to examine a female patient, she refused consent and we returned to our tutor having not done the examination. He was angry, and returned to the patient with the entire group of eight students. He performed a digital examination on her in front of us all and then stood beside her legs as each of us performed the same examination. I remember her crying into her pillow and my own helplessness to refuse to participate. I felt at the time that what we had done was wrong, but at the same time I was powerless to say no or to
walk away from performing the examination. I had been socialised into medical culture of the 1970s.

At that time, public hospital patients were “fodder for teaching” and were regarded as not having the right to refuse student teaching and examinations. Some teaching hospitals in Melbourne had a plaque in the foyer which stated public patient treatment was conditional on the patients allowing student teaching. Such a plaque was strategically hidden by a pot plant7 at Prince Henry’s Hospital Melbourne in 1977.

Medical socialisation does not necessarily take into account the contexts of women’s lives. In the examination story above the tutor did not understand the patient’s reasons for refusing an examination. Similarly some of my medical colleagues do not understand the impact of CSA on women. I am told my research work is “not quite right” when I hear the surprise in my male colleagues’ voices as I tell them about my research topic and by the questions that follow: “But what is your hypothesis?” they ask, “Why would anyone pick that topic?” they say in surprise, “Is it important?” Initially my reply was tentative: “It is important to some of my patients”.

As I read and reviewed the literature in preparation for starting my research, I became aware of the prevalence of CSA within the Australian community and the literature on its long-term consequences. I stopped doubting the significance of my research and began to wonder why such information and knowledge about CSA and other forms of family violence had been largely excluded from the medical curriculum. I

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7 Such a plaque was seen by the author in the foyer of Prince Henry’s Hospital in St Kilda Rd Melbourne in 1977. Unfortunately, I can no longer remember the exact wording and Prince Henry’s Hospital has since been demolished.
understood that medical training was not grounded in women’s experiences. Theory and knowledge had indeed “passed into the keeping of men, who had no way of knowing” (Diamant, 1998 p.3).

As a medical student I remember only one lecture on child abuse and one on domestic violence. Medical students in 2006 do a little better with family violence being introduced into first year through case based learning and communication skills, and again as part of their general practice rotation in year four. Current senior students report to me, when I teach them about family violence in general practice, that they receive no teaching on family violence in their medical, surgical, paediatric or women’s health rotations.\(^8\) Perhaps it is not surprising that my colleagues, and even current medical students, are unaware of the important role family violence plays in the ill health of their patients.

My reply has changed when my research topic is questioned. Now I reply, “because it is important—to me, to women and to the profession”. Every single time I have presented my research—to GP workshops, research meetings and ethics intensive courses—a woman has made herself known to me, offered me her support for my work and told me of her experience of CSA. Their contact and support made me realise the importance of my work and has helped sustain me through the process. As Audrey Lorde so aptly explains:

\[\text{I was going to die, if not sooner then later, whether or not I had ever spoken for myself. My silences had not protected me. They will not protect you. But for every real word spoken, for every attempt I had ever made to speak those truths for which I am still seeking, I have made contact with other women while we examined words to fit a}\]

\(^8\) The medical curriculum discussed in this section applies to a single Australian Metropolitan University.
world that we all believed, bridging our differences ...What are the words you do not yet have? What do you need to say? What tyrannies do you swallow day by day and attempt to make your own until you sicken and die from them, still in silence? (Lorde, 1984 p.41)

Even as I write I wonder why I didn’t pick a ‘safer’ topic for my doctoral thesis, the process that certifies me as a member of the academic community. The reason is simple; I couldn’t choose anything else. Every time I tried, I lost interest. Every time I found a safer topic, my mind returned to this topic. So, I share it with you, a journey into voice where the unspeakable is spoken by the women who shared their deeply personal experiences with me, and by me to my profession that still struggles to ask, understand, research and manage family violence.

**Chapter Outlines**

The next chapter provides the background to the research and reviews the literature on the prevalence of CSA in women, the long-term impacts of CSA with emphasis on pregnancy, birth and the post-natal period. Models that explain the impact of CSA are summarised. It establishes why research is needed to understand the breastfeeding and early mothering experiences of child CSA survivors.

Chapter Three outlines the research design, the methodology and methods used. To ensure that the research undertaken was of high quality, rigour is defined as it applies to this project. Ethical considerations were of particular importance to this project and therefore predicted ethical issues are discussed in detail in this chapter.
Chapter Four introduces the participants and describes their response to research participation.

Chapter Five explores how the feelings and emotion that were part of the interview interaction are carried through into the transcripts and analysis. Using observation and the interview interaction the transcript analysis is reviewed. The process is described and its importance in ensuring a high quality, trustworthy, qualitative analysis discussed.

Chapter Six presents the participants’ experiences of breastfeeding with emphasis on the challenges they face associated with their experience of CSA.

Touch is the theme explored in Chapter Seven. Touch is presented from two perspectives: maternal touch of the baby and professional touch of mother and baby. Once again the challenges that follow an experience of CSA are central to the data presented in the chapter.

Finally, in Chapter Eight, the findings and links to models that explain the long-term outcomes after experiencing CSA are summarised, and recommendations for practice are made and further research directions are outlined.
Chapter 2

Why Childhood Sexual Assault is Important in Mothering and Breastfeeding: A Literature Review

Introduction
This chapter starts with an outline of my working definitions and classifications of CSA. The definitions are discussed and choices argued.

The purpose of the rest of the chapter is threefold. Firstly, it outlines the literature on CSA, its prevalence and long-term consequences and establishes importance of CSA when considering health outcomes in women. Secondly, the literature on pregnancy, birth and the post-natal experience of women who have experienced CSA is reviewed with an emphasis on the gaps identified in the research literature and its application to my research and to the thesis argument that CSA affects early mothering. Finally, the models that have been proposed to explain the long-term associations and consequences of CSA are reviewed. How these models apply to the research findings are discussed in detail in results chapters.9

When I look at the paucity of research investigating the impact of childhood sexual abuse on early mothering, I could be led to assume either that it was uncommon or unimportant in the lives of women. The Lancet (2003) ran an editorial on ‘The Neglect of Child Neglect’ where it noted the lack of research activity into child abuse in spite of it being one

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9 See Chapter Five pp.143-144 and Chapter Seven pp.222-223.
of the major paediatric public health challenges. In this chapter I will argue that it is not just a paediatric health challenge but a lifelong public health challenge with particular repercussions for women as mothers.

Becoming a mother is a major milestone in a woman’s life. Pregnancy, birth and breastfeeding are times when childhood sexual assault can be powerfully recalled. Meg’s story in the introduction illustrates this. It is at this time that the maternal-child relationship is being established, bonding and attachment are occurring, setting the pattern for the mother-child relationship and the pattern for the child’s other significant lifetime attachments (Main and Goldwyn, 1984, Main and Hesse, 1990). Potential disruptions to the maternal-child relationship by the recollection of the mother’s own experience of CSA makes understanding the experiences of women, at this time, a critical research priority.

**Working Definitions**

There is no universal international definition of child abuse. In Victoria, the site of this research, the Victorian *Children and Young Persons Act 1989* describes child abuse as physical, sexual, emotional, psychological, neglect and abandonment. Although the categories are distinct, the divisions are an oversimplification of the complexity and multiplicity of child abuse. For example, 15-25% of children who experience neglect or emotional abuse in Australia also experience physical abuse (Tomison, 1995, James, 2000) and 40% of CSA occurred in families where partner violence was also occurring (Goddard and Hiller, 1993).

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10 To avoid confusion when discussing mothers and their babies, childhood sexual abuse refers to the mother’s experience, to make it clear that these experiences occurred in the mother’s past.
Who is a Child?

In Victoria, the legal age of majority is eighteen years. At this age the young adult can vote, drive a car alone and consent to medical treatment\(^\text{11}\) (Medical Practitioners Board of Victoria, 2004).

Worldwide definitions of the “child” in CSA research vary between studies. A child may be defined as less than twelve, fourteen, or sixteen while some studies include girls up to eighteen years of age (Astbury, 1996 p.164, Waller, 1994, Wyatt and Peters, 1986a). In some definitions of CSA, such as those used by Kinsey and Landis in the 1940-60s, CSA is defined as occurring before menarche or puberty.

Defining CSA by puberty is problematic because ‘puberty’ can be used interchangeably with ‘menarche’ or can be defined by physical stages in a stricter definition. Within a population this could mean that a nine year old who had started menstruating and was sexually abused did not meet the criteria for CSA but a fifteen year old who had not begun to menstruate and was sexually abused had met the criteria for CSA. If a stricter staged definition of puberty were used, it may be difficult for women and children to identify the stage of puberty at which their experience of sexual abuse occurred.

In addition to confusion around the definition of puberty by stages and the exact definition of each physical stage, a classification by physical

\(^{11}\)A mature minor may consent to medical treatment. The concept of a ‘mature minor’ in Australian Law is based on Gillick vs West Norfolk AHA (1986), AC 112 (HL). In New South Wales and South Australia, children may consent to medical treatment at 14 and 16 years respectively, in the other states 18 is the age of majority. In addition, under the Victorian Children and Young Persons Act of 1989, children who are mature enough to give instructions may seek separate legal representation.
maturity alone fails to consider the emotional and psychological and social maturity of the child.

Legal sexual consent in Victoria occurs at sixteen years of age. The age of consent is equivalent to sexual majority, where the young person can legally have sexual intercourse. Historically, Australian legislation defining the ‘child’ in the sexual act varies. Victoria’s *Crimes Act of 1891* defines sexual offences against children under sixteen years.  

Queensland’s *Criminal Law Amendment Act of 1891* and Western Australia’s *Criminal Law Amendment Act of 1892* define the same offences against children under fourteen years, and Tasmania’s *Criminal Code Act of 1924* at eighteen years. More recently, Victoria’s *Crimes Act of 1958* defines sexual offences against children under the age of sixteen, and at sixteen years, with different penalties. As well as the penalty being related to the age of the victim, the penalty changed depending on the age of the partner.

Child protection legislation differs from criminal legislation. Victoria’s *Children and Young Persons Act 1989* defines a child as under the age of seventeen years.

The difficulty with using the legal definitions provided by the Victorian *Crimes Act of 1958* and the *Children and Young Persons Act of 1989* in research is that while they provide the legal underpinnings for child protection and legal action against perpetrators of CSA, they do not take account of the changing social context of sexual behaviour in Australia.

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12 The Victorian Crimes Act of 1891 raised the age for sexual offences committed against children from twelve to the current sixteen years.
The average age of first intercourse for Australian women is changing. Australian women born between 1941 and 1950 had an average age of first intercourse of nineteen years. For women born four decades later between 1981 and 1986 it had dropped to sixteen years and the trend continues downwards (Australian Research Centre in Sex Health and Society La Trobe University, 2003, Rissel et al., 2003). Implicit in the recent statistics on first sexual intercourse was that significant numbers of Australian women have been sexually active before they are sixteen years old, so they and their partners potentially risk being outside the law of Victoria.

In keeping with the Victorian Crimes Act of 1958, the average age of first intercourse for Australian women, and most Australian research into CSA, I have defined a child as less than sixteen years of age (Kirkby, 1995 p.20, Dunne et al., 2003). This age-based definition has the advantage of being clear, and easily defined, as well as allowing for the development of physical, emotional, social and psychological maturity.

**Defining Child Sexual Abuse**
The Australian Institute of Health and Welfare (1995) defines child sexual abuse as “any act which exposes the child to, or involves a child in, sexual processes beyond his or her understanding or contrary to accepted community standards” (p.46). This definition of CSA is used throughout this research. A consequence of using this definition is the perpetrator may be a peer or an adult. Finkelhor’s study (1979) defined CSA as occurring only when the perpetrator is five years older than the victim. While this is said to screen out normal peer experimentation it is problematic to my study because it may exclude abusive sexual
relationships between family members close in age, such as siblings (Wyatt, 1985, Russell, 1986 pp.23-24).

Tess participated in the research, and her experience reinforces the importance of using definitions that include peer and sibling experiences. She had been repeatedly raped by her brother as a child and adolescent. Her experience was not one of normal peer experimentation. She describes childhood sexual assault.13

**Contact and Non Contact Child Sexual Abuse**
The definition of contact CSA includes: vaginal or anal rape, oral sex, unwanted genital touching, breast contact, masturbation and fondling. Non contact CSA includes: solicitation, exhibitionism and exposure to pornography (Wyatt and Peters, 1986a, Briere, 1992 p.4, Andrews et al., 2002).

The women interviewed in this study experienced unwanted contact CSA by a family member. They experienced vaginal and anal rape14, oral rape (mostly fellatio), unwanted genital touching, breast contact, masturbation and fondling.

**Prevalence**
Prevalence of child abuse refers to the total number of cases that exist in a given population at some defined point in time (Christie et al., 1997). Modern child abuse prevalence statistics increasingly began to be

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13 See details in Chapter Four pp.112-113.
14 None of the women consented to oral, anal or vaginal intercourse, therefore meeting the definition of rape.
published in the medical literature\footnote{There is argument over why CSA was increasingly recognised through the 1960s and 70s. It is likely that the recognition of the importance of CSA in the lives of children was directly related to the activity of the feminist movement at this time.} following the medical recognition of child abuse by Kempe \textit{et al.} (1962) with the publication of “The battered child syndrome” in the Journal of the American Medical Association (\textit{JAMA}) (Wyatt and Peters, 1986a).

Outlined in Table One below are the prevalence statistics specific for CSA collected prior to 1980 in the United States. Overall, these early studies show a lifetime prevalence of 19-35\%, with 4-12.5\% of children being abused by a family member. However, these studies were limited by their samples which were predominately middle class, college students or hospital patients.

Table One. U.S.A. Prevalence Statistics Prior to 1980

<table>
<thead>
<tr>
<th>Study</th>
<th>Sample</th>
<th>No. Subjects</th>
<th>Sexual Abuse by adult %</th>
<th>Abuse before puberty %</th>
<th>Mean Age of child</th>
<th>Abused by family member %</th>
<th>Abused by father or stepfather %</th>
<th>Sex of perpetrator</th>
</tr>
</thead>
<tbody>
<tr>
<td>C. Landis 1940</td>
<td>Middle class hospital patients/controls</td>
<td>295</td>
<td>23.7</td>
<td></td>
<td>12.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Kinsey 1953</td>
<td>White middle class</td>
<td>4441</td>
<td>24</td>
<td>9.5</td>
<td>5.5</td>
<td>1.0</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>J. Landis 1956</td>
<td>College students</td>
<td>1028</td>
<td>35</td>
<td>24</td>
<td>11.7</td>
<td></td>
<td></td>
<td>100</td>
</tr>
<tr>
<td>J. Gagnon 1965</td>
<td>White middle class</td>
<td>1200</td>
<td>28</td>
<td>9.9</td>
<td>4.0</td>
<td>0.6</td>
<td>98.5</td>
<td>1.5</td>
</tr>
<tr>
<td>D. Finkelhor 1979</td>
<td>College students</td>
<td>530</td>
<td>19.2</td>
<td>17</td>
<td>10.2</td>
<td>8.4</td>
<td>1.3</td>
<td>94</td>
</tr>
</tbody>
</table>

The reported prevalence of CSA in more recent studies varies from 6\% to 62\% (Wyatt and Peters, 1986b, Mullen \textit{et al.}, 1988, Finkelhor \textit{et al.},
1990, Anderson et al., 1993, Fleming, 1997). Differences in the reported prevalence are due to a number of factors which include: definitions of CSA, the sample (community or clinical), age of participants, ethnicity and class, religion, geographic location, and finally the point in time at which the population was studied (Astbury, 1996 p.164, Wyatt and Peters, 1986a, Wyatt and Peters, 1986b). The research methods used in studies also affect disclosure rates, for example, whether questions are behaviour-specific questions or questions about “rape” or “sexual assault”.16

Australian prevalence statistics presented in Table Two are more recent, and like the studies from the United States of America, arise from retrospective CSA research. These studies represent the current ‘best evidence’ because of the difficulties in prospective CSA research. Prospective studies are difficult because of ethical constraints in child based research and problems with control samples (see False Positives and Negatives in CSA Research later in this chapter).17

It is estimated that 28-35.8% of Australian women experience contact sexual abuse (see Table Two). Fleming’s community based study (1997) showed prevalence rates of 2% for anal or vaginal penetration, 5.4% for either attempted or actual vaginal or anal penetration, and 20% for genital contact. Only 10% of women had disclosed abuse to a doctor, teacher, the police or another authority.

16 See pp.26-27 for more details on this point.
17 For ethical and valid consent from a child, the child must have the maturity and capacity to understand the study and the consequences of participation, give consent freely without coercion, and refusal to participate in research must be respected (NHMRC, 2001). The Australian National Statement on Ethical Conduct of Research involving Humans requires consent from the parents “in all but exceptional circumstances” and that “the participation of children is indispensable because information available from research on other individuals cannot answer the question in relation to children or young people”. Consent from the parents is problematic as there is a significant chance the Australian perpetrator of CSA is a family member (Fleming, 1997).
Table Two. Summary of Australian and New Zealand CSA Prevalence Studies

<table>
<thead>
<tr>
<th>Author &amp; Year</th>
<th>Sample</th>
<th>Number participating in study.</th>
<th>Penetrative CSA</th>
<th>Attempted Penetrative CSA</th>
<th>Contact CSA</th>
<th>Genital Contact CSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fleming, J (1997)</td>
<td>Random sample Australian Women from federal electoral roll</td>
<td>3958</td>
<td>2%</td>
<td>5%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Mullen, P et al. (1994)</td>
<td>Random sample electoral roll Dunedin, New Zealand Women 18-65</td>
<td>1376</td>
<td>3.8%</td>
<td>7.3%</td>
<td>15.9%</td>
<td></td>
</tr>
<tr>
<td>Mazza, D et al. (1996)</td>
<td>General Practice Sample Melbourne, Australia</td>
<td>2181</td>
<td>6.0%</td>
<td></td>
<td>28%</td>
<td></td>
</tr>
<tr>
<td>Mazza, D et al. (2001)</td>
<td>Random Community based sample Women 50-69</td>
<td>395</td>
<td>6.7%</td>
<td></td>
<td>35.7%</td>
<td></td>
</tr>
<tr>
<td>Dunne, M et al. (2003)</td>
<td>Random male and female sample from federal election roll</td>
<td>1784</td>
<td>8% Female</td>
<td></td>
<td>6.4% Female</td>
<td></td>
</tr>
</tbody>
</table>

It is difficult to compare the work of Fleming (1997) and Dunne et al. (2003). Similar questions were asked but the results are classified differently making comparisons in some categories difficult. The prevalence of female non penetrative CSA by age group in Dunne et al. was 29.4% (18-29), 35.3% (30-39) and 35.5% (40-49). The prevalence of penetrative CSA experiences for women by age group was 9.5% (18-29), 13.9% (30-39) and 13.3% (40-49). No prevalence studies in antenatal populations were found for CSA, though they are available for other forms of family violence (Webster et al., 1994, Webster et al., 1996) in Australian antenatal populations. Thus the community based studies of Fleming (1997) and Dunne et al. (2003) provide the best estimates for extrapolating the prevalence of CSA in an antenatal and postpartum population.
The average age of all mothers giving birth in Australia in 2001 was 29.2 years (Australian Institute of Health and Welfare, 2001). Using the Australian community based data, it is estimated that one in three Australian mothers will have experienced non penetrative CSA and one in ten penetrative CSA.

**False Positives and Negatives in Child Sexual Abuse Research**

Retrospective research has been criticised as potentially overestimating the extent of CSA. Implicit in this criticism is that women imagine or lie about their experiences and this view has a long history in medical writing. As Charles Routh wrote in 1886:

*One lady once confided in me that her own father, when she was a girl of seventeen, had taken her to Brighton and there they had lived together as man and wife. This of course I did not believe for an instant. Another told me that her own brother had come into her bedroom at night and ravished her, an equally untrue delusion. Whenever I hear such stories, I suspect the women who tell them, for if, in the history they give of themselves, they can invent such terrible stories about those whom they ought most to love and revere, they seem to me to be very apt to invent and believe other more terrible stories about their medical attendants, whom they know less of, and which might seriously affect their happiness and future career* (p.489).

He continues later:

*Except upon the strongest corroborative evidence, the presumption is that they are liars, plausible liars, cunning liars ...* (Routh, 1886 p.500)
Australian women are unlikely to disclose (<10%) CSA to police, doctors or helping professionals (Fleming, 1997). Difficulties with disclosure can be due to professional attitudes, but a woman’s feelings about her abuse, such as fear and shame can also play a part (Head and Taft, 1995). Deme is one of the participants in this study\(^\text{18}\), I quote her here as her story illustrates the difficulties she had in thinking of her experience of CSA as ‘rape’, her fears that she would not be believed and, even worse, would be stigmatised by the professionals as a ‘liar’. She graphically describes her experience of rape as an eight year old girl by her stepfather, how she came to believe she was not being raped and her fear of disclosure:

I was really young, only about eight, when I said to him, “You can’t rape me.” He said “I’ll show you what rape is” and he pushed my legs over my head …\(^\text{19}\) really far back … and he pulled my pants back up to my knees and tried to really push himself in … there was no way he would fit, he would have split me … that would have been rape. He wasn’t into violence at all, in that way. I don’t know anything about criminology, I don’t know how a criminal mind works, but when he let me go, I was in tears, “That is what rape would be like, but worse. I could rape you, but you can’t call what I do rape, you can’t scream rape. I’m not going to rape you.” It stuck with me for such a long time, because from then on, I thought I wasn’t being raped. It wasn’t rape … I believed that for years that if I told the police, they wouldn’t believe me. I was just a kid and kids tell lies, because that is what I was told and there was no proof, what proof could they have … You know, it was just my word against his and he was an adult. People would listen to him, not to me. All that stuff.

Koss (1985) described how 43% of women in her study said “Yes” to questions about behaviours that met the legal definition of rape but answered “No” to the question “Have you been raped?” Martin et al. (1993) found that women tended to downplay their experience of CSA, so asking multiple funnel questions about specific behaviours, such as:

\(^{18}\) Participants in this study are introduced in detail in Chapter Four.

\(^{19}\) Transcription note … long pause, also see Appendix Three p.277 for full transcription notes.
“Before you were sixteen did you experience unwanted vaginal intercourse?”, “Before you were sixteen did you experience unwanted genital touching?” are more reliable than asking “Were you sexually abused as a child?”. 

Research indicates that over a third of women repress memories of CSA (false negative error). The number who imagine or report CSA when none has occurred (false positive error) is uncertain, although both occur in retrospective CSA research (Nash, 1994). Williams’ (1994) prospective study of documented victims hospitalised after CSA demonstrated that 38% did not recall the assault eight to ten years later, particularly if the perpetrator was a friend, peer or family member. Briere and Conte (1993) investigated self reported amnesia amongst adults who were currently in therapy following their CSA experience. Fifty nine percent of participants reported having no memory of their abuse at some time prior to turning eighteen. Variables associated with episodes of amnesia were violent abuse, early abuse (mean 5.8 years) and extended abuse. Similar lack of recall is found amongst adults with a documented adolescent history of family violence and who were interviewed nine years later (Femina et al., 1990).

The problem with memory outlined above has a number of implications for CSA research. It makes finding a control group for a study such as mine extremely difficult because up to 59% of women who report no sexual abuse even when asked specific CSA behaviour questions may have forgotten their CSA. I have termed this group No Declared CSA (ND CSA) rather than No CSA.
The difficulty with false positives, the reporting of CSA when none occurred, lies in estimating its prevalence. Part of the difficulty in estimating false positives in CSA research, lies in the secrecy surrounding CSA. Children frequently do not report their abuse. Fleming (1997) found that of the 52% of women who experienced CSA disclosed CSA, 28% disclosed or tried to at the time of abuse, leaving the majority (72%) unable to disclose their experience of CSA at the time of the abuse. The perpetrators of abuse were rarely strangers (8%), and of the abusers known to the child 41% were family members such as fathers, step fathers, grandparents, uncles, siblings and cousins (Fleming, 1997). CSA occurs most commonly in a private setting such as a home and is hidden by the perpetrator making corroboration from other family members or friends unlikely.

Retrospective Australian community based studies show that CSA is common. Based on Australian community studies I argue that CSA is a common past experience among child bearing women and new mothers: it is likely that nearly one in three will have experienced contact CSA and one in ten penetrative CSA (Fleming, 1997).

Being a common experience has not, in itself, made family violence and CSA a research a priority in medicine, despite repeated calls for this from the World Medical Association (WMA) and World Health Organization (WHO) (Watts et al., 1999, Krug et al., 2002, World Medical Association, 1996, World Medical Association, 1995, World Health Organization, 2005). It is this association between CSA and poorer health that makes research in this area so important. The long-term health implications of CSA for women’s well-being are significant and are outlined in the following section.
Long-Term Associations and Effects of Child Sexual Abuse

Having established that CSA is a common experience for Australian women, and therefore for pregnant and postpartum Australian women, this section explores its importance to the long-term physical and mental health of women.

I searched current medical literature online using Medline, Psychlit, later PsycINFO, and Current Contents. The literature searched was restricted to published studies in English and available at Melbourne or Monash University Libraries. Search words used were child* sexual abuse or assault, incest, sexual abuse or assault, violence, pregnancy, breastfeeding or lactation, puerperium and postpartum. A small body of research identified investigated the post-natal experience of CSA survivors as mothers.

Later the sociology databases including Sociology Abstracts, British Humanities Index, International Bibliography of the Social Sciences, and Sociology: A Sage Full Text Collection were included in the literature searched. The sociology literature search was concentrated on CSA and parenting. Key words were identified using the thesaurus as differences in terms were found between the medical, psychological and sociology literature. The sociological databases were searched using the words child sexual abuse, mothers, child rearing attitudes, touch or touching, parenting methods or parenting attitudes, infants, bonding and parent child relations, and breastfeeding. A small body of research identified was based mainly around parenting.
Physical Health

Physical health can be affected directly by infection, pregnancy or injury and by somatisation and risk behaviours. Chronic pain syndromes and poorer general health have been reported following CSA and are discussed in detail in this section.

Studies have shown that chronic pain syndromes are associated with both childhood physical abuse (CPA) and CSA (Walker et al., 1992, Walker and Katon, 1996). It is difficult to separate the long-term effects of CPA and CSA from the literature, (as outlined in Table Three) because many studies investigate one child abuse variable and do not control for other forms of abuse. Child emotional abuse and neglect were not included or controlled for in any of the studies, further complicating this area of research. The study by Leserman et al. (1996) highlights the difficulties in separating the long-term effects of CSA and child physical assault, as over 2/3 of the participants who reported CSA also reported CPA.

All samples included in Table Three were based in medical clinics, which may have selected for the reporting of physical symptoms. Community based research that investigated physical health and CSA was not found in the literature review.

The pain syndromes described in the literature include: irritable bowel syndrome, abdominal pain, pelvic pain and pelvic inflammatory disease, dysuria, vaginal pain, breast pain, headaches, musculoskeletal and back pain (Rimsza et al., 1988, Springs and Friedrich, 1992, Walker et al., 1992, Leserman et al., 1996, McCauley et al., 1997).
Table Three. Physical Problems Following Child Abuse

<table>
<thead>
<tr>
<th>Study and Year</th>
<th>Sample Total N</th>
<th>Significant Symptoms</th>
<th>Child Abuse</th>
<th>Sexual</th>
<th>Physical</th>
<th>both</th>
<th>Separate analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Springs et al. (1992)</td>
<td>Rural family practice N=1443 n = 550</td>
<td>Pelvic Pain Pelvic Inflammatory disease Breast disease Vaginal Infections Complications in pregnancy Obesity</td>
<td></td>
<td>9.2%</td>
<td>9.6%</td>
<td>Not asked</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20.5% Not asked</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walker et al. (1992)</td>
<td>Ob/gyn clinic Chronic pain n =100 (75%N)</td>
<td>Chronic pelvic pain Pain Non GI symptoms Increased disability More surgery</td>
<td></td>
<td>14%</td>
<td>Not asked</td>
<td>Not asked</td>
<td>No</td>
</tr>
<tr>
<td>Leserman et al. (1996)</td>
<td>Gastroenterology Clinic N=506 n =239</td>
<td></td>
<td></td>
<td>41.4%</td>
<td>67.4%</td>
<td>48.5%</td>
<td>67.4%</td>
</tr>
<tr>
<td>McCauley et al. (1997)</td>
<td>Primary care N=3203 n =1931</td>
<td>Headache Pelvic and genital pain Abdominal pain Breast pain Chest pain Face pain Short of breath Choking Tiredness Vaginal discharge Diarrhoea Constipation Eating problems Loss of appetite Binge eating Problems with urination</td>
<td></td>
<td>7.2%</td>
<td>6.1%</td>
<td>8.5%</td>
<td>No</td>
</tr>
</tbody>
</table>

Some of these pain disorders may be related to actual infection, such as pelvic inflammatory disease and some types of vaginal discharge, some to direct physical trauma during the assault, while others are related to indirect effects mediated by somatisation, mental health, maladaptive behaviours and chronic stress (Walker and Katon, 1996). Latthe et al., in a recent systematic review of chronic pelvic pain (2006), demonstrated positive associations between dysmenorrhoea and CSA, a positive
association between dyspareunia and both sexual and physical abuse, and a positive association between adult sexual abuse (ASA), CSA and CPA and non cyclical pelvic pain.

There is a reported increase in health risk behaviours such as smoking, alcohol use, drug use, obesity and inactivity, early intercourse and an increase in the number of partners (Felitti et al., 1998). Preventive health care tends to be avoided; for example, Pap smears are sought less frequently by sexually abused women, and they tend to present later for antenatal care (Springs and Friedrich, 1992). Victims of abuse have a higher rate of health care usage, more pain and poorer functional outcomes. They have more visits to the doctor and more surgery (Walker et al., 1992, Leserman et al., 1996, Walker and Katon, 1996).

In spite of these studies showing poorer health and a high utilisation of health care services, health practitioners are often unaware of their patient’s history of abuse. In Mazza et al. (1996) study of abuse among women attending fifteen community based general practices in Melbourne, 73% had not been asked by their doctors about physical abuse as a child or domestic violence. The main reason given by the women for not discussing abuse with their doctors was not fear or embarrassment but simply that they had not been asked.

Poorer health and an increase in disease and early death were associated with abuse, domestic violence and household dysfunction in a large USA study on adverse childhood experiences (Felitti et al., 1998).

It is clear from the literature review of long-term physical health outcomes in CSA survivors that there are significant associations between
CSA and poorer health in adult life. It is likely, therefore, that health professionals will have ongoing contact with CSA survivors. Of particular interest to my work is the challenge faced by survivors after the birth of a child. The literature suggests that pain may be an important symptom after CSA and that primary care providers should consider CSA in patients with chronic pain syndromes.

Mental Health
Emotional effects reported in adults following CSA include depression, anxiety, post-traumatic stress disorder (PTSD), eating disorders, personality disorders, somatisation disorder, suicide, self-mutilation, difficulties with interpersonal relationships and sexuality (Browne and Finkelhor, 1986, Pribor and Dinwiddie, 1992). Twenty percent of a New Zealand community sample of women who had been sexually abused were found to have psychiatric symptoms, this compared to 6.3% in the non-abused population (Mullen et al., 1988).

Physical violence and CSA have a similar pattern of associated psychological conditions. These include depression, anxiety disorder, suicide, eating disorders, somatisation disorder, and drug and alcohol abuse (Eisenstat and Bancroft, 1999). When researching mental health impacts of CSA in adulthood, other abuse variables were frequently not considered. Other forms of family violence include: witnessing parental violence, CPA, childhood emotional abuse (CEA) and neglect. Re-victimisation in adult life was also often omitted, in spite of higher rates of adult victimization, particularly in those who had experienced both physical and sexual abuse as children (Schaaf and McCanne, 1998). This makes interpretation of the significance of CSA alone on mental health
difficult. The research evidence available is further limited by the small sample size and a preponderance of clinical and college student samples.

Depression was the commonest symptom reported by adult survivors\textsuperscript{20} of CSA (Browne and Finkelhor, 1986, Mullen and Fleming, 1998). Beitchman \textit{et al.} (1992) reviewed eight studies of CSA and depression; six of the eight studies showed an association between childhood sexual abuse and depression. In a community study by Mullen \textit{et al.} (1988) depression was associated with CSA, depressive symptoms were found to be the most common, followed by anxiety and phobias.

Suicidal thoughts and behaviours have been associated with childhood sexual abuse, particularly when violence was involved. It has also been associated with physical and psychological abuse (Briere, 1992). Studies in this area are few and frequently small in number, particularly the size of the abuse samples, and therefore, more suggestive than conclusive. Self-mutilation has also been associated with survivors of severe child abuse. Suicide has been described as a way of escaping from severe psychological pain, and self-mutilation is thought to reduce psychological tension temporarily (Briere, 1992).

Eating disorders, such as anorexia nervosa and bulimia, have been associated with sexual abuse in clinical populations (Waller, 1994). Andrews’ (1997) research, with a small community sample of women, found that bodily shame was strongly associated with bulimia and that bodily shame was significantly higher in those women who had been abused as children (Andrews, 1997). Bulimia was more commonly

\textsuperscript{20} Adult women with a history of CSA have been called victims, survivors and victim/survivors. I have elected to use ‘survivor’ in preference to victim because it acknowledges what happened in childhood without the ongoing helplessness implicit in ‘victim’.
reported in association with CSA than is anorexia. Root and Fallon (1989) suggested that binge-purge behaviour was a way of coping with the stress of both physical and sexual abuse (cited in Briere, 1992 p.68).

Pribor et al. (1992) investigated the psychiatric correlates of incest in childhood by recruiting women from specialised programs and self-help groups for sexually abused women in an area of St. Louis, U.S.A. No statistically significant link between incest and anorexia was found. The psychiatric conditions of fifty two women who had experienced incest were compared to twenty three who had not but were involved with psychiatric services and community based psychiatric prevalence statistics. Anorexia is most common in adolescence and early adulthood (15-24 years) (Goldman and Hatch, 2000 p.1034). In the study by Pribor et al., the participants were older with an average age was 36.9 years, so the association may have been missed.

Three of seven studies reviewed by Beitchman et al. (1992) showed an association between adult anxiety, fear and childhood sexual assault. It was difficult to know whether the association between fear and anxiety was independently due to sexual assault or violence, or whether the association was due to a combined abuse effect. Once again, the artificial divide between the types of childhood abuse makes the interpretation of the findings difficult. Pribor (1992) found a significantly higher rate of anxiety disorders in incest survivors. The sample was drawn from women in specialised programmes for sexually abused women (N=52). It compared incest survivors, a group from the general population and a group of psychiatric patients, but due to its small size and problems controlling for incest in both comparison groups, its findings are suggestive rather than conclusive.
Post-Traumatic Stress Disorder

PTSD is characterized in Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV)\textsuperscript{21} (American Psychiatric Association, 1994) by a person being exposed to trauma and having a response of intense fear, helplessness or horror. The traumatic event can be re-experienced in a number of ways.

PTSD was originally described in war veterans but has since been applied to a wider group of trauma survivors (Astin \textit{et al.}, 1994). It is a cluster of symptoms, and while it is not specific for victims of abuse, it occurs with greater frequency among them. Resnick \textit{et al.} (1993), using a randomised phone survey of 4008 women, found a lifetime prevalence of PTSD of 32% among women who were victims of completed rape (2.6 times the prevalence of the total sample), 30.8% among other sexual assault victims (this included CSA and 2.5 times the prevalence of the total sample), 38.5% among physical abuse victims, 22.2% among women who had a close family friend or family member homicide, 25.8% if another crime victimisation, and 9.4% among victims of disaster or accidents. The lowest prevalence of PTSD (19%) was found among women where there had been no threat or physical injury. A prevalence of 26.6% was found among those who had felt their life was threatened, 30.6% among those who had suffered injury and 45.9% among those who had suffered both life threat and injury (Resnick \textit{et al.}, 1993). The sample included victims of sexual and physical assault as well as other crime and trauma victims—therefore, the findings cannot be generalised specifically to physical and sexual abuse victims. This study is important to the CSA literature due to finding that the greater the threat or injury experienced, the greater the trauma and the greater its cumulative effect. In Kessler \textit{et al.}}

\textsuperscript{21} See Appendix One p.265 for the full diagnostic criteria of PTSD.
al. U.S.A. based national comorbidity survey (1995) of 5877 persons aged 15-54 years, the trauma most likely to be associated with PTSD was rape, in both men and women, some 65% of men and 45.9% of women. For women who reported their most significant traumas, these were childhood physical abuse 48.5%, child sexual abuse 26.5%, being threatened with a weapon 32.6%, and physical abuse 21.3%. Of women with PTSD the most upsetting traumas were rape and CSA, accounting for 49% of women with PTSD (Kessler et al., 1995). In the study by Kessler et al., nearly one third of persons with PTSD continued to have symptoms for many years, irrespective of whether they received treatment.

Schaaf and McCanne (1998) included CSA, CPA and combined child abuse as well as adult victimisation in their college based study of PTSD. The diagnosis of PTSD was made in 14.8% (3.9 times the ‘no abuse’ prevalence of PTSD) of those adults who had experienced CSA, and 45.2% (11.9 times the ‘no declared abuse’ prevalence) in those adults who had experienced both CSA and CPA.

In a meta-analysis by Brewin et al. (2000) of risk factors for PTSD, childhood abuse accounted for an effect size (r) of 0.07-0.30. Life stress, trauma severity, lack of social support and other childhood adversity had a greater effect when measured by the correlation coefficient r. This means that pretrauma factors such as life stress and lack of social support interact with trauma responses and increase the risk of developing PTSD.

How women perceive the trauma was significant in the development of PTSD. Astin et al. (1994) report that previous trauma is a powerful determinant of the development of PTSD. Brewin et al. (2000) found a
higher correlation between PTSD and trauma severity than PTSD and previous trauma. Injury and threat remained important predictors of PTSD, confirming the earlier findings of Astin’s group.

**Sexual Behaviour and Interpersonal Relationships.**
Sexually abused children may show disturbed sexual behaviour as adults. The manifestations in women are fear, lack of pleasure, dissatisfaction and multiple brief relationships (Finkelhor, 1979, Beitchman *et al.*, 1992). Mullen *et al.* (1994) quotes one third of a community sample of sexually abused women as having fears or difficulties associated with sexual activity. Fromuth (1986), in her college student study, found that although women who had been abused described themselves as sexually promiscuous, there was no significant difference in actual behaviour between these women and those who had not been abused. Mullen *et al.* (1994) found similar frequencies of intercourse for CSA survivors but greater dissatisfaction in their community based study. They reported that women who had been more severely sexually abused or abused by a father or stepfather were more likely to report their sexual problems as associated with the abuse. Difficulties with intimate relationships were found in both sexual and physical abuse victims. The findings of Fromuth and Mullen *et al.* are important because, in both, women who have experienced CSA perceive their sexual behaviour more negatively even though their sexual behaviour was similar to that of women who had not been abused.22

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22 Similar negative perceptions of behaviour may occur in association with mothering and are explored later in the results chapters, see pp.219-221.
Re-victimisation\textsuperscript{23} has been associated with CSA. Forms of re-victimisation include physical or sexual assault, or both. Briere (1984) found 49\% of his victims of CSA were battered as adults (cited in Beitchman \textit{et al.}, 1992).\textsuperscript{24} Russell (1986) found 65\% of her incest survivors had later experienced rape or attempted rape. Schaaf and McCanne (1998) report that among college students 14.8\% of CSA survivors experience sexual assault as adults and 3.7\% for adult physical abuse. Survivors who experienced CSA and CPA had much higher rates of sexual re-victimisation as an adult (32.7\%).

Sex of the victim may be important in long-term outcomes. While women are more commonly victims of CSA, early studies with male survivors show them to have poorer social and sexual adjustment than women. Male survivors have increased risk of becoming sexual offenders themselves (Beitchman \textit{et al.}, 1992). There are a number of cofounders that may influence outcomes in boys: perpetrators are often strangers, violence is more common, and abuse tends to be in a slightly older age group (Finkelhor, 1990). Brownmiller and Summers recognise that expectation of sexual abuse has significant effects on the thinking and behaviour of women: women ‘know’ the threat of sexual violation is part of their world (Brownmiller, 1975) and they are socialised as to where they can safely go and even what they can ‘safely’ wear (Summers, 1975). It is not the same for men and this may increase the severity of their response. Indeed, as many as 62\% of women will experience sexual abuse in their life (Wyatt and Peters, 1986b). As shown earlier in the chapter, CSA is a common experience in women.

\textsuperscript{23} Re-victimisation refers to repeated experiences of abuse later in life. Re-victimisation usually applies to adult sexual and physical assault although psychological and emotional abuse are other forms of re-victimisation.

\textsuperscript{24} The original conference proceeding was no longer available either through the Monash University library or by direct contact with the author.
Perpetrators of CSA are usually men, who constitute as many as 98% of offenders against girls and 83% of offenders against boys (Finkelhor, 1990). Sixteen to 29% of girls are estimated to have been abused by family members, and 4.5 to 11% by fathers or stepfathers. Half of the perpetrators were seen as in positions of authority by the victims (Herman et al., 1986, Finkelhor et al., 1990, Mullen et al., 1994). In Mullen et al. (1994), of those girls subject to incest, one in ten stepfathers were reported as sexually abusive compared to one in a hundred biological fathers. Women who experienced sexual abuse by a father or stepfather were most likely to describe it as having serious or long lasting effects (Finkelhor, 1979, Herman et al., 1986).

There are a number of theories for the traumatic effect of incest. The first is that it is a betrayal of trust in one of the child’s most important relationships, first by the father or stepfather perpetrator and, as identified in some of the earlier literature, by the mother failing to prevent the incest (Finkelhor, 1979). In later literature the mother’s response to disclosure has been identified as an important moderator of the abuse effect. The higher risk of stepfather abuse may be associated with family dysfunction as well, increasing the traumatic effects (Beitchman et al., 1992). It is more likely that abuse by a parent occurs over a longer period of time and with greater frequency (Russell, 1986).

Longer duration of abuse may be associated with poorer long-term outcomes; this was supported by four of nine studies in the review by Browne et al. (1986). The study by Mullen et al. (1988) found more distress amongst women who were subject to a single rape as adults, which ran counter to the researchers’ expectations, and may have been due to the higher scores of these women on the general health
questionnaire biasing the data (Mullen et al., 1988). Finkelhor (1979) found frequency and duration unrelated to trauma. Herman et al. (1986) found victims of incest that lasted for more than two years experienced more trauma.

Force and violence are two factors where studies have shown agreement on their significance to long-term CSA outcomes (Russell, 1986, Beitchman et al., 1992). Five studies that demonstrate this effect are cited by Beitchman et al. (1992), but college students are over-represented in these samples and this may skew the results.

CSA involving penetration is generally thought to be more traumatic (Browne and Finkelhor, 1986, Beitchman et al., 1992). Fifty nine percent of women whose abuse involved penetration or attempted penetration, reported extreme trauma (Russell, 1986). Bagley and Ramsay’s (1985) community study showed an association between poor mental health outcomes and penetration (in Browne and Finkelhor, 1986). A difficulty with many of the studies reviewed here is the lack of differentiation between types of genital contact and this makes interpretation of actual penetration effects difficult.

There is considerable debate in the literature on the significance of the age of onset of abuse. Two early studies showed an increase in trauma for pre-pubertal children but further studies did not confirm this (Browne and Finkelhor, 1986). Some recent research by Perry suggests that young children are particularly vulnerable to trauma, particularly in the first years when the brain is rapidly developing. These children are not included in traditional retrospective research because they often have no memory of abuse as adults (Perry and Pollard, 1998).
In summary, what this means to my study is that women whose childhood sexual assault occurred over a long time, and/or experienced more severe forms of CSA (penetration or attempted penetration), and/or whose CSA was accompanied by violence, and it was perpetrated by a father or stepfather are more likely to have more serious mental health consequences. Of particular interest to my work is the impact on the mother-baby relationship and the breastfeeding one.

**Resilience and Vulnerability**
Outcomes are not necessarily the same for women with similar histories of abuse. Vulnerability to poor long-term outcomes following abuse can be thought of in three broad areas; the abuse itself as has been discussed, social and environmental factors, and the biological susceptibility of the individual.

Biological ‘susceptibility’ should be analysed with care, as its origins may in fact be social, traced back to last century and beyond, through the belief that the female body is “weak, defective and deeply untrustworthy” (Dykes, 2005 p.2287). Women are often thought to be more prone to mental health disorders than men and depression is frequently cited as twice as common amongst women (Astbury and Cabral, 2000). As Astbury points out in the introduction of her book, *Crazy for You, the Making of Women’s Madness*, proneness or biological susceptibility directs “attention inwards to the intrapsychic, rather than outwards to society” and into life experiences of women (Astbury, 1996 pp.1-2). The experience of family violence (including CSA) goes a long way to explain the gender differences in anxiety and depressive disorders (Mullen *et al.*, 1988, Golding, 1999). In a recent study of women
attending general practice in Victoria in 2000, the association between depression and partner violence remained significant even after adjustment for the social factors associated with depression (Hegarty et al., 2004).

Perceptions of behaviour may be different for CSA survivors; for example, they are more likely to perceive their parenting as uncaring or distant (Herman, 1993). Other studies have shown an association between sexual abuse and difficult family backgrounds (Russell, 1986, Mullen et al., 1993). One or both parents of children who are sexually abused are far more likely to be absent and have less than optimal parenting practices. There was a strong association found in Mullen et al. (1993) between physical abuse, sexual abuse and parenting practices that were emotionally abusive. Not only do these factors put the child more at risk of abuse but they also prevent the child from receiving effective support after abuse, which could diminish long-term problems (Mullen et al., 1993). Marital conflict, separation and divorce not only increase the child’s risk of CSA, but are factors in vulnerability (Wolff, 1995). Other factors associated with vulnerability included: marital discord, low socio-economic status, large family size, paternal criminality, maternal psychiatric problems, and the child being in community care (Rosenberg, 1987). Marital conflict and parental psychopathology were identified by Beitchman et al. (1992) as important factors in the victim’s negative response to abuse.

Resilience in children has been associated with a positive personality, being female, parental warmth, a positive relationship with the non-offending parent, and a supportive school environment (Rosenberg, 1987). Qualitative research with adult survivors of CSA suggests that
maintaining or regaining a sense of control is important for resilience (Himelein and McElrath, 1996). The four significant strategies identified in Himelein and McElrath’s study associated with resilience were: disclosing and discussing the CSA, minimising the impact, positive re-framing and refusing to dwell on the abuse experience. Unfortunately, while interesting, the study is small and age of abuse and invasiveness were significantly different between the high adjustment and low adjustment groups. Fewer women (43%) in the low adjustment group had disclosed their abuse compared to 85% in the high adjustment group. This may simply reflect the differences in severity of abuse between the two groups and bear no relationship to the actual disclosure being of assistance in recovery. Resilience studies must be reviewed with care, for associating resilience with personality factors in the child may mask the impact of factors associated with the CSA, such as who the perpetrator was, associated violence, severity and duration of the CSA.

In a small study of sleep disturbance in victims of trauma and abuse Chambers and Belicki (1998) found that there was a significant difference in sleep disturbance and nightmare frequency between the abuse trauma sample and the no abuse trauma sample. Victims of trauma who tested as resilient still had significant nightmares and sleep disturbance. The possible implication of this study is that although victims appear resilient in their social and behavioural functioning, there may well be significant disturbance present (Chambers and Belicki, 1998), and this in turn may have significant health impacts.

Romans et al. (1995) used a large community based sample in Otago, New Zealand to compare variables associated with outcomes. Married women who experienced CSA had less psychiatric morbidity than women
who were widowed, never married or divorced and had experienced CSA. They concluded that positive partner relationships were protective. Parental violence, verbal abusiveness to each other or lack of physical affection between parents was associated with higher levels of psychiatric symptoms in girls who were abused sexually before thirteen years. Physical punishment and sexual re-victimisation as a teenager were associated with poorer psychiatric outcomes. A good social life, being good at sport and enjoying school were shown to be protective factors (Romans et al., 1995).

Models to Explain Long-Term Outcomes
A number of theoretical models have been described to explain the long-term mental and physical health impacts of CSA. The first model is based on PTSD, the second on the traumatogenic model of Finkelhor and Browne (1985). Others relevant to early mothering include the developmental coping model and the attachment disruption model but these two models have little research evidence to support them (Nurcombe, 2000).

None of the models presented provides a completely satisfactory link between abuse and the long-term outcomes, particularly when looking for a model to explain breastfeeding concerns and early mothering difficulties faced by some CSA survivors. As I discuss when reviewing the models in detail below, the current models are missing research evidence to explain the link between CSA and the mothering outcome. Theoretical models are important to health professionals because these models form the basis for intervention and treatment (Nurcombe, 2000).
In my professional work, they provide the basis for the primary care management of CSA survivors.

**Post-Traumatic Stress Disorder Model**

This model is based on CSA being linked to adult psychiatric disorders by a chronic form of post-traumatic stress disorder.\textsuperscript{25} The original trauma causes stress and this leads to dissociation, flashbacks, amnesia and even multiple personality disorders (Kendall-Tackett, 2000) in an attempt to repress the trauma memories. These symptoms in turn lead to a post abuse syndrome in adult life. Some investigators (such as Perry (1994)) believe this stress leads to chronic hyper-arousal and altered brain development in the victimised child. These studies, although small, are of great interest as they include standardised psychometric testing and suggest a brain based link between CSA and adult outcomes (Rowan and Foy, 1993). Larger studies in this area are needed.

More recently research that investigates brain chemistry, chronic hyperarousal and three common sequelae of abuse: PTSD, depression and chronic pain (Kendall-Tackett, 2000) has been published. Chronic hyperarousal is a response to a very stressful or traumatic event. It is a variant of the normal stress response. Hyperarousal manifests in the brain by abnormal levels of stress hormones or by changing the number or sensitivity of hormone receptors. It may also alter brain structures like the hippocampus in response to high levels of stress hormones (Bremner \textit{et al.}, 1999, Kendall-Tackett, 2000). Hyperarousal from past trauma such as CSA makes survivors more sensitive to new life stressors (Perry, 1994), such as pregnancy, birth and breastfeeding.

\textsuperscript{25} See Appendix One p.265 for the complete DSMIV classification of PTSD.
The problem faced by survivors in handling stress by hyperarousal is that patterns are set for the future. Stressors can be smells, sights, sounds, feelings, and places. These stressors can cause the same reactions as the original assault, and these may be totally inappropriate or difficult for the adult survivor. For example, Meg’s terror when her baby smiled as she breastfed\(^ {26}\) and Tess (who participated in the research) telling of her fearful response after being given a toy turtle as a baby gift.\(^ {27}\) Both women remembered and associated the stressors (a smile and a toy) with their CSA. They responded strongly, over-reacting to the new stressors (Perry, 1994, Perry, 1997).

This model is not specific to CSA survivors—violence and other trauma can cause a similar response—nor does it apply to all CSA victims.

A further problem exists with medicalising CSA into a psychiatric diagnosis of PTSD with the survivor becoming the focus of treatment. A diagnosis of PTSD may be useful for health professionals to understand and treat the trauma related problems faced by young mothers. The difficulty lies in the focusing of interventions on the survivor alone by the medicalisation of CSA as PTSD. Such a process risks ignoring the social and cultural factors that contribute to the long-term outcomes and ongoing abuse of children.

Mullen and Fleming (1998 p.3), citing Herman’s feminist description in 1992 (without including the reference), criticised feminist descriptions of PTSD as the ‘combat neuroses’ of a ‘sex war’. They state: “ … the combat neurosis women suffer from as a result of the sex war neatly

\(^{26}\) Meg was introduced in the introduction.

\(^{27}\) Tess is introduced in full with the other participants in Chapter Four. See Emotion Chapter p.163.
conflates the post-traumatic stress model with the political agenda of some feminists”. They argue that there is a “considerable vested interest” in a post-abuse syndrome. Central to this argument is that while males are the predominant perpetrators of CSA, the long-term outcomes are not specific to the abuse but are influenced by other factors such as social circumstances and family background. As described earlier in the chapter, long-term outcomes are related directly to the CSA, with poorer outcomes associated with penetrative abuse, CSA associated with violence, and CSA perpetrated by a trusted family member such as a father. The community based research of Mullen et al. (1993, 1996) investigates the importance of socio-economic circumstances, family background, and marital dysfunction. In the latter analysis of associations, all forms of childhood sexual abuse are grouped together and tested against various risk factors: for example, socio-economic status, parental mental health, and parental separation (Mullen et al., 1996). The 1996 analysis did not separate the more severe forms of CSA from the types of CSA less likely to be linked with long-term mental health problems. The earlier (1993) analysis did separate CSA by severity. CSA involving intercourse was found on logistic regression to have an odds ratio of 12, and CSA involving genital touch had an odds ratio of 3.45, while non-genital CSA, parental separation and poor parental relationship were not statistically significant. Parental mental health and socio-economic status were not included in the analysis (Mullen et al., 1993). The importance of the severity of CSA demonstrated in the 1993 analysis was not included in the 1996 or 1998 analysis and/or reported in the latter papers. Furthermore the research of Mullen et al. (1996) failed to incorporate CSA-specific variables such as associated violence, the perpetrator, the duration of CSA, and the severity
of CSA which they had demonstrated was significant in their 1993 analysis.

Their study and Mullen and Fleming’s (1998) comments draw attention away from the gendered dynamics of power within the family, and this omission can also serve a political function. A feminist analysis of the gendered power dynamics within the family contributes to an understanding of why girls and women are abused within the family, why men perpetrate most of the abuse, and why women who have a past history of abuse, unlike their male counterparts, are far more likely to become victims rather than perpetrators (Finkelhor, 1979).28 Both Mullen’s perspective and the feminist perspective assist in understanding the complex biopsychosocial interaction between CSA and its mental health consequences for women.

In summary, the medicalisation of the long-term outcomes of CSA into a condition such as PTSD can be a problem as attention is directed towards the ‘disorder’ in the survivor. As Mullen points out, it can stop a community (including an academic one) from addressing the family and the social and cultural issues that contribute to the occurrence of childhood sexual abuse. It does, however, provide a ‘legitimate’ diagnosis, possible treatment, acknowledgement of the stress and trauma following CSA and recognition of the importance of this problem in women’s lives.

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28 Finkelhor was one early writers on the impact of CSA. His research work and the traumatogenic model he developed to explain diverse psychological outcomes remains relevant today.
Traumatogenic Model.

Finkelhor and Browne (1985) proposed a traumatogenic model to link the impact of CSA with long-term outcomes. The model proposes four trauma-causing factors that explain diverse psychological outcomes and behavioural changes. These are traumatic sexualisation, betrayal, powerlessness, and stigmatisation\textsuperscript{29} (a detailed summary of this model is found in Appendix One).

Traumatic sexualisation proposes that a child’s sexuality develops inappropriately in response to CSA. The child is rewarded by the perpetrator for sexual behaviour that is developmentally inappropriate; for example, by obtaining extra adult attention. Children then use this learned behaviour to meet their needs. Different parts of the sexually abused child’s body are given developmentally inappropriate meaning. Trauma can be caused when the child’s memory of the sexual abuse is frightening or painful. Traumatic sexualisation, as proposed by Finkelhor (1988, Finkelhor and Browne, 1985), is unique to CSA. The child feels confusion, guilt, and has negative associations with sexual feelings, which in turn alter behaviours. It explains why altered childhood and adult sexual behaviours are found in abuse victims; for example, promiscuity, increased risk behaviour and difficulties with sexual adjustment and satisfaction.

The second factor is betrayal. Children discover that someone on whom they are dependent causes them harm. The child’s wishes and well-being are disregarded. The sense of betrayal is not just directed at the perpetrator, but also the non-abusing family members for failing to

\textsuperscript{29} See Appendix One p.265 for a detailed summary of the Traumatogenic model
protect and believe them (Finkelhor, 1988). This factor is most relevant in incest and intra-familial abuse.

Stigmatisation is the third factor and refers to the negative feelings that sexually abused children experience about themselves. Stigmatisation manifests as feelings of badness, worthlessness, shame and guilt. They can be associated with the perpetrator blaming or emotionally abusing the victim (Finkelhor, 1988). The family attitudes, as well as social and cultural attitudes, contribute to these feelings. For example, children think negatively about themselves after abuse; for example, only “bad” girls get abused. The child can also assume that “bad” things happen because they are naughty and being punished, though one would expect this to be more significant at a certain developmental stage and not apply throughout childhood.

The final factor is powerlessness. Two forms of powerlessness occur in CSA: the ignoring of the child’s wishes and being taken over and invaded by the abusing adult. Sometimes there is the added threat of injury to their body and perhaps their life. Powerlessness doesn’t only occur with abuse, it can also occur afterwards when prosecution and police investigation separates families. The child can feel responsible for family trauma resulting from disclosure or prosecution.

Finkelhor and Browne’s model describes a range of long-term psychological effects and behaviour changes. However, it deals poorly with long-term physical health effects. No explanation or evidence is given to explain which aspects of the CSA experience support or mitigate against the development of each of the traumatogenic dynamics. Like PTSD, it is survivor focused, lacking an understanding and explanation of
the complex interplay between the individual, the family and the social and cultural environment.

**Somatisation and Somatoform Disorders**

Somatisation is a term used to describe a model in which psychological distress is transformed into bodily symptoms (Kirmayer and Young, 1998). In the clinical setting patients present with physical symptoms rather than symptoms of emotional distress or social problems. For the new mothers I worked with in the clinical setting, breast pain when breastfeeding was identified as a significant issue, and chronic breast pain appeared to be far more common in mothers who had experienced CSA.\(^3\)

Somatisation is very common in primary care settings (Kirmayer and Young, 1998, Katon *et al.*, 1984). Patients are likely to present physical symptoms to their GP as their presenting complaint; only later in the visit when rapport has been established are they able to cue the GP about emotional distress. It is only after these cues are recognised and acknowledged as legitimate by the GP that the patient may be able to speak openly about their emotion or social difficulties (Silverman *et al.*, 1998).

Katon *et al.* (1984) discusses the way that the medical system and its practitioners reinforce somatisation. Firstly, physicians recognise and treat illness based on somatic complaints. Secondly, physicians concentrate on the biological because of their training and often “do not evaluate the psychological distress that underlies somatic complaints” (p.211).

\(^3\) This may reflect me asking about CSA because I was aware of its association with somatisation and chronic pain syndromes.
The literature on somatisation is quite extensive and shows links between CSA and gastrointestinal, breast disease and pelvic pain symptoms but many of the studies have used hospital clinic patients (Springs and Friedrich, 1992, Walker et al., 1992, Walker and Stenchever, 1993). As well as using hospital based samples, many of these studies fail to consider other forms of child abuse and ongoing adult abuse in their analysis.

The most relevant literature to my study is based in general practice or community samples. Felitti (1991) investigated the link between CSA, rape and later medical consequences in a health maintenance organisation in the U.S.A. Such an organisation provided primary care and is similar to general practice in Australia. There are methodological concerns with the study—the question on rape and CSA did not describe behaviours but asked “Have you ever been raped or sexually molested?” and is likely to lead to a significant underestimate of CSA within the sample (Koss, 1985). Like so many of the studies in the early 1990s, other forms of child abuse and ongoing family violence were not included, further weakening conclusions that can now be drawn from the findings. The significant findings relevant to somatisation were an increase in chronic gastrointestinal symptoms and chronic headaches.

Chronic pain is not purely psychological. It maybe another symptom of hyperarousal because somatic complaints occur in association with PTSD (Kendall-Tackett, 2000). For some of the chronic pain syndromes in abuse survivors, such as irritable bowel syndrome, altered neuroendocrine and brain activation patterns have been demonstrated (Kendall-Tackett, 2000). Recent research suggests that chronic pain is not purely psychogenic somatisation but has a demonstrable physiological basis.
The chronic breast pain survivors described in my clinical practice may result directly from these physiological changes.

The research of Dickinson et al. (1999) investigated 252 women from three family practices in the U.S.A. Women were interviewed and if they had more than two unexplained symptoms they were included in the study. Women who had experienced severe CSA had significantly higher numbers of somatoform symptoms, medical and psychiatric symptoms. In addition, dissociative symptoms were found to have increased three fold between none/mild non contact CSA and severe (forced or non forced, attempted or actual penetration of the mouth, anus or vagina) CSA.

More recently research has investigated somatisation as an expression of emotional distress and found it to be present across cultures, although its prevalence and features vary (Kirmayer and Young, 1998, Keyes and Ryff, 2003).

**The Developmental Coping Model**
The developmental coping model was proposed by Cole and Putman (1992). They conceptualise incest as having a negative effect on social and self development by disrupting primary attachments through physical and psychological trauma, extended periods of guilt and fear and by the loss of a trusted relationship. Their model is based on the developmental tasks of self-integrity and self-regulation that occur in infancy, childhood and adolescence. Cole et al. (1992) propose that the development of self is closely related to social development and sense of others, and that a secure and integrated self is necessary to form successful adult
relationships (Cole and Putnam, 1992). While the model is plausible, it is theoretical rather than evidence based (Nurcombe, 2000).

Cole et al. (1992) investigated parenting after CSA by studying parenting attitudes among American college women with children. They found that incest survivors with alcoholic fathers were less confident and less emotionally controlled as parents when compared to women who had alcoholic fathers but had not experienced incest.

The Attachment Disruption Model
Alexander (1992) uses Bowlby’s attachment theory as the basis for her model. She uses research evidence on attachment in sexually abusive families, suggesting that CSA survivors are insecurely attached in their families and may repeat the pattern with their children. Once again research evidence to support the model is lacking.

Both the explanatory models described above have the potential to be useful and applicable to this study, particularly early attachment between the mother and her baby. At this stage, both are possible models in theory but lack a good research evidence base to support them. Furthermore, it is difficult to see how attachment and relationships alone account for the diversity of physical and mental health symptoms seen in adult survivors and described earlier in the chapter.

The Transactional Model
The Department of Child and Adolescent Psychiatry at the University of Queensland uses a transactional model in the treatment of children after

31 A critical analysis of this paper is found in Chapter Seven pp.205-206.
CSA (Nurcombe et al., 2000). The model, based on the work of Spaccarelli, maintains that outcomes are related to the abuse itself and the impact of the abuse within the child’s family and community (Spaccarelli, 1994). According to this model, child development depends on a series of child-environment interactions, which in turn lead to healthy or psychopathological outcomes. The advantage of this model is multiple factors are accounted for in the long-term outcomes after CSA: factors in the child, the family and the community.

Each of the models reviewed here was considered with the findings from my research. The models most relevant to the research findings are discussed in more detail in the results chapters. The discussion focuses on their application to, including links and weaknesses, the themes raised by CSA survivors as they breastfeed and care for their children.

**CSA and Pregnancy**

Pregnancy itself can be different for sexual abuse survivors. They report more genital infections, more pain and discomfort, more medical problems, have more interventions and use more medical services (Grimstad and Schei, 1999). A similar profile is reported for physical abuse survivors (Parker et al., 1994). Risk behaviours, like smoking in pregnancy, alcohol and drug use, were significantly increased in abused women (Jacobs, 1992, McGrath et al., 1998, Grimstad and Schei, 1999). Antenatal care often commences late (McFarlane et al., 1992, Parker et al., 1994) and their babies have a greater chance of being premature with low birth weight (Grimstad and Schei, 1999, Parker et al., 1994).
To further complicate matters, the risk of physical abuse increases in pregnancy and in the postpartum period (Parker et al., 1994, Stewart, 1994). The *Women’s Safety, Australia, 1996* survey found that violence occurred for the first time during pregnancy in 20% of women reporting violence, and 42% of all women reporting violence were pregnant at the time (Australian Bureau Statistics, 1996). It is estimated that between 4% and 20% of women experience violence during pregnancy (Berenson et al., 1994, Gazmarian et al., 1996). Women who were abused during pregnancy had an even greater risk of violence postpartum (Gazmarian et al., 1996, Gielen et al., 1994). In Stewart’s study (1994) 95% of women abused in the first trimester were abused in the first three months postpartum. A staggering 51.9% had obtained medical care for their injuries, yet none of these women could recall being asked about the cause of their injuries (Gazmarian et al., 1996). In an earlier study by Stewart (1993) only 3% of physically abused women were identified by their prenatal care providers (in Stewart, 1994). Pregnant teenagers had higher rates of sexual and physical abuse in the previous year than adult women. This persisted through pregnancy. Previously abused adult women, however, reported more severe physical and emotional abuse, and the abuse was usually from their partners (Parker et al., 1994). As reviewed earlier in the chapter, experiencing CSA places the child at greater risk of other forms of family violence and as a consequence, at greater risk of physical violence from intimate partners during pregnancy.

Anecdotal reports of pregnancy and labour reactivating the memories of past abuse are present in the literature. There are no longitudinal studies of abuse survivors and these phenomena. One study looked at the development of PTSD following difficult labours (Reynolds, 1997). Two common birth experiences which may predispose to developing PTSD,
were extreme pain and loss of control. Unfortunately, CSA was not considered in the Reynolds study. Women who have been victims of sexual assault report that intravenous lines and monitoring equipment made them feel trapped and constrained, just as they had been during the sexual assault. Commands by staff to “lie down”, “open your legs” and to be a “good girl” caused flashbacks and recollection of sexual abuse. Routine antenatal procedures such as vaginal, breast and abdominal examination may be more difficult for abuse survivors; routine medical procedures can bring back overwhelming memories of sexual violence (Kitzinger, 1990).

Issues of control were identified as important during labour. The prospect of losing control over pain, her body, her care, her own or staff behaviour, was associated with feelings of fear and vulnerability (Simkin, 1992). Some of the participants in my research developed birth plans with their partners to avoid this loss of control.

There are reports of delivery itself, pressure caused by the head of the baby in the vagina, causing recall of childhood sexual abuse for the first time. The pain experienced was reported as similar to the pain experienced when being sexually abused as a child: for some it is as if they re-experienced the actual assault. Feelings of being watched by students, nurses, doctors or partners has been reported as triggering feelings of violation and degradation, particularly in survivors of voyeuristic abuse (Kitzinger, 1990).

Pregnancy and childbirth can be a major trigger in the recalling of CSA, and it is possible that this can influence not only birth but the entire postpartum period (Courtois and Riley, 1992). Individual women’s stories
seem to confirm this but there are no longitudinal studies available on this group (Kitzinger, 1990).

The role of labour and birth in triggering women to recall CSA, as well as the associations between poorer physical and mental health, raises the possibility of CSA being remembered and/or influencing other aspects of mothering after the birth of a child. These include breastfeeding, maternal-infant attachment and post-natal maternal mental health.

**CSA and Breastfeeding**

In my clinical work women describe a number of breastfeeding experiences which have recalled sexual abuse, as outlined in Meg’s story in the introduction. Other mothers described fear for their babies. They feared their babies would be abused and that they, as mothers, will be unable to protect their children. Several mothers presented with chronic breast pain for the duration of breastfeeding and I was uncertain whether their pain was a chronic pain syndrome associated with their history of CSA. Their pain certainly failed to respond to standard treatments.

Some women with a past history of CSA dissociated and appeared absent when breastfeeding (Rhodes and Hutchinson, 1994, Kendall-Tackett, 1998), other women dissociated only when they experienced pain breastfeeding.

In a Victorian qualitative study of birth by midwife Jenny Parratt (1993), six incest survivors describe their experiences of breastfeeding. Four of the women are quoted in the following paragraphs. This is an important study because it is Australian and highlights the breastfeeding challenges
faced by CSA survivors. Each woman highlights how her experience of breastfeeding was challenged by experiencing CSA.

The women described in the following paragraphs took part in Parratt’s study and are called by the same pseudonym that was used within that study.

Alison highlights two issues that I later explore in my research—that of intimate breast touch and that of inadequate milk. Alison describes initially not wanting to have her daughters near her, even though she was able to breastfeed later. Her immediate response after birth was “I didn’t want them near my breast, near my body … they (the hospital staff) tried to put the baby on the breast and I refused, I didn’t want the baby” (Parratt, 1993 p.5). Her second daughter was admitted to hospital at four weeks of age with poor weight gain. Alison explained that she had “plenty of milk but there were no vitamins in it … some people have just got good milk and others haven’t”.

Kate raises issues of safety and exposure when breastfeeding. She did not want to breastfeed her first child because she still lived in the house with her brother, the perpetrator of her assault, and risked further voyeuristic and perhaps further sexual assault of herself or her child by exposing her breasts to breastfeed. “I never breastfed at all when I was living at home, I didn’t like the idea … my brother would probably have got a thrill you know” (Parratt, 1993 p.6). She goes on to relate how severe pain due to mastitis reminded her of her incest. It impacted on her relationship with her son to the extent that she saw him as a perpetrator: “I thought I wouldn’t like him near my breast … you’re supposed to be loving but
you feel like its incest … I was trying to get over that, I was fighting that” (Parratt, 1993 p.6).

Ruth describes her negative feelings about her breasts and their association with her childhood sexual assault, establishing a direct connection between her experience of breastfeeding and her CSA: “The dirty clean thing of breasts … it’s … what’s attached to them in memory, there’s guilt and fear and anger” (Parratt, 1993 p.7).

Susan successfully fed her four children for two to three years. She describes being really comfortable and enjoying breastfeeding but still felt that something was taken from her: “I just feel that that [breastfeeding] was somehow contaminated with the incest … I suppose in giving of myself … in giving more of myself than I really had” (Parratt, 1993 p.7).

These stories clearly demonstrate the challenges four Australian women faced in breastfeeding after CSA. They indicate its relevance to women and the importance of understanding each woman’s perspective. None of the women was breastfeeding at the time of Parratt’s study, and the age of the participants’ children varied from six months to twenty one years. While the breastfeeding experience was quite recent for some, for others considerable time had elapsed since they had breastfed. The need for a study of CSA survivors who are currently breastfeeding or had recently breastfed is clearly indicated and builds on Parratt’s earlier research. For this reason my research recruited women early in the postpartum period, and later extended to include mothers who had recently weaned their babies.
The descriptions of breastfeeding pain given by survivors in Parratt’s study reflect my clinical experience. Chronic breast pain was something I saw in my clinical practice amongst breastfeeding women who were CSA survivors. Breast pain in non breastfeeding women is described as one of the chronic pain syndromes associated with CSA (McCauley et al., 1997). No studies of lactation, breast and nipple pain could be found that included a maternal history of CSA.

Since starting this research, a telephone survey of child rearing needs in the United States of America has been published. This survey was of a nationally representative sample of parents with children under three and had a 55% response rate (n=2017). In the survey the researchers asked about initiation of breastfeeding and CSA. A greater proportion of women who reported CSA initiated breastfeeding (77%) compared to women who did not report CSA (65%, 95% CI=1.14). However, proportionally more of the women who reported no history of CSA (82%) breastfed for more than one month than those who reported CSA (73%), but this difference did not reach statistical significance (Prentice et al., 2002). Methodologically there were some problems with the study. The question about CSA was phrased exactly as follows: “When you were growing up, did you ever feel you were sexually abused or not?” The first part of the question is ambiguous and increases the risk of reporting error, because every woman in the study may not define “growing up” in the same way. Furthermore, by asking were you “sexually abused or not?” makes a yes/no answer impossible to interpret. If ‘yes’ was the answer, were they answering yes to ‘sexual abuse’ or ‘not being sexually abused’? Similar problems occur with the interpretation of a “no” answer. No details are given in the paper as to how respondents were expected to answer this question. This type of gate question can be regarded as quick
but dirty, with women saying ‘no’ to child sexual abuse\textsuperscript{32} when they would meet the definition of CSA.

Deme’s interview (a participant in the research who will be introduced in full with the other participants in Chapter Four) description\textsuperscript{33} of why she was not being raped as an eight year old girl because her stepfather ‘demonstrated rape’, graphically reinforces how words like ‘rape’ and ‘sexual abuse’ can result in under-reporting. Funnel questions, which ask about specific unwanted sexual behaviours, are far more likely to reflect the experience of CSA. This is reflected in findings of Prentice \textit{et al.} (2002) study where 7\% of biological mothers reported childhood sexual assault, much lower than the 20-30\% normally found in women in community surveys\textsuperscript{34} which use behaviour specific questions. Even though the numbers in this study are quite large (response rate 55\%, n=2017), the method used casts doubt on the accuracy of the comparison groups and therefore the overall findings (Prentice \textit{et al.}, 2002).

Breastfeeding itself can reactivate memories of abuse—the skin to skin contact with the baby, the milk ejection reflex and squirting milk remind some women of ejaculation they experienced during sexual abuse (Kendall-Tackett, 1998). Flashbacks to the abuse, intense fear and dissociation are all described. Some women felt that their bodies were shameful and dirty or contaminated and it would be impossible for their bodies to make milk that was good for the baby (Parratt, 1993, Kendall-Tackett, 1998).

\textsuperscript{32} ‘Abuse’ is used in this context to reflect the wording of the study being discussed.

\textsuperscript{33} Described earlier p.26.

\textsuperscript{34} Refer back to prevalence section pp.21-25.
There are also personal stories in the literature about breastfeeding being an important part of recovery from abuse. One woman in Pickering’s (1999) study states that “breastfeeding has helped me overcome the negative image of myself and my body. It has given me such pleasure to nourish all my children” (p.21). Some women found breastfeeding ‘protective’ for their infants as it fostered closeness and a positive relationship, while other CSA survivors did not want to feed, and others elected to express or pump their breasts and feed their babies with expressed milk in a bottle (Escott, 1998).

**CSA and Mothering**

CSA survivors have higher rates of anxiety, depression, phobias and PTSD. They may have a greater risk of depression in the postpartum period (Astbury et al., 2000). A difficult birth, a crying or sick baby can exacerbate these feelings (Kendall-Tackett, 1998). Depression may also be a factor in ongoing parenting difficulties (Buist, 1998). Specific parenting difficulties expressed by mothers with abuse histories include feelings of ambivalence and of being overwhelmed, having unreasonable expectations of themselves, low self-confidence and difficulties limit setting (Buist, 1998). These mothers are often the ‘caretakers’ for their relatives and friends. It is difficult for them to set limits and although they are often seen as ‘supermum’, they received little care themselves. It is often difficult for them to accept and receive support (Kendall-Tackett, 1998). Even if support is available, survivors may find it difficult to use.

An impaired sense of self, low self-esteem, shame and body image distortion are all long-term effects in abuse survivors. Thighs, abdomen and breasts are often areas of focus for bodily shame (Andrews, 1997).
Body image has a positive relationship with intention to breastfeed but I was unable to find research on body image and duration of breastfeeding.

**Gaps in the Literature**

In this chapter I have demonstrated that CSA is a common problem faced by women, with serious long-term physical and mental health sequelae and should be a research priority in Australia.

From this review it is clear that little is known about the responses to breastfeeding and the tasks of early mothering by women who were sexually assaulted as children. Having a new baby who cries, must be fed, allowed to suck at the breast, washed and have its nappies changed, can in some ways be similar to the dynamics of child abuse, in that the mother cannot control the baby’s needs or the need to access her body.

Without appropriate information to give these women available in the clinical setting, the survivors and I identified an area of need in primary care. Failing to respond to this need, both personally and professionally, ignores the experience of many Australian women. It suggests to women that their experience is unimportant, their abuse doesn’t matter, and they should remain silent.

My clinic patients, survivors who were new mothers and wanted to understand their responses to their babies and experiences of breastfeeding, demonstrated to me that such knowledge is urgently needed to inform the post-natal care of Australian women.

The literature reviewed here confirms this need.
In this chapter I outline the aims of the research undertaken, the research questions and purposes of the study. The methodology and methods used to undertake the project are explained. I conclude the chapter with a discussion of the conflicts that have arisen over the course of my research between method, theory and the practicalities of doing research with a vulnerable population.

Breastfeeding initiation, duration, weaning, pleasure, pain and touch will be explored in the research undertaken. These areas are chosen for three reasons. Firstly, because my clinical experience indicated that abused mothers have more difficulties breastfeeding. Secondly, because the literature on CSA suggests that various chronic pain syndromes may be linked to childhood sexual assault and thirdly, because anecdotal reports in the literature have identified problems initiating and maintaining breastfeeding following CSA.

The meanings mothers give to their breastfeeding and its relationship to the mother-infant relationship are explored, with particular emphasis on the impact of CSA on their experience.
Aims
The objective of this study is to explore the experience of breastfeeding in mothers with a past history of CSA perpetrated by a family member.

Purpose
This study seeks to redress the gap in medical knowledge outlined in the previous chapter and thereby improve the medical care these women receive.

It also seeks to improve the information directly available to CSA survivors about breastfeeding and early mothering.

The results of the study will be used to enhance the health care provided to CSA survivors by primary care health professionals. Primary care professionals are uniquely situated to assist CSA survivors as they face the challenges of early breastfeeding and parenting. In complex areas, where the social and clinical interact, as happens in a general practice when caring for the medical conditions of CSA survivors, in-depth research is more useful to the healthcare practitioner than generalisations. For example, providing information to mothers antenatally and post-natally about the different experiences of breastfeeding for CSA survivors may assist women in understanding their own responses and reactions. Similar information to primary care practitioners may alert them to women who are struggling with the sequelae of CSA and allow the practitioner to provide education, appropriate counselling and access to ongoing support services. Effective early intervention, when needed, may improve the developing relationship between the mother and infant,
enabling the child to grow in a supportive and safe environment, thereby reducing the risk of intergenerational transmission of CSA.

Of equal importance is that the results of this study will be returned to the women who participated and the community, so that women may directly access the information for themselves. Improving information available to women may assist them to overcome challenges they face as CSA survivors (or as family and friends of CSA survivors) and to seek assistance when needed.

**Research Questions**

In order to focus the research and to begin to understand the breastfeeding experience of CSA survivors, a set of research questions was developed. The principal question was:

**What are the breastfeeding experiences of women who were sexually assaulted as a child by a family member?**

To aid my exploration and understanding of their answers, two minor questions were developed:

- How do survivors of CSA understand and explain their mothering and breastfeeding experience?
- What challenges do women with a history of CSA face when mothering and breastfeeding?
Methodology

Using a Qualitative Method

Mothering, breastfeeding and CSA occur within a complex social and cultural context. The individual meanings women give to these acts, done to and with their bodies, was best investigated using a biopsychosocial model because it integrates the biological, psychological and social influences (Engel, 1977, Engel, 1980). Women, researchers and health professionals live in a social world. Their stories, interpretations and understandings are part of, not separate from, this social world.

An appropriate approach to answer questions about mothering and breastfeeding was to use an interpretive methodology. The benefits of qualitative methods to health research have become increasingly apparent, because these methods of research assist in understanding the various processes that lead to certain outcomes (Daly and McDonald, 1992, Jaye, 2002, Mays and Pope, 1995, Hudelson, 1994). While in the past, qualitative research has been labelled as ‘unscientific’ in medicine, where scientific knowledge is judged the highest form of knowing (Pope and Mays, 1995, Malterud, 2001), it is now becoming increasingly important in health and general practice research. In simple terms, because individuals give complex meanings to their life experience (Smith and Noblit, 1989) and act accordingly, understanding why and how they respond is as important as the action itself. The underlying assumption of qualitative work is that “the perspective of others is meaningful, knowable and able to be made explicit” (Patton, 2002 p.341).

Personal realities are socially constructed meanings based in time and culture (Lindenbaum and Lock, 1993). Understanding the world in these terms requires an understanding of people, their interactions and contexts
and the possibility of different realities. This paradigm allows for many voices, multiple truths and realities to exist together. The ‘one size fits all’ notion of truth for all women who experience CSA cannot be upheld on anecdotal evidence alone.\textsuperscript{35} For example, women who experience similar CSA by the same family member experience the short and long-term consequences differently. Breastfeeding was easy and joyful for some and difficult for others. My research seeks to understand that while women may continue to breastfeed (the outcome), their experience and meanings they give breastfeeding after CSA (the process) may be different. Therefore, a qualitative method provided the best opportunity to answer to my research question.

Interviews were the best method to answer my research question as they allowed me to explore the individual participant’s perspective in depth, and their subjective meanings and interpretations (Liamputtong and Ezzy, 2005 p.71), while minimising the risk\textsuperscript{36} to participants. In-depth semi-structured interviews had the advantage of allowing me to use pre-existing CSA literature in the framing of questions and to build on previous research, while still exploring the participants’ experiences.

The relationship was particularly important in my research because several of the participants were discussing their CSA for the first time. One mother in my study described carrying her memory of her penetrative CSA as a “huge rock sitting in my belly, poisoning my life”. It was only over the telephone after the second interview when I was trusted, safe and known to her that she could tell this aspect of her story. This information from her would have been inaccessible if a different

\textsuperscript{35} See Chapter Two CSA and breastfeeding literature review as an example pp.59-62.

\textsuperscript{36} Risk in the researching of CSA with women is discussed in detail in Chapter Five.
method had been chosen for my research, and as such excluded from the knowledge created by the search.\textsuperscript{37} The relationship we had established, the interaction, rapport, trust and safety were critical in the telling of her story, which she told for the first time, during the research process. She chose to participate in the research to test whether it would be safe to seek help through counselling. The interviews were the vehicle which gave her access to therapy. She could finally tell of the intense pain she had carried for thirty years. The researcher-participant interaction was critical to her; no other method could have held her safely as she told her story. The participant-researcher interaction was critical to me; no other method would have allowed me as the researcher to hear and feel the intensity of the emotions that surrounded her experience of CSA.\textsuperscript{38}

To answer the research question, women in this study needed to be able to discuss their experience of CSA and its effect on them as mothers. In-depth interviews were advantageous because the participants could talk and discuss sensitive matters such as their response and experience of CSA in a private setting. Other methods, such as focus groups, may prevent women from discussing such sensitive issues (Liamputtong and Ezzy, 2005).

While in-depth interviewing is well suited to the exploration of the impact of CSA with mothers, there are limitations to the method. The limitations of in-depth interview research are that it is time consuming and expensive, and that it generates large amounts of data. It is difficult to

\textsuperscript{37} Search is used deliberately in place of research, to make explicit that I am searching for knowledge based in the experience of women. In the words of Mary Daly (1978); “[…] feminist searchers are blocked/divided from knowing their sisters who have been erased by ritual atrocities, and the rituals of re-search function to ensure this blockage …” from Gyn/Ecology: The Metaethics of Radical Feminism, p.131.

\textsuperscript{38} The role of emotion is explored in detail in Chapter Five.
do well as it requires an awareness of, and sensitivity to, the interactions between the interviewer and the participant (Liamputtong and Ezzy, 2005). Interview interaction between the researcher and participant has been criticised for biasing the interview. This criticism is based on three assumptions: that it is possible to avoid bias, that interviewers are unaware of their role and finally that only one meaning is possible (Liamputtong and Ezzy, 2005).

The women participants speak for themselves in the interview data I present in this thesis, but their stories are spoken through me and my research. My presence is important in interviewing, transcribing, interpreting and presenting, and I have made choices and selections in each of these steps. For example, while conducting the interviews I made choices about when and what to follow up with a further question. Some things were spoken while others were left unspoken and unexplored. In reviewing the interviews, there was little in the transcribed words that explained why I made certain choices at certain times; I had responded to non-verbal cues from the participant, my own experience, emotion and intuition or perhaps a ‘gut feeling’. Another interviewer asking the same questions may not get the same answer because of factors including their rapport with the participant, their response to non-verbal cues, body position and tone of voice. Interview based research may not be reproducible, in spite of the same person asking the same questions and because of the human interaction involved in communication. I listened and reflected on all the interviews and as I did I explored the interaction and communication between the participant and myself. I listened for leading questions, whether I had left enough time for the participant to respond and whether I had explored the options and interpretations with
the participant. The technique helped me to recognise ideas and possible themes to explore further in subsequent interviews.

I discussed the analysis and findings with an experienced qualitative researcher. In the process we discussed alternative interpretations and meanings and critically analysed our differences in interpretation. The discussion encouraged new ideas and interpretations and some of these were used in subsequent interviews and/or analysis.

In Chapter Five, I further discuss the importance of reflection on the researcher’s role and the research process in ensuring the trustworthiness of the research findings. In Chapters Six and Seven, the different meanings participants give to their mothering experiences are explored.

**Rigour in Qualitative Research**

Rigour in qualitative research is important to ensure that the research was of high quality, particularly so when researching with vulnerable populations. The research undertaken for this thesis was challenging, the information shared within the interviews was highly sensitive and at times emotionally upsetting for participants. I needed to define rigour in a way that was appropriate for participants while ensuring the research quality and trustworthiness.

Garman defined quality in education research by using verity\(^39\), integrity, rigour, utility, aesthetics, ethics and verisimilitude (Garman, 1996 p.17). Her definition of quality for research in educational settings, where students are potentially vulnerable because of power differences between

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\(^{39}\) Garrand uses the French word *verité*, I have used verity, the English equivalent. She uses ‘rigor’, for consistency I have used ‘rigour’.
the researcher and the student, was most appropriate because it could be applied sensitively to the needs and potential vulnerability of CSA survivors participating in research.

Verity

Verity means a “true statement, especially one of fundamental importance” according to *The Australian Concise Oxford Dictionary* (Moore, 1987). I needed to ensure that I had the essence of the participants’ stories, that I had captured the fundamental truth they were telling me when I faced problems engaging the participants in the process of validation and reviewing transcripts, coding and analysis. How was I to assess whether the work rang true in these circumstances? Where it was possible I checked my interpretations within the interview. I reviewed the literature on the long-term effects of CSA, boundaries, attachment and breastfeeding after CSA to ensure the work rang true because most participants did not want to review transcripts or the data analysis. One participant reviewed her transcript and one reviewed the coding of the interview, the rest made a choice not to do either.

Integrity

Integrity relates to the ‘architecture of the project’: is it designed well and structurally sound? I have outlined in the methodology how the project was built and why it is based in qualitative methods. In the interview it was important that the questions were structured well, leading from each other and enabling the establishment of a good rapport between the interviewer and the participant. In addition, a safe environment needed to be established. Garman (1996) uses ‘integrity’ as the description for this process and emphasises its importance in the quality of the research produced.
In my research considerable thought and consultation went into the design and order of the questions asked in the interview. A reference group of two psychologists, a new mother, two GPs and two CSA survivors reviewed the structure and order of my questions before participants were interviewed. Ordering and wording were changed in response to their review—for example, one of the questions asked about the ‘physical, emotional and sexual’ experience of breastfeeding. Both CSA survivors felt this was too confronting for a survivor as they might think I was connecting sexual abuse with breastfeeding and on their recommendation ‘sexual’ was changed to ‘sensual’.

Rigour

The steps taken to ensure the soundness of my representation were not the traditional ones of giving the transcripts and analysis back to the participants for their verification. Knowing from the literature that the coping strategies women use include shutting out or minimisation of their past abuse and the refusal to dwell on their abuse (Himelein and McElrath, 1996), I could not ask them to revisit it over and over again in the transcription and analysis. I did, however, offer them the opportunity to do so if they wished.

Another important step was to reflect continually on my role as the researcher, taking note of my actions and reactions, my role in the research process and subjecting these to critical scrutiny (Liamputtong and Ezzy, 2005 p.43). An example of this reflective process occurred when I thought about the interview and listened to the audiotapes.

Interviews were the cornerstone of my professional interaction with patients but I had to stop and reflect on the differences between a medical and a research interview. How would my medical training impact on the research interview? The power balance in the doctor-patient and researcher-participant interview was quite different. I would need to modify my ‘natural’ interview style to be an effective research interviewer. The agendas are different: in the professional interview the patient’s story is often overtaken by needs of the practitioner and the medical history. Information needed to make a diagnosis is given priority and the patient perspective and experience is of lesser importance. In the research interview the participant’s perspective is actively sought. As I listened to the early audiotapes I sometimes found myself cutting short the participant’s discussion and following another line of thought. At times my reaction was appropriate, while at other times it limited the discussion. I became aware that I needed to listen more and interrupt less. The qualitative interview involved me in extending and using my skills in a different way, concentrating on the participant’s perspective and understanding.

**Utility**

Garman (1996) defines utility by whether the work is useful, professionally relevant and makes a contribution to the field. As outlined earlier in the chapter, the project redresses gaps in knowledge and is relevant to women who have experienced CSA and the health professionals who care for them.

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41 My interview style is not natural but is a product of a working lifetime spent in medicine. I have interviewed in this style for so long that it feels ‘natural’. Listening to the transcripts brought home how often I do indeed sound like a doctor but this experience also allowed me to explore issues deeply with participants.
Since completing the research for this thesis, I have worked with staff from Centre Against Sexual Assault (CASA) House and the Royal Women’s Hospital to produce a brochure on pregnancy and early parenting for CSA survivors and a second one for the health professionals who care for these women and their children. These documents were produced in collaboration with both organisations and are useful, allowing the findings of the research to be disseminated among survivors and health professionals, potentially contributing to improving the health care available to CSA survivors.

**Vitality**

In the background chapter I outlined how common CSA was among Australian women and the lack of research in this area, particularly in the area of mothering. My project fits Garman’s definition of vitality. It is meaningful and not trivial, it is intense and the words of the participants communicate their meanings powerfully (Chapters Six and Seven further demonstrate the vitality of the research undertaken).

**Aesthetics**

Aesthetics, according to Garman’s definition (1996), include: insights into my educated self, is the work enriching and does the work touch the spirit? Completing the designing, doing and writing up my research has been an amazing journey for me. I have learnt so much—about doing research, about writing and, perhaps more importantly, about speaking to professional audiences about women’s experience and speaking what I now know. The process of completing this study has given me insights into my educated self—it has certainly deeply touched my soul.

42 Draft versions of the pamphlets produced as a direct result of this research, in collaboration with CASA House and DVIRC, are in Appendix Five pp.290-307.
**Verisimilitude**

Garman (1996) describes verisimilitude as applying when a work represents “human experiences in sufficient detail so that the portrayals are recognizable”\(^{43}\) (p.19) as a possible experience. The women’s voices are heard in the transcripts with all their vitality, love, strength, pain, anger and despair. Their stories are not for the faint-hearted because the women live in them, and the difficulty lay in ensuring their portrayals were sound, when most of the transcripts and analysis were not reviewed by the participants. In this case I relied on the research literature to compare and contrast with the participant experience of breastfeeding, touch and attachment.

**Ethics**

Research into domestic violence and sexual abuse is ethically complex. Berg argues that social scientists have a greater ethical obligation to participants in research. Researchers who explore the private lives of human beings have an added responsibility because their research may lead to changes in policy, practice and the law (Berg, 2001). While I am a medical practitioner rather than a social scientist I am investigating the connection between post-natal problems, breastfeeding and CSA. The women who participated have new babies or young children. Their rights, welfare and the potential impacts of the research on their families all needed to be considered.

Because the participants had recently given birth and/or had small dependent children, asking about their experience as mothers and the impact of CSA on this experience was potentially upsetting and re-

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\(^{43}\) Throughout the thesis “s” is used instead of “z” in words such as recognisable, maximise and organise but in direct quotes and titles the original author’s spelling is used.
traumatising, potentially increasing the risk to the participants and their children. It also provided an opportunity to discuss concerns that may have otherwise gone unspoken, providing potential benefits to the participants and their families.

Garman (1996) argued that ethical considerations included privacy and dignity, conducting the inquiry in a careful and honest way, and whether the inquiry has an ethical sensibility. Garman’s definition provided a broad framework by which to consider the ethics of the project but provided little practical assistance when considering the complexity of researching with members of a potentially vulnerable population after birth and/or with small children.

The practical ethical guidance I required to consider, plan and conduct the research was provided by two other documents. One was from Australia, the *Human Research Ethics Handbook* (2001) produced by the National Health and Medical Research Council (NHMRC). The second was produced by the World Health Organization (WHO) to guide researchers who were investigating domestic violence (WHO/FCH/GWH/01.1, 2001).

The project was granted ethics approval by the School of Public Health Departmental Human Research Ethics Advisory Group (DHEAG), and by the Melbourne University Research and Innovation Office Health Sciences Human Ethics Subcommittee (HREC), HREC No. 040045.44

Women with a history of CSA are not easily recognised within a population of pregnant or postpartum women. New mothers and pregnant

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44 A copy of the University of Melbourne HREC Approval Document is in Appendix Four p.278.
women, like children, have traditionally been excluded from research due to potential risks to them and their babies (Merton, 1993, Mastroianni et al., 1994). Their exclusion from such research at best denies the ethical principle of justice and at worst prevents the development of more effective and sensitive interventions (Mastroianni and Kahn, 2001, Merton, 1993). In the paragraph below, Armstrong demonstrates the importance of including pregnant women in CSA research.

Armstrong (2001) identified a need to better understand the experiences of CSA survivors in her thesis. She describes one pregnant CSA survivor’s encounter with routine antenatal screening in a Melbourne hospital:

*I guess the hardest time for me was going to the doctor. I came in and he asked me a number of questions. Nothing on the personal level, just all medical, and then pulled the curtain across. Made me take all my clothes off and put a gown on ... these two people, were looking at me with mirrors and poking me ... The doctor had a feel [hesitation] then the medical student had a feel and like “Oh God” You Know ... [voice shakes] ... I went straight to the toilets and started vomiting. I was just terrible (Armstrong, 2001 p.150)*

Research participation may cause trauma to some participants by asking them to recall their CSA experience. The encounter above demonstrates that normal routine obstetric and post-natal care can be traumatic if knowledge about the possible experiences encountered by CSA survivors is not incorporated into routine health care.

My research looked at the sensitive issue of CSA and its impact on aspects of early mothering and, while I prepared and designed my study with ethical care, ethical issues still arose in the world of real research. I
will follow on in the next sections with predicted issues of safety and solutions for participants and researchers with actual issues that arose during my research—in the interviews, in the analysis and in writing up the research. Finally, I will discuss research involvement from the participants’ perspective using their transcribed responses.

Safety of Participants
The purpose of this section is to identify and predict ethical issues that may arise during the research that was undertaken and outline the steps I took during the project to avoid potential ethical problems. The purpose of this section is not to discuss or debate the various philosophies that underlie the Australian NHMRC or WHO Research Ethics Guidelines, even though both were used when considering participant safety.

In designing a project based on one or two interviews with CSA survivors shortly after they had given birth or when they had small children, not doing harm was a critical consideration. The immediate question raised by my study design was, “How risky was it to do an interview at four to six weeks postpartum and again at ten to twelve weeks and with women who had older children?”

In the interviews I asked about the baby/child, maternal-child relationships, breastfeeding, the mothers’ experience of CSA and how it impacted on mothering. In asking about CSA I was asking women to recall and report traumatic experiences and to explore their impact on their mothering, something that they may not have considered before. The process may have unintentionally made them feel more vulnerable or
inadequate as mothers, as if their experience of CSA stigmatises them as ‘bad’.

In managing the potential trauma and vulnerability created by my research I chose a recruitment strategy that gave women time to consider their participation without any pressure from me as a researcher. The participants were volunteers who responded to an advertisement. The details are in Chapter Four.

I knew, based on Fleming’s work (1997), that 48% of Australian women who were CSA survivors would not have disclosed their CSA previously. Of particular interest to me and not mentioned in Fleming’s work was how many survivors had told their partners? As my study participants had just had children I thought most of them would have partners, and this was the case with my research. Nine of my participants were living with partners at the time of the interviews and two were single mothers, one of whom lived with her parents, the other alone with her son. Eight of the nine partnered women had disclosed their CSA to their partners prior to their involvement with my research; one disclosed her CSA to her partner the night before her interview with me. As both the single mothers were no longer with their partners I did not ask if they had disclosed. Maria lived with her parents and they were aware of her CSA.

Women face barriers when disclosing family violence. Head and Taft (1995) identified internal and family barriers. Internal ones included: lack of confidence and self-esteem, shame, lack of trust, self blame and guilt, and normalisation of abuse. Family barriers identified were: fear of family members, lack of family support and social pressure on CSA survivors because the perpetrator is viewed as a wonderful person by the
family. During the course of the research participants talked of the importance of silence in protecting family members and the family—for example grandmothers when the grandfather was the perpetrator. Using these barriers as a basis, it becomes clear that privacy is an important issue in CSA research.

Privacy concerns started right at the beginning of the project. The description of the study was one of a research project which investigated women’s emotional experiences and breastfeeding. As such, family members could see the Plain Language Statement (PLS) and not be aware of the CSA component to the study, ensuring the participants’ emotional and physical safety within the family and not putting them at risk through my written documents explaining the research. Inside the PLS the CSA component of the research was fully explained so participants were fully informed prior to consent but this was not obvious to someone glancing at the document.

Privacy remained an important issue during the interviews. Interviews were frequently interrupted by babies and toddlers and the interviews adapted around their needs. Adults also interrupted. The interruptions were by partners, family members and friends. At the beginning of each interview I discussed what would happen if we were interrupted; my plan was to stop the interview if it was at a sensitive stage and go to more general breastfeeding or professional contact questions. Three interviews were interrupted by partners, each interview stopped and became general until the partner had left the room. One interview was interrupted by the participant’s mother-in-law and the interview was unable to be completed because of the interruption. I will return to this case later in the chapter because although I had predicted and responded as I had planned with the
participant, the ending of the interview was of concern to me. The participant was afraid she would be blamed for her CSA should her mother-in-law find out. We talked about the possibility of her mother-in-law arriving and how we would handle this event. We decided to stop the interview and discuss breastfeeding. However her mother in law’s arrival occurred just after Deme had disclosed the extent of her CSA—this included threats, burns and vaginal rape over many years. I felt she was placed at risk because we were unable to deal with important issues she had raised just prior to her mother-in-law’s arrival and because we were unable to close the interview properly.

Awareness of the problems faced in conducting CSA research is not enough (Mudaly, 2002). Strategies to minimise harm are needed. These strategies are outlined in the next section.

**Solutions for Participant Safety**
Researcher interview skills can assist in reducing the negative impact of research on the participant. Disclosure can be a positive experience, and research shows it is related to the reactions victims receive on disclosure (Lutz, 1999, McNulty and Wardle, 1994, Ullman, 1996a). The most valued responses were belief, emotional support, being listened to and not being blamed (Ullman, 1996b, Hindmarsh et al., 1998). Negative experiences were related to victim blame, minimisation of the trauma, and negative social reactions from others, such as professionals and family members making it clear that they did not want to hear about a traumatic event.
Interested GPs are trained as postgraduates to believe, listen to, support and not to blame women who disclose family violence (Hindmarsh et al., 1998). These responses assist participants to have positive emotional reactions to research (Ullman, 1996b) and therefore it is highly appropriate that an experienced trained clinical GP such as myself conducts the interview to minimise the potential trauma to participants. I have worked in clinical practice for twenty four years in paediatrics, psychiatry and general practice. The clinical skills I brought to the research enhanced it because I had extensive experience working with mothers and young children and, in particular, mother-infant issues. In addition I was able, if necessary, to assess, triage, engage and refer mothers who needed assistance beyond the scope of the study. I am older and have been a clinician for twenty five years which may be an advantage to my safety as a researcher. Age may be protective when undertaking research in complex and emotionally difficult areas but the evidence base in this area is conflicting (Ghahramanlou and Brodbeck, 2000).

I have additional expertise in advanced communication skills, in particular those communication skills required during the disclosure of family violence and when dealing with strong emotions. The latter I found particularly useful during the interviews as it allowed me to follow emotional cues and allowed a depth in the exploration of issues that would otherwise have not been achieved. My training had the added advantage in these interviews of allowing me to contain emotion at times; for example, sometimes I did not press participants for a deeper

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45 In 2005 The Justice Department of Victoria produced guidelines for general practitioners and a consensus statement of evidence about the best responses to family violence that reinforced the importance of appropriate responses to disclosure.

46 I teach and train medical students in advanced communication skills and family violence and GP registrars in family violence.
exploration of an issue because I sensed that it would be too distressing to go further. The communication skills I was able to employ during the interviews allowed me the benefit of an in-depth exploration, while sometimes recognising participant distress before it became overt.

A further safeguard was placed in the structuring of the interview. During the interview women were asked about past sexual abuse which was perpetrated by a family member. As these questions may appear confronting, participants were offered a choice by the interviewer. They were offered the option repeatedly through the interview, and particularly prior to the questions about CSA, of not answering questions they found uncomfortable or distressing. None of the participants elected to use this option during the study. The participants were then asked to describe their personal experiences of CSA and how that impacted on their mothering. The questions were deliberately placed later in the interview, allowing participants to get to know the researcher and to feel as safe as possible before the more sensitive questions were asked.47 Questions on the care by health professionals follow the CSA questions to allow the participant to answer some more general and less sensitive questions before the end of the interview.48

Support services were available to participants who became distressed; these were not limited to sexual abuse counselling as the support required may be for physical or mental health problems. All participants were

47 The ordering of interview questions was altered in response to feedback from CSA survivors prior to the first interview. I originally had the CSA questions last but survivors who reviewed the interview felt a more neutral question would be better at the end and the question about services and care provided by health professionals was moved to the end of the interview.

48 During the piloting of the interviews the CSA survivors felt that the questions on professional encounters were not a particularly sensitive issue and should be dealt with late in the interview. Some of the participants found their health professional encounters distressing and the topic was more sensitive for some than expected.
given a small card with a list of counselling and support services as well as my phone number. Dr Carolyn Worth at South Eastern Centre Against Sexual Assault (SECASA) provided emergency counselling support, but her assistance was not needed. To my knowledge, only one of the participants entered counselling after the research, and she made a deliberate choice to participate in the research as a way into counselling. Her entering counselling at the end of the research is a measure of how successful the interviews were and by taking part in the research she received the services she needed.

**Researcher Safety**

Researcher safety can be a forgotten area in interview based research. Interviews and talking to people are generally regarded as a safe non threatening thing to do. Interview based research in areas such as cancer, rape and family violence are much more taxing because of the content of the interview. Interviewers can become stressed and traumatised by listening to the participants’ experiences. Vicarious traumatisation or secondary traumatic stress disorder refers as the acute stress reaction that results from a traumatic event experienced indirectly (Phipps and Byrne, 2003). Vicarious traumatisation is recognised in clinical practice and research with trauma and family violence survivors (McCann and Pearlman, 1990, Herman, 1992, Hesse, 2002, Figley, 1995). A number of risk factors have been associated with vicarious traumatisation in researchers and therapists. The factors include: age, gender, indirect exposure to trauma, empathy, past trauma in their own lives, unresolved past trauma, cumulative exposure and exposure to child trauma (Figley, 1995, Figley and Kleber, 1995, Ghahramanlou and Brodbeck, 2000).
Empathy is a very important skill in interviewing, and while this is likely to improve the interview experience for the participant, it appears to increase the risk of trauma for the interviewer (Figley, 1995).

**Solutions for Researcher Safety**
The general selection of researchers who undertake CSA research should include an assessment of risk factors for vicarious traumatisation. Potentially vulnerable researchers should be fully informed of the hazards they face in participating in CSA research, as should all new researchers. Interviewers involved in CSA research need to be trained to recognise the early signs distress and vicarious trauma in themselves as well as research participants. Safety strategies for researchers could include practices that support research team members in processing upsetting clinical material. For example, in my research, supervision was particularly important when dealing with upsetting material. My supervision included attention to my personal reactions to participant interviews, transcripts and analysis as well as the academic rigour of the research. In hard-to-research areas it is recommended that supervision includes the personal and the academic, just as mine did (Ghahramanlou and Brodbeck, 2000, Hesse, 2002).

Organising emergency support contacts for participants brought me into contact with other therapists and researchers in the field. I shared experiences and emotional reactions to my research with them and found this a helpful strategy. External supports such as people at home or at work are often recognised as an important source of support for researchers. Discussing personal or emotional responses to a particular case with a friend or spouse who knows the researcher can be helpful in reducing and relieving stress, providing these discussions do not place the
research participant at risk of identification. I found this was not always possible, as sometimes the stories and experiences were so painful that I shared them with neither my partner nor my friends. The experiences were simply too traumatic. Sometimes I shared them by proxy, telling family and friends of my anger at the way the legal system had handled a particular case by handing down a suspended or lenient sentence to a perpetrator of child abuse. I did not tell them of the recurrent rape and torture. I did not want my supports hurt vicariously by my research.

It is also recommended that researchers should have personal self care strategies in place such as rest, relaxation and exercise, spirituality, being allowed to cry, and by seeking personal psychotherapy (Figley, 1995, Hesse, 2002).

Limiting the exposure of researchers to CSA victims is likely to reduce vicarious traumatisation. This can be done by limiting the number of interviews, taking regular breaks and holidays, and diversifying research work (Hesse, 2002).

Sometimes it is easier said than done49, because most of the participants responded to a single newspaper advertisement. This meant that the participants contacted me at around the same time, making it more difficult to stagger the interviews. Two potential participants were pregnant and their interviews were delayed until later in the year, the other seven were interviewed over eight weeks, some of them twice. A balance was struck between conducting the interviews in a timely manner

49 My other research involvement through this time was a project that examined the prevalence of and responses to occupational based violence in GPs, social workers and ambulance paramedics. I was chief investigator and responsible for the qualitative analysis. It was not the ideal project for diversity in research work! Delaying the grant awarded for this project because it coincided with my PhD research was not possible either.
and my own safety as a researcher. Some weeks were really tough with three or four interviews in the week. Even though I regularly debriefed with my supervisor and had self care strategies in place, the number of interviews in the week extracted their toll. I became emotionally and physically tired through this time. Such tiredness has the potential to influence the quality of the research in both the interview and the analysis. Lapses in concentration can occur and I may have been unable to hear the content because of a need to minimise my own response and protect myself from vicarious trauma. The ways in which researchers may defend themselves against anxiety and compassion fatigue is discussed in more detail in Chapter Five.50

The emotional impact of the interviews and analysis is discussed further in Chapter Five. The point I am emphasising is that, in order to conduct research safely in emotionally laden areas, researchers need to have support and self care strategies in place throughout the research and not just during the interview phase.

**Child Protection and Safety**

The last of the predicted issues to be discussed is child protection and safety. In this section I draw on the principles of beneficence and non maleficence to argue that child protection takes priority during my research.

Child protection is both a child safety and researcher safety issue. The children of women with a past history of family violence and sexual abuse have an increased risk of child abuse (Avery et al., 2002, Bifulco et

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50 See Defended Subjects: Researchers p.146.
al., 2002). It was possible that while conducting the interviews I may have become aware of child abuse in a number of ways: I may have observed it or seen injuries consistent with abuse or the mother may have disclosed her concerns. In Victoria I am mandated by law, as a registered medical practitioner, to report suspected child abuse. Even though in the context of the study I am a researcher the law makes no such distinction, I am still a medical practitioner.

Even had I not been mandated to report, in the research context I would see it as part of my ethical and moral responsibility in conducting the research to protect the children as well as the mother. In the hypothetical case of a participant abusing her child, I felt that it was still my first responsibility to protect the child. Others may argue that my first ethical responsibility is to protect the mother from harm as she is the one I am involved with as a researcher, but because the risk is greater for the child my priority was to protect the most vulnerable one. Reporting child abuse is not without hazards; potential harm is done to the family by being labelled as ‘abusing’ and ‘being investigated’. In Australia, parents have been identified as responsible for over fifty percent of substantiated child abuse and neglect (James, 1994), with these considerations in mind, reporting was the least risky option because of the risk of injury or even death of the child (Kinard, 1985).51 Going back to the original principles underlying research this course of action is the most consistent with beneficence and non maleficence.

To ensure participants were fully aware of the possibility of child abuse being reported, an explanation was included in the PLS.

51 I found only a very small quantity of literature that discussed the role of the researcher in responding to child abuse and child protection issues when undertaking research. The Kinard paper, even though quite old, was one of the few I found that discussed these issues.
In the process of reporting child abuse I may put myself at risk of violence. Perpetrators of family violence have been reported using psychological, physical and sexual abuse to intimidate child protection workers and researchers (Stanley and Goddard, 2002, Ellsberg and Heise, 2002). Fortunately, while conducting the interviews, the issue of child abuse did not arise.

Child safety can be considered in another way. In conducting interviews with mothers of young babies I was potentially putting the mother-child relationship at risk by causing traumatic maternal reactions to the interviews. The first interview was as early as six weeks after the birth of the baby in some cases. The literature suggests that some women with a past history of CSA have a number of parenting difficulties. These include attachment, expectations of the child and limit-setting of the baby or child’s behaviour (Main and Hesse, 1990, Kendall-Tackett, 1993, Kendall-Tackett, 1998). It is possible that research participation may exacerbate these difficulties. On the other hand, it is also possible that disclosure of CSA during the research interviews may assist in the resolution of these difficulties. The interviews may provide an opportunity to discuss concerns and receive support not normally available to new mothers.

The second interview documented the perceived impact of the research from the mother’s perspective, important information currently lacking from the literature.

In considering this risk I took a number of steps to minimise the potential for harm. The power structure of the interview was as egalitarian as possible, an exchange between the researcher and participant, making it
possible for mothers not to answer distressing questions and to ask the researcher questions if they wished. This model of interviewing was proposed by Oakley (1981) in her studies on transition to motherhood (Oakley, 1981) and has been used effectively in other studies of early mothering, including some in Victoria (Brown et al., 1994).

It is unlikely that this study will impact on baby health; it may impact on the attachment and the emotional relationship between the mother and her new baby, although this risk is very small, based on the study by Martin et al. (1996) discussed earlier in the chapter. CSA may be associated with difficulties forming emotional relationships and attachment for some new mothers. The interviews may be helpful, as they create opportunities to talk about mother-baby relationships that may have otherwise been unavailable to new mothers. As a professional expert I have the added advantage of being able to both answer questions the mother may wish to ask and assess, during the interview, whether extra assistance and referral is needed. In this way my clinical expertise adds to my research work, making the research safer for participants by assisting them to access required services for themselves or their children.

A decision was made not to ask for the fathers’ consent. This decision was made for two reasons, first and foremost for the protection of the mother, as some of the fathers may have been unaware of the mother’s past history of CSA. In addition, some women may be physically, sexually or emotionally abused by their partners after disclosure of CSA. Secondly, the research focus is on the maternal experience. Furthermore, because there was minimal risk to the health of the infant, consent by both parents was not thought to outweigh the privacy needs for safety for the mother as described in the WHO guidelines (1999).
Summary of Strategies to Minimise Participant Risk

Privacy
Introduction to study separate from consent
Informed consent
Freedom to cease participation at any time
De-identification of data
Sound methodology and research conduct
Trained female researcher
Experienced interviewer
Disclosure may be a positive experience
Participants will be believed, listened to and not blamed
Piloting of the interview with a reference group that included new mothers and CSA survivors

Research ethical issues encountered during the project
In the next section I have outlined the ethical issues encountered while conducting the project, in the interviews and during the analysis. These issues are raised because they have the potential to impact directly on the research findings.

Interviews and Ethics
Home interviews were, of course, interrupted by the needs of the baby and preschool children and, on occasion, by family pets! One interview, as I mentioned earlier in the chapter, was interrupted by the arrival of the participant’s mother-in-law. The research was explained to her as a study on breastfeeding. Deme knew of the planned visit by her mother-in-law and together we arranged the explanation at the beginning of the interview, in keeping with WHO recommendations. It was not possible to
complete Deme’s first interview and a second interview was planned, with Deme’s consent, for four weeks later. While I had ended the interview as planned (and according to the guidelines) I was not happy with the way it had ended. My concern was that Deme had just disclosed, for the first time since she was sixteen, her long history of incest and torture. She was obviously distressed and it had not been possible to debrief or end the interview with any sense of closure.

Deme was obviously upset and we had not had the opportunity to work through the issues she had raised thus increasing the risk to the participant of emotional distress associated with the interview. Leaving Deme upset and distressed had the potential to alter the second interview. Deme may have avoided issues that had the potential to distress her in the following interview in order not to be upset again. Although the ending had been planned, the timing of it within the interview was out of my control (and the participant’s). On reflection, I could not control this aspect of the interview but wonder if the second interview should have been scheduled earlier to deal with the issues Deme had raised. A phone call to see how she was going may also have been appropriate in this case.

I found myself caught between my professional roles as a GP and therapist, and my role as a researcher. If, as a GP, I had seen Deme I would have arranged to see her again as soon as possible and supported her with phone calls until a follow-up visit could be arranged. I had a clear and professionally defined duty of care. As a researcher I have a duty of care to prevent harm, but the boundaries of caring responsibilities were unclear compared to my professional ones. I felt that by arranging an earlier follow-up visit and ongoing phone support I was entering a therapeutic rather than researcher role. Separating the therapeutic and
research roles is a crucial part of undertaking research. It was also a very difficult separation to make because what was morally and ethically right as a clinician was not necessarily so as a researcher. To make a final decision I needed to be clear about the reason for the interview, in other words, the ‘contract’ we had entered. She had not come to me for medical care or therapy; I had visited her to research and understand the impact of CSA on new mothers. I could not, in my researcher role, provide her with appropriate medical care. She had not asked me to provide medical care, either. She was interviewed because of her expertise and experience as a survivor about the impact of CSA on her early mothering. My decision, therefore, as a researcher, was to leave the second interview as arranged, knowing she had my phone number and those of various support services on a card I had given her.

Clinician-researchers must be cognisant of the difficulties they face in separating the research role from the clinical one. Even so, the decision was a difficult one for me to make.

**Analysis and Ethics**

The major ethical issue that arose in this area was related to the accuracy of transcriptions and analysis. It was an ethical issue because as a researcher I was balancing participant safety against the best research practice.

I decided that the best way to resolve this issue was to ask individual participants. I asked if they were interested in reading the transcripts and analysis, and if they would like a copy of the transcripts or the analysis. If they were interested in receiving either or both, I asked how they would
like to receive them, in view of the topics we had discussed. In response, one participant read her transcripts, and they were sent by email. Another was not interested in her transcript but wanted to read the analysis. It was posted to her. A third participant wanted a copy of the transcripts to keep but did not want to read them to give feedback to me; she wanted them as a personal record. Her transcripts are to be posted with the final research summary. All but one of the participants requested a summary of the research findings.

Lily, one of the participants, commented when I asked these questions, that by doing the interview she was “helping other women”, but that she would rather forget about her CSA and “get on with” her life. She was the one who wanted no further contact after the interview. By her comments, Lily had nicely summarised my dilemma. One of the ways she coped with her memories of CSA was to block them out. Coping styles like Lily’s are reported in the literature and assist survivors to deal with their experience of CSA (Himelein and McElrath, 1996). Asking women to revisit their experience in the interview, in reading transcripts, and in reading the analysis added to the research burden, potentially increasing the risk of harm. I offered them a choice, and most elected not to participate in this way.

The research method used in the transcription and analysis was the best that was possible with the group of women I researched. I had consulted my participants and respected their needs.
In doing the analysis researcher safety emerged as an ethical issue I had not predicted. In designing the study I had thought mostly of researcher safety in the context of the interviews.\textsuperscript{52}

**The Interviews**

**Rationale for Interview Timing**

I originally planned two semi-structured interviews, at four to six weeks, and then eight to ten weeks, postpartum. The first interview was at four to six weeks to allow women some time to recover from childbirth but when most would still be breastfeeding. Approximately 80\% of Australian women are breastfeeding at the time planned for the first interview and this reduces to around 60\% by the planned second interview (Donath and Amir, 2000). It would allow me to interview women as they became established breastfeeding, and if they decided to wean early.

In the field it was very difficult to arrange interviews at four to six weeks because of the new babies’ demands on the mothers’ time. Three of my participants fitted these original criteria, and all continued to breastfeed. The other seven participants were interviewed later, the last being a woman who had just weaned a two year old. Two more were interviewed at twelve weeks and also continued to breastfeed. The other six interviews occurred later. Women with older babies had established breastfeeding, but two had recently weaned and one weaned between the first and second interviews.

\textsuperscript{52} The impact of researcher response on the interview and analysis is dealt with in greater detail in Chapter Five. See Defended Selves: Interviewers p.146 as an example.
The original timing was to coincide with Australian community breastfeeding behaviour. Approximately 80% of Australian mothers initiate breastfeeding. There is a steady decline in breastfeeding rates over the first twelve months with the maximum rate of decline occurring when the baby is sixteen weeks old (Donath and Amir, 2000). In other words, the rate of weaning was highest at sixteen weeks, and the second interview sought to capture the concerns women experienced prior to early weaning. As all the women I interviewed early continued to breastfeed I was missing the experience of weaning. I adapted my interview schedule and interviewed women later, so that the weaning experience was included, capturing a further dimension in the research.

The timing between interviews was to assist with maintaining rapport. Thus, any issues arising for the participant after the first interview would be discussed at the second, leaving me enough time to transcribe the first interview and do a preliminary analysis. This allowed me to explore and clarify issues arising from the first interview in greater detail in the second.

**Interview Structure**

Semi-structured interviews have a loose structure of open and closed questions, which allows for the exploration of specific themes and the ability to diverge if new themes arise (Britten, 1995). The flexibility of this design allowed for questions to be asked in any order in response to issues raised by the participant, and the wording of questions to be altered into language appropriate for each participant by the interviewer. The semi-structured interview guide⁵³ allowed each interview to be conducted

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⁵³ The full interview guides for this project are in Appendix Two, pp.269-276.
on the same basic lines while allowing the timing of each question and language to be tailored to each participant. Topic areas such as the overall breastfeeding experience, problems feeding, including breast pain, sensuality and the impact of CSA on the participant’s experience of breastfeeding, were explored with each woman. This method allowed me to incorporate and explore in more detail particular subjects that had been raised in other research or anecdotal reports, while still meeting the primary aim of the interview—to explore the experience of breastfeeding in CSA survivors. The method made it possible to uncover and explore new areas (during the interview) that had not been anticipated by the researcher. Possible weaknesses of this approach are as follows: important topics may be omitted, asking the questions in a different way and at different times during the interview may result in different responses, and this may need to be accounted for when comparing responses (Patton, 2002 p.349). Participants may find it more difficult to talk about particularly sensitive topics face to face. Martin et al. (1993) reported that survivors of father-daughter incest are less likely to disclose their abuse at interview but are more likely to disclose on a written survey. The issue of participants being able to “tell it like it is” in interviews related to this research is raised in greater detail in Chapter Five when considering the overt and covert messages contained within the actual research interviews.54

Interviews were conducted at the home of the participant for ten of the eleven participants. One participant chose to be interviewed at my workplace, Monash University Department of General Practice. The first interviews were conducted at six weeks postpartum for three of the participants, while for others the interviews were conducted at the earliest

54 See Chapter Five, p.133.
possible time after initial contact. The second interviews were ideally planned to take place four weeks after the first, but varied from four to six weeks in reality. All venues for the second interviews were the same as the first.

**Confidentiality and Transcription**

After consent to taping, interviews were numbered and recorded. First names for mothers, their partners and children were used on the recorded tapes and these changed to pseudonyms in the transcript. The transcription of tapes was done by the researcher and professional transcriber. The recorded interviews were transcribed verbatim, complete with all the qualifiers and conversation fillers, to ensure that the transcripts reflected the interview as closely as possible for analysis. There is some argument in the literature about the appropriateness of this (MacLean *et al.*, 2004), but I found it was particularly useful in recognising the emotional content of the interview. Ten of the eleven participants were interviewed in their homes; sometimes this caused problems for transcription due to baby or child noise, pet noise and noise from television or radio. Easton *et al.* (2000) recommend finding a quiet place to conduct interviews but this is not always possible when conducting interviews in the home with new mothers. Other errors that can occur are mistyped words and punctuation during transcription, and while ideally the interviewer should be the transcriber this is not always possible. Each interview in this study was edited and rechecked after transcription by the interviewer. Only after the analysis was complete were sections of transcript representing themes edited into grammatically correct written language. The edited written content was kept as close as possible to the meaning of the original spoken interview.
I had, originally, planned to leave the transcripts unedited, but in the written context of this thesis it was not appropriate to use the spoken word because it devalued the content when words were repeated, the grammar incorrect and the facilitating words left in place. Alice commented after reading her transcript that she “sounded stupid”. Alice’s remark brought home to me the importance of respect in the written reporting of the transcripts, and so I chose to edit them into a correct written form.

All analysis work for this thesis and any presentations or papers resulting was with the de-identified data. Analysis of de-identified transcripts was done at the Centre for Health and Society, Melbourne University, the Department of General Practice at Monash University and at the researcher’s home. Backup of the de-identified data and analyses were kept at the Department of General Practice Monash University, the Mercy Hospital for Women and at my home. All computer files were password-protected.

In keeping with person centred research principles, participants were given the opportunity not to answer during the interview and to withdraw from the study if they wished. No participant withdrew formally from the study, although one participant was not available after making an appointment for a second interview.

**Analysis**

The purpose of analysis is to find meaning from the interview data collected from the research (Minichello *et al.*, 1995 p.247). Data analysis involves arranging and presenting information so that ideas and themes
can be found and developed. The analysis process in this study involved was predominately a data driven approach (Boyatzis, 1998 p.44), which involved reducing raw data, developing themes and comparing between participants, creating a code, and finally, developing ideas or concepts that explained the themes.

The method of analysis I used for the interview transcripts was thematic analysis (Boyatzis, 1998). A thematic analysis was most appropriate to the study because it allowed themes to emerge directly from the data, while having the added advantage of allowing for some of the coding to be informed by CSA and breastfeeding literature. Examples of this included the mother-baby relationship, family relationships, disclosure and resilience.

Boyatzis (1998) describes four stages in the development of a thematic analysis: sensing the themes or recognising “the codable moment”, coding reliably, developing codes and interpreting the developing themes in the context of theory (p.11).

My primary aim was to explore the individual experience of mothering and breastfeeding after CSA, not to develop theory. Therefore, I chose not to use theoretical sampling in my study because I wanted to ask women similar questions, looking for variations in their responses between the two interviews and differences between individual women. Theoretical sampling involves the checking of central concepts developed during analysis by collecting more data from groups or subgroups (Liamputtong and Ezzy, 2005 p.50). In my study ethics approval was given for two interviews. It was possible to follow up first interview
concepts in the second interview with the five participants who had a second interview; it was not possible after the second interview.

One participant received a copy of her transcript and one participant a copy of the analysis, the rest chose not to receive copies of either of these documents. This meant that further input from participants and the potential for further theoretical sampling were limited. Without the possibility of further theoretical sampling my analysis was not grounded theory, but a thematic analysis.

Open coding represents the first pass at coding qualitative data and aims to “look at the data in new ways, to see new relationships between events or interactions, and develop new ways of describing these relationships” (Liamputtong and Ezzy, 2005 p.268). My first coding was simple and descriptive, allowing me to become familiar with the data.

My initial coding, simple though it was, allowed me to develop impressions and ideas. I then needed to recode more rigorously and test these ideas to further improve my conceptualisation of the data (Liamputtong and Ezzy, 2005, Orona, 1990). In the process I had reached another level. I was not simply describing the data but testing emerging ideas. One of the ideas I tested at this stage related to the lack of physical pleasure participants reported about breastfeeding. Several of the participants had described breastfeeding as a household or work task, like “sweeping the floor” or “filing”. In my initial descriptive coding I had coded this as a breastfeeding task, but I needed to consider why breastfeeding had been associated with these two particularly thankless chores. I went back to the data of those particular participants first and then to the data from all of the participants. The women did not talk of
breastfeeding as simply a thankless task, they talked of the benefits for the baby and the mother-baby relationship. Few talked of benefits for themselves and none of the participants described physical pleasure as part of their breastfeeding experience. Some participants talked of detachment and dissociation when breastfeeding, perhaps these feelings represented symptoms of PTSD. Other participants talked of the differences between the sexual and maternal breast, some relating their lack of breast pleasure to their experience of CSA. Two ideas emerged from the analysis to be tested against the data. The first was PTSD, and the second was a splitting or separating the dual maternal and sexual functions of the breast as coping strategy for CSA survivors who breastfeed.

Impressions and ideas can work in two ways. They can assist in the development of concepts as described in the previous paragraph and allow reflection on what is being lost in the same process. My experience of the interviews had already enabled me to develop ideas and themes. As I reflected on the coding I had completed, I noticed that the emotional interaction of the interview was lost. This interaction was such a key part of the research interview that I reviewed my original ideas, as part of the later development of the analysis, with an emphasis on emotion. What feelings were important in the interviews, why were these feelings important, what was happening in the interview interaction, what was told verbally and what was told with feelings?

The difficulty in coding the emotional content of the interviews was that the written transcript had lost emotion compared to the actual interview. It was difficult ensuring I had understood the interview emotion as the
participant had meant it to be understood, and the possibility of missed emotional cues during the interview.

As I continued to code sections of transcript the emotion associated with the interviews was further diluted. I faced a choice. I could ignore the emotional content of my interviews and code and analyse as planned, but I felt the analysis would be poorer for this. Doing so would be deliberately excluding emotion from the analysis. My other choice was to use my journal, my field notes and emails to my supervisor in addition to the transcripts, as the primary source for the emotional interaction. While these notes are largely about my emotional responses to conducting the research, they were invaluable in rewriting emotion into the analysis. With emotion in mind, transcripts were reviewed and recoded using emotion. The importance of feeling and emotion in analysis will be discussed in full in Chapter Five.

Finally, the ideas formed core concepts. In my data these included: the maternal-sexual split, PTSD, control and the sexualisation of touch. The details of these themes are the basis of Chapters Six and Seven.

In conclusion, in this chapter I have outlined the research question, and the aims and purpose of the research. I have discussed how the best method to answer the question posed was a qualitative one, using semi-structured interviews, because it was flexible, allowing women to tell of their experiences as well as the exploration of specific issues identified as important in previous research.

I have outlined and discussed how I ensured that the research was rigorous and trustworthy. Ethical considerations in conducting the
research received special attention because of the potential vulnerability of participants and research content. In particular, ethical issues and solutions for participant and researcher safety during the life of the project were outlined.
Chapter 4

Introducing the Participants

Introduction
In this chapter I outline how women were recruited into the study, together with the women who were excluded from the study, both deliberately and unintentionally.

The women who participated are introduced by their pseudonyms, and a brief description provided. The descriptions are brief by necessity, providing the reader with context, while at the same time protecting the privacy of the participant.

Later in the chapter I present the participants’ perspectives on their research involvement during this project. This section places the data presented in the subsequent chapters within the context of the participants’ research experience.

Sampling
Study participants were women who self-identified as being sexually abused as a child by a family member. Women were recruited by an advertisement, in English only, placed in maternal and child health clinics, general practices, private obstetric and gynaecology clinics, in the
rooms of midwives and lactation consultants, in mother-baby units and via an advertisement in a mother-baby magazine.

The advertisement asked, “Just had a baby?” and was headed with “Breastfeeding Research Study”. Perhaps not surprisingly, women who had not breastfed or who had breastfed for less than six weeks did not respond to the advertisement and thus were not recruited. All the study participants had breastfed for three months and as such can be regarded as successful breastfeeders. It is important to remember that the experiences of women who were unable to breastfeed after CSA or able to breastfeed for a short time only are not included in this study and may have very different experiences of breasts and breastfeeding from those of the women who participated in this research.

All study participants self-identified as having been sexually abused as a child by a family member. Childhood sexual assault was defined for this project as any unwanted sexual when contact less than sixteen years old and all participants who self-identified fitted this definition. The family members who perpetrated the CSA were all male—step fathers, brothers, grandfathers, uncles and cousins. Self-identification was a deliberate recruiting strategy, as it allowed women to think about their participation in the research before initiating contact with the researcher. The strategy deliberately excluded women who were uncertain or reluctant to participate and was done purposefully to minimise the potential for harm and distress. Using the terms ‘sexually abused by a family member’ excluded two groups of women from the research—first women who were sexually abused but had forgotten the abuse, second, women who

55 See Appendix Four, p.289.
56 For the argument and reasons for this choice of definition refer to Chapter Two pp.17-21.
were sexually abused as a child according to the study definition of CSA, but did not consider themselves ‘sexually abused’. Self-identification of ‘childhood sexual abuse’ can be a problem, as I discussed earlier in the background chapter in relation to prevalence research, because it risks under-identifying women who fit the definition of CSA but don’t recognise their childhood experience as CSA. In this research it was a deliberate strategy to minimise the risk of harm by research participation by selecting women who already recognised their childhood experience as CSA. I was concerned that my research could cause some women realise for the first time, that they had been sexually abused in childhood, and that this may increase the potential for harm to a participant, her baby/babies and family.

Twenty women contacted me in response to my advertisement. One was not eligible because she was a researcher, not a new mother. Two were excluded because they had weaned two and five years ago respectively. Seventeen were sent the explanatory statement and thirteen of these remained interested in participating. Keeping in mind the literature on the importance of control and the risk of passive compliance for CSA survivors in clinical, and possibly research settings, women who decided not to be interviewed were thanked for their interest in the research and not asked for explanations when I contacted them the second time. Their response was accepted as stated and in keeping with ethical principles and a feminist research method (Liamputtong and Ezzy, 2005 p.21, Oakley, 1981, Reinharz and Davidman, 1992). I was conscious of not using the power of my role as the researcher to subtly coerce women into participating.
Thirteen first interviews were booked, two first interviews could not be confirmed twenty four hours prior to the interview and were rebooked, but the same thing occurred. When the two rebooked interviews could not be confirmed, a letter thanking them for agreeing to be interviewed and asking them to contact the researcher to organise a suitable time was sent. One of the women contacted the researcher but a mutually convenient time could not be organised. One participant was booked for a second interview but the interview could not be confirmed and phone contact could not be made. Once again a letter was sent but when no response was received she was not contacted again. One eligible participant was not asked to participate in the second interview because of her ambivalence, demonstrated by repeated emails prior to the first interview, and her description of coping by ‘blocking’ in the first interview. I did not feel it was safe to ask for her continued participation. She was the only participant who did not want a summary of the research findings forwarded to her because she had “told” her story and didn’t want to go through it again.

Table Four. Summary of Participation

<table>
<thead>
<tr>
<th>Participant contact</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contacted Researcher</td>
<td>20</td>
</tr>
<tr>
<td>Eligible to participate</td>
<td>17</td>
</tr>
<tr>
<td>Agreed to first interview</td>
<td>13</td>
</tr>
<tr>
<td>Participated in first interview</td>
<td>11</td>
</tr>
<tr>
<td>Eligible second interview</td>
<td>7</td>
</tr>
<tr>
<td>Agreed to second interview</td>
<td>6</td>
</tr>
<tr>
<td>Participated in second interview</td>
<td>5</td>
</tr>
</tbody>
</table>
Selection criteria
The study recruited women postpartum, who spoke English, and self-reported CSA. Women with sick premature babies or babies with severe medical illness were excluded from the study as it was felt it would be difficult for women to explore early mothering responses, breastfeeding issues and CSA when caring for a baby who was ill or very premature. Illness and prematurity may also alter mothering responses and breastfeeding experiences, making it difficult to explore the experience of mothering after CSA. For safety reasons, women who experienced behaviours in childhood consistent with CSA but did not recognise their experience as CSA were excluded by self-selection. Women who had breastfed, but weaned their babies more than six months ago were excluded, because I was concerned about selective recall of their earlier breastfeeding experiences.

The recruitment method was purposeful to maximise the exploration of early mothering and breastfeeding with women who are CSA survivors, the aim of the study. The sample chosen was not representative of the Australian antenatal population as a whole and was small, with limited external validity, but was suitable for exploratory in-depth qualitative work such as this project (Creswell, 1994). The design provided a richness and depth about the individual experience of mothering and breastfeeding after CSA that would not be available by other methods and is, therefore, highly suitable for exploratory research where unexpected issues and experiences may arise. My clinical experience with breastfeeding CSA survivors who presented in my practice with mastitis and breast pain and particularly, chronic breast pain, helps illustrate this. If I had looked only at breast pain in this study I would have missed significant issues that were important to my participants—privacy and
exposure of their and their babies bodies and their experiences of
detachment during feeding. The issue of privacy and exposure around
examination of the baby was totally unexpected and without the in-depth
interview is something I would not have considered important or asked
about.

Participants

Participants in the study were from different social backgrounds, although
formal demographics were not collected because they were not essential
to the analysis. Two were single mothers—one on a programme for drug
dependency, the other with a significant disability due to a medical
condition. The remaining participants were partnered. Two of the
partnered women had significant post-natal depression (PND)—one on
medication and one receiving ongoing counselling. None of the partnered
women reported problems with her physical health or self-reported drug
dependency.

Alice had four children and was interviewed at home after the birth of her
fourth child. She was interviewed twice, the first time six weeks after her
baby’s birth, then the second interview five weeks later. She had
breastfed all her children. Her experience of CSA was genital touch by
her grandfather over a week, when he visited her family. She was seven
years old when that occurred. The following year, after a visit to her
grandparents with her family, she disclosed her abuse and received
support from her parents, with later counselling as a teenager.

57 Details are in Chapter Six pp.198-203.
58 See Chapter Seven pp.230-233.
Tess had three children and was interviewed twice at the Monash University Department of General Practice after the birth of her third child. The baby was present at both interviews. The first interview occurred when her baby was twelve weeks old and the second followed four weeks later. She was successfully breastfeeding her third child after having difficulties breastfeeding her twins. Her experience of CSA was repeated vaginal rape by an older brother over more than eight years. She had not disclosed her abuse to her family. After the birth of her twins she suffered PND and began to see a psychologist. At the time of the interviews she had disclosed her CSA to the psychologist and was receiving ongoing treatment for PND.

Caitlyn was interviewed once at her home when her baby was eleven months old. She had two children and had breastfed both. She had weaned her youngest child at six months of age, five months before the interview. Although she had weaned for medical reasons, she participated in the research because she wondered, after seeing the research advertisement, whether her experience of CSA had influenced her “weaning early”. She recognised her childhood experience as CSA. Even though she had disclosed to her mother in the past, she had not disclosed to her partner and only told him of her past experience of CSA the night before the interview. Her CSA experience involved genital touching, digital rape and attempted vaginal rape over four years by her uncle.

Deme was interviewed twice at her home. She was interviewed for the first time when her baby was six weeks old, and again six weeks later. Deme had two children and both were present during the interviews. Her experience of CSA involved vaginal, oral and digital rape by her stepfather over more than ten years. It finally ended when her sister
reported her CSA by the stepfather to the police; he was charged, convicted and gaolied. Deme’s CSA was associated with physical abuse and torture. After her experience with the police and the legal system, Deme refused counselling because she remembered feeling that her sister was “patronised” and treated as if she was “stupid”. She participated in the research because she had been experiencing night terrors involving dreams of her daughter being harmed. These nightmares became more frequent and she felt that if she could tell me her story, take part in the research, that she could go on to tell a counsellor and thereby alleviate some of her distress.

Eve was interviewed once at her home. Eve’s baby was eighteen months old at the time of the interview, and breastfeeding. On the morning of the interview her baby was at crèche. Eve’s CSA involved genital and breast touch by her paternal uncle over a time span of seven years. She doesn’t remember any penetrative abuse. Her CSA started when she was five and is one of her early memories of childhood. It stopped when she was between twelve and thirteen years, when she told her uncle, “What you are doing is wrong”. He kept following her and entering her room and one day, after staying over at his house, she came home and disclosed some of her abuse to her parents. After her disclosure, the CSA stopped, even though she continued to see her uncle intermittently.

Rosa was interviewed at her home with her baby present. Her baby was twelve weeks old at the time. Rosa lived alone with her baby in a small flat. She was receiving regular medication and support from a drug dependency programme. Rosa had been adopted from overseas as a small child. Her childhood experience was of physical and psychological abuse perpetrated by her adoptive mother, and contact CSA and oral rape
perpetrated by her adopted brother, who was five years older than she was. Her CSA started when she was eight and continued until she was twelve, when she was placed in care by her adoptive mother. She had recently separated from her partner because he was violent toward her and she worried that her baby might be injured. A second interview was organised with Rosa, but she could not be contacted again after the first interview.

Maria was interviewed at her parents’ home on two occasions. The first interview took place when her baby was eleven months old and the second, four weeks later. Between the first and second interview, her baby weaned. Maria lives with her son and her parents; her partner no longer sees her or her baby. She needs her parents’ physical support because of a significant physical disability. It is due to a medical condition, and this made her words difficult to understand at times during the interview. Her experience of CSA was vaginal and oral rape when she was fourteen, perpetrated by her twenty-nine year old cousin. She has attended a counsellor in the past to assist her dealing with her CSA.

Helen was interviewed at her home on one occasion. She has three children; the youngest are twins and were thirteen months old at the time of the interview. The twins had weaned at eight months of age. Helen had been diagnosed with PND at the same time and weaned because, “everything crashed and burned around me”. She remains on medication for PND. In retrospect, she felt that her depression had been there for many years, even before her children were born. Helen’s experience of CSA was oral rape and vaginal rape with a foreign body. It involved her adopted brother and, at times, his friends as well. Her CSA first occurred when she was five and lasted until she was eight. It stopped because her
brother was removed from the home for other reasons. Her family remains unaware of her CSA.

Lily was interviewed once at her home and her younger child was present. She has two children; her younger son was six months old at the time of the interview. Lily’s experience of CSA was oral rape, genital touch and masturbation of the perpetrator. The perpetrator was her paternal uncle. The CSA started when she was three years old and continued for approximately seven years, until she was ten. The CSA stopped after she disclosed her abuse “at the dinner table” to her mother and step father. Her parents reported her abuse to the police. Lily remembers being examined and receiving some counselling at the time, but has no idea whether her uncle was charged or convicted. She received more counselling later, when she became sexually active. Lily would, normally, have been interviewed a second time but it was felt to be inappropriate\(^\text{59}\) by the researcher and this was not requested.

Rebecca was interviewed once at home and her child and her partner were both there at the time. She has one child who was two years old at the time of the interview and had weaned just before then. Her experience of CSA was rape by her older brother. It occurred from when she was five until she left home.

Ruth was interviewed at home on two occasions. The first interview took place when her baby was six weeks old and the second, four weeks later. She has two children; the elder child was at crèche the morning of both interviews. Ruth’s experience of CSA was genital touch and attempted vaginal intercourse, perpetrated by her grandfather over several years.

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\(^{59}\) The reason for this decision was discussed earlier in the section on sampling, p111.
Table Five. Summary of Participants, Type of Abuse and Perpetrator.

<table>
<thead>
<tr>
<th>Participant number/pseudonym</th>
<th>Type of CSA disclosed</th>
<th>Perpetrator Duration</th>
<th>Number of children</th>
<th>1st interview</th>
<th>2nd interview</th>
<th>Baby’s Age 1st interview</th>
<th>Breastfeeding</th>
<th>1st interview</th>
<th>2nd interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Alice</td>
<td>Genital touching</td>
<td>Grandfather 1 week</td>
<td>4</td>
<td>6 weeks</td>
<td>11 weeks</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>2. Tess</td>
<td>Vaginal rape</td>
<td>Brother &gt; 8 years</td>
<td>3</td>
<td>12 weeks</td>
<td>16 weeks</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>3. Caitlyn</td>
<td>Genital touching, Digital rape, attempted vaginal rape</td>
<td>Uncle 4 years</td>
<td>2</td>
<td>11 months</td>
<td>No</td>
<td>Weaned at 6 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Deme</td>
<td>Vaginal rape</td>
<td>Stepfather &gt;10 years</td>
<td>2</td>
<td>6 weeks</td>
<td>12 weeks</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Eve</td>
<td>Genital and breast touch</td>
<td>Uncle 7 years</td>
<td>1</td>
<td>18 months</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Rosa</td>
<td>Oral rape Digital rape</td>
<td>Adopted Brother ~4 years</td>
<td>1</td>
<td>12 weeks</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Maria</td>
<td>Vaginal rape</td>
<td>Cousin 11 months</td>
<td>1</td>
<td>12 months</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Helen</td>
<td>Oral rape Foreign body rape Voyeurism</td>
<td>Adopted brother ~3 years</td>
<td>3</td>
<td>13 months</td>
<td>No</td>
<td>Weaned at 8 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Lily</td>
<td>Oral rape Masturbation Genital touch Rape</td>
<td>Uncle 7 years</td>
<td>2</td>
<td>6 months</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Rebecca</td>
<td>Genital touching Attempted vaginal rape</td>
<td>Brother 10 years</td>
<td>1</td>
<td>2 years</td>
<td>No</td>
<td>Weaned at 23 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Ruth</td>
<td>Genital touching Attempted vaginal rape</td>
<td>Grandfather ~2 years</td>
<td>2</td>
<td>6 weeks</td>
<td>10 weeks</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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60 Also burnt and physically tortured by stepfather

61 Adopted from overseas, also physical and emotional abuse by adoptive mother
Summary of Participants

Table Five above outlines the names of the participants, the CSA they experienced, the perpetrators, the children they have and the ages of the youngest children at the time of interview. At a glance, the CSA experience of the participants is summarised and the ages of their youngest children at the time of interview can be seen. It may be a useful reference when reading the transcripts of the various participants.

Tess, Deme, Rosa, Helen, Lily and Rebecca all experienced CSA associated with poorest long-term outcome62 (Beitchman et al., 1992, Resnick et al., 1993, Herman et al., 1986, Finkelhor, 1979) because their abuse was associated with all or some of the following: the perpetrator being the father or stepfather, CSA with penetration, associated violence and duration of CSA. Deme experienced all four, while Tess, Rosa and Rebecca experienced most of the indicators of poorer outcomes. Lily and Helen experienced some of these factors. The severity of the abuse each participant experienced is reflected in the stories they tell about their experience of motherhood, breastfeeding and the effect of CSA on their mothering. This experience is examined in detail in the following chapters.

Participant Perspectives on Research Involvement

In this section I present the participants’ views on involvement in this research. The data presented are based on the answers to two questions that were included at the end of the second interview in response to the literature and lack of information available on CSA survivor participation.

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62 The literature on types of CSA and outcomes was reviewed earlier, see pp.40-42.
in research. The first was how each participant felt about her involvement in the research. The second was how the interview could be improved for others. On the whole, participants had a positive response to the interviews.

Presenting the participants’ perspectives on research involvement gives context to the subsequent data and insight into why CSA survivors may opt in or out of research.

Alice talks of participation in the interview as good for herself. Involvement in the research let her measure how far she had come and reflected her success in dealing with her experience of CSA. In response to my question about her experience participating in research she responds:

It’s been good, I think. It is always good to talk about things because you know where you are, as well. I think sometimes you think that you have dealt with the abuse but you never really go over it again or talk about it. You know how far you have come, by your emotions or lack of emotion, or by comparing your response to the last time you spoke about it. You know how far you have really healed. I think that has been good for me, to be able to talk about it.

Alice explains in the preceding passage how she used the research to see how far she had healed and how it allowed her to gauge where she was in terms of her response to her CSA.

Alice was concerned for other participants in the research. She explained how research “could upset you” if you had “never or rarely talked about it”. I asked her if she thought mothers would be hurt by participating in my research project and, while this was not an issue for her participation,
she explains her concerns with particular reference to a friend who had a breakdown after her fourth child:

No, I don’t think it is an issue for me, no … not at all. I think that it is good to be concerned because it could be difficult for some people. I’ve got a really close friend who always knew that she was abused and she had a terrible upbringing, a really very traumatic upbringing. After she had her fourth baby, she started getting counselling, because things were not right and she was having difficulty in different areas. She had a huge breakdown, she started having seizures, all kinds of things went wrong that couldn’t be explained. Her mind could not handle the abuse that she had gone through. She tried to commit suicide, I don’t know how many times and she would drink and do all sorts of really bad stuff […]63 If a women has never spoken about it before and had heard that you were doing this and thought well, that’s me, it could be dangerous.

In this passage Alice explores how research involvement could be difficult for other participants. Her point of reference is a friend who also has four children, but who was more traumatised by her upbringing and CSA than Alice was. At face value, Alice expresses her fears for her friend as if the friend had participated in the research, but perhaps Alice is also expressing her own deep concerns about the risk of research participation destabilising the mental health of actual participants like herself.

Caitlyn, like Alice, was surprised at how well she dealt with her participation in the research. She expected to be a “basket case” but participated because she felt it was time she addressed issues arising from her CSA, in particular, her silencing within the family. Participation in the research provided her with a way of opening and addressing issues

63Transcription notes […] omitted text
that still troubled her. In response to my question about her participation in the interviews she replies:

I thought I would have been a basket case actually. I think it has been good because I think I now know what I have to do and I know that I have to address it. It is just a matter of me working out the best way to do it. Nothing was ever done about it because it would make my grandmother … it would kill her if she ever found out … what had happened.

There was a pact with my grandfather, who I was very close to, he was very much like my father before he died. When I was a little girl, mum, my grandfather and I made a pact we would not tell. In a lot of ways I knew better, as I grew up I always had this fantasy that I would have my uncle arrested, arrested at my grandmother’s funeral. When she died I would have him arrested in front of every one and that’s how I would get him back for my humiliation […] but that’s not going to solve anything, stop me feeling humiliated. I suppose I want to make the police aware that he is dangerous, and to watch him. I suppose that’s all I can really do.

Caitlyn describes how she thought she would be a basket case. She goes on to say how participation in the research had helped her to decide how to address her CSA because “nothing was ever done”. She talks of her fantasy in which her uncle was punished for her humiliation. Finally, she talks of how she would like to report her abuse to the police because she feels her uncle is dangerous and needs watching and implies that others may need protection from him. In this passage she describes how, as a child, she was silenced by the family pact but now, as an adult, she can behave differently by breaking the pact and telling the police.

Maria was the one who told most graphically how research participation had broken the silence she felt was imposed on her after her rape, and allowed her to regain her speech. She responds to my question on research participation:
For the first time since I was raped … I am speaking out about it, and it makes me happy you know, because my mouth was zipped [zipper action with her hand across her mouth] like it wasn’t able to open. I wasn’t able to speak about my rape. I’m telling you the truth and being genuine, after my rape I walked around like this, with my mouth closed [talking through sealed lips]. It was me but I couldn’t speak out. Now I have regained my speech [softly crying].

Deme talks of involvement in the research as therapy for herself. In the second interview she outlines how participating in research helped her to acknowledge that she was not to blame for her CSA. She felt she was able to talk about her experience and “get things of my chest”, allowing her to seek the counselling she needed. The interviews “stirred things up”, her nightmares became more frequent before the first interview but then stopped entirely, afterwards. She explains her response:

I know this sounds terrible but I think the interview has been good therapy, to talk about it in the open is such a good thing every now and then, just to let it out and go, it is okay. It happened and it’s not my fault.

She describes how she found it scary to initiate contact with me and why she decided to participate. She responds as follows to my question on her response to being involved in research:

At first it was scary making the phone call. I cut the little clipping out of the newspaper and I carried it round for a bit. I tossed it over, I ummed and arred and then I decided “fuck it, what can happen?” The worst thing is that I can get some stuff off my chest that I need to and I might have to see a psychiatrist if it sends me overboard. That’s the worst thing that could happen. The best thing that could happen is I could get things off my chest and feel a hell of a lot better. To get things off my chest, relieve me and make me feel that I’ve gotten rid of

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64 Transcription notes [zipper action] physical action to reinforce speech or emotional behaviour such as [softly crying].
some the weight that I carry. I might find that it’s exactly what I need to do. That’s the best thing or there could be some happy medium where it gives me the courage to go and seek help that I might need. I haven’t had the courage before because I saw my younger sister patronised and treated like she was stupid because she had been abused.

Deme phoned six weeks later while I was overseas and I spoke to her on my return. She had seen a counsellor at the local Centre Against Sexual Assault (CASA) the day before we spoke and had decided to attend ongoing counselling. I recorded the following in my fieldnotes:

Since my visit she had found herself feeling there was a lump “like an egg, sitting in her belly and it needed to be cracked open” and a “lump that was poisoning” her and now she could get rid of it. She had carried the lump around since she was abused and felt the time had come to get rid of it. We talked about the courage it had taken for her to take the first steps. She felt she would be a “better Mum” without it.

Ruth and Lily framed their participation as important because it allowed them to help others. Lily describes her research response:

I like to help people. I think even doing the survey today shows you that. You have to be someone that would want to do something for someone else unselfishly, because it’s not really something that you do. I am happy to be here and I am happy to do things like this for other people. I kind of like that quality in other people as well [...] that feeling is very strong, and makes me feel good about it.

Chodorow (1978), in her book The Reproduction of Mothering, argues that girls, unlike boys, tend to remain in a pre-oedipal relationship with their mother. Mothers, in their turn, experience their daughters as “more like, and continuous with, themselves” (p.166). According to Chodorow,

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65 The Reproduction of Mothering is an older reference. It was chosen by Contemporary Sociology as one of the ten most influential books in sociology in the last twenty five years. The book deals specifically with mothering in a social and psychodynamic context and, although older, remains very relevant in the context of this work.
this results in girls being able to experience another’s needs and feelings without feeling threatened in the relationship. The research by Gilligan into how men and women make a moral judgment came to similar conclusions: femininity was defined by attachment and in relationship, rather than by separation (Pollak and Gilligan, 1982). Crowley Jack (1991) draws on the theoretical work of both Gilligan and Chodorow in her work with depressed women. She notes the importance women place on their relationships, on their role as helpers and facilitators when in relationships and the resulting ‘silencing of the self’.

In the passage above, Lily described the importance of helping others even when it is “not really something that you do.” She talked of the strength of her desire to help and how it feels good. In this passage she alludes to a possible cost to herself. Participating in research was not something she would normally do; neither was remembering and retelling her CSA experience because, “I don’t want to go back”. She goes on to elaborate later in the interview: “Even though I am quite open about what I feel … I just feel it [CSA] is something I don’t want to think about or talk about any more than I have to. I just put it all behind me”. In these passages she describes the conflict between her role as a helper by being a research participant and her own need to put her CSA experience behind her.

Ruth felt that there were no negatives associated with her participation in research. Like Lily, Ruth values her role in helping others. The positives she describes in the following:

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66 Transcription notes [CSA] added word for clarity.
The positives were just to be involved. I read the ad and thought “I am going to do that.” I felt I am fine and I know that I am not going to be affected by it in a bad way so it was something I thought I could do … research to help. If I can help anybody who is not coping as well as I am […] I just thought if I can help anybody and put another resource out there for someone to help them cope better because they are not coping, then I am more than happy to do that.

Ruth went on to describe how she would not have coped as well if the research had been done after the birth of her first child because she was not coping as well at the time:

If you had come around at this stage with my first baby I was an absolute mess and I probably would have been crying during the interview. I have moved on with my life and put that behind me and I can talk about it and not be upset by it. Like when you left last time, if that had been years ago I probably would have dwelled on it for maybe be a couple of weeks.

Ruth, like Lily in the earlier passage, highly valued her research role as a way of helping other women cope with CSA. Ruth also talks of the possible costs to herself by being involved in research. She describes how the timing of research participation was important. If the research had taken place several years ago, she feels her response to participating in research would have been different. She felt that she would have dwelt on her CSA and been upset by it. However, at this stage in her life she is able to participate in research and not be upset because she has “moved on”. She highlights the importance of women who participate in CSA research being able to control the timing of their participation and being able to choose freely.

In their responses to my question participants in this project make it clear that being involved with research as survivors of CSA, and as new
mothers, was a positive rather than a negative experience. For some, being involved in research broke the silence that surrounded their CSA. Their experience and what they said about it were important, they were valued informants, they no longer needed to be silent to protect their families or society as a whole. For others it was the thought that they could assist others that made the research a positive experience.

These early responses from the participants in my research are in keeping with other research on the positive impact of interviewing vulnerable populations (Ullman, 1996b, Ullman, 1996a, Lutz, 1999, McNulty and Wardle, 1994). Martin et al. (1996) followed up 497 women who had participated in CSA research six years after the initial contact. The Martin et al. study is the largest body of research I found that followed the effect of interview-based CSA research on participants. Three hundred and fifty four (71.2%) of the original 497 women participated in the second study. Forty eight of the original women refused to participate in the post interview study, while the others had moved and were unable to be contacted. Younger women were over-represented in the latter group. Ten times more women who reported CSA remembered the initial interview as positive rather than negative. The experience of the interview was not related to whether women had disclosed their abuse previously: the most common response from CSA survivor participants was that it was helpful to talk about CSA because it was not normally discussed, and that helping other women by participating in research was important to them. Finally, the participants described the research as important because it took an interest in the experiences of women (Martin et al., 1996).
The CSA group reported some discomfort during the interview. The most difficult area identified was discussing their experience of CSA (Martin et al., 1996). Negative experiences included the recall of “terrible memories” (n=1)67, distress, “more of an ordeal” than expected (n=1) and sleep disturbance (n=1). Prolonged distress or mental health consequences were not reported. This study confirms that it is indeed difficult for a very small proportion of CSA survivors to talk about their abuse, but that this difficulty is not associated at six years post-interview with prolonged distress or mental health consequences. The study is large and has a good retention rate between the first and second interviews. However, a number of things are not clear: comparisons between CSA and ND CSA in the sample of 354, how many of the 48 women who refused to participate in a second interview responded to the questions on participation in the first interview, and how these results are incorporated or not incorporated into the data. Inconsistent and unclarified sample numbers in responses to various questions make the result section difficult to analyse critically. Furthermore, the data collected in this study is six years after the original interview and while it was a relief to see that none of the women had long-term sequelae to the interview six years earlier, women were not asked directly (or not reported as being asked) about their responses in the intervening years. The study is retrospective, for example, “How did you feel after the last interview?” which was six years ago and may have been more appropriately addressed at the time of the last interview or shortly afterwards.

For the participants in my research disclosure was a positive experience. The participants valued the opportunity to speak of their experience, to have their experience listened to and the potential for their story to help

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67 These experiences were reported by different women
other women. Participating in research broke the silence for a number of participants—in the words of Maria, “It was me but I couldn’t speak out. Now I have regained my speech [softly crying].”

A number of women used the interviews to assess how well they were coping with their experience of CSA. One woman used the research interview as a way of testing whether she could enter counselling, and went on to receive the therapy from CASA that she needed.

The importance of being allowed to speak of their CSA, as a mother with a young baby, was clear in the responses of the participants above.
Chapter 5

Emotional Research

_The white fathers told us: I think therefore I am. The black mother within each of us— the poet—whispers in our dreams: I feel therefore I can be free (Lorde, 1984 p.38)._ 

**Introduction**

In Chapter One I outlined how I came to be researching the impact of CSA on mothering and breastfeeding. I came to this project because of a particularly distressed young mother, her son’s smile while breastfeeding, and her terror and fear in response to his smile. It was the emotional content of the consultation that alerted me to the importance of her experience, making space for her disclosure of her CSA and explaining her flashback to her father’s smile as he sexually abused her. If I had remained in the intellect, thinking but unable to respond to her emotion, she may have remained silent. She would not have received the assistance she sought, and her baby may not have received the mothering he needed due to her detachment and fear.

Like the medical consultation, the ‘white fathers’ traditional ‘gold standard’ for research is to be objective and uninvolved, thought without incorporating feeling (Schwartz, 1997 p.71, Oakley, 1981, Lillrank, 2002). In this chapter I argue that feeling and being emotionally involved is a strength, important in conducting interviews, analysing data and important in the overall ‘trustworthiness’ of the findings of the research. I will demonstrate through the data that ‘thinking-feeling’, combining the
mind and the heart, allows the researcher to reach a deeper understanding of the interviewee’s experience.

The chapter starts with a definition of emotion and then goes on to outline the background to classifying human emotion, which forms the basis of the results and discussion presented later in the chapter.

The concept of ‘defended subjects’ was based on the work of Melanie Klein. She theorises that unconscious defences against anxiety influence our thoughts, actions, lives and relationships (Hollway and Jefferson, 2000 p.19). I explore how these defences influence research, from the perspective of the research interview interaction. The concept of ‘defended selves’ was explored in the interview interaction between the participants and me. I extend the concept to include the analysis of the data. Such reflection, I argue, adds to the transparency of the research process as a whole and the trustworthiness of the findings.

**Definitions**
According to Denzin (1990 p.88) emotion “involves self-feelings” and these self-feelings are the “lived experiences of emotionality”. He goes on to describe the three step nature of the emotional experience: first, a sense or experience of the emotion, secondly, becoming conscious of feeling the emotion and finally, the inner and moral meaning of the feeling are revealed.

I argue that, because both the researched and the researcher experienced emotion during the interviews, it is important to acknowledge the emotional content. As a researcher it is necessary to ensure that the ‘inner
and moral meanings’ that are constructed within the interaction and reflect the participant’s meanings rather than the researcher’s.

**Classification and Coding Emotion**
The early work on emotion dates back to 1872 with the publication of Charles Darwin’s *The Expressions of Emotions in Man and Animals*. He posited six readable facial emotions. These are: happiness, sadness, anger, fear, disgust and surprise. His schema was further developed by Californian psychologist Paul Ekman in 1966, adding guilt or shame, embarrassment, jealousy and contempt to the basic six of Darwin (Walton, 2004 p.xiv).

Darwin’s work was based on observational studies of faces in animals, adults and children. He had colleagues overseas working with indigenous people and they supplied him with data that suggested the universality of the basic emotions. It is difficult to assess how much of his work involved observation of women and particularly pertinent, to this study, mothers and babies. Throughout much of the text Darwin uses “man” to represent humankind and it is difficult to be certain whether his observations were based on men alone or included women (Darwin, 1872 pp.25-28).

Ekman’s eight basic emotions—happiness, sadness, anger, fear, disgust, surprise, guilt and embarrassment—assisted in my conceptualisation of the emotion I had encountered during the research, particularly in the interviews. Ekman’s classification was based on facial expression alone (Ekman, 1982, Ekman, 2003). During the interview I observed the participants’ facial expressions and body positions, I heard their voice tones, the hesitations and pauses, all of which were important in
identifying the participants’ emotions during the interview (Silverman et al., 1998).

Psychoanalytic theory, based on the work of Freud, explains emotion in terms of transference and counter transference within therapeutic interviews between an analyst and analysand (Chodorow, 1999 p.17). Transference and counter transference are based on unconscious feelings and fantasy. In the context of my research interviews these concepts confuse the real basis of emotion. Much of the emotion experienced in the research interviews I conducted with participants was related directly to the participants’ experience of CSA and was not based in the unconscious or in fantasy. To use psychoanalytical terms like transference and counter transference risks denying and making a fantasy of CSA, as Freud himself did. This denial has repercussion for survivors and their experience as adults and mothers. Furthermore, the interviews were not the ongoing therapeutic encounters like the interviews of conventional analysis.

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68 Internal fantasy is the basis of psychoanalysis. Freud’s denial of the reality of CSA in women’s lives was a major contribution to the denial of the reality of CSA in women’s lives in medicine and psychiatry through much of the twentieth century. In 1896 Freud published a paper L’Hérédité et l’étiologie des névroses outlining thirteen cases of “seduction in childhood”. At this time Freud was convinced that the person guiltiest of sexual abuse in children (primarily girls) was the father. He publicly presented his theory on the reality of seduction (CSA) in the same year and was widely criticised by his profession, colleagues and friends. Freud wrote of himself, “I felt despised and universally shunned” (Masson, 1992 p.134). It is perhaps not surprising that Freud revised his theory of seduction over the next years from external truth to internal erotic fantasy by women. In changing his theory, he denied the reality of CSA in the lives of women.

Emotional Research

When I designed the interview schedule, I had little idea of the intensity of the emotional content that was to come from the interviews with participants. I expected I would conduct the interviews, transcribe and analyse the data, and write up my thesis. It would be simple. I read about vicarious traumatisation and compassion fatigue and incorporated strategies to minimise the impact on myself as a researcher; I had planned well and included self-care strategies in my research design. In spite of working as a clinician for twenty five years I had little idea of what was to come. My questions were not to elicit symptoms and make a diagnosis, I did not need to formulate a management plan or start a treatment. These professional tasks, I discovered, help shield me from emotion. I simply listened, explored, analysed and felt. I listened to the stories of women’s lives and felt the “covert emotion, non verbally communicated emotional pain” (Lillrank, 2002 p.114), often more intense than the content of their words. Like Lillrank, my interviews contained “tensions between overt talk and covert emotion” (Lillrank, 2002 p.113).69 Women talked relatively freely of their CSA experiences but their emotions showed through the talk: in their faces, in the way they hugged their babies as if to protect them from a threat, in the way they held their own bodies, in the happiness they showed as they talked of their children, the sadness and the anger in the tones of their voices in other parts of the interview.

By its very nature interview based research is an interaction between the participant and researcher. As a research interviewer I could not ‘make it better’ because in doing so I risked denying the participants an

69 This is more obvious later when reading sections of transcript I reviewed for emotional content. In the process I used my responses to the participants’ emotion, field notes, and audiotapes as well as the transcripts. The words alone may not contain the emotion that was expressed. In the practice of coding and analysis I found, like Lilrank, that emotion was “covert” unlike the “overt talk” captured on the transcripts.
opportunity to tell their story in its verbal and emotional depth and detail. At the same time, as a researcher I did not want the participants to become overwhelmed and severely distressed during the research. It was a delicate balance between giving the participants the space to tell their stories in detail, including positive and negative emotions, and keeping the participants safe enough.

Reinharz (1992 pp.34-36) describes stress in feminist interview research and although she does not describe the source of stress as emotion, many of the examples she gives are related to the emotional pain experienced by participants and told by researchers. Many of the researchers she quotes name emotional pain as a source of distress in participants but only allude to the vicarious trauma they experience as researchers. In the following passage Rothman, who researched amniocentesis and prenatal diagnosis, writes of the emotional experience of her participants. In the last section she describes the experience as “a nightmare”, connecting it to the experience of the participants:

It was like lifting the proverbial rock and having it all crawl out – ugliness, pain, grief, horror, anger, anguish, fear and sadness. Women in their fifth month of pregnancy afraid to feel their babies move – because they may not be babies at all, but genetic mistakes, eventual abortus ...it was a nightmare. (Rothman quoted in Reinharz and Davidman, 1992 p.35).

While the obvious connection is with the participant experience, I found myself wondering about vicarious traumatisation of the researcher and whether the nightmare she described belonged solely to her research participants.
Emotions that emerged during the interviews I conducted were both positive and negative. Participants talked of the joy and happiness they experienced watching and holding their children. These positive emotions were important to the emotional healing of some participants and this aspect is discussed further in Chapter Six.\textsuperscript{70}

**Emotion, Interviews and Analysis**

The emotions that dominated the later part of the interviews, by their strength and the frequency, were negative ones. These emotions were closely associated with participants’ experiences of CSA and its effect on mothering. Three emotions stand out from the interviews: sadness, anger and fear. In this section I will use the emotion of sadness to explore how emotions influenced the interview and analysis.

The participants were sad and cried through parts of the interviews; I responded to their stories and became sad too. Their emotional response was important, part of a ‘thick’ description, adding depth and detail to the spoken word and to the analysis of the data.

My sad response to the emotion of participants needed to be reflected upon and considered if I wanted to produce rigorous trustworthy research findings. My reflection included the following questions. Did the interviews that made me sad receive the same treatment in transcription and analysis as those that didn’t engage my emotion in the same way? Did I do justice to the content or did I avoid some of it? Did I carry the emotional content of one interview to the next one I analysed? How did the emotional component interact with my thinking?

\textsuperscript{70} See pp.179-181.
The emotional content varied with interviews, but stayed with me as I analysed and coded the interviews. It was not over yet: I then transcribed, edited, analysed and re-read and re-listened to the interviews multiple times. I avoided some interviews for months, the sadness was too painful. As I transcribed the interviews I heard the woman’s voice, I could visualise her face, I could remember how she held her new baby, I could see, feel and hear her pain and her fear for her child as I edited and analysed transcripts. I found myself analysing the more difficult ones more quickly, unable to stay ‘immersed’ in the data for lengthy periods, because it hurt me too much. The emotional content altered the very basics of how I analysed my data. I had to work out whether these responses informed the data or made me analyse on a more superficial level because it was critical to the overall analysis and the results of my research. Reinharz (1992) reports similar researcher responses to transcription and analysis. Among the responses researchers reported were forgetting and minimising the abuse suffered by women survivors during analysis. Had I done this unconsciously in my research? Had I captured the essence of the stories I had been told? Were my representations sound? Had I engaged fully with the research and been able to listen to, hear and report difficult themes? I responded by leaving the data, and being cared for by my family and friends before returning to look at it again with fresh eyes. If my “pain by proxy” (Lee 1989 quoted in Stanko, 1997 p.80) was so great, it was reflecting a critical component of the analysis.

I was shocked at the severity of the sexual assault of the women, the accompanying torture, the guilt and blame some participants carried for not stopping the adult perpetrator, and their fear for their children. Their

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71 I transcribed some, but not all, of the interviews.
experience was trivialised by society. When restitution was sought through legal processes the perpetrators received good behaviour bonds and suspended sentences. I did not want to repeat the process of trivialisation as a researcher and yet, because of the intensity and depth of the research material, both the participants and I defended ourselves.

Reflection helped me recognise and acknowledge the role that my responses played in the analysis. Unlike dualist thinking, which dates back to the philosophy of René Descartes, I integrated my thinking and feeling rather than dividing and separating the two (Bordo, 1999).

In traditional scientific and sociological research emotions are written out of, rather than into, the research. In recent years emotional responses are increasingly recognised as important (Campbell, 2002, Damasio, 1994). Damasio, a professor of neurology, writes that while emotion can cause havoc and influences the processes of reasoning, the absence of emotion is “no less damaging and no less capable of compromising rationality” (1994 p.xii). Other researchers discuss the importance of their emotional reactions in conducting and analysing interview data in sensitive or difficult areas. These include: Wray (2004) in her doctoral thesis on gynaecological cancer, Lillrank (2002) in her work with parents of children with cancer, and Campbell (2002) in her research with rape victims. My responses were not unusual, emotional responses to research are not unusual. Overtly incorporating feeling with thinking in the analysis is unusual. Incorporating emotion and acknowledging it in the analysis of my data adds depth, strength and transparency to the research method.
How could I make sense of my emotional responses—to the interviews, to the transcripts, the analysis? I returned to the data, I thought and reflected on it: what was the participant trying tell me? What did she feel as she told the story? What was I responding to emotionally—was it from her or from within myself? Now I was combining intellect with emotion during this process, rather than trying to ignore the feelings that the participants and I had felt. I recoded the data, looking at the emotional content and its meanings for the interviewees and in the interaction between the researcher and participants, as well as the words of the transcription. In interview based research, emotion was generally best understood in the interaction between the participant and the researcher, and in the records of the interaction, such as the audiotapes, transcripts and field notes. Emotion was understood through the words that were spoken and the words that are omitted, the hesitations, the voice tones, the body posture and the facial expressions. It is a complex interaction influenced by both the participant’s ability to ‘tell it like it is’ and the interviewer’s ability to ‘hear it like it is’ at that time, as I discuss further in the next section.

The concept of ‘feeling-thinking’ originates in anthropology, and uses both thought and emotion in analysis to increase the depth and understanding achieved by the researcher (Wikam, 1991, Campbell, 2002 p.8). My initial, largely descriptive coding was reviewed and I repeated the analysis incorporating emotion. I did this in a number of ways. What emotions were important in the interviews? What happened to them in the transcripts? What was said, and what could not be said and why? What

72 Antonio Damasio argues in a number of his books that emotion is critical to the organisation and functioning of the intellectual centres of the brain. He cites cases where injury or pathology in the emotional centre of the brain, the frontal lobes, prevented the normal functioning of the person socially and at work. In several cases intellectual function was intact on psychological assessment even though they could no longer function at work.
was happening in the interview interaction, what could be told and what was only alluded to? What were the silences and pauses telling me? The difficulty in analysing the emotional content of the interviews was that the written transcript had lost emotion compared to the actual interview. As the transcript was coded, cutting the words into even smaller slices as I analysed the content, the emotion associated with the interviews was further diluted as the old context of the words was weakened.

On the other hand, coding and collecting similar themes together places the data in a new context where it can perform important work that was not possible in the old or original context. The new context still did not reflect the emotional content of the interviews. I faced a choice: I could ignore the emotional content of my interviews, code and analyse as planned, or incorporate feelings into the analysis ensuring the emotional content remained. Because the emotional content of the interviews was so powerful, I opted for the latter. To do this I found that I needed to code and analyse larger sections of data. As a primary resource to aid the incorporation of emotion, I used my journal, my field notes, the audiotapes of the interviews and emails to my supervisor. These notes were largely about my responses to conducting the research and the interaction between myself and participants and they were invaluable in rewriting emotion into the analysis. After identifying emotional themes from these primary sources, I relistened to the interviews. The transcripts were then reviewed, recoded and re-analysed incorporating emotional themes.

My emotional response to Tess’s and Deme’s interviews, outlined below, was strong. As I coded and did the thematic analysis, I became concerned (and sometimes relieved) that the emotional content of the
interviews dropped away. Mishler (1986) writes that the process of coding strips the response from its natural social context. I argue that from my experience in this project that the process of coding transcripts into small pieces of text removes the emotional dimension from the data by losing not only the context within the interview but also the interaction between the researcher and the participant. To lose data was to lose a very significant part of the research and yet, I had not set out to do emotional research; I had not looked at emotional research methods or analysis. I had recorded my thoughts and reactions to interviews in field notes, and followed this up further during analysis. I left the pauses in transcripts, I had written overt emotional content in amongst the words of the transcript and yet, I felt these written verbal symbols remained a pale reflection of the original experience.

**Defended Selves in the Interview Interaction**

**Defended Subjects: Participants**
At times during the interviews I sought to protect the participants from the pain by not continuing down a line of inquiry when they became distressed, or by moving on to less sensitive areas. Sometimes they protected me. On the way home from interviewing one of the participants, I had to stop the car and park on the edge of the road. I felt nauseous and thought that I would vomit; the physical reaction passed but I remained in my car at the edge of the road, weeping for the little girl whose story I had just heard. The emotional content of the interview had swept me off my feet. I struggled to stand (and to drive) in this sea of emotion that washed around me after the interview. I found myself crying on and off for several days after the interview; I was unable to face the transcription, analysis and coding of this particular interview for four
months. As I transcribed, edited and coded the interview, I revisited the feelings of the interview and my post interview emotional reaction. I felt again my fears, my sadness, and survived a very personal ordeal working with the data from this interview. I returned to do Deme’s second interview several weeks later than planned because I had a serious knee injury between visits and was unable to walk for some time. She was worried that I had been unable to return because “I dumped everything on you at the last interview”. While I denied this as being important during the second interview, she had recognised my distress as I interviewed her, just as I had recognised her distress as she described her experiences. I recognised for the first time, as she spoke, that I had been relieved that my knee injury had delayed our second interview; it had given me time to deal with the emotion of the first one. The second interview proceeded, we protected each other and because of this the emotional depths of the first interview were not repeated.

I have described my reaction to Deme’s interview in detail because it is an important consideration in the research methods. In the research design chapter, I described the interviews I would conduct and the questions I would ask. All research interviews are not equal, and this was very apparent during this research. I used my reaction to Deme’s first interview as a demonstration of this point: because of our emotional reactions and interactions in the first interview, the second interview was more superficial. The questions were asked as I had planned but the interaction was different, the second interview was different from the first. I needed to consider whether it was superficial and therefore poorer in content because of this. When I reviewed the audiotapes and transcripts the emotional content of the first interview was not there, but interestingly, Deme talked in-depth and openly about her fears when she
looked at her daughter’s body.\footnote{Details in Chapter Seven, pp.219-220.} In this case, although the second interview was different from the first, the depth of content remained.

The concept of defended selves is based on the work of Melanie Klein, and her theory that the unconscious defences against anxiety influence our thoughts, actions, lives and relationships (Hollway and Jefferson, 2000 pp.19-20). Holloway and Jefferson noted the idealisation of the past in the narratives of the victims of crime they researched. They explain using Roger’s story:

\begin{quote}
A conflict in his account suggests why he was invested in an idealized version of parts of his past. On one hand, he hated his father for his cruel exercise of power over the family. On the other hand, he ‘respected’ him for the exercise of authority (also through brutal means). A discourse of a golden age when patriarchal authority still worked legitimates and thereby mitigates an aspect of his past that caused him suffering (Hollway and Jefferson, 2000 p.18).
\end{quote}

Lillrank (2002 p.115) applies Klein’s concepts to research. She describes this process as “defended subjects”, where the interviewers and participants recognise and acknowledge the distress communicated but do not (and perhaps cannot) talk about “how it really is”.

Lily was concerned about participating in my research project from the beginning, and we had several email contacts before she agreed to participate. In the interview she appeared to be working very hard to maintain the image of herself as the perfect mother\footnote{Direct quote from fieldnotes.}, unaffected by her sexual abuse. In the following passage Lily talks of her disclosure of her uncle’s abuse. She discusses the impact on her family in detail, while
minimising the effect on herself. She takes responsibility for her family’s pain and distress. She says it is her disclosure and not the uncle’s abuse that was the source of family pain. After all, she barely ‘remembers’ how she felt, so she cannot have suffered. Lily’s response in blocking and not being upset can be explained as a means of protecting herself within her family and may be responsible for her resilience after CSA. She explains after I asked her if her family supported her after she disclosed her abuse:

Yes and no, because we were a divided family. My Mum and my stepfather were very [sounds like ‘upset’]75, they went straight to the police and they did all sorts of things. My dad and his family were quite protective of it all in that they wanted to sweep the whole thing under the carpet. My dad was very influenced by his mother, my grandmother. She had three boys and they were a strong Catholic family. She had a lot influence over her sons. They were her boys, she was very much a mum’s mum and they were her boys. If she wanted something sort of kept quiet then they would have done it for their Mum … and this one [the abuser] was the youngest son and very doted on. No-one wanted to make a fuss about it. So even though my father stood by me as his daughter, in a lot of ways I think he wanted to just make it go away. It was a lot to deal with, the fact it was his brother … and his daughter. I didn’t mean it [disclosure] to cause such a stir and I think I got a big shock at all of the response […] I wasn’t really sure of what I was saying when I said it, I did feel the repercussions, but I think I blocked a lot of it out too, to be honest I don’t really have much emotion at all about that time … I don’t really remember being particularly upset when I told of the abuse or if I was upset afterwards. I don’t remember really how I felt. I remember going to the police and making a statement but I just don’t remember it being a traumatic time […]

Throughout her interview Lily is disconnected from any feelings associated with CSA, she doesn’t remember “much emotion”76, she

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75 Transcription notes [sounds like ‘upset’] word unclear on transcript but sounded like ‘upset’. For detailed transcription notes see Appendix Three p.277.
76 Melanie Kline describes emotional disconnection as ‘splitting’. In this case Lily blocks out feelings that are dangerous and hostile towards CSA and her family. It is a strong but potentially destructive mechanism of defence as the destructive impulses are often turned internally towards the self.
minimises her response to her abuse and the impact that it has had on her as an adult. In PTSD terms she demonstrates significant levels of numbing and avoidance in her description of blocking out things, not having much emotion and not remembering or recalling aspects of her experience associated with CSA. Her coping response was one of avoidance and blocking rather than the idealisation described by Holloway and Jefferson.

The story above dominates the transcript, and it may be partly responsible for how well she has coped with her CSA experiences. There are snippets where she challenges this view. One example of this challenge is a story about her wedding, told from her husband’s point of view. Even here, although she tells the story, she is not responsible for the challenge to her family that it contains. Her husband recognises the level of her adult distress at the thought of having her abusive uncle at her wedding. He protects her, but challenges Lily and her family to recognise it instead of ignoring Lily’s distress. Lily explains:

My husband just said “Well no. [Very soft uncomfortable laughter]. Sorry Lily. We are getting married and this is a big issue for you, you don’t want your [abusive] uncle at your wedding. We will just deal with it. I don’t want you to be in the same room with him and I don’t think you should have to be. Why is your family putting you through this? Why are they even having him over?” […] My husband just brought a lot of things up for me that were hard; I wouldn’t have done it on my own. I wouldn’t have stood up; I guess I was more protective of my dad for some silly reason thinking, “Oh, I don’t want to upset Dad with all this”. It was hard for me to stand up to it all, but now it’s all happened. You know there’s still … I still think there’s still a lot of sweeping of things under the carpet.

In the first passage Lily takes responsibility for the family pain—it is associated with her disclosure and not the adult perpetrator of her CSA. She talks of how her grandmother’s sons (including her father) kept silent and didn’t “make a fuss”. The passage demonstrated how, in her eyes, the protection of the family took precedence over protection of the child, the grandmother’s pain over the granddaughter’s, leaving the uncle’s sexual assault of a child apparently unconfronted and unchallenged within the family. Her response was to “block” and “not feel much”.

In the second section she describes how difficult it was to stand up for her needs within her family because she wanted to protect her father. She expected herself to behave unselfishly, to protect family relationships, and see her uncle as if nothing had happened, even on her wedding day. It is only when her husband recognises how big an issue it was for her not to have her uncle at her wedding, that she is able to discuss how hard it is for her to stand up for her needs. Women are valued in society for putting others’ needs before their own, as mothers (Chodorow, 1978, Chodorow, 1994), partners (Crowley Jack, 1991) and in this case, as a daughter. This passage mirrors the quote on page 123, where Lily talks of her participation in research in terms of helping “someone else unselfishly, because it [research] is not really something that you do.”

These sections from Lily’s interview illustrate how participants talk about difficult subjects in ways that protect them from anxiety and are in keeping with their identity and their concepts of family and community. For Lily to have feelings about her CSA, the family response of silence would have to be challenged, and no longer swept under the carpet. Lily protected herself by not remembering or by totally dissociating from her
emotions and not feeling anything. In this way she could protect both herself and the family.

**Defended Subjects: Interviewers**

Tess’s interview was the second interview conducted in the study. I found the interview particularly difficult, and there was a sense of hostility and anger directed towards me throughout that I didn’t understand. I became quite defensive as the interview progressed. Towards the end of the interview it finally came out, “I have little time for GPs”. I felt she hated GPs because of the anger that had been directed at me during the interview and because of the way she spoke of GPs. I hesitated to ask what this was about but I finally decided I needed to know. To my surprise she responded as follows: when she was a little girl she had recurrent cystitis (urinary infections) and was frequently taken to GPs by her mother. Every time she went to the GP she hoped that the GP would discover that the cystitis was caused by rape and that the rape would finally be stopped. She was certain that if the GP had examined her that they would have seen the bruising and damage because of the amount of pain she experienced. None of the GPs looked and all she received was another pathology slip for a urine test; the GPs failed her every time. My immediate response was guilt as I went through in my mind the number of young girls that I had seen just like her. I wondered in how many children who presented with similar symptoms I had missed indicators of sexual assault.

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Verbatim transcript is not available for this section of the interview due to the softness of her reply and voice activation failure. The words are taken from field notes written immediately after the interview. My recollection is that she “hated GPs” but I recorded she had “little time for GPs and tried not to visit them”. I do not know if my recollection is correct or whether I was trying to minimise my response and reaction as I wrote the field notes immediately after the interview.
The other thing that strikes me now as I write, is how close I too came to ‘not asking’ because the interview had been hostile and unpleasant, I didn’t really want to know why she hated GPs, I wanted to end the interview. I was ‘defending’ myself. In not wanting to hear any more I nearly repeated the GP response she had expected and experienced in the past. She was asking me if I was I prepared to hear the story she really wanted to tell. She returned for a second interview and as I listen to the first and second interview transcripts I can detect no change in her voice, yet the first interview felt hostile, and the second, like I was interviewing an old friend. The emotional dynamics of the interview had undergone a major shift.

In interviewing, my response as a ‘defended self’ limits what I can hear and respond to as well as what the participants can tell. It is an important component in research involving sensitive issues, as the researcher’s own protective and defensive behaviours may limit some areas of exploration during the interview. Recognising and acknowledging these limitations is an important component of in-depth qualitative research.

**Situated Interviews**
The interviews are historically and culturally situated. In Australia in 2003-5 it is acceptable and usually safe for women to discuss their experience of violence with researchers, counsellors and health professionals, largely due to the recognition of the impact of family violence on women and its long-term associations with women’s poorer health (as detailed in the background chapter). The women’s movement of the 1960s-1970s was responsible for the recognition by society of
sexual violence in women’s lives (Herman, 1981 p.21). This has not always been the case.

Charles Routh (1886) described women who disclosed sexual abuse as liars—the detailed quote was included previously in Chapter Two. Bumstead and Taylor (1883), in their text on venereology, consider children who disclose sexual abuse untrustworthy:

Very young girls may be attacked with inflammation of the genital organs, producing a copious discharge from the vulva, and sometimes the vagina also, the cause of which has often been misapprehended. It has been supposed that the disease was contracted from men who had been seen to caress or fondle them, and innocent persons have been arrested and tried on this charge. No one in such cases has done more to honor our profession and for the cause of humanity than the late Mr. Wilde, of Dublin, who repeatedly came forward when the accused party was about to be convicted for the offence which he never committed, showed the groundlessness of the charge, and proved his innocence (Bumstead and Taylor, 1883 p.210).


With the quotes of Bumstead and Taylor (1883), Holt and Howland (1916) and Routh (1886) in mind, from medical texts still held at the University of Melbourne medical library, I think it is unlikely that medical practitioners trained at this time would have been sympathetic to a woman or a child of the late 1800s or early 1900s who disclosed sexual abuse. It is likely that any disclosure would have been met with

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78Chapter Two, p.25.
considerable hostility rather than being ‘believed or validated’. These quotes demonstrate quite clearly the importance of the historical and cultural context of responses to sexual abuse disclosure (Coles, 2000).

Women in Australia still face barriers disclosing sexual abuse and family violence to health care practitioners. These include feelings of shame, guilt, failure, helplessness, fear that GPs can’t help or won’t help or aren’t expert in the area. Sometimes women did not see themselves as victims or were afraid the GP would discuss the problem with the perpetrator, thus escalating the violence (Head and Taft, 1995 p.17). Women probably faced similar barriers to participating in research interviews though I could not find any studies that confirmed or denied this. However, these barriers were evident in the transcripts. As described so vividly by Tess previously in the chapter, after her experience with GPs as a child, GPs don’t help and don’t listen, and she knew I was a GP as well as a researcher and directed her disappointment and feelings from her past GP contact at me during the interview. She tested me at the same time—was I as a GP and a researcher, really prepared to listen to her story or would I behave like GPs in her past?

Rosa, a young methadone-dependent mother asked me at the end of the interview, “I’ve got one more question; do you think what happened to me in the past was abuse?” She was uncertain because for her, physical and sexual assault was a ‘normal’ family experience. Even as an adult, after the seriousness of her sexual, physical and emotional abuse, she needed my confirmation and validation that what she had experienced

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79 Current best practice advice to GPs following disclosure of sexual abuse by patients is that GPs believe and validate the victim’s disclosure
was abuse and should not have happened to her. Doctors of a hundred years ago (Bumstead and Taylor, 1883, Routh, 1886) would have assumed she was lying.

Sadness, Fear and Anger
Three emotions stood out from the transcripts of participants as important for mothers who have been victims of CSA. These three emotions will form the basis of the rest of the discussion and will be dealt with in the rest of the chapter. These were sadness, fear and anger. Each emotion will be discussed in a section, and while separating them is artificial because the three emotions were often intertwined, it does make a clearer discussion. It is the interaction between CSA and mothering that is the focus of the discussion. The sections that follow contain stories that may provoke emotional responses in the reader.

Sadness
During the interviews and whenever I worked with the transcripts, my overwhelmingly response to the interviews was sadness. The sadness was related to loss, birth traumas and early mothering. It was linked to the girlhood experience of the participants. They experienced CSA. They were not safe and protected within their families. Their CSA now replays in their adult lives as mothers with young children, sometimes when they least expect it.

Sadness is a common experience in the early days after a new baby is born: the “baby blues” occurring between day 5 and 12 postpartum are reported in 50-85% of women and the more severe post-natal depression in 14% of Australian mothers (Beyond Blue, 2004). This compares with
overseas rates of 10-15% (Leitch, 2002, Epperson, 1999). None of the women involved in this project was interviewed in the first two weeks. Two of the participants were on medication for PND, both of whom were mothers of twins.

The sadness in the interviews was related to becoming or being a mother. In becoming a mother the following themes were identified by participants as important: birth trauma (including the loss of an expected normal birth), maternal-infant attachment, mothering multiple babies and children, and baby illness.

Sometimes the sadness around birth was related to the mother’s experience of CSA and this is the focus of the following discussion. Tess described not planning to be a mother; the decision she had to make about continuing the pregnancy, her lack of adjustment to being pregnant and her experience after the birth of her twins. When she responded to my question about having new babies she was visibly close to tears:

I have very mixed feelings. I actually thought that they were better off in hospital because they were with people who … knew how look after them … because I never actually planned to have any children. Now I have three even though I was on the pill and I still conceived … We had to decide whether to go ahead with the pregnancies or not, but in the end we did. It was just … so very difficult … I hadn’t really even accepted that I was pregnant. I was just starting to show, I didn’t have anything bought. I just wasn’t prepared and then … they were there.

When I asked what she liked about mothering, she explains:

Not a lot. I have suffered from post-natal depression for which I’m on medication. It was sort of brought on by the twins and because I have been in a permanent state of pregnancy for a while. I still see a
psychologist for that. At times there’s not very much … I like at all about being a mum [Very quiet sad voice].

Her sadness was obvious as she spoke, in her tone of voice, the pauses and the closeness of her tears. Recognising the intensity of her sadness based around mothering assisted my recognition of her “not planning to mother” as one of the key themes in her interview. If, alternatively, I had analysed the content on sections of transcripts alone, I doubt I would have recognised its importance. My original transcript coding was based on emotional detachment and ambivalence; I had missed the importance of her not wanting to mother.

Later in the interview, I asked how her CSA had impacted on her as a mother. She confirmed the importance of CSA in her not wanting to be a mother when she stated:

I never wanted to be a mum … it happened anyway. I wasn’t going to be a mother because I just didn’t think I would be a very good mum. I wasn’t very confident.

Tess’s experience of CSA had made her doubt her ability to mother and was fundamental in her desire not “to be a mum”. Anne Summers (1975, p.96) argues that women’s work is defined in terms of her family and marriage, and that the family is the primary means for women defining themselves. Expected behaviour, sex roles and morality are learned within the family (Summers, 1975).\textsuperscript{80} Tess’s experience of CSA by her older brother had resulted in her not wanting to be a mother because, “I just didn’t think I would be a very good mum”. As she described her

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\textsuperscript{80} Although over thirty years old Summers’ book was a pioneering work on the role of women in Australian society and is still relevant to the social roles of Australian women in the twenty first century.
experience of not wanting children, and the difficulties she faced in forming a relationship with her twins in particular, her sadness bordered on despair. Good girls, good women, good mothers “would want to or have wanted to be a mother”. By her own definition she is the opposite of a good mother. She implies by her own words that she is the opposite, a bad mother.

Deme was bright, happy and engaging through the early parts of the interview, so much so that when I asked her what had happened to her as a child I expected her to deny any experience of CSA. In contrast to the preceding part of the interview her mood abruptly changed, and she became sadder as she described how her abuse escalated:

When I was about seven it started, my mother’s long-term boyfriend, started bathing me. He began babysitting me more often than the other children. After he bathed me, he would hide under the blankets naked, and get me to hide with him. Soon he wanted me to touch him and he wanted to touch me. That went on for a few years and he next wanted me to put my mouth on his [penis] and he wanted to put things into me, small things and that went on for a few years and then it progressed to he was physically stretching me … so he could fit inside me and … I started to not like it, it wasn’t very nice and I didn’t like doing those things … with my mouth and things. So he started threatening me as well. He did karate and he took me to karate classes, so he would let me know how strong he was and he would let me know how much force that he could use to control me. I had a scar on my arm, where one day he burnt me with a soldering iron just to show me he could do anything. He told my mother it was an accident that I walked into it. She believed him.

She goes on to describe her confusion:

At the same time as being cruel, sadistic and controlling, he was giving me the love and telling me that I was special and that I was better than the other children. That was why he gave me this extra special
attention that was our special secret. I wanted that special attention too. I really did, any child would. It continued on and eventually penetration occurred. Then he convinced my mother that we should move into a caravan. My mum was a big woman, she is still a big woman, she is about the size of twenty six and he convinced her that the two of them couldn’t sleep in the bed that was provided for the adult couple because it was too small. It would be better if I slept in the bed with him and she bolted down the table every night. So, for about three years we lived in this caravan and he had access to me … every single night.

Deme goes on in the interview to blame herself for not having “more guts” and for wanting “superficial things”, despite earlier describing how she was groomed as well as being physically and sexually tortured\(^{81}\) by her defacto stepfather into remaining silent:

I have been thinking things, if only I had more guts\(^ {82}\) as a child to do something about it! Why did I want all those superficial things anyway? Why did I have to want a doll’s house and a bike? Why didn’t I say no, I didn’t need those things?

The abrupt change that occurred when Deme started to talk of her CSA was a major shift in the interview. As Deme describes in the passages above, her CSA occurred over many years and was undetected. Her sadness and distress was unexpected; I had not detected it in the initial stages of the interview, but when she described her CSA it literally poured out, barely controlled. Once again, the emotional change informed my analysis. She was signalling the importance of her CSA experience. It was no longer hidden. Initially I coded these sections of transcript for detachment, child protection and isolation. When I analysed the transcripts again, keeping in mind the abrupt emotional change that had

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\(^{81}\) The sexual assault of Deme was described earlier in Chapter Two p.26, in the discussion of false positives and negatives in CSA research. Deme describes not being raped because ‘force’ was not used (she does not count the threat of force or the physical abuse she experienced as force) during her experience of vaginal rape by the perpetrator. See full description in background chapter.

\(^{82}\) Transcription note, bold indicates strong emphasis by participant.
occurred, control emerged as a theme. Deme, who had appeared initially so happy and controlled, was barely controlled under the surface.

She went on to explain how, as a mother of a young daughter, she had been having recurrent nightmares about her daughter being abducted. These nightmares had been progressively increasing in frequency over the last year. Along with her nightmares, she has experienced increasing sadness associated with self blame and guilt:

I hadn’t thought about it [CSA] I had almost gotten over it. Lately, for the last year or so, I have had days where I wake up and I’m just so blue because I have spent the whole night just going, “God why didn’t I do something, why didn’t anyone listen to me, why did it have to happen to me!” I have had two miscarriages. I think, if there was a god, he would think that I have gone through enough!

For Deme, her sadness is part of her ongoing response to her CSA. Motherhood and her daughter growing up have challenged Deme. She fears for her daughter’s safety and blames herself for what happened when she was a child, but at the same time her daughter has enabled her to glimpse at the lack of control a child would have had during CSA.

Both women describe their experience and in doing so express their sadness and self blame. Both were victims of severe childhood sexual assault—the ongoing vaginal rape by a family member—one perpetrator a brother, the other a de facto stepfather. The ongoing experience as mothers is quite different between the two mothers and their children but the emotional response in both was one of deep sadness.

83 Deme’s nightmares are dealt with in more detail in the fear section of this chapter.
Rebecca wept with sadness after the birth of her son. On the day of her interview she cried in the park. The staff caring for her in hospital diagnosed post-natal depression. A woman in the park thought something similar when she saw Rebecca crying. Rebecca described how her sadness was not depression but an emotional reconnection brought about by the birth of her son. It was a healing response, her description follows:

You can’t say I’ll deal with that emotion later [when you have a baby], which as a survivor you are really good at doing “Oh that, that’s an emotion I’ll deal with that later”. There is nowhere else to go; you have to deal with it. So that’s been a really huge change in me, I never used to cry and now I’m like a leaky sieve. I cry at the drop of a hat. Another change is getting close to those emotional things. I was thinking about this earlier today, the abuse has put a really cold place in your heart, and a child hits a really hot angry place. The child says, “No you can’t have a hot angry place, and you can’t have a cold place” and they actually take that place and turn it into something really magical.

I was at the park today doing the swing thing with my son. It just came into my head and I thought that is what I was like. There was another mother there swinging her kid and she’s looking at me going, “You’re crying.” “Okay I’m just upset.” She said to me “Are you okay? Have you got post-natal depression or something?” I said “No, it’s okay, I was just having a really nice thought,” and she said, “Oh okay”. I didn’t want to tell her because to tell a stranger is just really inappropriate as it’s burdening them. I just … I just realised how much I love my child …

In response to my question, she clarifies what happened after birth:

I just wept, the staff were going; “Oh no, no, no, she’s got post-natal depression. Oh may be she’s got PND”. They actually wrote it in my hospital notes, not realising that I had three friends on staff that came and said, “Have you really got post-natal depression?” They were people who knew me well enough that I was be able to say to them, “No it’s just years of sadness and I’m letting it go before he’s old enough to recognise it.” It was not the baby blues thing, I was crying, and they assumed it to be post-natal depression. I thought “No, it’s
actually a relief”. It’s good that I’m releasing it, because I’ve held onto it for such a long time.

Rebecca describes how the arrival of her son forced her to confront her emotions in a way that she had not done since her abuse. Her tears relate to an emotional reconnection; she was able to experience and let go of emotions she had held inside for many years. In her desire to be emotionally connected to her new son, she felt she had no alternative and for the first time she remembered and felt the emotion she had blocked. It was a step towards reuniting her emotional and physical self and away from the dissociation from emotion that she had used to cope in the past.

In the passages above Rebecca describes her tears and sadness. She challenges interpretation of tears as a manifestation of post-natal depression as the hospital staff and woman in the park assumed. Her sadness is a reconnection with emotion, a healing brought about by her son and her love for him. Tears are not solely about sadness—sometimes they represent joy, as they did for her when she thought of her love for her son.

The emotion Rebecca describes in the preceding passages challenges the assumption that sadness is always a negative emotion and a manifestation of depression. Her description reinforces that things are not always as they seem. Researchers need to fully explore the experience of the interview as well as the analysis: to not assume, as researchers, that they ‘know’. Her discussion of sadness directly challenged and informed my analysis.
Rebecca reported professionals and community members made the same mistake. They equated a crying new mother with PND. Importantly, the health professionals assumed they knew what was happening and didn’t ask Rebecca. Sadness does not always mean depression in new mothers: Rebecca describes her tears associated with the emotional reconnection she experienced with her son.

**Fear**

Fear was associated with loss, resuscitation at birth, baby illness, adequacy of mothering, breastfeeding and separation. Of particular importance to the participants was separation from their children, lack of support and the risk of abuse by leaving them in the care of strangers. Only one participant talked of her concern about separation and leaving her child with family members. Others may have left this fear unspoken, speaking instead of their fear of leaving their children with strangers, even though their own abusive experiences had occurred within the family. Participants seldom stated they were afraid; fear was more likely to be hidden in their descriptions.

After I asked her about her son, Rebecca talked of her experience of her son stopping breathing:

He’s an amazing kid. He came prematurely, he was six to eight weeks early depending on whose date that you take. I think he was very clearly saying to me was, “I’m here; forget work and all the crap that happened there. I’m here now, focus on me”. He died twice, after he was born, not just after, but he got a chest infection and stopped breathing and was actually grey and lifeless and the whole bit, I brought him back once.

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84 Rebecca’s son was not severely ill as a premature infant and therefore was included in the research.
He was with me in bed, my husband was saying, “Oh put him in the cot, put him in the cot,” and I just didn’t want to. Culturally with prem babies, you keep them close to you, you keep them on you to keep them breathing. The first time it happened I bought him back and then the next night my husband did. He went like completely grey and lifeless and hadn’t breathed for a minute. So we don’t know if there is residual brain damage or not, but it doesn’t seem like it …

In the passage Rebecca does not mention fear. She baldly states her son “died twice” without any obvious associated emotion. Later in the passage she talks about premature babies and how you keep them “on you to keep them breathing” and how she couldn’t put him into bed on his own even when asked by her partner. Implicit in her words is that to remove the baby from her body risks his breathing and therefore his life—she cannot separate from him because of this fear.

The fear expressed in the passage above is subtle and covert; Rebecca doesn’t talk about being afraid but implies what will happen if her baby is taken from her body. Her fear may have been enhanced by her previous experience of him stopping breathing and bringing him back.

In this passage the implied fear assists me to understand Rebecca’s experience more deeply. She is not simply ‘detached’ from the experience of her son stopping breathing, as my first reading of the passage suggested, her response is far more complex and subtle as she endeavours to protect him.

In this passage Rebecca confirms the fear she hinted at in the previous one. She goes on to explain why she was unable to contact her family for support during this time:
It was frightening and horrible. I didn’t contact anyone in the family to let them know my son was so sick. I thought if it gets to the point where he does not make it, then I’ll tell them. I didn’t want to worry them, and Mum was having radiation therapy and chemotherapy.

Rebecca confirms the fear suspected in the earlier passage. Her mother was unwell and Rebecca was reluctant to add to her mother’s burden. She planned to tell them nothing unless, as she states, “he wasn’t going to make it”.

Planning to tell her family of her sick baby as late as she planned would not make it easy for Rebecca to receive support. Her past experience of her parents’ responses to her CSA may shed some light. Rebecca describes how she wanted her brother to admit what he had done, so her parents would better understand her and the life she had led.

I took him to court. All I wanted him to do was tell Mum and Dad what he had done. So then they would understand why I have lived the life I lived, being a sex worker, being with an abusive partner, getting into drugs, not talking to Mum and Dad or coming home for a long time. I wanted him to just go and say “This is what I did”. May be that would have given them some understanding. My brother refused, so I took him to court and he ended up with a conviction … And my parents just didn’t get it at all. I have given up trying to get them to understand it. I say to my mother I won’t come in the house if my brother is there, especially if I have got my son with me. My mother says, “Don’t be ridiculous!” I say “You call it ridiculous, I call it being safe!”

When I asked if Rebecca if she had disclosed her abuse to her mother, she explained how she had tried but her mother had responded with denial:

I tried … and she did the “No, no no no!” I mean she is really Cleopatra, Queen of Denial … Sick joke but … she really is like that […] I think Dad just follows her.
In both these passages Rebecca talks of her mother’s lack of understanding. Her mother dismisses Rebecca’s feeling that her son is not safe if her brother is in the house, and when Rebecca disclosed her CSA she was not believed. Perhaps these responses Rebecca experienced in the past explain why she hints at emotions demonstrated by fear in the first passage. She is using cues to covertly ask if I really want to listen to her story. She may also be protecting herself by not experiencing fear when her son stops breathing, staying emotionally disconnected as she described happening after her abuse in the earlier section on sadness. Both these themes can now be incorporated into the analysis and their significance further investigated.

Alice talks overtly of her fear associated with trauma during labour when her son’s arm delivered and she was rushed to hospital for a caesarian section:

We weren’t at hospital at all, didn’t even have the midwife there yet and his arm actually came out. It was scary, we had to get the ambulance and go to hospital. So it was the whole emotion of having a child that could have died. I just remember lying down on the operating table just saying “This is not the way it is supposed to be,” that it was a really highly emotional time for me. I just had to cry and cry and let it out and read lots of stories and do lots of things like being involved now with the Maternity Coalition.

Alice uses emotion in this passage to reinforce the importance of her experience. Her son’s delivery was frightening, she was scared when she was rushed to hospital after his arm delivered, she feared for him and the experience was totally unexpected, taking her by surprise. She cries, reads a lot and finally becomes active in helping other women through the a pregnancy advocacy service. Alice remembers her parents’ response after her disclosure of CSA by her grandfather:
Dad didn’t know how to deal with it himself, I think he just wanted to kill someone, as you would, your own child! I get more emotional thinking about my own children, if your own kids had to go through that, it would be terrible. So I can imagine how Dad would be feeling when his little girl, something had happened to her ... Mum became a [child sexual abuse] counsellor for parents of victims. So I remember just laying on the bed listening to Mum talk to people, and even that is healing in itself, going through all the emotions, hearing Mum say things to people that I wanted to be told or that I needed to be told as well.

In the passage above Alice describes her parents’ response to her CSA, but mixed amongst it is her fear for her children, it would “be terrible” if her own children experienced CSA in the way that she had. Her mother, on the other hand, became a counsellor, talking to other parents and helping other parents who needed help. Alice describes this response as healing, listening to her mother say to others things that she wanted and needed to hear. In some ways Alice’s role with the pregnancy advocacy group is a similar trauma response to her mother’s—both women responded to their experience of trauma by helping others, and converted a negative experience into a positive one by helping others.

Sections of the interview with Tess were dominated by fear and distress. These emotions were felt in the interview interaction where, as an interviewer, I felt some of her distress as I saw her obvious pain. Part of the strength of my response was related to my own experience in relation to the one Tess describes. In response to my question on flashbacks, Tess talks of emotional distress triggered by gifts, wardrobes and children’s stories:

No, No. Just little specific things which I suppose would be specific to each person. I had to stand on a turtle; you know the turtle things that you get so the kids can reach the toilet? I had to stand on one of those
to get in to a certain position for my brother [when he raped me]. Someone brought me one as a baby gift, the turtle, so it’s … little things like that … that trigger things …

She explains further:

My brother was into photography and he had a dark room in a bit of the garage. He would often take me into the dark room in the middle of the day. It was shut off with a wardrobe of all things; you’d walk through the wardrobe into the dark room. Often the abuse would happen there. The twins’ auntie […] she was doing up a wardrobe for them and talked about how fantastic it was and the story of The Lion, the Witch and the Wardrobe, which is a book I have never read. The wardrobe was great because could they walk through the wardrobe and they go into the wardrobe, into … [Unable to finish sentence, evident distress].

In both sections of the transcript Tess talks of how gifts from friends and family made her recall her abuse. Both gifts, the turtle and the wardrobe, were directly associated by her with her past CSA. In the sections of text her distress is obvious, her fear not so apparent. In the interview and as I analysed the transcripts, I felt her fear even though it was unspoken. I felt as she spoke that she had been frightened standing on the turtle and entering the wardrobe. She spoke of her experience of a plastic turtle given as a gift and of a children’s story she could never read, her fear of entering a wardrobe—it was excruciatingly painful. In her telling I felt some of her pain and fear. My response to her was better understood when I contrasted it with the experience of others. The Lion, the Witch and the Wardrobe is a favourite fantasy book of children in Australia; in 2004 it was voted the fifth favourite children’s book in the Australian Broadcasting Commission poll.85 As Tess told her story, I responded—adding my knowledge of other children’s experience and contrasting it

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85 Results of the poll can be viewed at http://abc.net.au/myfavouritebook/kids/top10/default.htm.
with hers—allowing me to better understand the extent of her emotional response to the book, the wardrobe and the turtle.

Such a process is important for researchers to recognise and consider clearly during analysis, whether the emotion they are responding to is their own or the participant’s. In this case, comparing the responses of other children, other adults, my own and Tess’ to a book was not a particularly emotional one for me. However, what would happen in the analysis if it had been? Let me illustrate this point by hypothetically reversing the roles—Tess conducting interviews about favourite children’s book—and her interviewee starts discussing *The Lion, the Witch and the Wardrobe*. As the interviewer, it is likely that Tess’s personal experience will impact on both interview and the analysis, demonstrating the importance of the researcher being aware of her own emotional responses because of her own personal life story.

Particularly when incorporating emotion into analysis, researchers need to be critical. Am I responding to something in my experience or something in the participant’s? In interview based research, good field notes can assist this process, documenting why an emotional response was so strong. Was it the look on the participant’s face, the voice tone, the tremor, the shaking and the perspiration on the face? What was it in the interaction that made you, as an interviewer, feel that particular emotion? In being critical, it is important for the researcher to reflect on and be aware of, his/her own vulnerabilities, and make sure these do not intrude into the analysis. These strategies make for a better and more transparent analysis.
One area that challenged participants was separation from their children. As I analysed the transcripts I suspected that the challenge of separation might have been related directly to their CSA, associated with themes such as fear of abuse, child protection and safety. As I explored these issues during the interviews and again in the analysis, it became apparent that this was not always the case. For Caitlyn it was about safety, but more closely related to her baby’s reflux illness than her CSA. She explains how afraid she was leaving him and someone else feeding him:

One weekend I left him for the first time, I was terrified; I was so scared to leave him because he would never have a bottle from anyone else, except for my sister, occasionally. A bottle was fine, but he would hardly drink or eat.

Her fear was related to someone else feeding him, and whether he would be adequately fed while she was away. She made no association between her response and her CSA.

For other participants, the fear of separation was related directly to their experience of CSA. Fear of separation took two forms—forced separation and voluntary separation, such as child care. Deme has recurrent nightmares about the kidnapping of her daughter and explains her fear and helplessness in the following passages:

I’ve had dreams where people have broken in and kidnapped my daughter. Sometimes I get up in the middle of the night for a feed and walk down the hall and I’m thinking, God there is someone standing in my house. I’m just going to let them take everything as long as they let me have my daughter. They can have everything … as long as they let me have her. I’m sure normal parents who haven’t been sexually abused in the family might think that it is a bit extreme. Sometimes when my daughter is playing she goes up to a male … my heart just beats fast! When I see stories where children have been kidnapped I
really feel for them, that is my worst nightmare, and it could very well happen just like that. She is so precious to me. What happened to me is in my mind all the time now, more often than it has been in ten years.

There is another dream, someone had broken into the house. They decide not to take things but they are in my daughter’s room, standing over her. I’m not there but I can see what is happening. I am asleep and I am just standing there … oh my God, they are standing over the bed, standing over the bed! I wake up […] There are a lot of reasons why … but … they are just memories … but they are memories where something happened.

Deme is afraid for her daughter; she is not like a “normal parent” as she thinks in a way that “is a bit extreme”. Deme has nightmares and is frightened by them. She responds physically with a rapid heartbeat, possibly part of a fight or flight response, when her daughter goes up to a male. She is “not there”, so she can’t help her daughter but she can see what is happening. Saying “I’m not there but I can see what is happening”, she is describing a classical dissociative response of PTSD. She goes on to explain these dreams are memories of her own response to her CSA and to the dream. In her nightmares about her daughter she again experiences her emotional response to her CSA, another symptom of PTSD.

When Deme described her nightmares the emotion she felt was apparent. Fear and helplessness were clear in her face and in the way she spoke. She was obviously frightened as she told the story. Her childhood dissociative response would not protect her daughter. Responses she had learned as a child to cope with her CSA no longer served her in her role as a mother protecting her daughter.

It is clear that Deme’s nightmares represent, in part, her own relived memories when she described them as occurring because “they are
memories where something happened”. In the analysis the words describe the reliving of her abuse and her memories. The emotion I saw and felt in the interview assisted me to understand her memories. They were not simply visual flashbacks; they were visual, physical and emotional memories. It is the combination that gave her story its power.

A more typical response was difficulty with separation and concerns for the child’s safety. In the next passage Rebecca’s response to her own CSA is to be protective of her son. When I asked her how her CSA had influenced her as a mother, she responds:

I am very, very very very protective of him. Probably over-protective of him, probably over protective in most people’s eyes! I don’t care what most people think about that sort of thing. You only get one opportunity to keep a child safe and I know most people prefer to trust. I find that very difficult, he hasn’t been overnight with any one else. I don’t think he has actually been looked after by anyone except my husband or me.

Rebecca emphasises, in response to my question, that she is very protective of her son in the way she repeats words and her voice becomes louder. Protecting her son is important because she has only one chance to do this. She doesn’t risk trusting others, except her husband. In the analysis I asked myself what was behind her emphatic response. She mentions trust and her lack of it; this is one theme to explore but fear could also explain her response. Both need to be considered in the analysis.

All participants were abused by family members but their fear around separation was largely directed externally, away from the family, strangers were more commonly identified as dangerous. In response to
my question on how their experience of CSA impacted on her mothering, Deme replies:

Well, I am paranoid. I don’t want my daughter to go into childcare, in case someone ever touches her. I don’t trust any single males with her. It is not just someone twenty years older than her. He was twenty seven when I was seven. What twenty seven year old has already sexually molested children and when did he start? These are the things that worry me; he could have started when he was seventeen. So I don’t trust any male teenagers onwards alone with her unless I know them 100%. My husband’s Dad, I would trust him any day of the week. My husband … any time. I could never think that anything could ever happen with her father. That would be the worst. But we do have friends, even though they are great people and I love them but I wouldn’t want their twenty four year old son looking after her. So, my daughter doesn’t go to childcare.

Between the first and second interview Deme’s husband confronted a fear that Deme denied in the first passage. She explains:

My husband asked “How did the interview go today”? I said, “Well you know, she made me think a little bit differently about what had happened,” I said to him “I think I babbled a bit, I went off on a tangent”. The way I do, I tend to babble, and he’s going, “Oh did you?” “I said some things I’d never really said out loud ever before and there were some concerns.” And he said to me, “Are you worried about me?”, and I didn’t understand what he was asking me. He explained, “Are you worried about me touching the children?” And I went, “Oh God no”, and it never ever occurred to me that I would ever need to worry about my husband, never!

Deme openly discussed her fear of other men abusing her daughter, but the thought of her husband doing the same thing was one she couldn’t contemplate, even though she was abused by her stepfather over many years. The fear of abuse of their children by male family members was not openly discussed in the interviews; it was largely present by omission
or alluded to rather than spoken. Tess was the only one who openly discussed her fears of abuse occurring within the family:

I have thought about abuse when they go to bed at night and the other one isn’t there, but it makes no difference at all. When they stay with my aunt I don’t know who is in her house and who is with them. I can’t say “No visitors or anything like that” but I know I can’t be like that.

She explains further:

My Aunt has two bedrooms, she is all set up for them and two cots in her spare bedroom. I know at times she has friends stay over, they sleep in the spare bedroom, where my children are sleeping. I am not really confident with that. I trust her and I’m sure she would never mindfully put them in any danger. I know that doesn’t necessarily help because at the moment they are both so young. I know abuse can happen when they are young and I think when they are older then, they’re conscious of it, and I would be more worried. I am even wary at home because I know it is not necessarily going to happen somewhere else or by a stranger if it was to happen. It may very well happen, while I am home.

Tess and Deme were the only two to mention the possible risk to their children from family members, even though all participants themselves experienced CSA by a family member. Some fears are more difficult than others to explore. It is not clear from the transcripts whether participants did not think about their child’s safety within the family, whether they blocked that idea, or whether it was something they were unable to discuss within the interview. At this time, it was not an issue that many of my participants spoke about confronting.

Interestingly, some mothers were far more open about the fear and risk that they would continue the cycle and abuse their children. In response
to my question about how her CSA impacted on her mothering, Rosa talks of the following concerns:

Well, I don’t think it influenced me … I know I won’t abuse him or anything, if anything I’m almost scared I’m going to be too smothering. That’s why I say I want to just think about [him], I don’t want to be sad around him or depressed or do something stupid like possibly use again. […] Sometimes when I argued with my partner I would behave exactly like my adopted mother did when she argued with my father. So that got me thinking … about what I might do to him. I can’t see myself doing any of the things that she did to me, I can’t see myself doing that to him, but there is still this fear of that type of thing. Just the meanness that my mother had is coming out in me when I am angry. It’s hard.

Rosa clearly identifies her concerns that she might abuse her son by behaving by like her adopting mother, even though she consciously does not want to harm her child. She is afraid of this sort of behaviour when she is angry. It made mothering harder for her.

**Anger**

Anger is the last emotion to be discussed in this chapter and it is important when considering the previous section on fear. Child protection and fear of separation was a major theme. In this section anger is apparent largely in response to failure to protect the child. Participants direct their anger internally, at themselves and externally, towards the perpetrator, the family and society.

Deme regrets not having “more guts” and protecting herself. She is angry with herself, wishing that she hadn’t wanted the presents she received from the perpetrator and had said ‘no’.86

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86 For full transcript text see p.154.
Lily describes sexual abuse really never entering her mind when she mothers, but she becomes angry when she sees her son’s innocence. She responds to my question on her experience mothering after CSA:

I wasn’t sure, because it really never entered my mind. Sexual assault never has entered my mind in that context. It has been on my mind in lots of other ways with my children … But not in that way … I have a child, my elder son is a similar age to me when I was abused. From two onwards, I started looking at him differently and I started to get quite angry about things that happened a long time ago. I thought I was quite over it. I have, obviously, a lot of emotions because I am now a mother and I am so protective. […] I just look at my son and say and think “Oh, he is so beautiful and innocent at this age,” at two and three that’s what makes me angry, that what dredges it up for me all the time…I just look at him and think, there’s just no way I could ever justify what happened or not be angry about it.

While Lily responds that CSA doesn’t really impact on her mothering, she goes on in the passage to describe how she looks at her son, comparing his innocence with her own when she was abused. As she looks at him she becomes angry, unable to justify or excuse what was done to her. In mothering a child she is able to see herself differently and become angry.

Anger was not a feature of Lily’s interview, she didn’t feel angry, I didn’t experience anger directed towards me and overall it was an unemotional interview. Every now and then there were glimpses that perhaps things were not as unemotional as they seemed. The passage above was one of them.

Maria describes a similar response to her assault. Rather than a loss of innocence she describes how her “precious feeling” and sense of worth
was taken by the perpetrator. It was only restored when she became a mother.

Alice directs her anger outwards, blaming her parents more than herself. I asked her if she blamed herself. She responds:

No, I probably blame my parents more even though I know that it was not their fault. They didn’t do it, but really, their role was to protect the children and they didn’t. They saw warning signs and still didn’t protect me. Sometimes warning bells will go off for me and I don’t know whether it’s because I was abused myself or whether it’s just a parental thing. We were at a birthday party the other weekend and this man was paying particular attention to my 18 month old. That was OK because I was right there. He’s a nice guy, he’s a grandfather, and probably the mental connection was there. I’m thinking grandfathers must be evil. He was pushing my son on the swing. I didn’t say anything but in my mind I’m thinking, I’m thinking I know you … and then I turned around a little while later and my son was gone. I just thought ‘Ohh’ and panic went through me, so I’m looking and found him and he was fine and nothing had happened …

Rebecca was angry with her father:

That’s how it is with Mum and Dad, I’m not going to win. My son has had a huge influence on them, in terms of reconciliation stuff. I don’t think that they will ever understand. […] And I think Dad wishes that I had just never done anything, that I had kept the pretence up for him … I was really angry with him then.

Rebecca and Deme were both angry when the perpetrator was taken to court. Rebecca’s brother received a suspended sentence and Deme’s stepfather only thirty six months imprisonment for a third conviction. Ruth’s sister took her grandfather to court when Ruth became pregnant with her first child—she told Ruth that she wanted to ensure that her
niece or nephew was protected. Both girls had been assaulted by him. Ruth describes her response to his sentence:

I was pregnant at the time and she didn’t want him to have anything to do with my new baby. I was always happy for her to do whatever she felt she needed to do. She files a police report and then as a follow-on from her filing a report … it came out that it had happened to me too. I filed another report about me and that went to court just after my son was born. He got a good behaviour bond I think, or a good behaviour bond and a twelve month suspended sentence, so nothing, basically. I hadn’t cared what had happened up until then but when I found out what he got I was furious. Like, excuse me, he can just go on and live his life! Look, at the end of the day my sister felt better and that was important, because she just couldn’t deal with things. Unexpectedly, it was me at the other end, going … I was furious … this isn’t right!

In this section of the chapter I have outlined anger and the description of how participants experienced it. Each experience was different. Sometimes the anger was directed internally, towards the participant and at other times externally, towards parents, perpetrators and the courts. In analysing the transcripts further it will be important to consider not only why anger was triggered but how participants directed it. Once again, using emotion and incorporating it in the analysis is adding depth to the emerging themes.

In this chapter I discussed the emotional content within the interviews and how I used the emotional content to inform my analysis. I have focused on the three emotions of sadness, fear and anger, as they were the ones that stood out most strongly during the interviews and when doing the coding and analysis of the transcripts. For each of these emotions I outlined how each one informed my analysis. They assisted me to identify key issues and themes, as the emotional content often highlighted
their importance to participants. In addition, the emotion surrounding sections of the interview helped me with the subtleties—issues that were implied rather than spoken, and areas where the participants struggled to speak. These particular areas may otherwise have gone unnoticed, so incorporating emotion added depth and trustworthiness to the work.

On a cautionary note: researchers who use emotion to inform their work must reflect on their own vulnerabilities, ensuring that their emotion and experiences are not mistaken for the participants’ emotions. For research, this is done by exploring emotion meanings within the interviews and the transcripts with participants and by not assuming that as a researcher you ‘know’.
Chapter 6

Mothers and Breastfeeding

Breastfeeding
In the introduction I told Meg’s story of breastfeeding and her response to her son’s smile. In my clinical practice other CSA survivors presented with chronic breast pain associated with breastfeeding. The community sample I interviewed had different experiences of breast pain from my clinical one. While breast pain occurred it was not as significant as it had been in my patients. Visiting the doctor with breast pain may only happen when pain is severe or prolonged, and because of this I only recognised CSA survivors in a group of women who presented with severe pain. As a clinician, I thought breast pain was an important issue to explore with the participants in the study. Participants did experience breast pain but in this group of successful breastfeeders it was not an issue they reported as particularly important. The issues raised by participants are explored in this chapter.

In this chapter I outline motherhood as a time of stress and change, and specifically discuss how breastfeeding challenges physical boundaries and maternal sexuality in CSA survivors.

For the purposes of the discussion, breastfeeding is defined as the baby suckling milk at the mother’s breast. Other forms of breastmilk feeding such as expressing breastmilk and feeding it to the baby via a bottle on a

87 See discussion in next section for details of this p.178.
regular basis is defined as ‘breastmilk feeding’ rather than ‘breastfeeding.’

Motherhood
Birth marks an important transition in women’s lives; it is a time of change, of challenges and of stress. Issokson (2004) describes it as a normal developmental life crisis “that affects the physical, emotional, sexual, spiritual, relational and social realms of a woman’s life” (p. 1).

The physical changes after birth tend to be discussed by health professionals in relation to function: breasts become engorged, breastmilk comes in on day three, the uterus contracts in response to breastfeeding. The physical change in body boundaries, between the mother and her baby/babies, that occurs with birth was an area seldom considered by health professionals, particularly doctors. The internal foetus moved from within the mother’s body to be an external baby. The new baby was a separate being. There are now body boundaries between the mother and her baby, and yet these physical boundaries must be crossed and negotiated if the mother is to feed her baby at her breast, change a nappy and even hold her child.

Most people have experienced a stranger standing too close and the discomfort and even fear that accompany the stranger’s invasion of personal space, and the almost automatic step backwards made to separate from the stranger and make it safe. At a more personal level body boundaries define what is outside a person’s body and what is inside. Physically challenging boundaries can be threatening, as Young
(1992) eloquently describes this when writing on the trauma of sexual abuse:

To physically challenge or compromise my boundaries threatens me, as a living organism, with annihilation; what is “outside me” has now, seemingly, entered me, occupied me, reshaped me and redefined me, made me foreign to myself by conflating and confusing inside me with outside me (Young, 1992 p.91).

As children, all the participants in this study experienced unwanted boundary violations when they were sexually abused by trusted family members. In this chapter I discuss how they manage and respond, how their bodily feelings have been “reshaped and redefined” by their CSA, and how they feel as breastfeeding mothers.

Karen Horney (1885-1952), an early analyst and theorist, argued that psychoanalysis ignored motherhood because motherhood lacked status amongst men and psychoanalysis was the “creation of male genius” based on masculine psychology and development. Perhaps this is why motherhood has been ignored by much of the psychoanalytic literature. Like some of the participants, Horney speaks romantically of motherhood:

At this point I, as a woman, ask in amazement, and what of motherhood? And the blissful consciousness of bearing a new life within oneself? And the ineffable happiness of the increasing expectation of the appearance of this new being? And the joy when it finally makes its appearance and one holds it for the first time in ones arms? And the deep pleasurable feeling of satisfaction in suckling it and the happiness of the whole period when the infant needs her care? (Horney, 1967 p.60).
Motherhood is an embodied experience; the sheer physicality of it can bring with it special challenges for women, particularly for CSA survivors. It may be a time of healing for a survivor as she mothers her new baby, but it can also be the stimulus to relive old memories of abuse (Issokson, 2004). Mothering involves intimate touch to both mother and baby. Body boundaries must change to mother: they merge and separate at different times. Breastfeeding requires intimate touch\textsuperscript{88} between the mother’s nipple and the baby’s mouth—regularly, repeatedly, regardless of the pain or pleasure the mother experiences. Breastfeeding may occur in places where women would not normally be comfortable exposing their breasts. Breastfeeding can be challenging for a mother when the previously controlled breasts become uncontrollable: a baby cries, breasts leak; a mother thinks of her baby at work and finds she has two wet patches on the front of her shirt; she gives her baby one breast during a feed and milk squirts amazing distances from the other one; she has sex with her partner and discovers they are both covered in breastmilk.

This chapter outlines the breastfeeding experience of eleven women after they had experienced CSA. All of the women recruited for the study had breastfed a minimum of eleven weeks. As such they were ‘successful breastfeeders’ based on Victorian community statistics, where only 56% of Victorian women are exclusively breastfeeding at thirteen weeks and 61.7% are exclusively or partially breastfeeding at thirteen weeks (Donath and Amir, 2000).

\textsuperscript{88} Intimate touch of the mother is largely discussed in the CSA literature in terms of adult sexuality. The maternal experience of mother-baby touch was largely lacking from the literature. A larger literature on touch and bonding from the perspective of the infant is discussed in the next chapter.
As in the previous chapter, quotes from participant transcripts form the basis for the discussion. I have chosen quotes that either best illustrate a theme, or the impact of CSA.

**Breastfeeding Experiences**

Breastfeeding has been reported as a healing experience for some survivors (Issokson, 2004, Pickering, 1999). Tess described breastfeeding as a “validation” of her body and breasts: she experienced breastfeeding her third child as purposeful and healing. She gives her breastfeeding body a positive purpose, a good story, one that she had not previously told of her body. This story allows her to reframe her previously negative view of her breasts because of her sexual assault, allowing her to heal. When I asked her how her childhood sexual assault influenced her breastfeeding, she succinctly repeats, “It was a validation. That is what they [my body and breasts] were for. My breasts can have a positive story”.

Early development of positive feelings between mothers and babies is associated with labours of less than nine hours and breastfeeding (Lawrence, 1994 p.198)—experiences like Tess’s may be associated with improvement in the mother-child relationship as well.

**Breastfeeding and the Mother-Baby Relationship**

Relationships have been identified as an area of difficulty for survivors. Kendall-Tackett (1998) describes two dysfunctional relationship styles that can be found amongst some survivors: avoidant, where survivors have few close relationships, and intrusive (also described as smothering), where a high degree of closeness is constantly needed. Both these styles reflect the symptom profiles of PTSD and may reflect PTSD
rather than a specific association between CSA and relationships. Neither of these styles of mothering was obvious in the mothering by the participants during the interviews. However, the participants discussed their ease and difficulties forming relationships with their babies. Breastfeeding was identified by participants as playing a role in the emotional attachment and the building of their relationship with their babies.

When I asked Lily to describe her breastfeeding experience, she talked of the love between herself and her son, almost as romantically as Karen Horney did in the introduction. Lily relates the giving of milk and sharing of her breasts with him to her strong connection with her son:

It’s the love. It’s the giving of my milk to him and sharing with him. I am the only one that can do that for him and it is so strong, that love. To have this little baby attached to you makes me feel a really strong connection. I feel like I have a real bond.

I just love being in that little time capsule when I am breastfeeding him, because it is just us. There’s nothing else gets in the way or interferes. It’s the fact that I can nurture him and provide for him and that’s making him grow. It’s quite amazing to me that it happens, and that I can do it. I love it.

Like Tess, Lily is amazed by the good thing her body does breastfeeding. She can nurture him and make him grow. Two things amaze her: that “it happens” and that she “can do it.” Her surprise at being able to breastfeed so well suggests she doubts her body function and perhaps her ability to do it well. Tess states that breastfeeding gave her body and breasts a positive story: a validation. She implies that she has another negative story about her breasts but breastfeeding challenged this image of her body and allowed an alternative and positive story.
Deme responded similarly, talking of breastfeeding and its importance in her developing relationship with her six week old son. She describes her emotional attachment that is linked to the good nourishment her breast milk provides. She is delighted to see her son grow and his “eyes sparkle”. For her, providing milk and watching him grow provides part of her validation as good mother. She explains this in response to my question about her physical, emotional and sensual experiences of breastfeeding:

Breastfeeding is emotional because it is really bonding. You feel you are his whole nourishment. You are fully responsible for his growth and whenever you look at him you know that the milk you are providing for him is making him grow longer and grow stronger and making his eyes sparkle. You are responsible for all things when they are babies, whenever they laugh, providing for their growth and emotional needs. For me that shows you are such a good mum.

Rebecca described disconnecting and dissociating from her emotions after her CSA by her brother, and again later with her family’s denial of the importance of her CSA experiences. It was the birth of her son that made her reconnect to her emotions and breastfeeding was part of that reconnection process. She talks of bottle feeding as a “head thing,” lacking the complexity, intensity and the emotional connection of breastfeeding. Her emotional connections are complex—passionate love for her son linked with anger from the past. In the following passages she talks of the emotional and physical demands and the ambivalence towards breastfeeding when, as a mother, she was tired and hungry. As much as breastfeeding challenges her to remove herself physically and emotionally—her old post-CSA behaviour pattern—it also forces her to stay connected and develop her relationship with her son because she

89 Her reconnection to her anger described in the previous chapter pp.155-157.
alone can breastfeed. In response to my question about her experience of breastfeeding, Rebecca describes what she felt:

I think any intense relationship is not calm because there is heat in a relationship. It does not matter whether it is burning passionate love or passionate anger. There is nothing calm or controlled about relationships. It is the gut reaction stuff, I am talking about. Bottle feeding is a head thing, you can just go “Okay, you need a bottle” and give it. When it is may be the eighth breastfeed for the day, and you are really hungry and tired and the baby wants a feed you have to respond. Even though you feel “Oh no, I can’t.” There is nothing else to do but breastfeed. So it is that intensity and closeness [that is important].

She goes on to explain more about the physical demands:

When they are only feeding from you, there is that feeling that you can’t go, where you can’t go anywhere, in case they need a breastfeed.

She was amazed by how well she breastfeeds. At the same time she fears that emotionally, she may not always provide for him (due to her CSA) and that breastfeeding him compensates. She explains:

Breastfeeding was something I could do really well for a child. That’s the really amazing thing, that I could actually do something well with a kid. So that was interesting. It made me feel that if there is anything he was missing out from me emotionally at least he was getting breastfed.

Most participants discussed the importance of breastfeeding in developing their relationship with their babies; the three women quoted above illustrate this. All are amazed at the goodness of their breastfeeding bodies. For Lily, it was the sharing involved that developed her bond with her son. For Deme, it was seeing her son grow and develop well that allowed her to see herself as a good mother. For Rebecca, it was the physical and emotional connection during feeding that enabled her to
develop closeness with her son. While each breastfeeding experience was
different, each woman discussed it in terms of assisting them to develop
positive relationships with their babies, relationships that may have been
more problematic had they not been able to breastfeed.

Like Tess, for whom a second experience breastfeeding gave her breasts a
positive story, each of the women above frames her breastfeeding
experience in positive terms: sharing and love, growth and sparkly eyes,
and maintaining closeness. Each of their babies’ breastfeeds, suckling the
mother’s breast, is crossing a physical boundary but the process is
assisted by the mothers’ positive framing of the experience.

However, not all participants’ experiences were positive. Tess had not
always been able to frame her breastfeeding experience positively. In her
first pregnancy she delivered premature twins. Her relationship with her
first children was difficult from the start. She hadn’t wanted to become a
mother because of her abuse (detailed in the previous chapter)\(^90\) and had
barely become accustomed to the fact that she was pregnant when her
twin girls delivered. Tess explains as follows:

It was just … very difficult. I hadn’t really even accepted that I was
pregnant and I was a mother. I was just starting to show, I didn’t have
anything bought for them. I just wasn’t prepared and then they were
there.

I wanted to breastfeed the twins, because they were so young. It never
really happened, so I expressed milk for them for four months every
three hours. In the end I was trying to feed them and they wouldn’t
breastfeed, so I would top them up with a bottle. Then I would express
and it would be time to start feeding again, so that was enough.

\(^{90}\) See pp.151-152.
She described in both interviews how she had struggled with her relationship with the twins. Her relationship was complicated by her lack of acceptance of her pregnancy (above), by their prematurity requiring care in hospital, trying to express and breastfeed two premature babies, and later, by the sheer physical demands of having two babies to care for. Her first breastfeeding experience with them was not a positive one, even though she had wanted to breastfeed.

In response to my asking about her loss at her separation from her twins while they were in intensive care she describes how she felt somewhat relieved:

I actually thought that they were better off in hospital because they were with people who ... knew how to look after them and because I never actually planned to have any children.

She goes on to explain how different her latest breastfeeding experience was and frames it in terms of her relationship with her new baby:

I love breastfeeding now, it’s great, really good with my new son, but not with the twins, they were so used to other people. You know, they’ve never been mine, anyone could pick them up. My new baby is different; I have a wonderful connection with him.

In Tess’s breastfeeding story it is difficult to tease out the complex breastfeeding relationship with her premature twins, the role of the sex of her children in her response, and the impact of not wanting to be a mother she associated directly with her experience of CSA.

Helen also had twins. She had difficulties with her relationship with two babies at once, even though they were expected and arrived on time. She
has three children, her daughter was born prior to her boy/girl twins. Like Tess, she describes relationship difficulties with her twins right from the beginning:

The first year of the twins’ life there wasn’t much of a relationship … I didn’t have time to form a relationship with them or the inclination to do so. They were just surviving.

Later in the interview she tells of her initial response to the babies:

[...] I was in shock, two babies! They were born naturally and really quickly. The nurse said “Oh here you go, we'll pop them on the breast.” and I said, “No, I don't want them yet. Take them away”. The nurse wanted to put them, straight on my breast within an hour or so of giving birth, just like you normally do. I said no, I was not ready. So even at that point, I didn’t want to breastfeed them.

She describes extreme pain with cracked nipples breastfeeding her daughter early on but persisting because it was best for her daughter. She breastfed initially for financial reasons, had cracked nipples, but overcame this experience to finally “loving” breastfeeding.

The pain was just dreadful and I thought I had had pain before [physically cringing]. I mean labour has got nothing on that. It was just the most painful thing, so my husband would actually put her on the breast because I couldn’t. My husband asked “Why won’t you just give it up?” and I said “No I can’t”, I felt I was compelled to continue breastfeeding because it’s the best start for your baby. So I started breastfeeding for financial reasons, then it became compelling for the baby and then because that is the person that I am, I don’t give up!

Helen was able to, in spite of her initial pain, reframe her first breastfeeding experience as positive. She is never able to reach the same level of breastfeeding enjoyment with her twins. She is physically trapped by feeding two babies at once, she cannot look after herself as she feeds
and illustrates this by her inability to even get a drink. She describes being nothing except a body to be used, a body “everything” is taken from and finally left, empty, used and discarded.

I loved breastfeeding, absolutely loved it with my daughter, so I was really upset when I had to give it up. I remembered how good breastfeeding had been, and when it came to my twins, I wanted that experience again. With the twins, I was Daisy. I was just this milking cow. There was no specialness because I was feeding them together … It meant getting one on and then struggling to get the other one on, and to get yourself a drink at the same time was impossible … It was, and that is why I say I was really Daisy, really just a milking machine. I felt that I was only there for them to hang off both breasts, get everything they can from me, and then crawl away.

She further illustrates her vulnerability and her sense of exposure when describing breastfeeding while visiting the maternal and child health nurse. She is unable to establish a safe and controlled space to feed at the Maternal and Child Health Centre.

I remember once I walked to the Maternal and Child Health Centre. The twins had their check and then it was time to feed them. They were never going to make the forty five minute walk home without a feed. I sat on the floor with my legs crossed and had my knees up so I could hold them and fed them on the floor of the Maternal Child Health Centre. I said to the nurse, I said, “Could you just kind of drape something over my legs please?” because I had a skirt on with my knees crossed you could see everything. I felt, Oh God … I’m not going to do this again … I didn’t think I would ever get my legs down again.

When asked directly Helen did not consciously associate any of the experiences above with her experience of CSA. However, Helen’s description of her body being immobile, taken over by others, used, discarded, and her inability to feel in control and safe may well be closely
related to her experience of CSA. It is not surprising that she asks to be covered and thereby protected by the nurse.

**Breastmilk**

Breastmilk has been given healing, magical and divine properties over the centuries, starting with the ancient Egyptians, who believed that godliness was suckled from the breast. It continued into the middle ages; divinity and saintliness were passed through the milk of Mary’s breast (Yalom, 1997). Pliny the Elder (24-79 AD) cites breastmilk as an antidote to poisons and a cure for many illnesses, calling it the sweetest and most delicate of all female products, particularly useful for diseases of the eye, ulcers, abscesses and gout. Pliny comments in Natural History (Book 28.76) that the breast binder of a breastfeeding woman relieves headache when tied around the head (Jones, 1963). In recent times breastmilk has been promoted as reducing obesity, atopic disease, heart disease and for its immunological function in preventing infections, increasing intelligence and reducing sudden infant death (SIDS) in breastfed infants (Minchin, 1989, Lawrence, 1994). The “Breast is Best” advertising campaign has been widely used in Australia by breastfeeding associations, the health industry and Australian federal and state governments.

While studies show that women know that breastmilk is best for babies (Dix, 1991), breastmilk may provide special challenges for CSA survivors. Survivors can have a negative image of themselves as mothers, as well as a negative image of their bodies (Kendall-Tackett, 1998, Wenninger, 1998, Young, 1992), promoting feelings of inadequacy and fears that their bodies are not capable of doing good things. A ‘bad’ body

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91 Atopic disease includes allergy, asthma and eczema.
cannot make ‘good’ breastmilk, or be trusted to make ‘adequate’ amounts. The body blamed cannot be trusted to do the right thing.

The nutritional and protective value of breastmilk was important to participants, with ‘best for baby’ a theme running through much of the discussion.

In my first interview Deme describes breastmilk as having the right nutrients for her baby and its importance in building the baby’s immune system as well as protecting from infection. She associated breastfeeding with growth and good nutrition and, as I have discussed previously in this chapter, with good mothering. In the second interview with her, six weeks after the first, she describes her distress at her son’s poor weight gain, his continuous crying and difficulties settling. She had gone on a diet and she describes the nutritional value of her milk as missing because of her diet. She describes herself as selfish because she had not put the baby first and, by her own definition, was no longer a good mother.92 Her ‘badness’ was not inherent in her body but was a result of putting herself first and dieting, making her milk less nutritious. Not surprisingly, in view of the link she makes between good mothering and breastfeeding, she wanted to make things right, regardless of the cost to herself. When I asked her at the second interview how she was feeling about breastfeeding she responded:

My husband and I talked about putting him on the bottle, he said “The breast isn’t that important let’s just do formula,” but I didn’t want to give my son formula. My husband said “Look you are really stressed, the baby is obviously not getting enough milk, so let’s just give him formula.” It made me more determined to give my son breastmilk, I

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92 See p.180.
really, really wanted to give it my best shot. I’d screwed up. I didn’t just want to go, “Oh well, I’ve screwed up, let’s just bottle feed”. If I screwed up, I wanted to fix it. I don’t know if that’s the right way to think about it, but I was so determined to breastfeed. I felt that I really wanted to make it work. My husband felt I was just too emotional about it. It was hard for both of us to deal with. He could see that I was stressed, and the baby was stressed and to him there was an easier way out, but not for me.

Earlier in the interview she comments on the depletion of her milk by her diet and how going off the diet would make things better: “I think that it will get better as my milk gets thicker and has more substance; more sugar, more fat and more protein”.

Following the ‘best for baby’ theme, Eve describes the importance of breastmilk in protecting her son’s health. Eve raises issues of disease prevention as her family history gives an added impetus to giving him breastmilk and thereby protecting him in the short and long-terms. When I asked what was important to her about breastfeeding, she responded:

I have eczema and it was really bad when I was a baby, really bad. My brother’s sons also get eczema. A lot of children have asthma, and I think breastfeeding can certainly contribute to a better environment for them. In the last couple of years, we have found out that my mother’s family has a cholesterol problem, a triglyceride issue. I read that babies that are breastfed have a healthier system and better control of cholesterol. So I say to you that, for me, the long-term benefits of breastfeeding my son are tremendous. He is a healthy young boy now and I want him to stay healthy, like fighting off infections, giving him my immunity with breastmilk.

Breastfeeding was not always easy for participants in spite of their desire to give their babies the best start. At times, participants were uncertain about the appropriateness of their milk, with adequacy of their milk
supply the main focus. Alice describes her uncertainty and wishes she could be certain her supply is adequate:

I have never really felt like I have got enough milk. I don’t know whether it’s actually true, or whether it’s my own feeling. Probably a lot of people think their baby is not getting enough, because you can’t see what they are actually getting when you breastfeed. You only measure the time they feed or if they are swallowing but it’s not a real measurement. I’ve bottle fed friends’ babies … they say the baby has this many millilitres a feed. I don’t know, I feed him until he doesn’t want any more.

Even though Alice has successfully fed three children previously, she doubts that her body can appropriately respond to her baby’s needs. She needs reassurance and seeks it by measurement. As she can’t measure her supply or trust her body, she relies on his weight gain for reassurance. In my clinical work such a response is not uncommon among first time mothers with new babies, but is much less common in mothers with other children. In Alice’s case she is a very experienced mother, but is still uncertain of her supply. She recognises that her worry about her breastmilk supply is her own fear, “my own feeling,” rather than a reality, but can’t trust her body enough or her ability to read her baby’s cues.

The participants in this study did not demonstrate a clear link between their body image, breastmilk and CSA. Deme related her poor milk supply to diet, and Alice’s uncertainty related to being unable to measure her milk. None of the participants described her body as bad, though Alice may have perceived her body as untrustworthy.
Coping with Breastfeeding: The Maternal Sexual Split

In western society breasts are the most recognisable sign of a woman’s femininity. The mass media of the USA, Britain and Australia “are obsessed by women’s breasts” (Ussler, 1989 p.22) and continually use sexual images of breasts to reinforce the role of the breast as ‘sexual’. Walk into any Australian newsagency and there are shelves of glossy magazines whose covers display women’s breasts. The same mass media remain reluctant to use images of the maternal breast or breastfeeding, thus privileging the objectification of women’s bodies and breasts for male pleasure. Little has changed in the twenty five years since O’Brien wrote, “Breasts have been sometimes flaunted, sometimes flattened, understood as sensual tit-bits rather than purposeful instruments of nurture” (O’Brien, 1981 pp.50-51).

The most universal cross-cultural admired feminine feature is plumpness and not the breast (Ford and Beach, 1965). Less than a quarter of cultures participating in a broad cross-cultural survey on sexuality favoured breasts (Latteier, 1998 p.5) as objects of desire. An earlier study of human society by Ford and Beach (1995) observed that the type of breast admired varies between cultures. Long pendulous breasts were most admired in some cultures, while only two of the thirteen cultures admired that breasts favoured young, upright and hemispherical breasts, western society being one of the two (Ford and Beach, 1965).

Within western culture the form of the body and breast most admired has varied over time from small flat breasts to large ones, and from thin to plump bodies, to the current favourite: big breasts with thin bodies, a

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93 This forty year old study was the only cross cultural comparison of the cultural perspectives of breasts I could find.
virtually impossible ‘natural’ female form (Latteier, 1998, Carter, 1995 p.149). For western women at the beginning of the twenty first century, the breast is often the emblem of femininity and a measure of their success or failure as a sexual woman (Perry, 1992 p.131). With the breast defined in Australian society as a sexual and heterosexual object, it is not surprising that scant attention has been paid to the maternal breast. As a consequence the normal experience of breasts and breastfeeding from the woman’s perspective has been largely ignored in the medical management of pregnant and postpartum women (Meckelburg, 2000).

This section explores how CSA survivors experience the sexuality and sensuality of their breastfeeding bodies.

Breast shape is important, with women often judging themselves according to the shape, size and attractiveness of their breasts (Young, 1990). With having a baby and breastfeeding, the breast changes in contour, colour, and size. The breast that was once pert,94 constant and well behaved is now constantly changing: sometimes hard with milk, sometimes soft and empty, and leaking milk at the least provocation. The breast itself can be a focus of negative feelings for CSA survivors, associated with shame and body image distortion. Andrews (1997) reports that thighs, abdomen and breasts are areas of focus for bodily shame. With this in mind, survivors face particular challenges breastfeeding. Firstly, their breasts change from the socially admired young breasts to lactating ones. Secondly, the breasts can be a bodily focus for shame resulting from their experience of CSA. Thirdly, the breasts are associated with sexuality (Carter, 1995), with petting, stroking, sucking and kissing of the breast part of sexual foreplay.

94 The most admired form in western society, see Latteier (1998).
The association between sexuality and breastfeeding can trigger memories and fears associated with CSA (Issokson, 2004). This area was reviewed in Chapter Two.95 Much of the literature on sexuality and breastfeeding focuses on a heterosexual parental relationship, rather than on the mother-baby experience. However, women do report breastfeeding arousing sensual and sexual feelings in themselves, and some women experience orgasm while breastfeeding. Weichert’s (1977) study found that up to 25% of lactating women experience sexual arousal while breastfeeding. While some women in the study were comfortable with this, others found it uncomfortable, distasteful and even intolerable, prompting them to wean (in Reamy and White, 1987 p.177). In a small study by Alder et al. (1986) it was reported that the majority of women found breastfeeding pleasurable. In a more recent survey of new mothers by Avery and Duckett (2000) (n=576), sexual arousal never occurred in 59.4%, occurred infrequently in 23.7% and more frequently in 16.7%. One woman always experienced arousal with breastfeeding.

Survivors can be concerned and confused about the dual role of their breasts as a source of food and pleasure for the baby. A baby playing with her breasts during a feed can be confronting. Some women may report shame if they become aroused during feeding (Issokson, 2004 p.17), because women do not recognise it as a normal response to breastfeeding. Breasts may have a dual role for the woman herself: the maternal breast that is a source of nutrition for her child and the sexual breast that gives sexual pleasure to her and/or a partner.

The importance of pleasure and touch in infant development is widely acknowledged, and will be dealt with in more detail in the following

95 Chapter Two pp.59-63.
chapter. The role and importance of pleasure and sexuality for the mothers is far less established (Weisskopf, 1980). Newton (1973) argues that the split between the maternal and sexual is a disadvantage, and suggests that sensual pleasure while breastfeeding has a survival advantage (in Weisskopf, 1980). Pleasure during breastfeeding may be important in the relationship between the mother and infant, assisting the establishment of emotional bonds. Robinson and Short (1977) proposed that nipple sensitivity may have a key role in controlling the infant’s milk supply and the mother’s behavioural response.

The participants in my study largely resolved any potential conflict by splitting the maternal breast from the sexual one. Helen describes her unhappiness with her maternal body. Particular emphasis is given to her breasts and the loss of their sexuality; she tells how her breasts and their sexuality have become nothing:

Everything has changed about my body. I’m not at all happy with my body. I don’t feel my breasts are sexual anymore because of breastfeeding. They are a feeding tool for babies and that’s it! They’re null and void now and I don’t feel anything. They’re no sexual thing at all anymore.

Other participants echoed Helen’s views, describing breastfeeding as a task, something that was done with and to their bodies, but the experience held little pleasure for them. Alice equated breastfeeding her fourth child with a routine household chore. In response to my question about her favourite time to breastfeed she responded:

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97 The maternal sexual split has a long history in western society predating modern scientific thought. Images of naked sexual Eve and the clothed Mary Madonna breastfeeding or holding the Christ child date back to the 14th century. Reference: Carter, P (1995) Feminism, Breasts and Breastfeeding p.117.
No, I don’t have a favourite time to feed … probably because I don’t really view it as something for me, even though I know it is good for my body as well. I can’t have a favourite time because I don’t feel anything about it. I’m just … may be I’m even detached; I don’t know … I never thought about it. I’m feeding him and it’s done now … It’s like do you have a most favourite time to sweep the floor?

When asked about her physical, emotional and sensual responses to breastfeeding, Rosa directly relates her lack of breast responsiveness to her abuse:

My breastfeeding experience wasn’t sexual at all. I’ve never been a big sex person anyway because I was abused when I was younger. My breasts have never really been of interest for me, even when I was with my partner, playing with my breasts was never a turn-on.

Ruth describes her breastfeeding as a mothering job, a task like filing at work. Even though she enjoys watching her baby, she feels indifferent and detached and experiences little body pleasure and no sensual feelings. She distracts herself with other things, such as watching TV and reading, as if these are deliberate strategies to get through the feed and make the time spent feeding tolerable. When asked what she felt when she breastfed she responded:

Sometimes I feel indifferent, like I’m just feeding. It is a bit like filing at work, something you need to do. She is feeding and I could be on the phone chatting or watching telly or reading, looking through a brochure or something. Other times I find it really relaxing and nice and watch her.

She responds later in the interview to my question on the physical, emotional and sensual experience of breastfeeding:
The physical is fine, it’s a little awkward on that one side because she clicks her tongue as she feeds but it is not every feed and it is not for the whole feed. Sensual … I don’t feel that.

Two of the participants responded quite differently, describing the pleasure and the sensuality they experienced breastfeeding.

Lily talks of her second breastfeeding experience in terms of sensual skin to skin contact and relates it partly to the fact that she is breastfeeding a boy. In keeping with the social emphasis on a heterosexual breast, she describes her breastfeeding relationship in terms of male-female contact rather than mother-baby nurturing. In response to my question to her about her physical, emotional and sensual responses to breastfeeding, she replied that her main feeling was “happiness”. She goes on to explain the sensual aspects:

It is difficult to describe. Holding him close skin to skin, his mouth, everything is beautiful and sensual. Just the fact that he is a boy, and he is a male, and yes, it’s at a different level but it is because I’m a woman. I do feel quite sensual in a way because I am half naked when he is there feeding. I don’t feel that really strongly though, I feel the happiness more.

Eve, like Lily, linked breastfeeding her son with male-female response. She explained it by describing her breast as “his boobie”, giving him ownership and responsibility for his bond with her breast. She talks of breastfeeding establishing a bond for her and talks of that bond in the following section:

The mother-child bond is important to me when breastfeeding. I wouldn’t go without all those sleepless nights otherwise. My son has never taken a bottle. His boobie is everything. He has this bond with

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98 See pp193-194.
my boob, more than any other part of my body. People say he is a boy, and comment on the bond that he has with my boob, I'm sure his bond is with me too, but the breast definitely plays a big part in the picture.

She explained further when I asked about her own sensual responses to feeding:

I have very sensitive nipples. My son has this obsession now, if he is sucking on one the other one is a toy. So I have to put my arm across and cover my other nipple because he wants to play with it. He is already completely obsessed by them. But for me it is not really sensual, just a sensitivity. It is not arousing or anything like that for me. It just tickles.

Both women described breastfeeding as a sensual experience and explain it in terms of a heterosexual male-female rather than mother-baby relationship. This description demonstrates the cultural embeddedness of breastfeeding and was in keeping with Australian society’s preoccupation with the sexual breast to such an extent that the maternal breast is rarely considered.

Lily struggles when she explains the sensuality of the experience and finally gives more emphasis to the more acceptable maternal emotion of happiness. Eve explains her experience differently, giving her son the responsibility for his bond with her breast. She dissociates herself from her breast; it is no longer her breast but “his boobie”.

As a group, survivors who participated in my research describe little sensuality or sexuality associated with breastfeeding. Not one reported a feeling of sexual arousal breastfeeding and only one reported the physical contact while feeding as sensual. The dominant description was that of
breastfeeding as a task, a duty, best for baby, with little in the way of physical or sensual rewards for the mother. The role played by the lack of pleasure for the mother in breastfeeding and in the ongoing mother-child relationship is an area that warrants further exploration in the future.

**Breastfeeding in Public: Control and Exposure.**

Breastfeeding in public is a challenge for many breastfeeding mothers as it exposes their breasts in a public setting and may be censured by community members. Breastfeeding in public, be it the workplace, the shopping centre or even in parliament remains problematic in 2006. Many Victorians will recall the furore in the press when Kirsty Marshall, as the member for Forest Hill, breastfed her baby during a sitting of the Victorian Parliament in 2003.99 It is here in these public spaces that we see breastfeeding, physical boundaries, the maternal and sexual breast most clearly contested.

To explore this element of breastfeeding I asked survivors about places in which they liked and disliked breastfeeding. Breastfeeding in public was an area identified as difficult, that is: at home, in hospital, at the office and in the wider community. In Chapter Two100, Kate was unable to breastfeed her first child because she still lived with the perpetrator of her CSA. For some participants it was exposure of their bodies *per se*, for others it was not so much exposure as their lack of control in deciding who could safely see their bodies.

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99 Kirsty Marshall was ejected from parliament under a 146 year old rule forbidding MPs from bringing a ‘stranger’ (non MP) into parliament during sitting times. The speaker, Judy Madigan, later gave her permission to breastfeed in parliament should the need arise.


100 See p.60.
Deme has never breastfed in front of anyone but her husband, even when at home. She prefers to feed in private. She is also uncomfortable when other women breastfeed in front of her, fearing they will be upset if they observe her looking at their breasts. Consequently, she wishes other women would not feed in public places. When I asked Deme how she felt about feeding, she talked of her feeling of exposure with her first child:

I would never feed in front of anyone. If we had friends over I would go into my daughter’s room. I had it especially set up with a chair and a foot stool and a little table of drinks. I was … embarrassed, I didn’t like my breast showing, any flesh showing. I was paranoid that people would see my breast. It’s not that I didn’t like breastfeeding, it’s just that I didn’t like the thought of anyone seeing that part of my body.

Even my family, I wouldn’t feed in front of my family. My husband was the only one that I feed in front of. If I was in a situation where I had to feed when I was at a friend’s house I would try and leave before I had to feed or I would perhaps cover it completely, I was really very paranoid of some one seeing my breast.

She related her response directly to her confusion between the sexual and maternal breast and how the resolution of this confusion allowed her to feed more openly with her second baby:

I think the lack of confidence was due to my body image and thinking that my breast was still a sexual object rather than feeding thing for my child.

I’m okay with showing my breast and feeding now, because I realise now that it is not a sexual part of my body, or a part that people are really going to look at. It’s about feeding my child, that’s really more important.

Perhaps part of her distress is related to the way she describes using her breasts and her sexual behaviour at seventeen, immediately after her CSA had stopped:
I was seventeen. I had a size ten waist and size DD bust, which was very attractive to men. I felt very sexy and that’s what I used to pick up who-ever I wanted. It was slutty behaviour, I didn’t want to be like that anymore. I didn’t want to be that slutty person, so I gained weight because I didn’t want men to look at me like that.

For Deme, resolution of her distress was associated with the acceptance of the breast as an object of nurture rather than a sexual object for the men to look at. Her fear of watching breasts extended to other women. She seeks to protect them from her gaze and would be much more comfortable if they fed in private:

Even when I saw another woman breastfeeding I couldn’t look at that woman. If I look, she may see me looking at her breasts and I don’t want her to see me accidentally looking at her breasts while she is breastfeeding. I didn’t want her to think I was looking at her boob.

Now I’m a little bit better, when I see someone breast feeding. I still feel a little bit ashamed, because you don’t know if she is feeling the same way I used to feel, hoping no one is looking at their boob.

I still feel a bit funny, though, about women breastfeeding at the supermarket. Women who go through the checkout and sit feeding. Lots of centres have a breastfeeding room, that’s what they are for. I know it’s a choice; we should be able to breastfeed wherever we like, but my choice wouldn’t be having people sitting on benches in supermarkets breastfeeding. I breastfeed in feeding rooms and if I find myself in a position where I don’t want to feed in public, I’ll go and sit in the car and feed in private.

Rosa, too, found it difficult to feed in public and again her breasts were the focus:

I used to not want to feed outside, in public, but now I’m a bit more relaxed. I like to find the mothers’ room in the shopping centre and I’ll go there. If I can’t, then I’ll get my little blanket and put it over us both. I can do it in my local suburb, but not anywhere else. I’m just not comfortable. It was people looking at my breast that worried me.
Caitlyn describes feeling uncomfortable breastfeeding at a market and the censure she felt from other women. She talks of her inability to control her breastfeeding environment in hospital with her parents and later at home with a friend of her husband’s. Two important elements arose for her: her breast exposure while feeding equated her with a cow, and her lack of control of who viewed her breasts. She responded as follows to my question on pleasant and unpleasant breastfeeding experiences:

I was breastfeeding at the Queen Victoria Market and I felt really uncomfortable. I had never felt like this before. I was in a hurry and my son was screaming for a feed. I sat down in a café and he just wanted a drink so I started breastfeeding him. Then I stopped and thought, thank God. I turned around and everyone was just staring at me. I thought, I’m just a frazzled mother and I’ve got a hungry baby, leave me alone.

It stuck in my mind … The old ladies that thought I shouldn’t be breastfeeding in public, that I should go into the mothers’ room that you can’t breastfeed in front of everyone!

I asked about feeding in front of her family. She responded with the story of an early feed in hospital where she felt uncomfortable and unable to do what she needed to do:

At first I wasn’t comfortable. I remember when I was in hospital and I was trying to breastfeed my son. Mum and my dad divorced so they were both there with their partners and my husband. The milk hadn’t come in and I was trying to feed him. I had no idea what I was doing and I felt pretty uncomfortable with them there. They asked “Do you want us to leave?” but I was unable to say yes. I really wanted to do this right. I said no but I should have kicked them out and said, “Come back in half an hour.”

She goes on to describe an encounter at home with her husband’s friend:
I remember once I when I was feeding my son on the couch and we both fell asleep. My son was asleep on my lap and my breast was fully exposed. A friend of my husband’s came to the back door, knocked and came in. I went … Whoa! He had three young kids, so he was chuckling and in the end we both laughed a lot. I was so embarrassed. It was the fact of me being exposed and that I looked like a cow. I felt exposed and open to the world … It is exposing something that is personal, so personal between you and your family and your baby, that when someone else comments or sees when you are not prepared for it, it makes you embarrassed … it is like being in a shower, and someone walks in, you can’t hide anywhere.

I then asked her why it was different from showing your breasts in a dress or on the beach and she responded by discussing the importance of control.

You don’t choose to be exposed when you feed, but when you are in bathers and dresses you choose, it is your choice to be seen.

Tess described similar experiences in hospital with her twins and when feeding at home. Her experience differs from Caitlyn’s in that it is not the exposure of her breast in itself that makes her feel vulnerable but the difference in her ability to control the two environments:

I remember at the hospital, trying to learn to feed the twins in the nurseries. They have one feeding room open to the nursery. One day I was feeding, the nurse left the curtain open and a group of what looked like high school children walked in … It is especially hard when you feed two babies, because you can’t be discreet and with twins people stare even more. It was really hard and embarrassing. I couldn’t ask the nurse to shut the curtain, so there I was exposed to the world [visibly upset].

Later in the interview she described a not dissimilar experience at home with one of her husband’s workmates but at home she is able to move or cover up and control what is seen. Her description follows:
We have a lot of subcontractors ringing the bell and dropping around at home for one reason or another. One walked in the other day when I was breastfeeding and he was very apologetic. Obviously, if I didn’t want him to see or something then I would have moved or covered up or something but it was fine for me.

In this section participants raised the issue of public exposure of their bodies when breastfeeding. For some it was difficult because of the sexual connections with the breast. For others it was about being looked at, what was private became public. Body boundaries were crossed, not by the baby feeding but by the gaze of others watching a mother breastfeed. Privacy was important to participants.

Control was an important theme to survivors. Tess lacked control in hospital and became distressed when she was unable to ask for a curtain to be drawn and was seen by a group of visitors when breastfeeding her twins. Control, and not breast exposure, is the issue because a contractor seeing her breastfeed at home does not elicit the same distress. In both cases her breasts are seen. At home she is able to move or cover up, she controls her physical space: in hospital it is controlled by the nurses and she is helpless. For others the control was important in how and when breasts were exposed. Caitlyn felt comfortable with the sexual display of breasts in clothes because she was able to choose when and how much, unlike breastfeeding, where she had no choice. Breastfeeding in public, for CSA survivors, was associated with feelings of vulnerability, embarrassment and loss of control.
Chapter 7

Mothers and Touch

In this chapter I review the importance of maternal touch in infant development and then discuss the difficulties survivors faced with particular mothering tasks involving intimate touch. In the last chapter I reviewed the experience of breastfeeding and how the participants managed when their babies needed access to their breasts. The emphasis early in the previous chapter was based on intimate touch of the mother’s body. The emphasis here is on intimate touch of the baby by the mother and how this is negotiated. Examples include nappy changes and baths.

As in the previous chapters particular emphasis is given to the participants’ view of how their experience of CSA impacted on these tasks.

In the latter part of the chapter, touch in the clinical encounter is described from the participant perspective. In clinical settings with maternal and child health nurses, ward nurses, obstetricians and GPs, participants describe the challenges they faced. These challenges included repeated vaginal examination, issues of breast exposure, baby exposure, baby touch and feelings and perceptions of safety.

These challenges and difficulties that the participants faced as patients form the basis of recommendations for changing practice, particularly
examination, in the postpartum period and will be dealt with in greater detail in the final chapter.

**The Role of Maternal Touch in Infant Development**

Fraiberg *et al.* (1980 p.164) write of “ghosts in the nursery”, describing how events from the parents’ past can be played out subconsciously with their new babies, sometimes in “terrible exacting detail”. Their discussion continues based on a number of case studies involving abandonment and child abuse (though not CSA) repeating across generations.

According to Bowlby’s work on attachment theory (Bowlby, 1969, Bowlby, 1988, Holmes, 1993), children who have a primary caregiver who is accessible and responsive to their needs develop relationships that are secure and based on trust. Children whose needs are not met develop insecure attachments, becoming anxious, avoidant, ambivalent and excessively demanding. Early attachment patterns between the mother and infant predict the quality of later mother-child relationships (in Egeland and Sroufe, 1981). In the next section on touch I outline some survivor responses. Some mothers in my study faced challenges with touch, raising the possibility there may be an association between touch and insecure attachment. Insecure attachment may impact on their long-term relationships with their infants and be mediated, in part, by touch.

Evidence suggests that CSA is another nursery ghost. Cole *et al.* (1992) investigated parenting attitudes amongst three groups of predominantly college women with children between two and fourteen years in the U.S.A. They compared parenting attitudes on a questionnaire of twenty women whose fathers were incestuous and alcoholic, with twenty five
women whose fathers were alcoholic only and thirty nine women whose fathers had no known problems. Their results suggested that incest survivors with alcoholic fathers were less confident and less emotionally controlled as parents. Their study is small and limited to incest survivors with alcoholic fathers. While they had a control group of twenty five who had alcoholic fathers, an assumption is made in the design that other behaviours associated with alcohol use are the same and that incest is the only behaviour that separates the two groups. An additional group who had experienced incest without their fathers being alcoholic would have improved the design and interpretation of the study. Less emotional control may result in a mother being inconsistent in her responses to her child, varying from unresponsive at times, to responsive and overly responsive ‘smothering’ associated with an increase in insecure attachment.

Burkett’s study (1991) was small, comparing 20 mothers who had a history of CSA with 20 who had no declared experience of CSA or CPA. The study incorporated both qualitative and observational methods. While the observational time was short—a single twelve minute session either at the participant’s home or at a university owned house—the observational data suggested a blurring of boundaries between the mother and child, and that CSA mothers, compared with controls, focused more on themselves and consequently less on their children. They communicated with the child in ways that were belittling and blaming, with fewer positive messages. The interview data are reported to suggest two parenting categories, one that struggled with depression, chemical abuse and despair, which were classified by the author as under-functioning, and a second positive, excited and enthusiastic group.
However, the results presented in the paper did not support this conclusion.

Banyard’s work (1997) compared a sample of 237 self-selected women involved with child protection services and 281 with welfare services in the USA—response rates were 75% and 74.7% respectively. The sample was mostly poorly educated (61% had not completed high school) African American women (79%) who had never married (98%). It is not clear from the method section whether questions were administered by questionnaire or by a researcher. This may be significant in view of the education level of the population. The results showed that CSA remained a significant factor in parenting, even when other negative family-of-origin experiences were taken into account. While this study adds to the evidence on CSA and parenting applying in lower socioeconomic African Americans cohorts, the sample limits its generalisability.

Egeland and Sroufe’s study (1981) was a prospective one—267 women of lower socioeconomic backgrounds were enrolled in an antenatal clinic. The actual number approached is not mentioned, raising the question of sampling bias. Of the original 267 who consented to participate, 209 were tested for attachment at twelve months and 194 again at eighteen months. Early neglect and abuse of babies was detected by visits to the home at three-monthly intervals and on completion of a child-care rating scale. Four cases of physical abuse, three of neglect and abuse and twenty-four cases of severe neglect were identified. All cases identified were reported to the appropriate child protection agency. Infant attachment was tested, using Ainsworth’s ‘strange situation’ procedure, and was then compared between the inadequate-care group and a group of thirty-three mothers from the same sample providing excellent infant care. Attachment was
compared at twelve and eighteen months. The excellent-care group showed higher rates of secure attachment, 75% at twelve months and 76% at eighteen months, compared to 38% at twelve months and 56% at eighteen months in the inadequate-care group. The difference was significant only at twelve months, where abuse and neglect were associated with insecure or anxious patterns of attachment (Egeland and Sroufe, 1981). The difficulty with the interpretation of this study was that it was likely that mild to moderate abuse was hidden and that this study only identified the most severe cases of abuse and neglect, leaving the remainder within the ‘control’ groups unidentified. Sexual abuse was not considered. Differences in age and education between the groups may also be relevant to the analysis; a regression analysis was not performed. At best, the study suggests that abuse and neglect may be associated with insecure attachment at twelve months. Further research is indicated, including the use of antenatal and early post-natal measures of attachment, before any conclusions can be made.

Maternal touch and physical contact are a central part of the attachment process as well as being important in the social, cognitive and physical development of the infant (Hertenstein, 2002, Weiss et al., 2000, Weiss et al., 2004). Weiss et al. (2000), in studying mothers of low birth weight infants, found that maternal touch was significant in the infant developing secure attachment to the mother. Nurturing touch such as kissing, hugging and caressing was found to be significant, as was the mother’s childhood experience of touch. Mothers who were secure about their own childhood touch were more likely to develop secure attachments with their infants.
CSA survivors may find the baby’s constant demands and needs difficult because the baby needs constant physical contact and knows no boundaries. Sometimes the touch the baby demands can resemble the perpetrator’s, making maternal touch and relating physically to the baby even more difficult (Issokson, 2004). Sometimes survivors fear that they will hurt the child and become a perpetrator, they may fear being alone with the child (Issokson, 2004). These are conflicts survivors may experience as they mother and can impact on baby/child development.

Main (1990) found that physical touch was the primary signal to the baby that it was safe and secure (in Weiss et al., 2000). Hertenstein (2002) argued that touch has a number of communication functions. Firstly, it may communicate the mother’s “perceptions, thoughts and/or feelings” to the infant. Secondly, the mother’s touch may alter the infant’s “perceptions, thoughts, feelings and behaviours” without communicating the mother’s perceptions and feelings (Hertenstein, 2002 p.72). In both previous cases the infant’s state was altered by the mother’s touch but the two communications were different. A third alternative is possible, where the mother’s emotions are communicated but the infant does not respond with a change in the same emotion. For example, the mother may be fearful, as was the case for a number of participants in my study. The infant may perceive the mother’s fear but not become fearful itself.

While much of the work above has been done with normal or low birth weight infants, it raises interesting possibilities for my research, and for the role of touch in the maternal-infant attachment in CSA survivors.

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101 Hertenstein refers to touch in relation to the ‘caregiver’. In my study I look at maternal touch and so focus on mothers.
In the previous chapter I outlined the challenges of breastfeeding with regard to the mothers’ physical boundaries. The specific difficulty in defining the inside and outside of their own bodies was discussed in relation to breastfeeding after CSA. In this chapter I will show that these challenges extend to both baby touch and professional touch. In the next section I explore how the mothers in my study explained their challenges with touching their babies after their experience of CSA.

Mothers, Babies and Touch after CSA

For some participants intimate touch of their babies was particularly challenging, whether this was by friends, other members of the family, or by themselves as mothers. The difficulties they experienced associated with their CSA are discussed in this chapter.

Rosa spoke to a counsellor after she became afraid and felt unable to trust herself. While not related to any particular touch or incident she became afraid that she would repeat abusive patterns of behaviour that she had learned as a child from her adoptive mother. In response to my question on how her experience of CSA impacted on her as a mother, Rosa explains:

Well, I don’t think it influenced me … I know I won’t abuse him or anything, if anything it’s the opposite … may be it’s from not having family that I feel really close to him … sometimes I’m almost scared I’m going to be too smothering […]

I was speaking to a counsellor, someone to share my thoughts with; I told her I was scared because they say your mothering is like your parents’. I was scared that I might react and treat him like I was treated by my adopted mother unconsciously. I worry I will do something to him that was similar to what she did to me and I would think “that’s what she would have done”. I don’t want to do that. I’m scared of that
happening. So while I’m not doing it consciously but I’m afraid I might do it unconsciously.

Rosa’s first response is to say that she will not abuse her child, suggesting this is something that she is concerned about. She expresses her concerns about overcompensating for her abuse and “smothering” her son. She goes on to express her fear that she may not always be aware of her potentially abusive behaviours and treat him unconsciously as she was treated, repeating the emotional abuse of her adopted mother without meaning to do so. In this she was unable to trust herself. As a loving mother she may be too smothering and at the other extreme she may be unconsciously abusive. There is little room left for her to be comfortable with her mothering.

**Baths and Nappy Changes**
Breastfeeding involves intimate touch of the mother’s body. Childcare tasks such as bathing, changing clothes and nappy changes involve intimate touch by the mother of the baby’s body. Sometimes these tasks are done with others or for others; an example of the former is described by Helen as she bathes her children together. An example of the latter is a professional examination. In this section I will explore the challenges faced by mothers during bathing and nappy changes. Just as I showed in the previous chapters, experiences explored are directly related to CSA by participants.

Helen describes a routine family bath with all her children in together. She responds to her three year old playing with her thirteen month old son’s penis by forbidding her to touch, feeling that the touch is “rude” and “dirty”. She remains uncertain whether her reaction is “normal” or
part of her response to her CSA by a sibling. She links the depth of her reaction to her own CSA. In response to my question on how CSA influenced her mothering she responds:

At the moment I suppose it could be affecting me when all the kids are having a bath and my three year old starts going ding, ding, ding on my thirteen month old’s doodle. I’m like “No, don’t touch that! You are not allowed to do that”. I don’t know whether this would be a normal reaction for a mother or not. I feel that it is rude, that it is dirty, things like that. I say things like “Sisters and brothers don’t do that” but I don’t know whether that’s something that a normal mother, a mother who wasn’t abused by her brother would say or not. Would they just let it go, knowing it is a phase that the kids are going to get over and it’s not a sexual thing? I know it’s not a sexual thing. My daughter is like, “What’s that hanging there, ding, ding, look it moves” but that’s where I don’t know, “I don’t like you doing that”. I don’t like her touching, or any of them touching anybody else.

In this passage Helen related how she felt when her three year old daughter touched of her son’s penis, and her feeling that her daughter’s behaviour was rude and dirty. She instructed her children not to touch each other because brothers and sisters “don’t do that”. She was uncertain of her response and the appropriateness of it, at one level knowing that her daughter’s behaviour was the normal exploration of a three year old. At another level, because she was abused by her brother, she cannot help feeling that it was inappropriate and dirty. She knows her daughter’s game was “not a sexual thing” but her own response was a sexualised one.

Like Helen, Alice has taught her children about inappropriate sibling touch. Alice talks of her mothering in response to her experience of CSA:

We’ve talked over and over again about what’s good touching and bad touching. Each child knows that his bottom and willie are his, and that
no one is meant to look at it or touch it, not even his brothers, no one. It’s only for him. My eldest has told us before when his brother has tried to touch him in the bath or whatever and he will tell us. So I’m hoping if it happens anywhere that they will tell us.

Alice, like Helen, discusses sibling touch in the bath. She has taught her children that “no one” is allowed to touch their bottom or penis. Their body is their own, “only for him”. She describes her eldest telling her when a younger brother touches him, describing it as a protective behaviour and hoping he will be able to tell her if anyone touches him regardless of the circumstances.

Rebecca talks of teaching her son protective behaviours “even when” she changes his nappy. When I asked how her experience of CSA impacted on her as a mother, she responded:

I think I am more aware of protecting my son than other people. I am teaching him protective behaviours, even when I change him. “That’s your penis, you can touch it, Mummy can touch it, Daddy can touch it, but nobody else can touch it”. Even saying things and finding that I do things like that… [is related to my CSA].

Rebecca was abused by her brother, and like Alice, she teaches her son protective behaviours. Rebecca talks to him while she changes his nappy explaining who can touch and who can’t. Her son has recently turned two and she recognises that her response is, in part, due to her CSA and her need to say and do things to protect him.

Maria feared her son was abused when she left him briefly with a friend while she had a shower. She repeatedly tells me of her concern at each interview and later by telephone, finding it difficult to resolve her fear that her son has been abused.
When my son was a month old, I stayed at my friend’s for the night. I was going to take a really quick shower and my son was lying on the couch where I could see him. My friend said to me […] “I will hold him, alright, I will take him to my bedroom” […] I said, “No leave him on the couch” and she said “No let me take him take him”. I said, “Just leave him, he is my son”. She said, “I know” and she took him. I was very quick, I just put soap on me, rinsed it off. I had my period, I put a tampon in the bin, I quickly put my towel around me, went to her room, and my son was lying there happy. I got him back off her.

Two days passed, I noticed the rim of his penis was red. Later I was talking to another friend of mine, and asked “Hey how do you know if your son is been, you know, played with?” I was told the rim around his penis would be red, because if you pull it, it stretches because it is closed in a baby. I started thinking and I thought back, his penis was red and … I spoke to a counsellor; she said there is nothing that you could actually do about it now, because you have no evidence. I stopped going to her house even though she used to be my friend. It scared the living daylights out of me. That is why I am so protective; I haven’t even left him alone with my Dad, only with my Mum and Dad together.

Maria tells of wanting to keep her son in sight, and how she raced through her shower so she was separated from him for as short a time as possible. She was unable to trust a friend with her son, wanting to keep him in sight. When his penis becomes red two days later she suspects that her friend has touched her son in an abusive way and her suspicions were confirmed when another friend describes how his penis would become red if he had been sexually abused. Maria then seeks the assistance of a counsellor and seeks to keep her son safe by not visiting her friend or leaving her son alone with her father.

While participants talked of their fears of strangers, friends and family members touching their children, a number discussed their own fears about touching their babies. Changing nappies and cleaning genitals was
particularly challenging and that this would be the case had not occurred to me (nor was it taught to me) as a health professional.

As a GP I treat many babies for nappy rash. I advise frequent nappy changes and leaving the nappy off, as well as various creams applied to the genital area. It had never occurred to me, before doing this research, that some mothers would find the treatment advised difficult because it required intimate touch. I did not understand the repercussions of CSA for some mothers because I did not realise what a challenge these tasks would be. The challenges to participants are outlined in the next section.

Deme describes dirty nappies, cleaning the genitals of her son and washing her children’s clothes as the mothering tasks she least likes. She responds to my question about the mothering tasks she least likes as follows:

Probably the pooey nappies. With a boy it so hard to clean around the areas, but the ball bag moves, it is loose and you are chasing the mess and continually washing it. My daughter was quite easy to clean.

Deme disliked changing her son’s nappies and bowel actions were particularly disliked because they involved her cleaning round the scrotum which continually moved making it difficult to clean. Interestingly, cleaning her daughter was not as difficult for her. Deme did not associate her reaction with her abuse but I think her CSA may explain her reaction to nappy changes, particularly when she has no difficulty cleaning her daughter. Perhaps because Deme was abused over many years by her step father and her early abuse involved her touching his genitals (it also involved him touching her and later progressed to vaginal
rape), there were unconscious similarities as she described her response to the genital touch and cleaning of her son.

Other participants responded in a similar vein but with more distress. Ruth describes two areas of touch that caused her concern. The first was when the maternal and child health nurse showed her how to clean the vaginal area of her daughter. Because of problems with the microphone in the first interview I have to rely on the field notes written immediately after the interview:

The maternal and child health nurse was showing Ruth how to clean the labia and around the vaginal entrance and Ruth talked of how confronting this was. She was concerned about how far inside the labia and vagina she should go and how often she should clean inside. She described how concerned she was about what was too far and abusive and what was good mothering. She found it difficult to distinguish the difference.

In the second interview she clarified her mothering response after CSA because of the missing recording of the previous interview:

The maternal and child health nurse showed me her way of changing a girl. I wasn’t doing it properly because I was being much more conservative with what I touched. I just … felt funny … and I think it is because I feel … where is the line? … Who tells you where it is and is someone looking at you checking … it was that.

In the next passage Ruth explains how her experience of CSA framed how she does things. This is not because she thinks about her CSA but because it has changed the way she feels she can touch. She explains:

It doesn’t affect me everyday. Rather than actually thinking about it while I’m doing things it probably changes the way I act. I wasn’t cleaning her as I should have been. I don’t think that it was because I
was consciously stopping myself. I just did what I felt I should do. It wasn’t until I was shown later that I realised that I was stopping myself … because I didn’t want to clean like that, it wouldn’t be right.

Ruth felt “funny” watching the MCHN clean her daughter because she felt a line had been crossed. She was uncertain; “Where is the line?” she asks. In response she placed physical boundaries around her child, particularly the genital area, preferring not to clean her daughter as she “should”. Crossing these boundaries to clean her daughter feels wrong, “it wouldn’t be right”, so she doesn’t cross the boundaries. She described the process as unconscious, something she feels but does not “consciously” stop herself from doing. Ruth and her sister were both sexually abused by their grandfather. Ruth remembers predominately genital touch as part of her abuse and one episode of attempted vaginal intercourse but only recalls fragments. The funny feeling she described touching her daughter may be a recollection of old sensations associated with her own abuse.

Caitlyn experienced difficulties with nappy changes with her son. She has particular difficulty with his erection during nappy changes, raising the question of how she cleans him when she can’t look or touch. She sounds quite disgusted by the thought of touching her son’s erect penis as she replies to my question about her experience mothering after CSA:

I only have boys. When my son gets an erection I find myself thinking “What will I do?” I obviously can’t touch it [sounding disgusted], but you think … “How do I get the nappy on? Do I look at it? What am I meant to do?” I immediately think, Oh God, don’t touch it, don’t look at it. I’m sure other mothers who haven’t experienced sexual assault wouldn’t think the same way, but I think it is just because I’ve got that little demon in the back of my mind. I worry about what’s going to happen when he gets into masturbating and things. I think, Oh God how am I going to deal with that? I talked to a friend about child
masturbation and she said, “Oh that’s disgusting” and I felt relieved, she made me feel better.

Like Ruth, Caitlyn puts barriers, strong physical boundaries, between herself and her son’s body. She cannot touch or look at his penis, but more than this she is disgusted by the thought of touching it. She feels her reaction is not a universal one but is shaped by her CSA experience. Her CSA has altered the way she thinks of her son’s normal response to touch in a negative way; she describes her reaction as “the little demon in the back of my mind”.

**Play**

Mothers touch their children during play, their touch varies from superficial to intimate depending on the game being played and the age of the child. Touch and play are a normal part of the maternal-child interaction. Touch, as outlined earlier, is associated with normal social, physical and psychological development. Play is part of that process.

One mother talked of touch during play, and how the censure of an adult made her doubt herself and the appropriateness of her game with her two year old son. Ruth was playing with her son; they were poking their tongues out at each other. Ruth was comfortable with the game until her husband’s brother commented. In response to my question about mothering after CSA she discussed both nappy changes (above)\(^{102}\) and play; she explains:

As a Mum I am much more conscious of doing things with my son. Just the way he plays with you and things like that. Like poking his tongue out and wanting you to poke your tongue back, we were

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\(^{102}\) See p.216.
playing. My husband’s brother made a comment “That’s just wrong” to my son. Anyone else would have thought, oh whatever. You know it hits me deeper, was I doing the wrong thing? My son was just playing and I didn’t feel funny about it at all, so I thought it was OK but I don’t trust myself with little things like that.

Ruth was discussing a game where her son was poking his tongue out at her and she responded in kind. She and her son were comfortable with the game until her brother-in-law made a comment that the game was “just wrong”. Her reaction was to feel that she had done something wrong, that the game they were playing was wrong. She doubts herself not trusting her feelings about the game or, by implication, herself to set appropriate boundaries on their play.

**Looking**

In this final section on maternal touch I explore how mothers look at their children’s bodies and what they see. Two mothers talk of their experience watching their children, relating their experience to CSA, seeing the beauty of their children’s bodies in the light of their abuse. The pleasure they experience looking at their children becomes tangled with a sexual view. They doubt their responses, as they see through their eyes and with a paedophile’s lenses, relating their experience back to their CSA.

The sexualisation of their children’s bodies was explained by the traumatogenic model of Finkelhor and Browne (1985), who suggested that sexualisation may occur during parenting in response to CSA.

For Deme it was after her daughter was toilet trained and was out in the garden without undies, looking at roses. She was unable to enjoy the beauty of her daughter’s body and became uncomfortable. In the second
interview I asked her how she thought her experience of CSA was currently impacting on her mothering; she replied:

At the moment there have been a few thoughts where I have wondered because I’m looking at part of her body differently. My daughter is now toilet training, so she’s no longer in a nappy and she wears undies all the time now. I keep thinking, today for example, I was looking at her bum thinking it is like an adult’s bum but in a smaller version. That’s how paedophiles think of it. They don’t think of it as a child’s. May be that’s what I was asking myself. Do they think a child’s bum is just a smaller version of an adult’s or one that they can manipulate because it’s exactly the same? We haven’t looked at her bum because it has always been in a nappy, now she’s running around in these undies and it’s cute as …

When I asked if her thinking her daughter’s bottom was cute made her uncomfortable or not, she responded:

It did because I was looking at her bum and not looking at it going, “Isn’t it a cute little bum”. I took a photo. There it is on the calendar up there. She was wearing a T-shirt, gum boots with no undies on and picking roses off the rose bush. I thought that was really cute and I took that photo as a cute photo, but I was looking at her as if … I was looking at her bottom … and thinking that’s how a paedophile would look at her bottom. I hope I’m not, but it wasn’t a cute little baby’s bum anymore. I felt a bit uncomfortable thinking about that, but I couldn’t help it, it was there in my face. So I thought, well, okay, I’m thinking it, that’s how paedophiles must think. It’s not abnormal for me to have different thoughts to the average person on that.

Deme described her how daughter’s toilet training raised issues related to CSA. Her daughter was no longer in nappies and Deme noticed her bottom, finding it “cute as” but was made uncomfortable by this feeling wondering if “that’s how a paedophile would look at her bottom.” As soon as she thought it, the moment was destroyed and her daughter’s body was no longer cute and admired. Her pleasure in looking at her
daughter disappeared when she associated her response with that of a paedophile. Like Helen’s experiences bathing her children, Deme was aware that her response was coloured by her own experience of CSA, that she can’t help “thinking it”, but she remained unable to admire her daughter’s body.

Rebecca described a similar experience with her son who was two, a little younger than Deme’s toilet training daughter. She was distressed and horrified when watching her son move that she can see her son’s movements as sexual and understands how a paedophile would interpret her son’s play.

There are horrifying things for me; I can actually see where paedophiles get their ideas about the sexualisation of children, because my son does some incredibly sexual things. You can impose adult sexuality on what a child does, in exploring their body and the way they move their body. He does this thing, where he lifts his legs up, or he bends over and shows his bum. You know it could be misinterpreted as porno stuff if a paedophile saw it.

Rebecca was horrified when she noticed her son doing “incredibly sexual things”, and the risk of “imposing” an adult’s view of sexuality on a child. She describes him lifting his legs and bending over and how these behaviours could be misinterpreted by a paedophile as pornographic. In this passage she was describing the sexuality of an adult paedophile and his sexualisation of the child’s body and activity. She also described her own sexualised thinking as an adult survivor, interpreting the non-sexual behaviour of the child in the sexualised light of her own CSA, once again demonstrating the psychological impact of CSA and sexual thinking associated with its long-term effects.
Discussion of Maternal Touch

In the section above the challenges associated with maternal touch for CSA survivors have been reported. Themes arising include trust in themselves as mothers, difficulties with negotiating physical boundaries, particularly associated with the genital area, the association of emotions such as discomfort, disgust and fear with touch and finally, the sexualisation of the body of the infant and child. These issues were directly related to the mothers’ own experiences of CSA.

Finkelhor and Browne’s (1985) model\textsuperscript{103} was useful when thinking about how maternal touch was influenced by CSA. It is apparent from the discussion above that the traumatic sexualisation\textsuperscript{104} was a key area. Finkelhor and Browne proposed that the perpetrator transmitted negative misconceptions of sexual behaviour and morality, sexual issues become more prominent for survivors and inappropriate sexualisation can occur during parenting. This is important not only to the mothers’ conceptualisation of themselves but how they view their babies. Deme and Rebecca both described how they see their children’s bodies as sexual, through the paedophile or perpetrator’s eyes. They described how their experience of their children was altered, how they are “horrified” and “uncomfortable” with their responses. They struggle with seeing and not seeing, imposing and not imposing an adult sexuality on their children.

Touch and attachment may be two of the factors in child development that are associated with the intergenerational transmission of CSA. Maternal touch and physical contact are central to the attachment of

\textsuperscript{103} See Models in Chapter Two pp.50-52 for a more detailed review.
\textsuperscript{104} See Appendix One pp.266-268 for full description of traumatic sexualisation
mother and baby and the social, psychological and emotional development of the infant (Weiss et al., 2000). The description of the challenges that CSA survivors face touching their babies may, therefore, be of critical importance to the development of the infant. The survivors in this study talked of how they limited touch because of their responses: Ruth has difficulty cleaning her daughter’s bottom because it “feels wrong”, Caitlyn could not look or touch as she changed a nappy because she was “disgusted”. These responses raised significant questions that are beyond the scope of this thesis. Do these responses mean that some CSA survivors touch differently from others? Do CSA survivors touch differently from women who have not experienced CSA? Are their children touched less often? What is the quality of the touch? Nurturing touch and secure attachment may be more difficult when mothers respond in the ways described.

Touch has a number of communication functions in infancy, as outlined by Hertenstein (2002). Not only does the mother’s touch alter the infant’s “perceptions, thoughts, feelings and behaviours” but it can also communicate the mother’s “perceptions, thoughts and/or feelings” to the infant. The mothers above are largely describing negative emotions: fear, discomfort, disgust and horror are examples from the transcripts. These responses raise questions about the importance to the baby of the mother’s emotional response to touch. Are the mother’s emotions communicated with the infant through touch and if so, is the impact important for infant attachment and development? Is it possible for the infant to feel the mother’s emotion and not be affected?

The results from this study show that maternal touch after CSA is an area in need of further research.
Professional Touch

Another aspect of touch that confronted and challenged CSA survivors as mothers was professional touch. In a qualitative study of ten women with a past history of CSA and somatization disorder in a family practice in the U.S.A. a lack of trust and understanding in the patient-doctor was reported by all participants (Morse et al., 1997).

It was common for health professionals to touch both mothers and their children—this occurred during examination at birth, when assisting mothers to breastfeed, the routine six week check, and at regular visits to the maternal and child health nurse and GP.

Most participants had no problems with their health professionals’ contact, while two describe facing difficulties during birth and two post-natally. In this section I focus on the areas that participants found challenging, the links they made to their CSA and how, from their perspective, health professionals could improve their care.

Control and power were important in the clinical environment. Participants felt unable to protect themselves and their children, and for one participant the professional encounter was particularly traumatic.

Birth and Labour

Professional touch before and during birth may also be an issue, and the literature on this was dealt with in detail in Chapter Two. A number

105 All participants were asked about post-natal professional touch. Antenatal and birth touch was discussed by some participants but was not a question asked as part of the interview, making it difficult to accurately assess the numbers who had difficulty with professional touch.

106 See pp.56-59.

107 I did not enquire about birth plans during the interview. However, three participants told me of birth plans during the course of the interview. I do not know how many of the remaining eight had birth
of participants had birth plans in place and involved their partners in ensuring certain procedures were not performed during labour. While not explored in detail during this research, a number of participants commented on their antenatal experiences.

During her labour Caitlyn was transferred from a small rural centre to a large regional centre. Her GP, who was to deliver her, was aware of her history of CSA. The treating doctors and midwives at the regional centre did not know of her past abuse. Early in the interview she described the birth of her first child as part of her answer to my question about her new baby:

> We lived in the country in a small country town then, and my first child was big and late. I was forty three weeks pregnant and was trying to have him in the country town which has a very small ten bed country hospital. Anything that was complicated they freaked out and sent you to a regional centre, so in the end I ended up going there, and having all these things poked and prodded. It was a pretty horrible experience.

Later in the interview she responded in more detail, elaborating on the distress her repeated vaginal examinations caused, which was minimised in her previous response. To my question on how her experience of CSA impacted on her as a mother, she responds:

> When I was in labour with my first son it was a bit traumatic. I told my doctor in my town what had happened [CSA], but he wasn’t there because I was transferred out to the regional centre. I remember because I had so many other different people, I had a female doctor when I was in labour, a female doctor, a male doctor and then the obstetrician and the paediatrician coming in and out. I just felt really violated because they were all coming in and feeling what my cervix was doing and one minute it was fine and then the next would come in.
It was just in and out, like a dunny door half the time … and it hurt, like … I just wanted to say, I was emotional as well, “Oh God, just leave me alone!” I had to bite my tongue and do whatever. I can remember thinking that it was not pleasant and I wondered if my usual doctor was here, if he would have said, “Can we just have one person doing the vaginal examination?” […] I think I had something like six internals within ten hours. It would have been alright if just one person had done it but there were three or four different people. It got painful because you know, it hurts […] I think I just felt uncomfortable and a bit violated. Whenever you feel violated that becomes the number one feeling. As a young girl I didn’t understand when it was happening but as an older woman I understood.

Caitlyn alluded to the difficulties being examined early in the interview. She described being “poked and prodded” and it being a pretty horrible experience. Later in the interview she responds in more detail, describing how she felt “violated” by repeated vaginal examinations by hospital staff. How she felt like a “toilet door” with staff going in and out of her body and, by implication, being dirty as well as the staff paying little attention to her needs. She was hurt physically and emotionally during this process and wanted to tell the staff to leave her alone, but couldn’t. She wished her usual doctor, who knew of her CSA, was there because she felt he may have been able to protect her from repeated examinations by speaking up. She had been repeatedly digitally raped by her uncle as a child.

In the breastfeeding section Tess talks of a similar process while breastfeeding. She wanted to ask the nurse to draw the curtain while she breastfed her twins but was unable to do this and as a consequence felt embarrassed and upset at being “exposed to the world” and unable to control the viewing of her body in the hospital environment. Tess, like Caitlyn, was unable to verbalise her needs within a hospital.
Finkelhor and Browne (1985) discuss the dynamics of the sense of powerlessness that results from CSA\textsuperscript{108}. During CSA the child is unable to protect herself or express her wishes, and this vulnerability to ‘invasion’ continues. In Tess’s and Caitlyn’s hospital stories their vulnerability to invasion repeatedly played out within a hospital environment. In this setting both women were both unable to make their wishes known and protect themselves.

Eve described her fear of forceps and how she wished to avoid their use during labour. During the trauma of her son’s birth, her partner ensured forceps were not used when Eve was unable to do so during labour:

> My obstetrician explained that he would use a ventouse\textsuperscript{109} extractor to lift the baby out. He tried to put in the ventouse, it hurt like hell … Using the ventouse was very traumatic. My husband was obviously standing right beside me when it failed; he tells me that I became frightened about it. When they went to do it the second time, I overdosed on the oxygen [probably nitrous oxide] and nearly lost everybody. I felt I was falling down the hole and I couldn’t hear anybody. Apparently I was screaming and they were going, “Eve breathe, breathe, breathe”, so obviously, eventually I calmed down, and it was all right [detached and distant]. They tried another time without gas and this time the doctor tore me and I lost a lot of blood in that episode. The obstetrician says, “Forceps” and I’ve said “Whatever” because I’m just away with the pixies. I had advised my husband and my mother, no matter what happened I didn’t want forceps. I saw those forceps in the prenatal classes, I just knew, “I do not want those things forced into me”.

In the preceding passage Eve discusses the difficulties she faced with instrumentation during childbirth. She describes having seen forceps in her antenatal classes and not wanting them “forced into” her body. She

\textsuperscript{108} The most recent classification of PTSD by the American Psychiatric Association in the DSM-IV-TR includes helplessness in the diagnostic criteria.

\textsuperscript{109} A ventouse extractor is a suction cup that is attached to the baby’s scalp within the vagina and used to lift the baby assisting the delivery.
equated the use of forceps with force. The experience she described with the ventouse extractor was traumatic and painful, and she became frightened by it. She described herself as nearly losing her connection with those around her and finally, after her vagina tears, being “away with the pixies”. It is difficult to be certain whether Eve is describing a reaction to the gas she breathed or an episode of dissociation associated with a traumatic delivery—either way, her experience was traumatic. She did not make a direct link between her experience in labour and her CSA but it may play an unconscious part, given the strength of her reaction to forceps, her dissociative response and the words she used to describe her reaction before birth and to the ventouse during birth.

Maternal Examination
Alice, with baby number four, has not yet found time for her six week check. She has had no difficulties with examination and pap smears performed in the past but reports an unnecessary pap smear and an unpleasant antenatal breast examination during her first pregnancy. She responded to my question about her experience with health professionals and how it could be improved:

He was absolutely shocking, this doctor. He just [didn’t listen]. I told him I did self-examination and I didn’t need him to do a breast examination, and he said, “That’s what we do”, so he did it anyway. He looked at my nipples and charted that they would be okay for breastfeeding. How can you tell? If they were terribly inverted, you might want to give advice or something, but you could just ask, you don’t need to look. I had only just had a pap smear six weeks before that and he insisted on doing a pap smear and a pelvic exam at the same time. I said to him, “I’ve just had a pap smear, I don’t need one”. “Oh no, we do one when you are pregnant and you have to do one at

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110 CSA survivors are less likely to participate in preventive health screen programs such as pap smears, they tend to present late to antenatal clinic and have less antenatal care (see background chapter). I could not find any literature on participation in routine post-natal health checks such as the six week check among CSA survivors.
the start of your pregnancy”. Now I know that there is no such rule and what are you going to do anyway if you find a problem, abort the baby and have chemo? … No, so there is really no point checking me for cancer, because there is nothing I would do anyway. So, he was just totally terrible. If I had known what I know now I would have just got up and walked out and said, “You don’t need to check me for any of those things. What are you, a pervert? Go away”.

I asked how he made her feel, she says:

I felt very disempowered, I didn’t have a choice in the matter. Instead of explaining, “Okay, I would like to look at your breasts to see if your nipples are okay because you are going to breastfeed and there are some instances where …” Please tell me and ask, “Would you be comfortable with that?” Don’t just assume that a woman wants to show their breasts to a man. Why would they want to do that by choice? Yeah … It was really bad. Later I talked to a friend that went to the same hospital and she had a really bad experience with the same doctor and he was just totally inappropriate, and she didn’t go into detail but I think it was far worse than any normal pelvic exam.

She goes on later to explain how the disempowerment made her feel:

I guess it makes me feel angry, because people are using their profession as a way of putting you down and making themselves feel better. Obstetricians and gynecologists give one-sided opinions on certain things, just so that a woman will choose what they want them to choose, without giving the woman all the options and a real choice. […] You feel guilty about not sticking up for yourself. Not having the right words to say.

[…] I think that professionals get the same kick out of power over others as abusers do. Abuse only occurs because someone feels they have power and they can dominate another person.

In the passages above Alice likens the power difference between doctors and patients to the power relationship between perpetrators of abuse and their victims. Alice’s previous experience of CSA makes her more
vulnerable in situations where she feels powerless (Finkelhor and Browne, 1985), such as in a health professional-patient relationship. She argued that better doctor-patient communication would assist women in similar situations. Alice suggests that allowing women to make an informed choice would alleviate much of the problem for survivors.

While survivors may be more vulnerable in their contact with health professionals, dismissing Alice’s concerns as survivor vulnerability risks denying sexual exploitation by health professionals. Bullying and sexual exploitation are common in healthcare: between healthcare workers, and between health care workers and patients (Murtagh, 2003, Kolanko et al., 2006, Galletly, 2004). In an Australian survey of psychiatrists 7.6% reported erotic contact with patients during or after treatment (Leggett, 1994). Similar boundary violations by medical practitioners are regularly reported to the Medical Practitioners Board of Victoria (MPBV) and documented in the yearly annual report available on the MPBV website.111

**Baby Examination**

Professional touch continued to be an issue for Alice. Prior to her breast examination she talked of an experience with a visiting maternal and child health nurse (MCHN) where she felt coerced into undressing her son. The story demonstrates how the touching of her child by a professional was as important in her reaction as an unwanted touch was to her own body.112 The passage that follows is the other story she told in response to my question about her experience with health professionals:

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112 See pp.227-229.
Last time I saw the maternal and child health nurse she did a few things that made me really unhappy. They like to take all the children’s clothes off. Now, I have a bit of a problem with this because in South Australia they don’t do it so it’s obviously not essential. At my centre they can’t even wear their T shirt. He’s nearly two, and I really think at that age they don’t need to be weighed naked. What’s 200gms here or there, the scales are not even that accurate. He hasn’t been weighed since he was six weeks old, so who cares if the clothes are on or off? There is very little difference, nothing to compare it to. So anyway, I told her no ... I prefer him not to take his clothes off. “Oh no, that’s the way we do it.” So I took his clothes off and she did her check, and then I went to put his nappy on, and she said, “No, he hasn’t been weighed yet”. And like, he is older, I’m sure he doesn’t need to have his nappy off. “Oh no that’s what we do”. And I thought, who are you, to tell me that I’m not allowed to put my baby’s nappy on! I felt so disempowered by her saying that.

In this passage Alice demonstrated her concerns about her child being undressed unnecessarily in a professional setting. She initially refused to comply, then after being told “that’s the way we do it” she undressed the child. Alice tried to dress her son at the end of the check but was again forbidden, and not allowed to put her son’s nappy on, by the health professional. At this stage Alice felt disempowered and unable to control what was happening to her child.

In Alice’s story she cued her health professional that undressing her child was an issue. At no time during the process did her MCHN appear to respond in a way that addressed Alice’s concerns. Instead, the MCHN used her professional power, she tells Alice, “that’s the way we do it.” Not only does she use her own role as a MCHN, but by saying “we” she links herself to a more powerful professional group.
Alice seeks to protect herself and her children. On the way out, things get worse; her other son had pulled apart a small polystyrene ball and spread the toys across the floor:

Then, another thing that happened which really disappointed me with the maternal and child health nurse. My three year old likes to know how things work and pulled apart this ball that she had given the children to play with. It was a small polystyrene ball. He had it in tiny little pieces. He could have swallowed it or anything; it is really not a toy which should have been at a health centre. When the Nurse saw it, she said “You naughty, naughty boy”. It was as if my son was the one with the problem, when really you should never, ever have anything like that around children. So, anyway, I said to her, “You shouldn’t really have that in here anyway”.

[…] All the toys were on the floor, I went to pick one of them up, just so that I didn’t step on them and to get to where I was going. The maternal and child health nurse said, “No no, Mum, don’t do that, get him to do that.” I picked it up anyway and she said, “You shouldn’t have done that, you should teach him to pick up after himself”. I do teach him to do it, my children clean up all the time. All day we are cleaning up together!

Alice’s final response at the end of the visit was to walk out crying, yelling at her children. She responded to my question on how she felt at the end of that Maternal and Child Health Centre visit:

I felt totally disempowered. When I walked out I was crying uncontrollably and yelling at the children. All these things that are a chain reaction to … her making me feel bad. She made me feel bad about myself as a mother, and about my children and their behaviour.

Alice talked of her total disempowerment during the encounter, each part building on the previous until she leaves in tears feeling that she’s a bad mother. Alice speaks of her disappointment with the MCHN’s response but still turns on herself: she was a bad mother.
Once again Alice suggested that improved communication would have made the visit so much better for her. The communication style Alice suggested should be much less authoritarian, more equal and involve a greater understanding of the patient perspective by the health professions. When I asked how the MCHN could have made her feel better, Alice replies:

I think instead of demanding things of me, she could have made suggestions. If she didn’t want me to pick up the toys, she could have said to me, “Do they normally pick up their own toys or are they able to pick up their own toys yet?”, something like that, instead of saying, “No, Mum, don’t pick that up, get him to do that”. She could have even not said anything at all. Just look at the situation, three children running around and she doesn’t want me to pick a toy up. Is it really important? If she thought that it was a problem, and during the course of the conversation, she could have said, “So how is he with picking up his toys for himself?”

Alice linked her response to, and disempowerment by, health professionals to her experience of CSA. She explains how, because of her past CSA, it remains difficult for her to stand up for herself in a medical setting and so protect herself and her children. When I asked how the research interview could be improved for other research participants, she explains how her past CSA replays in medical settings:

I think, as a participant you have to start exploring different areas to actually connect them with your past abuse. Sometimes you do things you don’t even realise you do because of your past. It’s just the way you are used to dealing with people. Like the doctors and the health nurse, I felt like I couldn’t really say too much about it because I couldn’t just stand up and say no.
Discussion of Professional Touch

Earlier in the chapter I used Finkelhor and Browne’s (1985) traumatogenic model to assist in the understanding of CSA survivors’ responses to maternal touch. Its concepts are useful in understanding the participants’ responses to professional touch.

The dominant theme running through the participants’ negative experience of professional touch was a sense of powerlessness, their bodies and/or those of their children were ‘invaded’ by professionals against their wishes. The vulnerability they experienced as children has not only continued in their responses as adult women, but as mothers, it included their children as well. Alice linked her sense of powerlessness and her response directly to her abuse; she is unable to control the professional environment and protect herself or her children.

A number of issues are raised consistent with the model of Finklehor and Brown. Alice associates her sense of powerlessness directly to her CSA experience. Her abuse occurred against her wishes and she was helpless to stop it—these dynamics are replayed in her professional relationship. The immediate impact was to make her feel less able, more fearful and teary, consistent with recreating the trauma dynamics and psychological impact of powerlessness proposed by Finkelhor and Browne. Alice’s professional interactions were problematic. Less clear was the respective role played by the health professionals’ behaviour and Alice’s vulnerability due to her CSA. Alice’s CSA experience may have made her more vulnerable but hierarchical professional behaviours also contributed.
The concept of traumatic sexualisation can be extended to examination. The examination can become sexualised or associated with CSA; for example, vaginal examination and procedures like forceps. Eve equated forceps with force, Caitlyn felt violated after repeated vaginal examinations during labour.

Professionals and normal examinations can be mistrusted and sexualised. Alice wondered whether her doctor was “a pervert”. Another participant wondered what the doctor was examining during a normal hip check when the baby’s legs were “forced apart” and felt her baby was about to be sexually assaulted.

Finkelhor and Browne’s model does not consider the role of traumatic sexualisation, stigmatisation and powerlessness in the health care context but, based on the findings, above these three concepts can be extended to the health professional-survivor relationship.

Some doctors do behave in a sexually abusive manner with patients, ranging from inappropriate touch during examinations and unnecessary examinations, to the worst case scenario, when doctors rape their patients. Cases of sexual abuse by doctors appear regularly in the *Medical Practitioners Board of Victoria Bulletin*. None of the examinations described was unusual in the circumstances. However, the trauma experienced by participants was significant because of the association between their examination experience and their past CSA.

Examinations and tests are significant challenges for survivors, even if they are routine for health professionals during pregnancy, birth and post-natally. Survivors experienced a variety of responses: pain, dissociation,
fear, blame and guilt are a few outlined above. They feel vulnerable and even abused.

Simple measures for health professionals were suggested by participants to relieve their distress. The following suggestions are in keeping with the principles of informed consent:

- Never assume consent
- Explain any professional touch, including examination or procedures, what is to be done, how it will be done and why it is necessary. Where possible explain and offer alternatives
- Explain baby examinations as carefully as you would an adult one
- No procedure or examination should be ‘routine’ as most professionals will be unaware of the patient’s (or the patient’s mother’s) past history of CSA
- Obtain informed consent for maternal and baby touch, including examinations and procedures
Chapter 8

Conclusion

In the final chapter I summarise the major findings of my research and the potential implications to maternal-infant attachment. In the latter part of the chapter the limitations of the study are outlined and recommendations for health professionals and further research discussed.

Summary of Findings

Ethics
In Chapter Three I outlined the importance of ethical considerations in doing retrospective CSA research with women who are new mothers.

In planning to do the research ethical issues identified were safety of participants, researcher safety, child protection and safety and finally, privacy and confidentiality. Solutions to each of these issues were outlined and are a key component when preparing to do retrospective CSA research. Solutions involved making the research as safe as possible for participants and researchers.

Child protection and safety may be an ethical issue faced by researchers as they carry out retrospective CSA research with new mothers. Researchers need to be clear about their roles and responsibilities should they become aware of child abuse during their research. I argue that all researchers have an ethical and moral responsibility to protect the child
because the child is at greater risk than other family members, regardless of the focus of the research.

Inevitably, further ethical issues will arise during the course of the project; in my case these involved the early ending of an interview without proper closure and beyond my control as a researcher. Conflicts between my role as a researcher and my professional role as a GP were important during the research. What ‘felt right’ initially, was more closely related to a professional duty of care, on reflection, than my role as a researcher. To resolve these conflicts I needed to remain very clear about the purpose of the research interview.

In Chapter Four I explored participant perspectives of research involvement. All participants found participating in the research positive. Two talked of their research experience as a way to measure how they had come to terms with their CSA. Another used the experience as a test to see if she could talk to another person about her CSA prior to entering counselling. Two others found it helpful just to talk about their CSA and have it “in the open”—one of these women described the research as “unzipping” her mouth and letting her “regain my speech” for the first time since her rape. Two others described their feeling of helping other women as a beneficial part of their research experience.

Three participants described possible negatives from research. One was scared prior to contacting me and, even though her nightmares ceased after the interviews she wasn’t sure how she would feel in twelve months’ time. One described a friend whom she felt was too unstable to participate in such a project, and may have been associated with her own fears for herself. The third described how she would have been unable to
participate with her previous child because she had not “coped well” with her first baby. The possible negative experiences reinforced the importance of my recruitment strategy in letting women choose whether they were able to participate, prior to any contact with me.

**Emotion in Research**

In Chapter Five I argued for, and gave examples of, how emotion from the interviews and transcripts informed the analysis of the research data.

In interview based research it is often assumed that participants can tell it ‘like it is’ and that interviewers can hear all. In the section on defended selves I discussed how participants and researchers both defend themselves from anxiety during the research interview. In analysing the interviews it is important to consider how the overt and covert interaction between the researcher and the participant hinder and enhance communication during the research. Emotion may be part of overt and covert communication.

Emotion was an important component of the interviews in this study. It assisted me to recognise the importance of the discussion to the participant. In addition it helped my recognition of areas that were difficult to talk about and areas where I needed to be more supportive of the participant. It was similarly important during the reading, coding and analysis of the transcripts, assisting me to recognise important themes, and themes that were difficult for the participant to discuss. In these difficult-to-talk about areas content was implied rather than spoken. Without the emotional cues, these areas may have been unrecognised and missing from the analysis.
In the process of using emotion to inform a thematic analysis, researchers must be aware of their own vulnerabilities and not confuse their emotion with that of the participant. A useful way of overcoming this was to explore emotional meanings during the interview directly with the participant. Tess’s interview was an example of this. Tess had little time for GPs and I had felt her anger was directed at me for much of the initial interview. When I asked she explained how GPs had let her down in the past when she was a young girl, treating her urine infections and failing to recognise her CSA.

**Breastfeeding**

Breastfeeding was a healing experience for some mothers. It was presented by one mother as important in rewriting the story of her body. She explained how, by breastfeeding, her body was “validated” and “my breasts can have a positive story”. For three others the importance of breastfeeding was in establishing an emotional connection and relationship with their children.

Breastfeeding wasn’t a positive experience for every participant. Breastfeeding twins was difficult for both of the twins mothers in the study. Some of the difficulties of breastfeeding were associated with feeding two babies at once, as well as establishing a relationship with two babies at once. One set of twins was premature and required intensive care, further complicating the breastfeeding picture.

Women have described breastfeeding as arousing sensual and sexual feelings. One way CSA survivors in my study managed breastfeeding was to split the maternal breast from the sexual one. Only one participant
reported experiencing physical pleasure, sensual or sexual feelings while breastfeeding. A more common response was to feel nothing or feel detached from breastfeeding. Breastfeeding was more often framed as a task to be done for the baby rather than pleasurable for the mother. Overtly rejecting behaviours such as not wanting the baby at the breast were described by one mother after the birth of her twins. The lack of pleasurable breastfeeding described by participants may be interpreted negatively by both the mother and the baby, ultimately impacting negatively on attachment.

Breastfeeding in public was a particular challenge to four\textsuperscript{113} of the participants in my study. One participant was unable to feed in front of anyone because she didn’t want anyone looking at her breast. For another it was not exposure of her body itself but her ability to control that exposure. In the hospital she felt unable to draw a curtain or to ask for it to be closed and it was here that she felt embarrassed when feeding her children. At home a similar thing happened but she was not embarrassed because she was able to move or cover up; at home she was in control.

**Touch**

In Chapter Seven, I outlined the challenges CSA survivors faced with intimate touching of their babies and with health professional touch, such as during examination.

Two mothers found sibling touch while bathing a challenge, instructing their children not to touch each other. Another mother talks to her two year old about protective behaviours as she changes his nappy. Three

\textsuperscript{113} Participants were asked if they found any places difficult in which to breastfeed. Four discussed breastfeeding in public. They were not asked specifically about breastfeeding in public.
other mothers had difficult cleaning their babies’ genitals, not sure of the appropriate boundaries for their touch.

Two mothers discussed their concerns about looking at their children and because of their CSA experience, being able to see what a paedophile would see. Pleasure in their children’s bodies was lost in the process.

Intimate touch and watching their children raised concerns for the participants. They avoided genital cleaning, censured physical touch and were horrified when they saw their children’s bodies as sexual. These responses added to the negative associations with infant touch for CSA survivors and potentially impact again on maternal-infant attachment.

Health professional examination and procedures were difficult for some survivors. The difficulties they faced extended beyond their own bodies and included their children. Vaginal examination and instrumentation during birth were difficult for two participants. One felt disempowered when her child was examined without his nappy. Powerlessness to protect themselves and their children was an important theme in the discussion.

The challenges faced by CSA survivors in breastfeeding and touch in routine baby care may be important factors in the attachment process. This area warrants further research.

**Limitations of the Study**
This study is an in-depth analysis of the breastfeeding and mothering experience of eleven CSA survivors. It provides a unique insight into their experiences of breastfeeding and with infant touch. However, during
the course of the analysis, it became clear that a comparative literature on
the experience of early mothering and breastfeeding in women who had
not experienced CSA was sparse and a control group may have been a
useful comparison.

The literature on the early experiences of mothering for CSA survivors is
small and does not address the difficulties associated with false negatives
within the control groups used.

When planning the study I had considered a control group but decided not
to because Williams’ (1994) research showed that 38% of women
requiring a hospital visit or hospitalisation for CSA had no recollection of
their CSA ten years later. The implication from Williams’ research is that
a control group would be likely to have women who had experienced
CSA but had no memory of it. Williams’ study represented the severe end
of the CSA spectrum, with children requiring a hospital visit or
hospitalisation. I could not find corresponding data for women like those
in my study, who did not require hospital attendance, but whose CSA was
verified and retained in their memories as adults. However, because of
the possibility that any control group could contain women who had
experienced CSA I felt its usefulness would be limited.

The findings of this study are, therefore, limited. Early mothering and
breastfeeding were affected by CSA, as I have demonstrated in the
previous chapters, but cannot be causally related to CSA because of the
small numbers and lack of a control group.

All women who participated in this study were volunteers who felt able to
be interviewed after the birth of a child. This may have excluded women
with severe reactions to CSA, or with mental illness (such as severe depression or PTSD rendering them too distressed to be interviewed) or those who felt that the interview process may have been too upsetting. PTSD responses create specific difficulties for an interview based study: coping strategies such as dissociation and disconnection may mean that some women did not make a connection between their reactions as mothers and their CSA experience.

It is noteworthy that none of the participants’ CSA had been perpetrated by a father. This may reflect the methods chosen for the study, as there is some evidence that women find father-daughter incest easier to disclose on paper than at interview.

Those who felt their CSA had little impact on their mothering may have excluded themselves because they felt they had little to contribute.

The study was limited to women who breastfed after CSA, women who could not breastfeed excluded themselves. The experience of women who could not breastfeed may be quite different from the experiences explored within this thesis.

This exploratory study demonstrated some difficulties breastfeeding and mothering, such as separating the maternal and sexual role of breasts, breastfeeding in public and intimate touch during bathing and nappy changes. A causal relationship cannot be established because of the limitations discussed above but the findings suggest further research is required in this area with larger numbers and control groups.
Professional Recommendations

My recommendations to primary care health professionals are a universal precaution. GPs and MCHNs are not going to recognise all CSA survivors within their practices, even if health professionals ask when they suspect CSA. Patients may not wish to disclose their CSA, they may not see its relevance to medical care and some survivors may not recall their abuse themselves. Nevertheless, CSA is prevalent in Australian women and everyday medical care can cause distress among survivors. To minimise distress and potential harm among survivors, based on my study, and to improve health professional care, the following ‘universal precautions’ for health professional care are:

- Never assume consent
- Ensure privacy
- Explain any professional touch, what is to be done, how it will be done and why it is necessary
- Explain baby examinations as carefully as you would adult examination
- Expose sensitive areas such as the breasts and genitals only if necessary and then only with consent\(^{114}\)
- Whenever possible invasive examinations such as vaginal examinations should be done by one person
- No examination should ever be seen as ‘routine’
- Always obtain consent for maternal and baby touch before proceeding with touch, examinations or procedures.

\(^{114}\) Excluding life-threatening emergencies.
Research Recommendations

Further research is urgently needed in the area of mothering after CSA as this study confirmed the challenges faced by survivors. Breastfeeding was explored in this study amongst women who successfully breastfed: further research is indicated with CSA survivors who are unable to breastfeed.

Intimate touch and its role in infant attachment was identified as potentially significant among CSA survivors, further research is also indicated in this area.

Finally, health professionals working with mothers need to be aware of the possible challenges CSA survivors face breastfeeding and mothering. An educational intervention for health professionals should be developed, based on input from expert reference groups that include both CSA survivors and professional experts.

Early interventions that respond to the needs of CSA mothers may identify those who have maternal-infant attachment difficulties, and have the potential in those cases to improve the relationship and long-term outcomes for the mother and her baby. Interventions that recognise and respond to PTSD may be beneficial to those mothers who respond to mothering with responses like avoidance, numbing and dissociation in developing new responses, with healthier outcomes for themselves and their babies.
## Abbreviations

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<th>Full Form</th>
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<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<td>APA</td>
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</tr>
<tr>
<td>CHS</td>
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</tr>
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<td>CSHS</td>
<td>Centre for the Study of Health in Society, now CHS</td>
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<td>Diagnostic and Statistical Manual of Mental Disorders 4</td>
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<td>Domestic Violence and Incest Resource Centre</td>
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<tr>
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<td>Lactation Resource Centre</td>
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<td>Maternal and Child Health Nurse</td>
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<tr>
<td>MPBV</td>
<td>Medical Practitioners Board of Victoria</td>
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<td>National Health and Medical Research Council</td>
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<td>ND CSA</td>
<td>No declared child sexual assault</td>
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<td>Post-traumatic Stress Disorder</td>
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<td>SECASA</td>
<td>South Eastern Centre Against Sexual Assault</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
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<td>WMA</td>
<td>World Medical Association</td>
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Glossary of Terms

Purposive sampling – deliberate choice of respondents, subjects or settings for research
Statistical sampling – representative sample of total population
Triangulation – use of three or more research methods in combination, principally to check validity
Internal validity – extent to which the measurement truly reflects the phenomenon under study
External validity – generalisability of study findings
Reflexivity – attending systematically through the entire research process to the effects of the researcher and the context of knowledge construction (Malterud, 2001)
Reliability – extent to which a measurement reproduces the same answer each time
Hawthorne effect – The impact of the researcher on the research subjects or setting, notably, in changing their behaviour (Pope and Mays, 1995)
Objectivity – freedom from bias (Higgs, 1997)
Child sexual abuse – 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 (AIHW, 1995)
Child sexual assault – as for child sexual abuse
References


Appendix One:

Models for Understanding the Long-Term Consequences of CSA

Model One

Post-Traumatic Stress Disorder

DSMIV Criteria
A. The person has been exposed to a traumatic event in which both of the following are present:
   1. the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
   2. the person’s response involved intense fear, helplessness, or horror. In children, this may be expressed instead by disorganised or agitated behaviour
B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
   1. recurrent and intrusive distressing recollections of the event, including images thoughts or perceptions
   2. recurrent distressing dreams of the event
   3. acting or feeling as if the traumatic event were recurring
   4. intense psychological distress at the exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event
   5. physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event
C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, as indicated by three or more of the following:
   1. efforts to avoid thoughts, feelings or conversations associated with the trauma
   2. efforts to avoid activities, places, or people that arouse recollections of trauma
   3. inability to recall an important aspect of trauma
   4. markedly diminished interest or participation in significant activities
   5. feeling of detachment or estrangement from others
   6. restricted range of effect e.g., unable to have loving feelings
   7. sense of foreshortened future
D. Persistent symptoms of increased arousal, as indicated by two or more of the following:
   1. difficulty falling or staying asleep
   2. irritability or outbursts of anger
   3. difficulty concentrating
   4. hypervigilance
   5. exaggerated startle response
E. Duration of symptoms more than one month
F. Disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of function.
Model Two

Traumatogenic Model. By Finkelhor and Browne (1985)

Traumatic sexualisation

Dynamics
- Child rewarded for developmentally inappropriate sexual behaviour
- Perpetrator exchanges attention and affection for sex
- Perpetrator transmits misconceptions about sexual behaviour and morality
- Sexual activity associated with negative feelings and memories

Psychological Impact
- Prominence of sexual issues
- Confusion about sexual identity
- Confusion about sexual norms
- Confusion of sex with love and care-getting and care-giving
- Negative associations with sexual feelings
- Aversion of sexual intimacy

Behaviour
- Sexual preoccupation and compulsive sexual behaviours
- Precocious sexual activity
- Aggressive sexual behaviour
- Promiscuity
- Prostitution
- Sexual dysfunction
- Avoidance of sexual intimacy
- Inappropriate sexualisation if parenting

Stigmatisation

Dynamics
- Offender blames or denigrates victim
- Pressure for secrecy
- Child infers shame about activities
- Others shocked by disclosure
- Blame child for events
- Victim ‘damaged goods’

Psychological Impact
- Guilt
- Shame
- Lowered self-esteem
- Sense of differentness from others behaviour
- Isolation
- Drug and alcohol abuse
- Criminal involvement
- Self mutilation
- Suicide
**Betrayal**

Dynamics
- trust and vulnerability manipulated
- violation of expectations of care and protection
- disregard of child’s well-being
- lack of support and protection by parent(s)
Psychological Impact
- grief
- depression
- extreme dependency
- impaired ability to judge trustworthiness of others
- mistrust
- anger and hostility
Behaviour
- clinging
- vulnerability to further abuse
- allowing own children to be victimised
- isolation
- difficulty with intimate relationships
- marital problems
- aggressive behaviour
- delinquency

**Powerlessness**

Dynamics
- body territory invaded against child’s wishes
- vulnerability to invasion continues
- force, coercion and trickery used to involve child
- child unable to protect self and stop abuse
- repeated experiences of fear
- child unable to make others believe
Psychological impact
- anxiety
- fear
- lowered sense of self-efficacy
- perception of self as victim
- identification with aggressor
Behaviour
- nightmares
- phobias
- somatic disorders
- eating and sleeping disorders
- depression
- dissociation
- running away
- school difficulties
- employment problems
- vulnerability to re-victimisation
- aggressive behaviour and bullying
- delinquency
- becoming an abuser

References: Finkelhor and Browne (1985)
Appendix Two:

Interview Schedules

Interview One

Introduction
Thank you for seeing me and agreeing to be part of this study. This interview is about what has happened since you brought your baby home and your experiences breastfeeding. There are some questions that relate to past sexual abuse experiences. All responses are confidential and you can stop the interview at any time if necessary. If some questions are too difficult to answer we can skip them, you can just tell me you’d rather not answer. Are you comfortable with that?

To start things
- Can you tell me about your new baby?
  - How does this compare to your other children?

The next questions are about Mothering
- What is it like being a mother?
  - The things you like most about being a mother
  - The things you like least about being a mother
- How do you picture a good mother?
- What is it like for you caring for your baby?
  - The things you like and things you like least about caring for a baby
- How does the baby respond to you?
- Can you describe in detail your relationship with your baby?

The next question is about your body since having the baby
- Can you tell me about your body and being a mother?
  - What do you like most about your body since having the baby?
  - What do you like least?
  - Breasts

The next questions are about feeding your baby
- How are you currently feeding your baby?
- How did you start feeding your baby?
- What influenced your choice?
- Can you tell me as much as possible about your experience breastfeeding your baby?
- Can you give me a list of words that describe your baby feeding experience?
  - Either breast and bottle
- What do you feel when you feed your baby?
- Have there been any difficulties with feeding?
- Some women have pleasant and unpleasant experiences breastfeeding. Can you describe in detail your experience of breastfeeding?
  - Pleasant experiences
- Unpleasant experiences
- Other women have talked about the emotional, physical and sensual experiences of breastfeeding. How would you describe your experience?
- Are there any special places where you like to feed your baby?
  - Special places
  - Places you avoid
- Are there any special times when you like to feed your baby?
  - Special times
  - Times you avoid
- What would you tell other mothers about breastfeeding?

This project is asking women who where sexually abused as children by a family member about their experience as new mothers. I am now going to ask you some questions about your sexual abuse experience. Please feel free not to answer any question if it is too difficult for you.

- Can you tell me about your experience of sexual abuse as a child?
  - How old were you?
  - How often?
  - What type of assault?
  - Who was the perpetrator?
  - Was it associated with any other family problems?
  - Was violence part of your experience?

- Can you describe in detail if your experiences of sexual abuse have influenced your experience of being a mother?
  - What do you think your childhood sexual abuse experience influenced the most?
  - What do you think your childhood sexual abuse least influenced?

- Can you tell me if you feel your experiences of sexual abuse have influenced your baby feeding experience?

The final section deals with your health professional contact since your baby’s birth

- How have you found your doctors, care since the birth of your baby?
  - Your O &G doctor
  - Your GP
- How have you found your nurses’ care since the birth of your baby?
  - Nurses in hospital
  - Lactation nurses
  - Maternal and child health nurses
  - Pharmacy nurses
- Have I forgotten any health people you have seen?
  - How have you found their care since the birth of your baby?
- What have you liked most about your health care or medical treatment?
- What have you liked least?
- Overall, how do you think health professionals could have improved their care of you?

Is there anything you would like to add?
What has it been like for you to be part of this project?

That is the end of the formal interview.

Thank you.

I am now going to turn off the tape so we can talk about being involved in this research.

Tape off

**Discussion and support**

At this stage the tape will be switched off and discussion space allowed.

How are you after the interview?

A small business card will be left with contacts for ongoing support.

If the participant is very distressed ongoing support will be organised.
Interview One Summary Sheet

Q1.1 Can you tell me about your new baby?
Q2.1 What is it like being a mother?
The things you like most about being a mother
The things you like least about being a mother
Q3.1 How do you picture a good mother?
Q4.1 What is it like for you caring for your baby?
The things you like and things you like least about caring for a baby
How does the baby respond to you?
Q5.1 Can you describe in detail your relationship with your baby?
Q6.1 Can you tell me about your body and being a mother?
What do you like most about your body since having the baby?
What do you like least?
Breasts
Q7.1 Can you tell me as much as possible about your experience breastfeeding your baby?
How are you currently feeding your baby?
How did you start feeding your baby?
What influenced your choice?
Q7.2 Can you give me a list of words that describe your baby feeding experience?
Q8.1 What do you feel when you feed your baby?
Have there been any difficulties with feeding?
Q9.1 Some women have pleasant and unpleasant experiences breastfeeding. Can you describe in detail your experience of breastfeeding?
Pleasant experiences
Unpleasant experiences
Q10.1 Other women have talked about the emotional, physical and sensual experiences of breastfeeding. How would you describe your experience?
Q11.1 Are there any special places where you like feed your baby?
Special places
Places you avoid
Q12.1 Are there any special times when you like to feed your baby?
Special times
Times you avoid
Q13.1 Can you describe in detail if your experiences of sexual abuse have influenced your experience of being a mother?
What do you think your CSA experience influenced the most?
What do you think your CSA least influenced?
Q14.1
Can you tell me if you feel your experiences of sexual abuse have influenced your baby feeding experience?
Q15.1
Can you tell me about your experience of sexual abuse as a child?
How old were you?
How often?
What type of assault?
Who was the perpetrator?
Q16.1
How have you found your doctors’ care since the birth of your baby?
Your O &G doctor
Your GP
Q17.1
How have you found your nurses’ care since the birth of your baby?
Have I forgotten any health people you have seen? How have you found their care since the birth of your baby?
What have you liked most about your health care or medical treatment?
What have you liked least?
Q18.1
How do you think health professionals could have improved their care of you?
Q19.1
Is there anything you would like to add?
Q20.1
What has it been like for you to be part of this project?
That is the end of the formal interview.
Thank you.

Tape off
Interview Two

Denotes key question  
Denotes prompt question

**General**
It is good to see you again, thank you for agreeing to be interviewed again. Some of the questions are the same as last time but the answers may be different because your baby is now older. We can stop at any time if you need to, just let me know. If there are any questions you don’t want to answer, just tell me you would rather not answer. Are you comfortable with that?

**Introduction**
Can you tell me how things have been for you since our last interview?  
Did anything come to mind after the last interview?  
Can you tell me about your thoughts after the last interview?  
Q2.2. What’s it like being a mother now?

**Like the last time we met there are several areas I would like to explore with you.**

**The next few questions are about being a mother.**

Q1.2. Can you describe in as much detail as possible what it is like being a mother now?  
The things you like most  
The things you like least  
How are these different from the last time we spoke?  
Q3.2. How are you feeling in yourself?  
Did you expect to feel like this?  
Q4.2. What is caring for the baby like for you?  
What do you like most about caring for your baby?  
What do you like least?  
Q5.2. Can you describe your relationship with your baby now?  
Do you think this has changed since we last spoke?  
Can you describe your relationship with your partner now?  

**The next question is about your body, we spoke about this a little bit last time.**

Q 6.2. Can you tell me about your body now and being a mother?  
What do you like most about your body now?  
What do you like least?  
Do you think this has changed?  

**The next questions are about feeding your baby now and your thoughts since we last spoke. There are a few short questions and some longer ones.**

Q7.2 Can you tell me about breastfeeding your baby now?  
How are you feeding the baby now?  
Breast solely  
Breast and bottle  
Bottle  
Solids  
What has influenced your choices?  
Q8.2. **Describe in as much detail as possible your experience breastfeeding/feeding your baby.**  
What you like most
What you like least
Why do you think your experiences are like this?

**What do you feel now as you feed your baby?**
Q9.2. Some women have pleasant and unpleasant experiences breastfeeding. What is your experience since we last spoke?
Q10.2. Other women have talked about breastfeeding as being an emotional, physical and sensual experience. How would you describe your current experience?
Q11.2 and 12.2. We spoke about special places and times to breastfeed last time. Has anything changed?
What advice would you give to other mothers about breastfeeding?
Q13.2. Last time we spoke I asked you how you thought your experience as a child of sexual abuse had influenced you.

**Have you had any further thoughts on this?**
Q14.2. Can you describe in detail how this has influenced you as a mother?
Has it influenced your baby feeding?
How did it work to influence your baby feeding now?
Q15.2. Is there anything else you can add to help me understand better?

**Medical Contact**
Have you seen any doctors or nurses since we last spoke?
Any other health care professionals?
Who have you seen?
Q16.2. Doctor
Q17.2. Nurse
Maternal and child health nurse
Allied health
How did these visits go?
How did you find the care of (insert person)?
Have you had any examinations?
How was the examination?
Any difficulties for you with the examination
What have you liked most about your health care visits?
What have you liked least?
Q18.2 How do you think health professional contact could be improved?
Q19.2 Is there anything you would like to add?
Q 20.2 What has it been like for you being part of this research project?

**Impact of Research Questions**
How have you found the research visits?
What have you liked most
What have you liked least
Do you think the research put you at risk in any way?
What about the baby?
Does anyone know you are assisting in a research project?
How have they responded to you being in the project?
How has being involved in research made you feel?
How could the experience be improved for you?
Did you ever want to stop being part of the study?
Could you stop?
Why not?
What advice would you give me about interviews in other similar studies?
What advice would you give other women taking part in studies like this one?

Q21.2 Any comments or questions?

Is there anything you would like to ask me?
Thank you
Tape Off

Discussion and debriefing

How did it go this time?
Appendix Three:

Transcription Notes

All participant names are pseudonyms.
Family member names omitted in favour of non-identifying descriptive names e.g. my son, his daughter, her father.

, short pause

... long pause

[… ] transcript text omitted

[word] word added for clarity

[sounds like ‘word’] word not recognisable on tape but sounds like ‘word’

[unknown] words not recognisable

Bold strong participant emphasis

[emotion] emotion content or action e.g. [softly crying, weeping].

Sections of transcripts presented within the text of the thesis were edited from the verbatim transcripts, omitting ums, you knows, like, yeah etc. and correcting grammatical errors that are part of normal spoken language. Originally, I had planned to use verbatim transcripts within the text of the thesis, as I had during analysis, so I could remain as close as possible to the original interviews. However, when the verbatim extracts appeared within the thesis text they did not do justice to the women I interviewed, making them appear poorly spoken and almost illiterate (as did some of the questions I asked!). For this reason the spoken text of the transcripts was edited into written text. As much as possible, during the editing process the sense of the original transcript was maintained.
Appendix Four:

Ethics Documents

3 June 2004

Dr A Brookes, Dr M Guillemim & Professor J Astbury
Centre for the Study of Health & Society, Public Health

Dear Dr A Brookes, Dr M Guillemim & Professor J Astbury

Thank you for providing the additional information about the project. I am pleased to advise that the Health Sciences Human Ethics Subcommittee approved the following project:

MUMee - Mothers' emotional experiences, breastfeeding and childhood adversity
Dr A Brookes, Dr M Guillemim, Professor J Astbury & Dr J Coles
HREC No. 040045

The Project has been approved for the period: 27/5/04 to 31/12/04. It is your responsibility to ensure that all people associated with this particular project are made aware of what has actually been approved.

Research projects are normally approved to 31 December of the year of approval. Projects may be renewed yearly for up to a total of five years upon receipt of a satisfactory annual report. If a project is to continue beyond five years a new application will normally need to be submitted.

Please note that the following conditions apply to your approval. Failure to abide by these conditions may result in suspension or discontinuation of approval and/or disciplinary action.

(a) Limit of Approval: Approval is limited strictly to the research proposal as submitted in your application.

(b) Variation to Project: Any subsequent variations or modifications you may wish to make to your project must be notified formally to the Human Ethics Sub-Committee for further consideration and approval. If the Sub-Committee considers that the proposed changes are significant, you may be required to submit a new application for approval of the revised project.

(c) Incidents or adverse affects: Researchers must report immediately to the Sub-Committee anything which might affect the ethical acceptance of the protocol including adverse effects on subjects or unforeseen events that might affect continued ethical acceptability of the project. Failure to do so may result in suspension or cancellation of approval.

(d) Monitoring: Projects are subject to monitoring at any time by the ethics committee.

(e) Annual Report: You must submit an annual report on this project at the end of the year, or, at the conclusion of the project if it continues for less than a year. Requests for annual reports are sent out by the Human Research Ethics Office in November/December of each year. Failure to submit a progress report at the end of the year will mean approval for your project will lapse.

(f) Auditing: All projects may be subject to audit by members of the Sub-Committee.

If you have any further queries on these matters, or require additional information, please do not hesitate to contact me on telephone no. 8344 2013 or e-mail: k.murphy@unimelb.edu.au.

Please quote the HREC registration number and the name of the project in any future correspondence.

On behalf of the Sub-Committee I wish you well in your research.

Yours sincerely,

Kate Murphy
Executive Officer, Human Research Ethics

e.c. Chair, DHEAG, Public Health
Dr J Coles
Plain Language Statement

Participant Information

Version 3b, 28/4/04

Dr Jan Coles (doctoral student)
Centre for the Study of Health and Society
Phone 8344 0822

Department of General Practice
Monash University
Phone 8575 2226

Dr Alison Brookes (supervisor)
Centre for the Study of Health and Society
Phone: 8344 0826

Project: “MUMee – Mother’s Early Experiences and Breastfeeding”

This Participant Information and Consent form is 6 pages long.
Please make sure you have all the pages.

1. Your Consent
You are being invited to be part of the “MUMee” study.
This Participant Information contains detailed information about the research project. Its purpose is to explain to you as openly and clearly as possible all the procedures involved in this project before you decide whether or not to take part in it. Please read this Participant Information carefully. Feel free to ask questions about any information in the document. You may also wish to discuss the project with a relative or friend or your local health worker. Feel free to do this.
Once you understand what the project is about and if you agree to take part in it, you will be asked to sign the Consent Form. By signing the Consent Form, you indicate
that you understand the information and that you give your consent to participate in
the research project.
You will be given a copy of the Participant Information and Consent Form to keep as
a record.

2. Purpose and Background

The MUMee study is looking at the early experiences of mothers feeding their babies.
All participants in the study will be women who have experienced sexual assault by a
family member as a child.

The aim of the study is to understand if and how childhood sexual abuse influences a
mother after birth, particularly their feeding choices. The results of this study will
allow information given to mothers with a similar life experience to be improved and
provide professionals giving medical care a better understanding of the issues for
women who have experienced child sexual abuse. Approximately twenty women will
participate in this study.

Some mothers feel past experiences have an effect on them and their relationship with
their babies. Other mothers report that feeding a baby helped them overcome past
concerns and was a very positive experience.

The results will be used to help the researcher, Jan Coles, complete the requirements
for a doctor of philosophy.

This project has been approved by the Human Research Ethics Committee.

3. Procedures or What will I be asked to do?

Should you agree to participate, you will be asked to participate in two interviews.

Approximately twenty women will take part in two interviews after the birth of their
babies. The interviews will be held at your home or at the Department of General
Practice in Centre Rd, East Bentleigh. The site depends on what suits you. There are
two interviews in the study, one at four weeks to six months after your baby’s birth
where possible and another at about four weeks later. Each interview will last
approximately one hour and not exceed an hour and a half. You will be asked
questions about being a new mother, past experiences, including your experience of
childhood sexual abuse, and feeding your baby. Some questions are similar in both
the interviews; this is so the researchers can understand changes that occur as your
baby grows. In this research project you will be asked about being part of this
research project and its impact on you and your family.

With your permission the interviews would be tape recorded so we make an accurate
record of what you say. The tape will be transcribed into a written document and
issues that arise during the interview will be analysed. After the interview has been
analysed, you will be asked for comment on the accuracy of the analysis, this is
important in making sure what you said during the interview is accurately understood. Your comments on the accuracy are very valuable to the researcher.

4. Possible Benefits

Most participants will not benefit personally from this study. Some research has found that talking about childhood experiences is helpful to women. The main purpose of the study is to improve the future medical care given to other mothers with new babies, and while the individual participating does not benefit, other new mothers who are survivors of child sexual abuse will.

5. Possible Risks

A number of participants may find some of the questions in the interview difficult to answer and for some, upsetting. Should a participant need immediate counselling this will be arranged by the researcher with Dr C Worth at South East Centre Against Sexual Assault (SECASA). If you become distressed the researcher will assist you to make the appropriate professional contacts to provide ongoing support. A small card with available support and counselling services will be given to each participant after each interview. This will give you contact numbers of support services should you decide at a later date that more support is needed.

6. How will my confidentiality be protected?

Any information obtained during this project and that can identify you will remain confidential. It will only be disclosed with your permission, except as required by law.

Your name and address will be kept in a separate password-protected computer file; it will be separate from any interview data we have. This will only be able to be linked to your responses by the principal researchers stated at the beginning of this document. The completed survey and transcribed interview will be entered into a computer database and analysed. This database will be password-protected. Analysis of the de-identified data may involve other research staff. A CD of the de-identified transcription data will be kept securely at the Department of General Practice, Monash University for five years from the date of publication and then destroyed. Audio files will be kept until the qualitative analysis is completed, then deleted. Analysis of the de-identified data will be done at the home of researcher, the Department of General Practice and Centre for the Study of Health and Society. Computer files may be transferred electronically or by CD for database entry or transcription. These will be de-identified, encrypted and password-protected.

In any publication, you will be referred to by a pseudonym. The chances of anyone identifying you from any published data are extremely small because of the de-identification that has occurred during the study.

It is possible that the de-identified results will be presented at academic conferences and in medical publications.
The only exception to the disclosure of personal details is when disclosure is required by law. For example, if the researcher were to discover that a child of a participant was being hurt or abused, she is required by law to report the matter.

7. How will I receive feedback on the project?

Participants who would like to hear about the results of the project will be offered a summary of the findings. A summary will be provided by mail on the completion of the study. A complete thesis will be available through the University of Melbourne Library and the Domestic Violence and Incest Resource Centre.

A brochure on survivors’ breastfeeding experiences will be produced (funds permitting) and available on request from the Domestic Violence and Incest Resource Centre and Breastfeeding Australia. This brochure will be available to the public and medical professionals.

8. Where can I get further information?

Should you require further information, or have any concerns, please do not hesitate to contact either of the researchers on the numbers given at the beginning of the form. After hours contact is through Dr Jan Coles on 0417 585 514.

9. Other Issues

Should you have any concerns about the conduct of the project, you are welcome to contact the Executive Officer, Human Research Ethics, The University of Melbourne, on 8344 2073, or fax: 9347 6739.

10. Will participation prejudice me in any way?

Participation in any research project is voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. Once the transcript of your interview has been analysed it cannot be withdrawn from the study even though the original can be withdrawn and deleted.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your routine treatment or your relationship with those treating you.

Before you make your decision, a member of the research team will be available to answer any questions you have about the research project. You can ask for any information you want. Sign the Consent Form only after you have had a chance to ask your questions and have received satisfactory answers.

If you decide to withdraw from this project, please notify a member of the research team before you withdraw.

11. Ethical Guidelines

This project will be carried out according to the National Statement on Ethical Conduct in Research Involving Humans (June 1999) produced by the National Health
and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies. The ethical aspects of this research project have been approved by the Human Research Ethics Committee of the University of Melbourne.

12. Reimbursement of costs

You will not be paid for participation in this study.

13. How do I agree to participate?

If you would like to participate, please indicate that you have read and understood this information by signing the Consent Form. The researcher will then arrange an interview time.
Consent Form
Version 2 Dated 22/10/03
Site Melbourne University

Full Project Title: MUMee - Mothers’ early experiences and breastfeeding.

I have read, or have had read to me in my first language, and I understand the Participant Information version dated x.
I have had the opportunity to ask questions and I am satisfied with the answers I received.
I freely agree to participate in this project according to the conditions in the Participant Information.
I will be given a copy of the Participant Information and Consent Form to keep.
I understand that the researcher has agreed not to reveal my identity and personal details if information about this project is published or presented in any public form.

Participant’s Name (printed) …………………………………………………
Signature Date

Name of Witness to Participant’s Signature (printed)
……………………………………………
Signature Date

Declaration of the researcher*: I have given a verbal explanation of the research project, its procedures and risks and I believe the participant has understood the information.
Researcher’s Name (printed) …………………………………………………
Signature Date

* A senior member of the research team must provide the explanation and provision of information concerning the research project.

Note: All parties signing the Consent Form must date their own signature.
Revocation of Consent Form

Centre for the Study of Health and Society
Level 4 207 Bouverie St
The University of Melbourne
Vic 3010

Revocation of Consent Form
Full Project Title: MUMee - Mothers early experiences and breastfeeding.
I hereby wish to WITHDRAW my consent to participate in the research proposal described above and understand that such withdrawal WILL NOT jeopardise any treatment or my relationship with Name of Institution.

Participant’s Name (printed) .................................................................

Signature .......................................................... Date
Dr Jan Coles is interviewing women who have a past experience of child sexual assault by a family member, about being a new mother and breastfeeding a new baby. The study involves two interviews lasting approximately an hour and a half.

If you have recently had a baby and are interested in participating please contact Jan Coles for more information on 8575 2226 or email jan.coles@med.monash.edu.au

You can participate even if you are not currently breastfeeding.
Appendix Five:

Draft Documents for Survivors and Health Professionals
*Produced in collaboration with CASA house and DVIRC

CHILD SEXUAL ABUSE Survivor information for Health Workers

Title: Pregnancy to Parenting:
Information for health workers and support givers about survivors of childhood sexual abuse

Production
CASA House
DVIRC
Monash University Department of General Practice

Acknowledgements
The idea for this booklet, format and some of the content is based on a booklet originally produced by Women’s Health Statewide South Australia.

Contents

Information for Women
This booklet is written for women who have experienced sexual abuse in childhood, and to aid their health care workers or support people during pregnancy, birth or parenting.

The aim of this booklet is to provide you with information that will help you to obtain better support during your pregnancy, birth and when you are a new mother. The idea for this booklet and much of the information it contains was developed by mothers who have experienced childhood sexual abuse.

What is Child Sexual Abuse?
Child sexual abuse is common with one in three women and one in six men reporting sexual abuse when they were children. Childhood sexual abuse is any sexual activity in which an older person uses their power and authority over a child or young person for their own gratification. The offender may be a family member, a trusted friend or a stranger. Child sexual assault is a crime. The child or young person is NEVER to blame.

You may not think of what happened to you as ‘sexual abuse’ or as ‘sexual assault’ and you may never have told anyone. Managing the experience of sexual assault is
different for each survivor and new situations can be challenging to your sense of competence, particularly in situations where you feel you have little control.

**CSA is never your fault.**

Becoming a parent can be a joyful and happy time. Women who have survived Childhood sexual abuse may face challenges with pregnancy, childbirth and early parenting. These challenges can be healing for some, while others experience difficulties. This booklet is designed to help health workers and others support you better.

Every experience and situation is different and because of this you may find you can relate to some issues discussed while others are not so relevant to you. You may feel uncomfortable using this booklet or giving it to other people but many health workers are aware of it and are prepared to receive it.

**Giving the booklet**

There are many ways to give this booklet to your health care worker. You could give it before, during or after your appointment. You could post it or send it with other information, such as a referral letter or booking form. You can give it directly to your health worker.

When you give the booklet to the health care worker it may be hard to find the right words. Some women don’t say anything while giving the booklet. Others explain that the booklet has information that is very important to their health and ask the worker to read it before providing any health care. You need to decide what best fits your situation.

**Information for Health Workers**

The woman or mother you are treating or supporting was sexually abused as a child. She has given you this booklet because she trusts you with the information and wants to obtain better support during pregnancy, birth and parenting. Better support may lead to better health outcomes for her and her child. She has given you this booklet so she won’t necessarily have to retell her experience. Your response is critical. It is important that you listen and believe the information she gives. Do not make judgements about her or her experience. Acknowledge the courage it took to tell you or give you this booklet of information. Be open to her suggestions about her own and her baby’s health care needs.

We acknowledge that you may be very busy so the booklet has been divided into sections on pregnancy, birth and parenting. Each contains information about the possible effects and suggestions for supporting and responding.

The most important things to consider for your patient/client, be it the woman herself or her baby, are issues of: personal space, privacy, control, boundaries, touch, informed consent for the woman and her child, and being very clear about her rights.

Women say: “Childhood sexual abuse is a part of my life, it is not all of my life”.
Information about childhood sexual abuse

Definitions
Child sexual abuse is the involvement of dependent children or adolescents in sexual activities with someone who has more power than the child. The child or young person is used as an object of gratification in a relationship where they are unable to give consent due to unequal power between the child and the other person.

Responsibility for abuse
Child sexual abuse is a crime throughout Australia. The child or young person is NEVER to blame; perpetrators are responsible for the abuse. The majority of perpetrators of child sexual abuse are adult and adolescent males known to the child. Some women are perpetrators but this is far less common. Most perpetrators are heterosexual in their adult relationships, but may sexually abuse male or female children. The majority of abuse occurs in the home of the child by a known adult. Strangers perpetrate only a small proportion of abuse.

Perpetrators trick children and young people into feeling they are responsible for the abuse. These are some of the strategies used by perpetrators: making children play sexual games, including children in sexual activities, making children feel unsafe, making sure the abuse is kept secret, isolating children from family and friends, making the child feel responsible for the abuse, and making children confused and afraid.

Sexual abuse behaviours
Contact sexual abuse behaviours include: touching the child in a sexual way, masturbation either by making the child touch their own or the adult’s genitals or by the adult touching the child’s genitals, oral sex, vaginal or anal penetration with the adult’s penis, fingers or objects, or by kissing the child in a sexual way. Non contact sexual abuse includes: photographs of the child in sexual poses, or photographs of the child used by the adult in sexual ways, flashing or exposing genitals to the child, watching the child undress or bathe in a way which makes the child uncomfortable and making lewd or suggestive comments about or to the child. Child sexual abuse includes any other way a child is used by someone for sexual reasons.

Effects of childhood sexual abuse on the victim/survivor
Childhood sexual abuse is associated with many short and long-term physical, psychological, spiritual, social, cultural and emotional effects. The following list represents some of the more common consequences:

- Guilt
- Feeling responsible
- Shame
- Fear
• Anger
• Loss of trust
• Secrecy
• Isolation
• Marginalisation
• Self blame
• Eating problems
• Triggers and flashbacks
• Mental health issues including somatisation, anxiety, depression and post traumatic stress, self harm and suicidal behaviour
• Sexualised behaviour
• Risk behaviour, alcohol, smoking and drugs
• Passive compliance
• Vulnerability to repeated abuse
• Physical problems which include various chronic pain syndromes
• Low self-esteem
• Boundaries

Story: To be provided by CASA House

**Effects on pregnancy**

There are a variety of effects on pregnancy that women may experience after childhood sexual abuse. During pregnancy she may remember her past abuse for the first time, either consciously or unconsciously in dreams. Sometimes the effects of child sexual abuse manifest in physical ways and are related to past injury, infection or somatisation.

The physical effects can include: pelvic pain, headaches, gastrointestinal disturbance, neck pain, endless nausea and gag reflexes. Mental health effects can include depression, post-traumatic stress disorder, anxiety, substance abuse and eating disorders.

Some women are concerned about whether their body will carry a baby; sometimes this is because they think they have been physically damaged by their abuse, while some think their body is not “good enough” for the development of a healthy baby.

Having examinations and procedures performed during pregnancy may be difficult. Many women identify vaginal examinations, vaginal ultrasounds and Pap smears as particularly difficult, while some others identify breast examination. Having a vaginal examination may be extremely uncomfortable and traumatic and they may refuse this procedure. Some women consent to the procedure but find it distressing and traumatic. Body language during the vaginal examination may alert you to this issue.

It may be difficult to do the examination due to muscle spasm—this should alert you to the possibility of abuse and stopping the procedure. Even though a woman may consent to an examination, it may cause unexpected reactions, as one survivor describes:

_I guess the hardest time for me was going to the doctor...[the doctor] made me take all my clothes off and put a gown on...these two people were looking at me...poking me...The doctor had a feel (hesitation) then the medical student...Oh God, you know (voice shaking)...I went straight to the toilets and started vomiting. I was terrible._
Women may become labelled as ‘difficult patients’ when they are responding to the effects of their abuse; for example, they may not keep appointments or may present late for antenatal care.

There may be issues related to weight or body shape changes in pregnancy. These issues can be associated with eating disorders. Women may also be concerned about the sex of their child and the baby’s safety after birth.

The gender of her health worker/s may be an issue during pregnancy, particularly if it is the same as the perpetrator/s.

**Ways of responding**

An important way to respond is to read and discuss her birth plan. This will identify predictable key issues and the most appropriate response. If she doesn’t have a birth plan, offer her support to develop one.

Remind her that she has the right to have a support person present during examinations. Your client/patient may not be aware of her rights, so restate them for her.

Provide her with information so she can make an informed choice before consenting to the procedure. This means providing the alternatives available and discussing them fully with her. For example, an abdominal ultrasound may provide you with sufficient information for management and it may be possible to avoid the more invasive vaginal ultrasound.

During vaginal examination ensure privacy. Make sure the room is comfortable. Some women feel vulnerable when they remove their clothes so you can discuss the possible options prior to examination. A private and secure room, not wearing a hospital gown split up the back and not fully undressing can be options. Where possible allow her to choose where the examination is performed, if the only possible space is shared, draw the curtains and give her privacy while she undresses. Before starting the procedure ensure her comfort as much as possible by providing her with choices, of coverings during examination, ask how her support person can best assist—for example, by sitting inside with her or outside the curtains holding her hand. Explain what the procedure involves and obtain consent prior to any touch. Make sure the speculum temperature is appropriate before starting the examination. Talk in professional and respectful language, not sexual or childlike or patronising language. As you do the examination, respond to any cues of distress or discomfort and give her the option to stop. Respect her choice and what she tells you.

Validate her physical and emotional responses to her pregnancy and the changes in her body.

**Effects on birth and labour**

The issues women who experienced child sexual abuse have varied. The concerns women express about birth may include:
• fear of examinations, feeling violation after repeated examinations and/or repeated examinations by different people
• language used by health professionals
• dissociation as a protective response to what is happening to her body
• flashbacks
• passive or ‘difficult’ behaviour
• fear people will see she has been abused and ‘damaged’
• fear of being restrained, for example, by drips, foetal monitors and stirrups
• being watched
• removal of clothing
• touch without consent
• intrusive procedures
• loss of control
• gender of the practitioner
• examinations by multiple people
• mistrust with changes of health workers at each appointment or during the birth.

Giving birth is the time most likely to trigger a post-traumatic stress response. Triggers for this can be related directly to care or the care environment. Pain and contractions can be triggers, as can be sights, smells, sounds, touch, examinations, feelings and sensations. Flashbacks and dissociation can occur.

Women may be extremely concerned for the safety of their child during and after delivery.

**Ways of responding**

During initial assessment check with the woman and ask if she has any concerns about vaginal examination, other examinations or procedures related to pregnancy, labour or birth. This is an opportunity for her to disclose her abuse experience, however, do not pursue it if she is not willing to disclose since research does not support the routine use of screening questions for child sexual abuse at this stage. If she discloses her abuse, validate and believe her.

If the woman discloses abuse or if you suspect there is possibility of abuse because of her reactions, you can assist in the following ways: ask how she feels about having an examination in general and vaginal examinations and/or procedures. Re-evaluate the frequency of vaginal examinations. Best practice for examination and procedures requires a private room; where this is not available it should be discussed with the woman and the reasons explained. As much as possible allow her to choose the gender of the health worker doing the examination or procedure. Prior to labour discuss with her how to best manage flashbacks should she experience them and incorporate this information into her birth plan.

Touch can be associated with painful memories for survivors of childhood sexual abuse. For this reason it is necessary to ensure you describe what touch is required and why; that you make sure you have informed consent before proceeding, that you are aware of your physical distance from the woman and, where possible, maintain distance, avoid unnecessary physical touch, and check with verbal and non verbal
communication during examination. By behaving in this way you demonstrate that you are willing to share information and control. This can be further improved by allowing the woman to become familiar with the room, knocking and saying who you are before you re-enter, checking how the room and lighting is impacting on the woman, explaining where there are separate male and female bathrooms.

The language you use is important in minimising the power imbalances between you and women. Avoid using medical jargon, check and understand the woman’s starting point and knowledge, provide information clearly, in small chunks and check for her understanding. Demonstrate you are listening by your verbal and non verbal behaviour. Continue to explain what you are doing and why as you do the examination/ procedure. Whenever possible tell the woman of your overall findings when she is dressed and sitting up. Provide written information, ensuring it is in the language that the woman is comfortable with and provide the opportunity to ask questions.

If a woman communicates discomfort, either verbally or non verbally, during an examination, stop immediately. Ask her what she is feeling, reassure and normalise, validate her experience.

Women know their bodies, so listen to what they tell you.

Women who have been sexually abused as children may have difficulties with pain because of their abuse. Address pain issues in a systematic, non judgemental and thorough manner.

**Identifying flashbacks**
Flashbacks can be identified by language regression, conversation that doesn’t fit the current environment, a sudden memory of childhood sexual abuse, or the impression she is ‘not there’.

**What to do when flashbacks occur**
If you have discussed the possibility of flashbacks with the woman prior to labour, respond in the manner you planned together. If a flashback occurs unexpectedly (CASA to add in)

**Effects on Parenting**
A woman who has been sexually abused as a child may respond in a variety of ways to her parenting experience. This may happen with her first child and/or with subsequent children.

A woman can experience difficulty bonding to her child. This may be directly related to her past abuse.

When touching her baby she may worry that what she is doing is violating her child’s trust. Changing nappies and bathing may be difficult.

The mother may be very concerned about the safety of her child. The vulnerability of her child may trigger questions about her own abuse and vulnerability at the same age. Her concerns may relate to her child’s gender. If she has a son she may worry
that he will become a perpetrator or that he may be safe because he is a male; she may worry that her daughter is unsafe and at risk because she is a girl.

Her concern for the safety of her child may include the baby or child visits to health workers. She may be unsure that the health worker is trustworthy and/or uncertain of her ability to protect her child. It is important that health workers obtain consent before touching the baby/child, explain clearly about examinations or procedures, discuss examination/procedure options with the mother, and discuss the level of undress necessary and possible alternatives. Never assume consent because the mother has brought the child to see you.

The mother may fear that by association the child is damaged. ‘I am damaged therefore my love is damaging’. This may lead to a fear of loving her child. Similarly, she may fear that because her body was ‘damaged’ by abuse, it cannot produce good things like ‘good’ breast milk.

Women have a variety of responses to breastfeeding. Some women are reminded of their abuse when they breastfeed and are therefore resistant to breastfeeding. Some may not feel comfortable breastfeeding at all and elect to bottle feed from the start. This may be associated with the sexualisation of her breasts or she may hate her breasts. The child suckling may trigger memories of abuse/flashbacks. Other women feel that breastfeeding assists them to see their bodies in a new and different light and may help them to bond with their babies.

There is an increased risk of post-natal depression and post-traumatic stress disorder; these sometimes result from specific triggers during birth and/or post-natally or are related to inappropriate care.

**Ways of Responding**

**Breastfeeding**
It is appropriate to provide and discuss options for breastfeeding. Talk through breastfeeding clearly and respectfully, offering helpful alternatives. It is important to remember not to blame the woman for her responses and to respect her choices if she chooses not to breastfeed.

It is important to obtain consent from the woman before touching her breast, even in situations where consent seems to be implied; for example, if she asks you for assistance when breastfeeding.

**Mother-infant relationships**
If you feel a woman is not responding appropriately to her child, consider the possibility of birth trauma and/or past abuse experiences. Reassure her that she is not to blame, believe and validate her experience and affirm her ability and strength. Provide her with resources and support.

Sometimes women may fear they are not relating well to their children, even when their responses are appropriate. Appearing in control is a way of coping with past abuse experiences. Be aware it may be difficult for women with this managing style
to ask health workers for help or support. Remember there is always social pressure to be seen as a good mother and to present as coping well.

Acknowledge that sometimes the experience of birth can be overwhelming and lead to feelings of sadness or depression in many women. Ask her if she would like support regarding these feelings, discuss her options with her.

Do not blame her for how she feels. Remember she is responding to the effects of childhood sexual abuse and/or inappropriate care.

Normalise bathing a baby and nappy changing, talk to the woman about this being safe touch. Make time to have a full discussion and take plenty of time when showing her these skills. Allow time to respond to her cues if she has difficulties. Reassure her that maternal instincts and skills are learned rather than innate or natural.

If you are concerned about child safety please consult further.

Checklist
CASA to do
Referrals and Support
CASA to do
Title: Pregnancy to Parenting
A supportive guide for survivors of child sexual abuse

Introduction
Becoming a parent can be a joyful and happy time. Women who have survived child sexual abuse may face challenges with pregnancy, childbirth and early parenting. These challenges can be healing for some, while others experience difficulties. This pamphlet is mostly relevant for female survivors, but male survivors may also have concerns around early parenting. Every experience and situation is different and because of this you may find you can relate to some issues discussed while others may not seem so relevant.

What is CHILD SEXUAL ABUSE?
Childhood sexual abuse is common with one in three women and one in six men reporting sexual abuse when they were children. Child sexual abuse is any sexual activity in which an older person uses their power and authority over a child or young person for their own gratification. The offender may be a family member, a trusted friend or a stranger. Child sexual assault is a crime. The child or young person is NEVER to blame.

You may not think of what happened to you as ‘sexual abuse’ or as ‘sexual assault’ and you may never have told anyone. Managing the experience of sexual assault is different for each survivor and new situations can be challenging to your sense of competence, particularly situations where you feel you have little control.

Child sexual abuse is never your fault.

Past connections
Pregnancy and parenting are life-changing events. During pregnancy there is an intense focus on the mother’s body, after birth there is a baby to protect and care for. It is common and not surprising that many survivors of child sexual abuse experience particular difficulties. You may find that during pregnancy, and later as a parent, feelings from your past resurface. You may feel that you are not coping. These feelings are normal and you can feel a range of emotions at this time.
Here are some things women have said:

I never made the connection between my experiences and the present until I was pregnant with my third child, a girl. I would like to make some sense of it. Instead I couldn’t figure out what was wrong with me. I felt crazy, neurotic and scarred.

Having a baby proved how innocent and beautiful a baby was… I was like that once… That’s hard.

Women who have experienced child sexual abuse can find that pregnancy and parenting is a turning point in their healing. Pregnancy and breastfeeding may give you an opportunity to relate to your body in a different way:

What a thrill to produce a new life out of my body. This body of mine could be of good use.

Breastfeeding gave my breasts a positive story.

Pregnancy

You may or may not have conscious memories of your childhood abuse. In some cases pregnancy, childbirth and mothering can trigger these memories. Sometimes memories are triggered in later pregnancies, and not the first one. Feelings of fear and lack of control are common for women during pregnancy, birth and when they take a new baby home, whether or not they have experiences of child sexual abuse. You may find some situations remind you of your childhood trauma, and may emphasise negative feelings about yourself and your body. You can feel anxious about medical examinations of yourself and your baby, and be concerned about having control in these situations.

Medical examinations, procedures and events at this time may contribute to your feeling invaded and powerless, connecting to feelings of humiliation and lack of control from your past and flashbacks, nightmares, mood swings and feeling disconnected from your body. In addition, some women find the attitudes of health workers remind them of their experience with the perpetrator of their abuse. These attitudes include not listening to your concerns, superiority or aloofness and by not providing you with alternatives to physical examination.

...their professional attitude during vaginal examination I took as aloofness; their professional attitude during vaginal exams in particular I took as direct proof of their perpetrator status...

I guess it makes me feel angry, because people are using their profession as a way of putting you down and making themselves feel better... I think that professionals get the same kick out of power over others as abusers do. Abuse only occurs because someone feels they have power and they can dominate another person.

Alternatively, health workers can play a major supportive role during and after your pregnancy. Women describe supportive health workers as having the following qualities: listening and respecting your feelings, respecting confidentiality, explaining procedures clearly and why they are necessary, offering choices, making a shared birth plan with you, being flexible in the way they do procedures, asking you how you are coping emotionally as well as physically, believing and understanding when you tell them about your abuse, and offering you access to other support services.

A maternal and child health nurse with her quiet, gentle advice and encouragement was my lifesaver.
**Birth**

Many women speak of feeling their bodies are not their own during their contact with the health care system. Some women have felt that childbirth was “a reminder about sexual abuse”.

Coping with the pain of childbirth can be difficult. Some women have found that thinking of the pain as having a positive purpose helped them to reduce their anxiety during labour and childbirth. Other women say that dissociating from the pain or ‘zoning out’ helped them during pregnancy and labour.

Some women experience flashbacks and feel a lack of control during birth. You can talk to your health care worker should you experience these problems.

Some women describe their experience of birth as traumatic and wonder about the possible link with their experiences of child sexual abuse. Some find themselves silenced by health professionals, their concerns trivialised and feel unable to talk about the difficulties they faced during delivery because of pressure to have a ‘good’ birth.

**Breastfeeding**

Some mothers are challenged by breastfeeding and this can be made more confusing by conflicting advice and lack of support from health professionals. There may be added difficulties for those who have survived abuse. If you feel comfortable to breastfeed, the experience can bring a sense of satisfaction and new enjoyment in close physical contact with another human being. Some survivors find breastfeeding allows them to experience their bodies in new positive ways.

*Breastfeeding was a good bonding experience for me, although at first I felt uncomfortable.*

You may find that there is little pleasure for your body when you are breastfeeding. Alternatively, you may fear the sexual arousal and the sensuality of breastfeeding, as it may remind you of the abuse. You may find that breastfeeding provokes anxiety for you, making you feel exposed and unsafe. Breastfeeding in front of others may be especially difficult, particularly if you feel you cannot control those who may watch you feed.

*I tried to breastfeed. I lost my appetite and couldn’t produce enough milk. Today I have a greater understanding of what the experience was all about.*

You do not have to breastfeed. It is important to remember this. You are not denying your baby a happy and healthy infancy by choosing not to breastfeed. Forcing yourself to breastfeed may affect your relationship with your baby by making you both feel tense and uncomfortable.

*I felt that I had let my baby down because I couldn’t breastfeed her very long, despite the fact that everyone was telling me I should because breastfeeding is so important. More guilt!*

Women commonly feel inadequate at this time. A health worker can encourage and support your feeding choices.

**Baby touch**
Part of early parenting involves close physical contact and intimate touch. Some survivors find they feel uncomfortable touching their babies; bathing and nappy changes are two examples. Some women report distress and experience flashbacks. It can be difficult knowing where to clean and touch a baby and you may find that a baby of one particular sex is more difficult for you than the other.

I only have boys. When my son gets an erection I find myself thinking, “What will I do?” I obviously can’t touch it, but you think... “How do I get the nappy on? Do I look at it? What am I meant to do?”

I wasn’t cleaning my daughter as I should have been. I don’t think that it was because I was consciously stopping myself. I just did what I felt I should do. It wasn’t until I was shown later that I realised that I was stopping myself. I didn’t want to clean like that, it wouldn’t be right.

**Post-natal depression**

Some 80 percent of women experience baby blues which occur between the third and tenth day after birth. The blues are transient and pass with understanding and support within a few days. Post-natal depression affects 10 to 15 percent of mothers. It can occur straight after the baby is born or months later. It can start suddenly or slowly. Both first-time mothers and those with other children can be affected. Post-natal depression can include: feeling sad and tearful, feeling anxious, worried, irritable and frustrated, being physically and emotionally exhausted, feeling unable to cope, feeling guilty about not behaving like a ‘proper’ mother, having difficulty concentrating on a simple task, feeling full of nervous energy, experiencing a loss of interest in things previously enjoyed, and having suicidal thoughts. Some of these symptoms can also occur in response to child sexual abuse and being a new mother. It is important you get support and help. Post-natal depression and post-natal stress and anxiety are well recognised by health professionals and may be treated in a range of ways.

**Early parenting**

For many survivors of child sexual abuse, raising a child and creating a new family has a special significance. You may be acutely aware of the preciousness of childhood and not surprisingly, be very protective of your children. Despite the challenges and difficulties, raising your child can be a good experience. You have the ability to give love and affection to your child and to be a central contributor to a loving childhood.

**Health professional examinations and interventions**

Medical examinations and health professional touch are a big part of pregnancy, giving birth and after birth. Some procedures, such as Pap smears and internal examinations in pregnancy, check for possible health problems that may be important during pregnancy. Sometimes due to urgent health concerns for you or your baby, instruments such as forceps may be used or a Caesarean operation performed. Some of these examinations may be repeated after birth. In addition, your baby may be examined after birth. Medical procedures, examination and health professional touch can feel invasive. Cervical smears, internal examinations, the use of instruments and stirrups, procedures involved with abortion or internal ultrasounds can be particularly difficult. General anxiety around such procedures can be lessened with the help of a
sensitive health practitioner, by knowing exactly what to expect, and having your choices explained: for example, a less invasive procedure may be possible, such as an external instead of an internal ultrasound, having a support person with you, having the procedure done by the same person each time or by a female practitioner. As an adult you have the right to refuse any type of procedure or examination at any time. If you refuse a procedure or examination you may be asked to sign a document to say that you were offered but refused a particular treatment or examination.

**Things that can help**

- Take a support person with you to examinations
- Make a birth plan and keep a copy with you
- Take someone who will help speak up for your wishes
- Talk to a friend or counsellor about how you feel
- Make a list of questions to ask your health worker
- Many procedures and examinations can be invasive. Ask to have procedures and examinations, including the alternative options, fully explained beforehand
- If you experience a flashback or feel panicky, it may help to look around at where you are now, talk to someone or remind yourself that you can ask them to stop

**Finding Support**

**Where To Go For Help**

**Royal Women’s Hospital Services**

If you are a patient of the Royal Women’s Hospital the following services can help you. You can call them yourself or speak with your midwife or doctor about assisting you to contact them.

**Sexual Assault Services**

**CASA (Centre Against Sexual Assault) House**  9344 2210

CASA offers women who are victims/survivors of sexual assault, including childhood sexual assault, with access to free and confidential crisis support, information, counselling and support, advocacy and support groups.

**Sexual Assault Crisis Line**  1800 806 292

After hours telephone counselling, support and advocacy. Assistance to access crisis support after hours for recent victims/survivors of sexual assault.

**Women’s Social Support Services**  9344 2451

Provides information, support, counselling and advocacy for women who are or have experienced family violence.
Culturally Specific Services

**Aboriginal Women's Health Business Unit**

9344 2160 or 9344 3358

Provides information, support and referrals to women who identify as Aboriginal and Torres Strait Islander.

**Family and Reproductive Rights Program**

9344 2211

Provides information, support and referrals to women from cultures that sometimes practise female circumcision.

Other Services

**24hr Sexual Assault Counselling and Support Line**

1800 806 292

This 1800 number will direct you to your regional Centre Against Sexual Assault (CASA) service during business hours. After hours this number will connect you to the Sexual Assault Crisis Line (SACL). CASA offers women access to free and confidential crisis support, information, support, counselling, advocacy, support groups and referrals.

**24hr Women's Domestic Violence Crisis Service of Victoria**

9373-0123 or 1800 015 188 (regional)

Crisis support, information, referral to safe accommodation (refuge) for women experiencing abuse in their relationships.

**Elizabeth Hoffman House**

0407 937 202

(24 hours per day & 7 days per week)

An Aboriginal women's refuge for Aboriginal women by Aboriginal women. Provides emergency shelter for Aboriginal women and their children in need of support due to domestic violence.

**Aboriginal Family Violence Prevention and Legal Service Victoria (FVPLS)**

1800 105 303

Provides legal advice, outreach services and other support such as counselling, information and referral.

**Immigrant Women’s Domestic Violence Service**

9898-3145

Is a service which provides support and crisis intervention to women and children of culturally and linguistically diverse backgrounds who experience domestic violence.
Women’s Legal Service Victoria 9642 0343 or 1800 133 302 (Regional)

Provides FREE legal advice to women on a range of issues.

Police 000
Call if in immediate danger and/or if wishing to obtain an intervention order and/or to make a report.

Telephone Interpreter Service (TIS): 131 450; 24hrs a day seven days a week:
Provides translating and interpreting services in a range of languages; there may be a cost; some interpreting services are provided free of charge to individuals. You can call TIS and the interpreter will contact the service you want to speak to.

Preparing a birth plan
You may find it useful to prepare a birth plan and discuss it with your partner, family, health professional and/or friends.

A birth plan may assist you during your pregnancy, labour and post-natally to communicate your needs and choices to the health professional caring for you at the hospital. If you do have a birth plan it may be useful to carry it with you and/or ensure that it is in your medical record.

The following is a list of options that may help you decide what you would like to include in your birth plan. If you would like support with writing a birth plan the hospital staff will help you.

During Pregnancy
Choice of caregiver and support – this may depend on your medical care needs and the hospital can discuss this with you
Hospital based midwife
General Practitioner
Obstetrician
Shared care midwife or doctor
Independent midwife
Other support people and health professionals who you have chosen to be involved in your care

Place of Birth
Hospital Labour Ward
Hospital Birth Centre
Examinations
Full information on choice of medical procedures, including risks and benefits
Presence of support person during examinations

Childbirth Education
Group and/or individual childbirth education sessions

Labour and Birth
Preference of gender of midwife and/or doctor
Freedom to choose positions and activity in labour
Vaginal exam for specific medical indication only
Full information on risks and benefits of each suggested medical procedure
Options and choice of medical procedure explained
Preferred type of pain relief
Consent to have students present during labour
Partner/chosen support person presence during labour
Presence of interpreter
Skin to skin contact with baby immediately after birth
Assistance with breastfeeding – how this will happen, physical contact
Who to tell about birth – family/friends/support people/health professionals

Post-natal
Baby remains with mother all the time
Breastfeeding on demand from birth
Help with breastfeeding on request and how this will happen, i.e. type of physical contact if any
Formula feeding
Early discharge from hospital as soon as you wish
People visiting and visiting hours
Support at home
Appendix Six:

Support Services

Victorian Community Resources
Victorian Police (24 Hours) 000 or 1444

Women’s Domestic Violence Crisis Service of Victoria 9373 0123
(24 hours, seven day crisis line) 1800 015 188
- counselling, advocacy, information
- refuges
- referral short term accommodation
- assistance to women leaving violent partners

Immigrant Women’s Domestic Violence Service 98983145
9.30am – 5.30pm
- cultural and linguistic support and advocacy
- crisis intervention support
- advice GPs 9853 3917

Telephone Interpreter Service 131 450

Centre Against Sexual Assault (CASA House) 9344 2210
9am – 5.30 pm
- crisis care
- counselling and advocacy
- referral for ongoing counselling
24 hour helpline 1800 806 292

SOCA (Survivors of Childhood Abuse) 9419 3306
9am – 5.30pm
- assessment and counselling survivors
- secondary consultation service
- training courses for professionals
Gatehouse Centre – Royal Children’s Hospital
9am – 5pm  9345 6391
24 hour service  9345 5522
- crisis care
- counselling
Breastfeeding Problems
Nursing Mothers Association Helpline (24 hour)  9885 0653
Men’s Referral Service  9428 2899
12noon – 9pm Monday to Friday  1800 065 973
- counselling, information and referral for men who use violence at home
- contact point for men making first moves but don’t know where to go
- women can call for information on help for partner
- information for GPs on programmes for men
Victims Referral and Assistance Service  9603 9797
- victims counselling  1800 819 817
- victim support
- legal and financial assistance
Women’s Legal Resource Group  9642 0343
- advice and referral service  1800 133 302
- face to face legal advice
- solicitors available on Thursdays at Melbourne Magistrate Court
Victoria Legal Aid  9269 0234
1800 677 402
Lactation Resource Centre (NMAA) 9am – 5.30pm  9885 0855
Domestic Violence and Incest Resource Centre  9380 4343
Copy of Support Service Card Given to Participants

**Sexual Assault Counselling**
Centres against sexual assault (CASAs)
Sexual assault counselling, information, support groups and advocacy
9349 1766 5.30pm-9am/weekends 9344 2210
9am-5.30pm

**Maternal and Child Health Line**
Support, advice, information and referral 132 229
24 hours

**Parentline**
Information, advice and referral for parents 132 289
24 hours

**Women’s Information Referral Exchange**
Information and referral for women’s issues, well being, health and legal rights 1300 134 130
Mon-Fri 9.30am-5.30pm

**Australian Breastfeeding Association** 9885 0653
24 hours

**Domestic Violence and Incest Resource Centre** 9486 9866
Mon-Fri 9am-5pm

**Statewide services**
**Victorian Police** 000

**Women’s Domestic Violence Crisis Line** 9373 0123

**Lifeline** 131 114

**Child Protection Crisis Line** 131 278

**Men’s Referral Service**
Counselling, information and referral for men
9428 2899 12 noon – 9pm Mon-Fri 1300 659 419

**Women’s Legal Service Victoria** 9642 0343

**Legal Aid** 9269 0234