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The Experience of Pregnancy, Childbirth and Motherhood in Women with a History of Sexual Abuse

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1. Introduction

Sexual abuse is a traumatic experience that marks a person for the rest of their life and has numerous consequences. Some effects may manifest immediately, others only years afterwards. The trauma may even be transferred to the following generations. The purpose of this paper is to present the *theory* and existing *research* in the field of sexual abuse. It also provides an exploration of clinical practice, with descriptions of group therapy cases. It presents the findings of three therapy groups for sexually abused women. Each group included ten participants who met with a family therapist and co-therapist for one year. On the basis of *analysing the content* of their diaries, we describe the therapist's notes and supervision notes (in line with the *grounded theory* method) regarding the most typical experiences relating to pregnancy, childbirth and motherhood.

This paper begins with the definition of sexual abuse, its consequences and the survival methods most commonly used by the abused.

We continue by considering the impact of sexual abuse on the victim's experience of **pregnancy, childbirth and motherhood**.

During pregnancy, a woman's body is particularly sensitive. This is due to the many organ changes that effect her psychic and physical state. Research results show that, during pregnancy, a sexually abused woman has more health problems and is more frequently in conflict with her partner. Furthermore, she experiences higher levels of anxiety and fear, compared to those who have not been sexually abused.

During childbirth itself, a mother with a history of sexual abuse has more trust issues with the personnel. Moreover, during gynaecological examinations, she experiences flashbacks that subconsciously trigger her body's memory of the sexual abuse. During the contractions and

pushing, when the woman in labour needs to co-operate most with the medical staff, her body or psyche can react by freezing, panicking or taking complete control. She is also more prone to a caesarean section and other complications.

These feelings and experiences are also often present *in motherhood*. Compared to a mother who has not been sexually abused, a mother with a history of sexual abuse experiences more feelings of guilt, troubles with breastfeeding and various fears.

We conclude this paper by expressing our hope that one can work through the trauma of sexual abuse and start living a full life. Clinical experiences have shown that a woman who resolves her trauma is much more relaxed and happy during pregnancy. She is calmer during childbirth and is a more compassionate mother, compared to a woman who does not resolve her trauma. After all, if the little girl survived the trauma when it happened, she can now survive as a grown woman - the abuse is **no longer** happening, it is only awakening.

2. Definition of sexual abuse

Sexual abuse is a traumatic experience involving an involuntary sexual contact between the abuser and the victim, with the intention of sexually arousing the perpetrator who transgresses all limits of human dignity [1]. The actions are not limited to a forced sexual intercourse but include a wide range of sexual behaviours, most commonly the following: exposing one's genitals, observing a child, using pornography, groping, masturbating in front of the victim or forcing the victim to masturbate while the offender watches, fellatio, cunnilingus, digital or object penetration of the anus or vagina, sodomy, etc. [2].

Clinical practice has shown that it is very difficult to predict what consequences a victim will experience. This is because they depend on several factors: the age and sex of the abused, the seriousness of the abuse, the relation between the victim and the offender (whether the offender is a family member or not, a known person, an unknown person, etc.), whether the child told anyone about the abuse and, if they did, what the response was and the duration of the abuse [3-6].

Many abused individuals are too focused on survival to notice how the abuse has effected them. Even worse, most do not even think that the effects and problems they experience could be related to sexual abuse. They are ashamed of what they did to survive, even though, in the given situation full of pain, that was the best possible solution. The most common kinds of behaviour that the abused adopt to survive are: derogation, rationalization, denial, forgetting and running away from reality (split, dissociation), constant control, hypervigilance, perfectionism, freezing, absentmindedness, busyness, escape, humour, lying and stealing, religious fanaticism, drug and alcohol abuse, overeating, engaging in unhealthy and risky sexuality, obsessive masturbating, etc. [7].

3. The consequences of sexual abuse

In general, it is difficult to say how sexual abuse impacts an abused person. This is because sexual abuse effects everything: self-confidence, sexuality, intimate relationships, parenthood, work, mental health, body, etc. Additionally, some consequences may be visible immediately, whilst others only come to light years after. They awaken in various situations reminiscent of the abuse. Recent studies have shown that they can even come to an intergenerational transmission of trauma. This means that the effects manifest in future generations, in children born after the trauma had already taken place (e.g., war veterans and their children and grandchildren) [8]. Sexual abuse has an impact on both the physical and the psychical area of human action, which strongly marks and changes a person's life. In most cases, the effects are long-term, extremely radical and harmful. More rarely, the effects can be short-term [7-10].

Short-term consequences: unwanted pregnancy, higher risk of sexually transmitted diseases, infertility, various gynaecological inflammations and pains in the lower abdomen, infections of the urinary bladder, abrasions and laceration on various parts of the body, bruises and redness, more frequent chronic somatic diseases, a negative attitude towards one's body, chronic fatigue and exhaustion, sleeping disorders, eating disorders, very painful menstruation, fear, apprehension and anxiety, troubles concentrating and thinking, emotional irritability and hypersensitivity, hate and aggression, promiscuous behaviour, etc.

Long-term consequences: many of the above also belong among the long-term consequences but the effects that most often come to light after many years, on the other hand, can sometimes appear soon after the abuse. The most frequent among them are: post-traumatic stress disorder, social phobias, fear and anxiety, guilt and shame, substance abuse and eating disorders, running away from home, depression, suicide, panic attacks, excessive distrust, troubles with interpersonal relationships, partner relations, infidelity and physical violence, sexual dysfunctions and other problems with sexuality, personality disorders and dissociations, likelihood of re-victimization, low self-esteem, sexualized behaviour in children, regression in behaviour, self-harming, etc.

4. The trauma of sexual abuse, body and health issues

Sexual abuse first occurs at a physical level. This is precisely why many victims of sexual abuse blame their bodies for having responded; for being attractive, small, vulnerable and susceptible to arousal and pleasure. They accuse themselves for even having bodily sensations. Thus, in some respects, relaxation can pose a subconscious risk of something bad happening. This is why victims feel it is safer to be alert and awake - a sexually abused child can never really relax. Many victims of sexual abuse experience their bodies as a burden and a nuisance. They do take it into account because, precisely when it should have defended itself, it ran away and betrayed them. Part of not paying heed to their bodily needs is not hearing the body. This also applies when people are ill; they hold in their urine because they want to finish a small task, they do not rest when it is high time for them to

take a break, they go to extremes with eating and performing physical activities, they harm themselves, develop various forms of addiction, etc. [7].

It is often the case that medical examinations and tests do not explain the symptoms of a patient who has experienced a trauma. This does not mean that the patient does not suffer physical pain, only that the cause of the pain is psychosomatic. A traumatic experience affects not only the structure and functioning of the brain, but also the stability of one's psyche, one's thought processes and the health of one's body. In extreme cases, traumas can contribute substantially to psychiatric disorders [11]. Most of these patients seem demanding, afraid, uncertain and sometimes do not trust even those closest to them who ensure them that they are perfectly fine. Many suffer due to various medical symptoms, most often digestion problems, chronic fatigue and sleeping disorders. Scaer [11], who has worked as a doctor for many years and encountered various patients (those also injured in accidents or otherwise traumatized), believes that the various physical syndromes (pains) in traumatized people are more often a consequence of a certain experience, rather than a proven organ injury. *For example, stomach pain may be the result of a psychic distress experienced by a sexually abused person, rather than organ damage or food poisoning.* The trauma of sexual abuse can also impact neurological and hormonal (endocrinological) changes, the immune system, etc. A person's emotional state affects their physical wellbeing and health. There is an increasing number of scholars [11-13] who emphasize that the mind, brain and body are related. The brain operates and responds on the basis of stimuli that come from outside and inside the body. It compares present experiences with past ones. The body then responds to the brain's orders and changes, according to the stimuli and messages it receives through the brain. In view of all the stored memories, the mind then directs the body's behaviour and influences the content of the memories to be stored.

The above suggests that the atmosphere and emotional and physical states during the trauma are very closely connected to the operation and functioning of the brain. This then effects bodily changes, which also include diseases and one's health condition.

Studies in the field of health care and medicine [14] have generally shown that people who have been sexually abused in the past have more health issues, report more somatic symptoms and pains than people who are not victims of sexual abuse. They also report a greater degree of chronic diseases. The most common and most general are: gastrological diseases, stomach diseases (ulcer), respiratory disorders (e.g., asthma, bronchitis, emphysema), heart problems, hypertension, arthritis, diabetes and gynaecological problems. Gynaecological problems are most often related to the loss of the menstrual cycle or excessive bleeding, sexual dysfunctions, frequent pains in the lower abdomen (even when not during menstruation), frequent inflammation of genitalia and pains during sexual intercourse.

Golding [15] interviewed a group of women who were seeking help due to severe PMS. She found that 95% of the women reported that they had experienced at least one attempt of sexual abuse or were sexually abused. Furthermore, 81% of these women were raped.

Additionally, other studies [11,13] report chronic inflammation of the bladder and frequent and painful urinating - which only intensify during menstruation. Such studies estimate that 90% of women with a history of sexual abuse experience these problems.

It is precisely the above health issues that can lead to sexually abused women turning to pills and other medical devices.

In general, the trauma of sexual abuse can have a direct impact on the health of an abused person. This is because the victim could have been exposed to infection or even infected with an STD during the abuse itself. The abuse can also indirectly harm the victim's health. This is because abuse increases the probability of the abused person getting involved in abusive relationships. In this regard, relational family therapy explores the subconscious attractiveness of abuse or the loyalty to feelings reminiscent of abuse (disgust, shame, disdain, fear, etc.). The psyche subconsciously seeks such an atmosphere, with the hope that these effects will be resolved and that something new – non-abusive – will happen [16]. Studies have shown that people who have been raped are much more inclined to experience physical violence from a partner in a relationship, compared to people who have no history of rape [17]. It is this physical violence that increases the chances of those victims suffering more serious injuries.

Some scholars [18] have found that victims of sexual abuse can quickly begin to perceive their bodies as dysfunctional. This can lead to psychosomatic problems. Some victims also become preoccupied with every bodily change. Furthermore, upon every - even the slightest - sign of illness, they suffer real horrors as if they were seriously ill. The consequences of such psychical distresses and experiences are manifested physically, in organs. In other words, the psychical pain is transferred to the victim's body and her body tells her that there is something she can no longer endure.

All these physical signs are psychosomatic and can manifest in: headaches (only as tensions or migraines), sleeping disorders, appetite disorders, stomach problems, gynaecological issues (chronic pains in the lower abdomen, dyspareunia, vaginismus, non-specific vaginitis, menopausal disorders, etc.), asthmatic and heart problems, muscular tension, fainting fits, vertigo, fatigue, etc.

The same scholars explain psychosomatic problems that are consequences of sexual abuse with a chronically stimulated autonomic nervous system. This nervous system increases the release of hormones (epinephrine and cortisol). It is this constant releasing that has long-term effects on the body.

Sometimes, the psychosomatic problems in a certain part of the body injured during abuse appear much later, even after several years, e.g., pains in the jaw if the person had been raped orally. Additionally, problems may emerge that are more difficult to notice such as a weak immune system, susceptibility to colds and flu, chronic fatigue and exhaustion, etc. [7].

All the mentioned studies show that the trauma of sexual abuse is related to a higher degree of health problems. Such problems can also have an effect on pregnancy, which we will consider next.

5. Pregnancy and the history of sexual abuse

Body memory can awaken when a woman's body starts to change during pregnancy. When the pregnancy becomes visible, this can be a sign that the body is no longer untouchable, that

someone has already crossed the “line”. Thus, a woman’s gestational belly becomes part of the public arena, where everybody notices and sees it. For a woman without a history of sexual abuse, this can be the most beautiful thing. However, for a woman who has been sexually abused, her body becoming more noticeable and different can be extremely distressing. This is particularly the case if, for years and years, she had hidden every bodily change caused by the sexual abuse - even if only in her feelings and experiences.

Some studies have shown that girls who have been sexually abused in childhood are three times more likely to get pregnant before the age of 18 years [19] than those who have not. Similarly, Saewyc et al. [20] argue that 60% of pregnant underage girls have been victims of sexual harassment, rape or attempted rape in their past. According to other studies, pregnancy (as a consequence of sexual abuse) occurs in 11% to 20% of girls. Furthermore, more than 96% of underage prostitutes who have run away from home have been victims of sexual abuse in their childhood [9].

A study on a sample of 3,128 sexually abused underage girls showed that they engage more often in sexually risky behaviour (promiscuity, prostitution and pornography – seeking contact through sexuality). This study also reported that, compared to girls who had not been sexually abused, these girls were more likely to have had intercourse by the age of 15 years and more than one sexual partner. They were also less likely to use birth control during intercourse. Additionally, they more often used alcohol or other substances before having sexual intercourse. Among others, the following variables strongly stood out in this study: lack of parental supervision, presence of physical abuse, higher levels of school absenteeism, less involvement in extracurricular activities and lower grades (in comparison to those who had not been sexually abused). The difference between the two groups was statistically significant. The study also demonstrated that underage girls with a history of either sexual or physical abuse were twice as likely to become pregnant as teenagers, compared to girls without such a history. If they had experienced both sexual and physical abuse, they were four times as likely to get pregnant [21].

Seng et al. [22] found that women who had experienced PTSD during pregnancy were more susceptible to a spontaneous abortion, ectopic pregnancy and hyperemesis. Other studies report that sexually abused women have a statistically significant higher number of complications during pregnancy. Among the most common are: bleeding, severe vomiting, x-ray or radiotherapy in the first semester, alcohol, smoking, medications, accidents, infectious diseases, threatened abortions with hospitalization and severe illness [23]. Some abused women report several health complications and a higher use of health care services during pregnancy. However, these women do not experience more obstetric complications during their pregnancies and deliveries [24].

Women with a history of sexual abuse **experience depression in the prenatal and the postnatal period much more often** than women who have not been sexually abused. In general, children whose mothers were depressed during pregnancy show changes in their neurological functioning. They are more withdrawn, irritable and inconsolable than children whose mothers were not depressed during pregnancy [25]. Prenatal depression can lead to deficient

care during pregnancy and bad eating habits, as well as the abuse of various substances like tobacco, alcohol and illegal drugs.

Smoking can lead to spontaneous abortion, as well as increasing the risk of an enlarged thyroid gland in children, low body weight and deformation. It has been recorded that children whose mothers smoked heavily during pregnancy had lower mental abilities measured by the age of 19 months with the Bayley Scales of Infant Development [14]. The foetuses of women who chronically drank **alcohol** during pregnancy exhibited serious morphological (related to the form of the organism) and developmental abnormalities. Not all children exposed to alcohol during pregnancy suffer such serious conditions. However, there is a high probability that they will have neurological and cognitive disorders such as a lower reaction time and reduced attention spans.

Using illegal drugs during pregnancy is also problematic. Using **marihuana** during pregnancy can lead to a child having lower mental abilities, hyperactivity, impulsiveness, carelessness, inattention, delinquency and the externalizing of problems. **Cocaine abuse** during pregnancy is associated with a weakened, impaired processing of aural information, an increased risk of spontaneous abortion, premature labour pains, a stillborn child and microcephaly (the child having a small head). Heroin abuse and the use of other narcotics can cause a premature birth, the death of the foetus, the child's addiction, low body weight and cognitive and behavioural problems. **LSD and inhalants abuse** can be related to various deficits at birth [26].

In addition to drugs, women often silence their abused bodies with food. Waugh and Bulik [27] have found that women **with eating disorders during pregnancy** are more exposed to a caesarean section and have more problems in maintaining breastfeeding. Often, the disorders continue after the birth, leaving them at a high risk of developing postnatal depression.

Katarina Neff [28], a doula who has a lot of experience with pregnant women who have been sexually abused, believes that when a sexual abuse survivor with PTSD becomes pregnant, she may develop the following symptoms:

- Feelings of body betrayal
- Feelings of physical intrusion and invasion
- Flashbacks to the original abuse
- Depression
- Anxiety or panic
- Abuse memories resurfacing for the first time
- Antagonistic or hostile feelings toward the foetus
- Projecting feelings about the abuser onto the foetus
- Feelings of guilt (associated with her feelings)
- Feelings of shame (associated with body changes)

“Because birth is so different for every woman,” comments Kristina, “women who have dealt with the same trauma may react in completely different ways and have completely different fears. Mostly, they are afraid of dealing with the first trauma again, regardless of if it was an abusive situation or a previous traumatic birth.” There are some **specific fears that may manifest for a sexual abuse survivor with PTSD**, such as:

- Fear of the intensity of her feelings
- Fear that the child will be born deformed (like her)
- Fear that the child will be born dead (i.e., as punishment, wish fulfilment or self fulfilling prophecy)
- Fear of being an incompetent parent
- Fear of being an abusive parent

Sometimes the consequences of sexual abuse are not extensive or it does not seem that there are any. However, some women have been surprised and distressed by the feelings or memories that surface once they are pregnant, giving birth or mothering their child.

“Until I got pregnant, I had no problems or any difficult memories of the sexual abuse I had suffered in my childhood. It seemed to me that those who said it was a serious trauma exaggerated, since my life was quite okay. I don’t know what happened afterwards, but I can’t even describe the degree of worry, fear and anxiety I started experiencing after I got pregnant, especially after I started showing. A terrifying fear that I’d lose the child because my body was dirty due to the abuse and the child couldn’t develop in such conditions...sudden and severe anxiety attacks because I no longer had control over my body, my weight, my belly, which kept growing...”

“My pregnancy was nothing special until the moment the child began kicking in my belly. I was overwhelmed by the uncontrollable feelings of panic. Once, I even had to go to the ER. I felt guilty because I just wanted to pull the child right out, since every movement that was not under my control unnerved me intensely. At moments, I even wished for the child to die so that the distress would stop but I knew that, then, another would begin. I was somewhat appeased by being told I was having a girl because I realized that a boy would obviously remind me too much of the perpetrator.”

Clinical practice has shown that many pregnant women who have been sexually abused in the past often experience distress and new traumas in situations where women without a history of sexual abuse do not experience - or to a substantially smaller degree [29]. Even the usual gynaecological examinations can be very unpleasant due to the groping. In this case, it is very important that the gynaecologist is professional and sensitive. Nevertheless, when a woman is pregnant, carrying a developing and growing being, she is all the more sensitive to every touch and procedure related to her womanhood and her body [30].

“The visit to the gynaecologist reminds me very much of rape. You lie there like a victim, while he shines his light down there and touches you. I think that someone inserting their fingers in your vagina is a matter of sex and I can’t imagine what else this action would be good for. I find the stirrups particularly horrible. But, on the other hand, I am also aroused. When I was at the gynaecologist’s last year, I had the same feeling as after sex, only without the kissing and petting. Like a rape I myself wanted. I was

very much aroused when I went home and I was quite ashamed. I felt disgusted with myself and wished that someone would actually rape me. I'd pay him to go to bed with me and treat me really nastily, like his slave."

"It's the most horrible doctor's examination in the world. I go there when they send me the third invitation because I have to have regular check-ups. There I am, all stiff, keep my eyes closed and try to think of anything but this dreadful, humiliating, disgusting position I am in. The thought that I will have to go there almost every month when I'm pregnant makes me not want to ever get pregnant."

"What bothered me most was that some people touched my baby bump without permission. There were a few times when I had to leave the company and go to the toilet to vomit because I was so disgusted with the touching and, at the same time, angry with myself that I didn't draw the line and say I didn't like it."

Post-traumatic effects of sexual abuse can be a big problem for survivors and a source of great fear. This is due to the subconscious triggering of traumatic memories during pregnancy (prenatal care) and delivery (the experience of birth). Women may avoid necessary medical care because of these fears. Furthermore, they may be so devastated by their experiences that they have difficulty enjoying and caring for their newborns. With this in mind, it can be highly beneficial if the personnel (midwives, doctors, doulas, etc.) that a woman encounters during pregnancy, childbirth and the postnatal period are acquainted with her trauma and react appropriately. This ensures an even greater feeling of safety and support for the traumatized woman. Compassion in such hard times accelerates the healing of the reawakened trauma. At the same time, unkindness, roughness and unprofessionalism re-traumatize the pregnant woman and cause her additional distress and pain [29].

6. Childbirth and the history of sexual abuse

It is normal for every pregnant woman to be afraid of giving birth. Evidence suggests that the fear of childbirth exists in a psychological domain of its own. For some women, the fear is of a very low level but for others, it can be extremely high [31]. Extreme fear of childbirth has been estimated to affect around 2.4% to 5% of pregnant women [32].

Numerous studies report that a great fear of childbirth is strongly related to negative sexual experiences in childhood and youth [33]. Fear may manifest itself by tearfulness, sleeplessness, nightmares, preoccupation with fear and the objects of fear, restlessness, nervousness and tachycardia. Fear of childbirth may include fear of any of the following: the labour and delivery process, labour pain, lack of care by health professionals, the health of the baby or mother, surgical procedures, damage to the vagina and perineum, loss of control, not performing well, panic attack, physical exposure, uncertainty about the process of labour and becoming a parent [34].

In addition to the fear of childbirth, other fears may also be present. For example, the fear of vaginal examinations, health professionals noticing that you are damaged even if you don't have scars, being touched without consent and loss of control.

A study that included 2,365 pregnant women reported that a history of sexual abuse significantly increased the risk of experiencing severe fear of childbirth among primiparae. Fear of childbirth among multiparae was most strongly associated with a negative birth experience [35].

Similar conclusions can be found in a study that included 1,452 pregnant women (at 18 weeks of gestation) and measured their fear of childbirth (with the W-DEQ questionnaire) and anxiety (with the STAI questionnaire). In this study, the serious fear of childbirth effected 5.5% of the women. The fear of childbirth is not associated with the mode of delivery. However, sexual or physical abuse in childhood is negatively associated with the mode of delivery [32]. A small number of studies have shown that a history of child abuse has a minimal effect on the complications of labour and mode of delivery [36]. Having said this, the majority of studies have shown the opposite [37-39].

An experimental study, which used the cold pressor test, has shown that women who are afraid of childbirth have a reduced level of pain tolerance during and after pregnancy, compared to women who are not afraid of childbirth [40]. Other studies have shown that pregnant women who fear childbirth are prone to report fear during the actual labour and postpartum [41]. Fear of childbirth has been associated with elective CS, hyperemesis gravidarum, induction of labour, use of EDA and prolonged labour [42].

Compared to women with no history of sexual abuse, women with a history of sexual abuse are significantly more likely to be transferred to hospital due to complications. Furthermore, they use more medical pain relief, while primiparae are more likely to give birth with a CS [39].

A Norwegian study has shown that only half of women who report having an experience of physical and sexual abuse in childhood have a vaginal delivery without complications, as opposed to the 75% of non-abused women.

Similarly, a study in which 103 women were interviewed four weeks after giving birth showed that women who have been sexually abused are 12 times more likely to experience the childbirth event as traumatic [43].

The traumatic experience of childbirth is particularly associated with the subconscious awakening of the trauma of sexual abuse. This manifests through flashbacks and body memory. The most frequent triggers are vaginal examinations or other procedures (e.g., enema, shaving etc.). Additionally, pain during or after the childbirth itself can be a trigger, particularly in the woman's vagina, stomach, back, breasts or crotch. It is the person who a woman should trust the most during childbirth who can subconsciously remind her of the perpetrator who abused her trust as an authority figure (e.g., teacher, parent, stepfather, coach, priest, etc.). The woman then (re)experiences the feelings of powerlessness, humiliation, shame and horror [29].

During the labour pains, a woman with a history of sexual abuse can start to feel that she no longer controls her own body - just as she did during the abuse. This is why, for an abused woman, having no control often feels like she is no longer emotionally and physically safe and that something bad is about to happen. This is why she feels stronger and safer if things are

structured – if she knows what will happen during labour, how it will roughly take place, what is normal and what she can expect. This information will help her to take a break from the constant control, worrying and waiting for what is to come. It is precisely these feelings that are very strongly related to the abuse they have suffered. Abuse teaches a person that it is “safer” to be constantly alert. Furthermore, the feeling of being endangered can lead to extreme behaviour, e.g., aggression, submission, rituals, constant crises, etc. [44].

“I had a problem with gynaecological examinations as long as I can remember. I can never completely relax. Having to spread my legs in front of a man that’s not my partner instantly puts me in situations that I experienced as a child. I also faced traumas during childbirth. My subconscious spewed memories from the past and, even though I suffered painful labour pains, I couldn’t help myself. The cervical exam...Horror, despair, panic, tears, anger...At that moment, I couldn’t calm myself and make myself understand that the obstetrician was only going to examine me. Despite the labour pains and big belly, I lifted my backside from the bed and sought refuge at the wall. My husband and the nurses tried to calm me down, but I didn’t care. The simple fact that someone wanted to examine me in the middle of my labour pains seemed extremely intrusive and horrible!”

During the sexual abuse of their bodies, some women are threatened. This can be not only verbally and psychically, but also physically (e.g., with a weapon). *“The labour pains intensified so quickly that I felt the gradual loss of control. I became more and more afraid. The pains got stronger and more intense. The body started contracting. My mind was full of thoughts and pictures of a rape that happened when I was two and a relative on my mother’s side tore my vagina...”*

Thus, the midwifery care or the midwife’s attitude, demeanour and responses are extremely important during childbirth. The body of a sexually abused woman has already been violated and tortured once. As a result, she may experience the midwife’s care as additional torture and violation. Additionally, phrases spoken by the midwife, e.g., “relax”, “nothing to worry about, I’ll just feel around a bit to see what the situation is”, “it will soon be over, hold on a bit longer” etc., are likely to awaken the subconscious organ memory of the same or similar words being spoken by the perpetrator, under different circumstances – during the sexual abuse [45]. This is why it is highly important that the midwife knows how to ensure safety and that she follows the reactions of the pregnant woman. The midwife needs to be open and accessible for a possible conversation in which she can reassure the mother-to-be that no abuse is taking place and that everything is normal. Above all, she must be respectful. In such moments, it is even better to have someone beside the pregnant woman who knows of her abuse and whom she fully trusts. This person can reassure her that what she is experiencing are reawakened feelings pertaining to her abuse; that the abuse is no longer happening and that it is safe. This double recognition and distinction between the past and the present is extremely important for the mother-to-be [46, 29, 47]. “Flashbacks” can be triggered and reawakened by a touch, words, the position of the woman or the care professional at the maternity hospital or a gynaecological clinic. The woman can react in various ways. She can freeze, become rigid, apathetic, her breathing or facial expressions can change and she can even exhibit signs of panic.

Women who are aware of their abuse and are consciously prepared for these feelings will be able to more easily control the situation. Furthermore, such women will be able to discern

that their feelings do not originate in the here and now, but have only been reawakened - it is safe [29, 48].

“My first childbirth was a real nightmare because I couldn’t cope with what I was feeling and with my body that failed me completely. When I should have pushed out my baby, I failed, despite numerous attempts, and so the child was born with a CS. When I got pregnant the second time, the push-out was what I was afraid of most. I feared that the same psychological and physical pain would repeat. I started going to therapy and I was set at ease when my therapist helped me understand what transpired during my first childbirth. The pain I felt in my vagina subconsciously reminded me of the pains I felt when, after practice, my coach would grope me and shove in my vagina everything - from his fingers and various objects to his penis. I always considered that part of my body the most dirty and disgusting. When I should have pushed my little baby girl through that space, I was repulsed and couldn’t do it, even though time was running out. As long as she was in my belly, she was still pure but then I had the feeling that she would have to swallow all the sperm and all the disgust the coach had given me. With this awareness and strongly determined that my body was clean, while the perpetrator was dirty, I went to give birth for the second time; this time, my son. I gave myself strength with words that my body could not be dirty, ugly and damaged if it was going to give birth to a new life. The birth itself would finally heal old wounds and give me back my dignity as a woman. Although my brain knew all this, the moment the midwife announced that I was fully dilated and ready for the push-out, I started feeling the same horror and anxiety as the first time. As if an invisible force wanted to drag me away again to the world of abuse. I couldn’t believe my body would fail me again. I started calling to God for help. And he actually answered. In my mind, I heard the words of my therapist calmly and tenderly resounding: “You are safe now. The earthquake is over. This is only a reawakening of the feelings you were not allowed to feel during abuse...Your uterus is a place where life is born and your body has a remarkable power,” she said. “Bring it back into a place of power and life-giving...” And that’s how I managed! Prouder than ever in my life, I heard the cry of my second-born child!”

It is much more difficult when a woman is not aware of her abuse. This is because the psyche and body experience are precisely what the woman has suppressed and unprocessed (fear, shame, anxiety, panic, despair, disgust, powerlessness, anger, etc.). Clinical practices have shown that many victims of sexual abuse freeze during the abuse itself (a subconscious defence mechanism that helps them survive the difficult events). This is why many victims feel that experiencing the consequences (e.g., flashbacks during pregnancy, childbirth, etc.) is even more traumatic than the original trauma (the abuse). In situations that are subconsciously reminiscent of their past experiences, the flashbacks awaken what they were not allowed to feel during the abuse itself due to apathy and dissociation. This often happens to victims who experience severe pain during their abuse. Consequently, such women may experience dissociation during childbirth. Here, their minds may wonder and they may not feel the pain. They are subconsciously fighting the pain. This can prolong and hinder the course of childbirth. In moments like these, it is very important that the woman can be “present” during childbirth. To do this, her midwife or partner (if he is beside her) need to “calls her back” with words, calm her, tell her she is safe and to believe that all will be fine with her body [45, 29, 47].

“Until the strongest labour pains started intensifying, I was really proud of how well I was doing because I was very afraid of giving birth. But the more the pain grew, the less present I was emotionally. I

suddenly felt I had tuned out into another world even though I didn't want to, but it was as if I had no power or influence any more. Only now and then I still managed to look around and the only thing I remember is the doctor coming to me and calling me by my name. When I heard my name, it seemed as if my brain had realized that I was safe but the body would not obey me. As if it had detached from me. The doctor suggested epidural analgesia and, even though my birth plan said I didn't want it, at that moment, I clung to every kind of help. Truly, the epidural helped me come back and also be emotionally present when my son was born. Having the possibility to decide at the most crucial moment has been one of the most powerful and most positive experiences in my life so far."

Women in therapy often say that, when dissociation occurs, what helps them the most is someone calling them by their name. In the above described case, the epidural analgesia helped because the physical pain (the labour pain), which was reminiscent of the pains during her abuse, triggered dissociation. In other cases, the epidural may cause dissociation or a panic attack. This is because the pregnant woman may feel that she is not in control of her body or that she is, in a way, tied, captured and cannot escape. As a result, she may experience feelings similar to those she experienced during the sexual abuse when her body froze.

Dissociation is strongly associated with the feeling of not being safe: *"I felt as if I followed the entire delivery from outside my body, looking down from the ceiling to the bed where I lay. This made me feel safer. But when contracting and dilating began, I started pushing and crying out for my mother...In my mind, I tried to escape to a safe place...I know it sounds weird, but I couldn't manage being present. I was exhausted from the touches..."*

Physical sensations, such as the stretching of the pelvis, tensions in the body, etc., can strongly remind a woman of, and reawaken, the sexual abuse recorded in her somatic memory – in her body. This impact is stronger and greater if the abuse she suffered involved painful penetrations or rape. General anaesthesia, especially the feeling of losing control over her body, can also arouse fear in a woman with a history of sexual abuse. However, in some cases, general anaesthesia facilitates a woman's ability to cope with childbirth [44].

"My partner and I really looked forward to the childbirth, although we were also afraid about how everything would unfold. I had heard a lot of stories, read a lot of literature, but despite all this I was still completely unprepared for such intense triggers and memories which seemed like a bolt out of the blue. All the horror began when I heard the screaming, bellowing and quick and loud breathing of a woman giving birth in the next room. My chest stung with pain and my heart began pounding with all its force. My legs froze. The more I was supposed to cooperate with the personnel, the more I began to fail. All the old feelings – lying in bed with my legs spread, shouting, panting, pain, the feeling of having no control – and the people around me, whom I was supposed to trust and who were supposed to take care of me, reminded me of the rape I had experienced when I was 12..."

Flashbacks can also be triggered by the **position of the body**, for example lying in bed. A woman who has been sexually abused night after night before sleep, while having to lie on her back in her bed, can experience bad and unpleasant feelings in this position [47].

"The most disgusting thought about giving birth was having to lie naked on my back with my legs apart because, for me, it's the same as rape, with the addition of people walking by and looking into my crotch. The moment I found out who my midwife was going to be, I took a risk and told her what I was most

afraid of and what worried me most. Thank God she was understanding and even thanked me for telling her. Her words that I could give birth also standing up or squatting calmed me so much that there were no more problems or complications because I could relax and believe that it really was safe."

"Until I got into a darkened delivery room, I was fine. But then I suddenly couldn't breathe anymore and the familiar panic and feeling that I'd simply die began intensifying. At that moment, they gave me sedatives so I could cooperate at least somewhat and hear what everyone who came into my room wanted from me. When I was almost completely calm, a bearded older doctor came into the room and my distress began again, but not as intensely. I can't believe that my body failed me again and it seemed as if I was falling into an abyss..."

In therapy, it transcribed that the above mentioned woman had, during her childhood, been sexually abused by her stepfather (man). This man had a beard similar to the doctor and would come into her room in the dark. During her labour, the health professionals entered without knocking or in any other way announcing their entrance, similar to how the perpetrator had come "unannounced".

Most often, the medical personnel is not even aware that they have the power to re-traumatize a woman who has been sexually abused. At the same time, with kindness and professionalism, they can help her experience the delivery as something beautiful. Sometimes a sentence is enough to calm a woman down or, quite the opposite, enough for everything to fall to pieces. Most abused women undergoing therapy report that they find it immensely difficult to tell their midwives or doctors that they have been sexually abused. This is because they are too afraid that the personnel might then look at them funnily or treat them differently. Furthermore, it is likely that some of them have never told anyone about their experience, not even their partner. Many women say that it would be most helpful if, during pregnancy, they had a person (perhaps a doula, a chosen midwife, a determined partner, etc.) who they could communicate their worries and fears to. This person would then be present at delivery. For a mother with a history of sexual abuse, it can be highly reassuring to have someone beside her who knows how she is feeling and understands her reactions to situations which reawaken painful memories. If the mother struggles, this person can speak to the personnel instead of the mother, making the situation "safe" again. When the abuse took place, there was nobody there to protect the girl and provide safety; to speak for her and draw the line or just reassure her that everything would be fine. This is why such a positive experience can be very healing for the victim.

7. Motherhood and the history of sexual abuse

The child is born. Even before giving birth, some mothers are afraid and worry about whether they will be competent mothers, whether they will feel the child, whether they will know how to protect it from dangers, etc. In this section, we explore the studies and clinical experiences relating to sexual abused mothers and their child (during breastfeeding, caring for the child and in their attachment to the child). Furthermore, how they raise their children and how sexual abuse can manifest in subsequent generations.

The first contact after birth is most commonly related to breastfeeding. This involves not only the connection between the mother's and the child's body, but also a very strong emotional bond accompanied by the most varied experiences. If a sexually abused mother feels an aversion to breastfeeding; perhaps this reawakens feelings relating to abuse and reminds her body that someone has been disrespectful to it, then she needs to be given as much support as possible and not be pressured to breastfeed at any cost. Even though her body is completely ready to breastfeed, this does not necessarily mean that her psyche is. This is why emotional contra-indicators need to be taken into account [30].

Accounts of clinical experiences have shown that this often happens to women whose breasts were groped during abuse. As a result, the baby's suckling can act as a trigger that reawakens their fear, anxiety and disgust. Nudity reminds them of how it felt to be exposed and unprotected during abuse. Thus, the first contact between the mother and the child in the maternity hospital, when the baby is laid on the mother's breasts, is extremely important.

"When they laid the child on my breasts immediately after the delivery and tenderly neared its head to the nipple so it began suckling, I felt very comfortable. It meant a lot that the midwife was nice and didn't do anything by force. But the second day in the ward, it was completely different: an unkind nurse grabbed my breast with one hand and the baby's head with the other and pressed the baby on my breast so roughly that it only choked, while I cried and couldn't say anything, I just froze. In addition, she said that breastfeeding was no science since every animal knew how to feed its young. I was furious with myself for not being able to say anything back to her but I felt so helpless and vulnerable that I cried long after this incident, blaming myself for being a worthless mother who can't protect her newborn child."

Some mothers feel that their milk is dirty because it comes out of their breasts (that were "dirtied" by the perpetrator during abuse). Many mothers feel more relaxed if they have had a daughter, as opposed to a son (because a man abused them and now a "man" is suckling). Other mothers still limit the breastfeeding to daytime. At night they only bottle-feed the baby with pumped milk.

"Strange, but true, I couldn't feed my baby at night because I would find it hard to breathe and I saw in the baby someone who wanted to hurt me. I organically couldn't press it to my bosom. During the day, I didn't experience these feelings at all and I felt like a horrible mother, guilty for having such feelings towards someone completely innocent. Even if I turned on the lights, moved from the bedroom to the living room, it didn't help. Only when I became aware that this was related to my being abused at night; when my father would come to sleep with me because my mother worked the night shift, did the guilt lessen a bit. As long as I breastfed, I was not calm as a mother. I felt much better when the child gradually began eating solid foods and didn't wake up as often during the night."

Clinical experiences show that a similar or an even greater distress is caused by an abused woman's partner's jealousy of their child. This happens during breastfeeding in particular. During breastfeeding, the mother tenderly gives the baby all of her attention. With this, the mother establishes contact through feeding and changing her child, putting it to sleep and cuddling it. A partner who is jealous of this most likely demands attention, exclusively for himself. He may oppress the mother, even when she wants to get up in the middle of the night

to comfort and calm the crying baby. He may stand in front of the door, for example, or not allow her to go so as not to “spoil” the child. Even worse, he may demand that she be sexually available to him, perhaps even before her check-up six weeks after the birth and before she is psychologically ready.

Women in abusive relationships much more often have an unplanned pregnancy a few months after the birth [49]. Many other studies [18, 50, 51, 44] report that CSA survivors are less content in intimate partner relationships. Overall, there is more discord and violence. Furthermore, there is a higher probability of divorce.

In such a distressful situation, if the mother is lonely and has nobody to support her, she can lose her milk. Furthermore, in order to have some peace from her partner or her awakened feelings, she may decide not to breastfeed anymore. It is extremely important that her environment and medical personnel (the visiting nurse, paediatrician, gynaecologist, etc.) do not judge such a mother or guilt-trip her as this could be devastating for her. This reaction to breastfeeding does not make her a bad mother. If she were to breastfeed, the extreme anxiety she would experience would harm her relationship with her child - far more than not breastfeeding.

“If only I had at the time one person to tell me that I wasn’t to blame and that I was a good mother, for I did my best, but I just couldn’t manage. Due to the violence I was subjected to daily by my partner and due to his jealous outbursts if I cuddled our child, I stopped breastfeeding because I had constant problems. My baby girl cried because she waited for me to press her to my bosom, but I had to “calm” him first to gain the “right” to breastfeed the child. I was so relieved when he went to work. When the same thing repeated with the second child, I couldn’t manage anymore and I got help. I feel better today when he’s not here because he went elsewhere. I prefer not to remember that difficult period.”

Heightened sensitivity, hormonal changes, sleepless nights, possible discords in the partner relationship, adaptation to the rhythm of feeding and putting the baby to sleep, crying and comforting – any of these strongly affect a mother’s wellbeing. However, if the mother has an experience of sexual abuse, it is even harder for her to trust her body and intuition. If she experienced her body already failing her during childbirth, she is even more afraid to trust herself afterwards. She is not sure that she is right about what the child needs when it cries, cannot sleep or refuses to breastfeed. This is precisely why feelings of shame, guilt and anxiety frequently manifest in a sexually abused mother.

All of these feelings are even more present if the woman grew up in a family living in utter chaos or in which everything was wrong and there was no safety. If this was the case, she may develop an intense need to do everything right as a mother. Endeavouring to raise her child differently can lead to extremes – to perfectionism. This can manifest in selfless devotion, that is, in her putting all the child’s needs above her own, while suppressing a lot of anger and frustration deep inside her. Such a mother will probably be very critical of how other parents raise their children. She will see herself as different, often stigmatized (as a little girl, she already felt different and stigmatized due to abuse) [49].

The results of a study [52] that measured the parenting characteristics of female survivors of childhood sexual abuse have highlighted some prominent traits: difficulties in setting clear

generational boundaries between parents and children, two extreme parenting styles – either permissive parenting or the use of harsh physical discipline. Mothers with a permissive parenting style may avoid invoking parental authority because of their own negative experiences as victims of adult power [53]. They may feel less efficient and “in control” in the parental role. Consequently, they have less confidence in setting appropriate boundaries [54]. Moreover, because they are emotionally more wounded due to the sexual abuse, they have less energy to enforce discipline or appropriate behaviour of their children. They can be easily manipulated by crying children, presumably due to an over-identification with their children's unhappiness [55].

Contrary to this, using physical violence and other harsh parenting methods are likely indicate that the parent is repeating what they were subject to as children. In this, they must not feel the child's pain, for this would mean that they would first have to face the pain they had experienced with their parents. Thus, they subconsciously preserve contact with their parents, albeit in a negative sense, and transmit the patterns of violence [46]. Zuravin et al. [56] suggest something similar. They claim that the maternal history of sexual abuse involving intercourse is related to the increased chances of physical abuse, sexual abuse or neglect in the second generation.

“I remember my aunt telling me once that my mother had been raped as a teenager. I can't understand how this experience didn't make her protect me from the abuses of my father and brother. As if she didn't know what it meant for someone to dirty you like that and seal your fate?! Once, when she came into my room, she saw what my father was doing to me, but she just closed the door, went away and never said anything. THIS hurt me even more than everything I experienced from my father and brother. And I felt guilty, as if I was stealing her husband. I feel sick just thinking about it. She was so cruel as a mother. I fear whether I'll know how to protect my daughter so that nothing like that ever happens to her.”

Additionally, children of abused mothers are often parental, taking care of the emotional needs of their mothers who are, in a way, emotionally dependent on them (no healthy boundaries). Compared to their peers, these children look much more grown up. However, in the long term, their own development can suffer [57]. Clinical experiences show that mothers often treat their children as confidants and friends. This is particularly the case if they do not get along with their partner. Mothers reporting a history of incest were more likely to interact with their sons in a subtly seductive manner, considered to be indicative of generational boundary dissolution [58].

“Until recently, my mother and I were best friends. She confided everything in me, even the sexual problems they had with my father. How I felt or what went on with me never interested her. She often even said that if she hadn't had me, she'd have rather died. She was jealous of my friends who were never good enough for me. I thought all this was normal, even more, it seemed a special privilege that not all daughters were entitled to. But when I was treated for bulimia, I discovered what she did to me. She attended the sessions a few times and the therapist discovered that just like she overstepped all emotional limits with me, so a man in her childhood overstepped all limits with her, also in the sexual sense.”

In general, children of sexually abused mothers show a more helpful, protective, managing and controlling behaviours towards family members. On the other hand, children of non-

abused mothers show significantly more trusting, deferring, relying and submitting behaviours [59]. Grocke, Smith and Graham [60] have found that, compared to children of non-abused mothers, children of CSA survivors are more prone to interpreting ambiguous pictures of children and strangers as negative or frightening. They also believe that sexually abused mothers teach their children about the male and female sexual development and contraception-related topics in more detail. Such mothers find this increased communication essential. This is because they presume that it will protect their children from experiencing a similar sexual abuse. On the contrary, Douglas [61] reports that mothers with a history of sexual abuse are more anxious in child care, requiring intimate contact such as changing, bathing and putting to bed. Even though these activities, as such, are not “sexual”, they may indicate that, because of the mother’s unease, sexuality and intimacy will be taboo topics in the child’s growing up.

Women who are aware of having been sexually abused may often fear that they will themselves **abuse** their child. The fact that the mother is afraid is a sort of safeguard and it is, therefore, quite unlikely that she would sexually abuse her child. However, there can be situations in which she feels aroused. For example, during the changing, bathing or breastfeeding of her child. Her body tells her that what is happening is not natural, that it is perverted. Particularly, this can happen if she, herself, has been sexually abused on the changing table. In this case, she may not even have the images in her explicit memory, that is, she cannot recall the event of the abuse. It suffices that her body remembers it, that the abuse is recorded in the organ memory - in implicit memory. If arousal or disgust occur, it is important that the mother controls herself, that she takes time to evaluate her feelings. In other words, it is necessary that she sets boundaries and becomes aware that it is her abuse reawakening; that her child deserves pure love. She has to feel able to withdraw, go to her partner and communicate these feelings if she is unable to process them herself. When this does not work, it is necessary that the mother seeks the help of a professional who will assist her in going through the emotions of abuse (disgust, shame, etc.) and help her work through them. It is not necessary for inappropriate touching to occur during the changing or bathing of the child, the atmosphere can already become terrifying and abusive when the mother feels aroused by the child’s innocent and powerless body (just like someone who sexually abused her as a little girl was aroused by her as an innocent and powerless child). At the same time, the mother feels contempt for and disgust with herself for having these feelings. These feelings and real bodily sensations are unfair, both on the mother who experiences them and on the child who, through the projection-introjection identification, senses and feels her distress or, even more, when the child drinks these feelings of abuse on her bosom [29]. In such an atmosphere, it is more likely that the unresolved feelings (perhaps even the action itself) will lead to an intergenerational transmission of the trauma of sexual abuse, which we will discuss in the next section.

8. Intergenerational transmission of the trauma of sexual abuse and motherhood

Johnson [62] claims that people who are victims of emotional, physical or sexual abuse are six times more likely to continue the abuse they have suffered. Other studies [63] have shown that

half of the mothers whose children have been sexually abused have, themselves, been victims of sexual abuse. If the act of sexual abuse is not transmitted, this does not mean that the children of sexually abused parents will be safe from sexual abusers. Relational family therapy [16] discusses the unresolved effects of abuse, including disgust, shame and anger. These are vertically transmitted from the abused parent to the child through the mechanism of projection-introjection identification. Even if this parent tries to warn the child about all the dangers of abuse [64], but is not in touch with the unprocessed effects and therefore does not know how to protect him/herself and set boundaries, it is much more likely that the child will become a victim of sexual abuse [16]. Miller suggests something similar in her *The Body Never Lies: The Lingering Effects of Hurtful Parenting* [65]. Here, she argues that childhood abuse is resolved in two ways: grown-ups who have been sexually abused as children transmit their unacknowledged emotions to their children or other people around them. Alternatively, the effects are suffered by the body of the abused person with psychosomatic or chronic diseases. In his study, Cross [55] reports that 34% of mothers whose children have been sexually abused have, themselves, been victims of sexual abuse. In their work, McCloskey and Bailey [66], state that it is three to four times more likely that a daughter of a mother who was a victim of sexual abuse would herself be sexually abused, than in cases when mothers had no experience of sexual abuse. They believe that a common reason for the transmission of sexual abuse between generations is the preservation and continuation of contacts with the family members involved in the sexual abuse of the mother and then, also, the daughter. Other studies have shown that mothers of children who had been sexually abused like them exhibit a higher degree of stress and symptoms of post-traumatic stress disorder [67]. Additionally, they express fear that they will be bad mothers, directing hostility and frustrations towards their children [55]. Sexually abused mothers also show difficulties establishing a structure, expressing affection and love for their children. They feel mixed emotions towards them and fear that their children will also become victims. This often results in them socially isolating their children, in order to protect them [55]. The results of a study by Hall, Sachs and Rayens [68] show that mothers with a history of sexual abuse use physical punishment on their children six times more often than mothers who have not been sexually abused. Cohen [69] stresses that, if they have not worked through the abuse, sexually abused mothers are less skilful and functional in the parental role.

One of the responses to an unprocessed sexual abuse can also be seen in the mother's negative behaviour towards the child. For example, if the mother has been sexually abused as a little girl just as she started saying her first words, she may subconsciously feel an intense dislike and negative attitude towards her child when it starts to talk. She will not know what is going on but her body will testify to her distress. If she is able to take this distress seriously and allow herself to feel the girl inside her, then she will be able to accept her child. If not, this rejection and refusal of the child may intensify to a degree of neglect [30].

Some cases of unprocessed and repressed sexual abuse of a mother can come to light when, at a certain age, a child begins to frequently get ill or when various psychosomatic signs appear, sometimes also behavioural or learning problems. Usually the age at which certain symptoms emerge, (e.g., headaches, bedwetting, troubles sleeping etc.) coincides with the age at which

the mother was sexually abused. With an ailing child, the mother may feel powerlessness, fear and even anger for having to keep going to the doctors. However, all of these feelings actually belong to her sexual abuse. Her child merely activates and reawakens them as they have not yet been processed. This is because she is not in contact with them. As a girl, when her body was exposed and unprotected, she felt fear and powerlessness. She had to suppress her anger at an injustice she suffered. When she senses the child's distress and sympathizes with it, she will help herself and contribute to the resolution of the feelings from her abuse. This will help not only her child, but also the little girl still living inside her who never really received any compassion, safety and support.

9. Conclusion

The body never forgets sexual abuse. Even if the psyche pushes it to the subconscious because the pain is too great, the body will cry for help in every possible way (through psychosomatic troubles, health issues, addiction, workaholism, conflicts in a partner relationship, depressions, etc.). Years, even decades, can go by before the consequences of the abuse surface. If the abused woman functions normally, it may seem that she has no problems. However, one trigger, like pregnancy or childbirth, may suffice for sensations and feelings similar to the ones during the sexual abuse to start uncontrollably emerging. Most survivors do not even relate this to the original trauma, looking for the causes somewhere else completely. Yet, the problem is not solved until the trauma is. In the safe and trusting therapeutic environment, there is a way out of the vicious circle of distress and pain. However, it is a long process for which the abused needs a lot of strength, determination, resolution and encouragement, especially when the occasional crises occur. Clinical experiences have shown that, with an in-depth and successful therapy, an individual can live a very good and decent life. After successful therapy, they feel that they finally have "control" over the past - and not the other way round. At the same time, due to the distinction between the present (when something merely awakens) and the past (when something actually happened), such a person is much more relaxed as a parent. She can trust her intuition and body and feel her child as a mother. This means, of course, that she does everything to protect the child from experiencing a violence similar to the one she had. She emotionally equips the child so it is able to go out into the world. She ensures to sever the intergenerational transmission of the trauma of sexual abuse.

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