Sexual Assault and Birth Trauma: Interrelated Issues

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Full Text: Headnote ABSTRACT: A host of corresponding sensations and dynamics may be present during birth and during sexual abuse. Physical, emotional and environmental similarities between the original experience of birth and sexual abuse imbue these traumas with common symptomology, feelings and life patterns. The "terrain" of both traumas is the body which often stores both memories and affect. Later sexual abuse traumas often become merged with earlier birth and prenatal traumas. In the therapeutic setting the symptomology, abreaction and artistic expression of these two issues can be highly similar. These issues and concerns have only been briefly dealt with in the literature. Only a handful of clinicians, consulted during the preparation of this paper, were familiar with or knowledgeable about significant psychological relationships between sexual abuse and the trauma of birth. PRIMARY THEMES OF THIS ARTICLE Childhood sexual assault is one of the later life experiences which: 1) has a particular propensity to reform a latent birth stress into full blown trauma; or 2) can further activate reverberating elements of a painfully traumatic birth creating a compounding of the birth trauma (Grof, 1985; Roth, 1987). In compounded birth trauma an incidence of sexual assault, and what has been designated as "rape trauma syndrome" by Burgess and Holmstrom (1974), are experienced through and layered upon earlier interpretations of the traumas of birth (Grof, 1975). 3) Similarities between sexual abuse (SA) and birth traumas (BT) predispose their issues and symptomology to interconnection in the psyche (Irving in Carter, 1991). The experience of birth and sexual abuse, and the nature of how the psyche copes with these traumas means that as separate experiences they can have a legacy of similar feelings, life patterns and symptomology. 4) Sexual assault and traumatic birth can therapeutically present in manners which for all intents and purposes appear similar. While working psychotherapeutically with either sexual abuse or birth trauma the symptomology and issues of the other trauma may simultaneously and spontaneously appear (Bernhardt et al., 1993). COMPOSITE EXPERIENCES OF A TYPICAL CLIENT The client in regression is gagging, has feelings of a weight pressing down. There is the sense of being hot, sticky and maybe even being naked. In amidst the feelings of chaos and confusion, the body feels drugged and nauseated. There are few spoken words coming forward in expression which is largely body memory retrieved from what feels like a place of darkness and betrayal. The terrified person is overwhelmed with helplessness and despair, it feels like there is no way out of an imprisonment. In the sensation of suffocation and physical torment there is fear of impending death. Indeed the original primary recourse to survival of this long ago trauma was psychic death or some form of dissociative splitting. Seeking reprieve and understanding of the rising quagmire the client struggles with the few words of, "I do not know where this is coming from." Watching this scene it is clear the client is experiencing great suffering and that a request is being made to be helped through terribly painful memories. The scene just described could be a client in regression to birth or regression to sexual abuse traumas. ENVIRONMENTAL SIMILARITIES The shared metaphors, feelings and somatic expression of birth trauma and sexual abuse which can be observed in various stages of the therapeutic process are in part a result of their similar original environmental conditions. Bass and Davis (1994) in Courage to Heal: A Guide for Women Survivors of Sexual Abuse, reassures survivors that as sexual abuse memories surface, "You may physically reexperience the terror, your body may clutch tight, or you may feel that you are suffocating and cannot breathe" (p. 83). This sounds quite similar to Khamsi (1987) in Birth Feelings: A Phenomenological Investigation reporting that when birth memories surfaced, "Subjects reported having felt crunched, crushed or squished . . . . Not getting enough air, of choking and feeling suffocated . . .[and] fear of death" (p. 53). The weight and pressure of birth is due to the tightening womb and the constricting birth canal (Lake, 1981b), the weight of sexual assault comes about as a result of the heaviness and force of the perpetrator's body. Suffocation feelings in birth are due to reduced oxygen in hard and prolonged labour, premature (partial) separation of placenta, an umbilical cord around the neck, a cramped or kinked umbilicus or too early clamping and cutting of the cord directly after birth (Hull, 1986). Suffocation during sexual assault can be experienced in response to oral penetration, the pressure and weight of the abuser's body or from assaults involving direct strangulation or suffocation (Irving, 1993b). Birth occurs in the darkness of the womb and the birth canal, sexual assault can be perpetrated in a darkened room (Carter, 1991). Khamsi (1987) reports that in reflecting on birth regression, "A few subjects mention a sense of being in darkness" (p. 53). McClure (1980) notes that in incest flashbacks "The images are of shadowy figures, always described as dark, featureless silhouettes" (p. 14). This flashback imagery is reminiscent of assaults taking place during the dark silence of the night. Sensations of hot and cold during birth are in response to the physically active and arduous birth canal and sudden movement into a cold delivery room (Lake, 1978a); the body heat of sexual assault or lamps used in making child pornography can create uncomfortable feelings of heat and being naked during sexual abuse can result in chills and feelings of cold (Weiner, 1989). Numbness and drugged feelings at birth may be manifestations of psychological overload (Lake, 1979) or anaesthesia (Janov, 1983); similarly deadness during sexual assault can be initiated by the overwhelming degree of trauma (Herman, 1992), or the numbing associated with sexual abuse may be artifacts of drugs or alcohol given to the child during abuse to pacify and fog out awareness of what is happening (Oksana, 1994). Penetration, physical invasion, violence and violation at birth can be experienced as a result of insensitive suctioning, abrasive wiping, heal lancing, circumcision and other medical examinations (liedloff, 1985); penetration and physical violation are often components of sexual assault (Roberts, 1983). Birth and sexual assault can have experiences of pain associated with sexual arousal (SA-Forward and Buck, 1978; BT-Grof, 1985). Later sexual sensations, especially when associated with pain or near death can bring one back to the realm of birth (Carter, 1991). Chamberlain (1989) notes, "some men carry conscious memories of circumcision" (p. 303). At birth circumcision as a mutilation of a sexual organ is a sexual assault with long lasting consequences (Chamberlain, 1994). Some parents have noted the look of rage, bewilderment and betrayal on the face of the child upon being circumcised (Rich, 1976; Peterson, 1984). Chamberlain (1989) shares one father's observation of his infant's response to circumcision, "It was one of the saddest occurrences of his babyhood and that he cried more that afternoon than anytime in his first year" (p. 303). SHARED SYMPTOMOLOGY Sexual abuse and traumatic birth experiences can be manifested in many common symptoms which may plague the person for a life time such as: a fear of tough and tactile defensiveness, difficulty swallowing, feelings of no room to breath, feeling trapped, a sense of being pushed too far into something one is not ready for, claustrophobia, fears of being confined or aversion to confined spaces, hyper-vigilance in making sure there is always a way out or an open door, fears of penetration or violence (SA-Herman, 1992; BT-Grof, 1985). Feelings of betrayal, isolation, lack of safety, difficulty in trusting can be associated with the overwhelming qualities of traumatic birth or sexual assault (SA-Herman, 1992; BT-Gabriel, 1992; Turner and Turner, 1993). The degree of trauma in sexual abuse and traumatic birth can create shock with the symptoms of splitting and dissociation (SA-Briere, 1989; BT-Carter, 1991). Khamsi (1987) reports common emotions attached to birth trauma can be, "feelings of anxiety, desperation, discomfort, helplessness, hopelessness, loneliness, neediness, powerlessness, sadness, and vulnerability, and impressions of being abandoned, unloved and unwanted" (pp. 53-54). Feeling you can not tell anyone, no one cares, no one listens, one's distress and terror goes unnoticed and one is alone in suffering are normal responses to the isolation of these traumas (SA-Rush, 1989; Butler, 1978; BT-Turner and Turner, 1993). Herman (1992) specifies, "At the point of trauma, almost by definition, the individual's point of view counts for nothing" (p. 53). For the victim, even therapeutically addressing and working through these traumas can be an isolating experience, in that there is significant professional and social denial questioning the validity of birth and sexual abuse trauma and memory (SA-Bass and Davis, 1994; BT-Verny, 1981). Suicidal and self-destructive urges are well known symptom manifestations of childhood sexual abuse (Bass and Davis, 1994). Courtois (1988) reports that, "sexually abused clients were twice as likely as nonabused clients to have made at least one suicide attempt in the past and more frequently reported suicidal ideation" (p. 305). Janov (1983); Salk et al. (1985); Jacobsen (1988) and Roedding (1991) have shown a relationship between birth trauma, suicide and suicidal impulses. Roedding (1991) states, "It is the varying severity of dying at birth that differentiates the degree and nature of behavioral acting out for suicidal or non-suicidal persons" (p. 48). Grof and Halifax (1977) report "Severe suicidal urges disappeared completely when some patients worked through and integrated prenatal material" (p. 213). The sensation of a difficult birth and sexual assault will somatically revisit the person particularly during times of stress. Janov (1983) states that when the birth traumata is triggered, "under anxiety he will feel pressured, dizzy, fatigued, suffocated; he will gag, have localized pains, choke" (p. 71). Sexual abuse and traumatic birth experiences as physical assaults and as traumatic stresses are stored in the body (Marcher, 1990) and can be associated with somatic difficulties such as a predisposition to throat or bowel problems, pressure on the chest, difficulty breathing, asthma, stomach disorders and headaches, joint and muscle pain, neck and back problems and panic attacks (Finkelhor, 1986; Morrison, 1989; Grof and Halifax, 1977). Hendricks and Hendricks (1987) report that: Common physical experiences and symptoms appear in those clients replaying perinatal issues. Then tend to have histories of respiratory distress or illness, such as strep throats, bronchitis, allergies, chronic colds. Breathwork will often elicit tremendous congestion or mucous discharge. Stress or energetic situations tend to create nausea with headaches, dizziness or head pressure, (p. 234) Generalized guilt, shame and self blame are basic to trauma (Herman, 1992). Sexual assault or a painful birth can be experienced as punishment for being born the wrong gender or as reproof for even simply existing (SA-Engel, 1989; BT-Gabriel, 1992). It logically follows that sexual assault can effect sexuality (Butler, 1978), but it is also the case that painful birth experiences can influence feelings and attitudes related to sex (Levand, 1991; Rossi and Cheek, 1988). Responses to both birth trauma and sexual assault can be a fear of losing control, fear of convulsions, fear and avoidance of sex, going dead or numb during sexual intimacy or at the point of orgasm (SA-Lew, 1988; BT-Janov, 1983). Khamsi (1987) reports that when research subjects tried to cognitively describe aspects of birth regression, "the most common comparison of birth feeling was to sex." Clients commented, "its like sex but not at all sexual," "there's some similarity with orgasm [but there] isn't that lovely feeling of an orgasm." The numerous shared environmental and symptomological similarities of birth trauma and sexual assault destine them to an interrelationship in the psyche and the therapeutic process (Marcher, 1990). According to Grof (1985): Because of this similarity [ies] between the experience of rape and the birth experience, the rape victim suffers a psychological trauma that reflects not only the impact of the immediate situation, but also the breakdown of the defenses protecting her against the memory of biological birth, (p. 215) TRANSMARGINAL STRESS The phrase transmarginal stress delineates a response to those painful experiences which threaten the very integrity of the self and which transcend the margins of normal coping abilities (Moss, 1986). Transmarginal stresses can be physically life threatening events or psychological conditions in which the psyche is devastated to the degree that the emotional pain itself feels life threatening or annihilating. Maret (1995) explains, "When the absolute margin of tolerable pain has been reached and passed, paradoxical and supra-paradoxical response patterns result" (p. 13); Lake (1981a) forwards that at this point, "The self turns against itself, willing its own destruction and death" (p. c41). The shock response to transmarginal adversity affects the ability to consciously meet and integrate the challenges of the moment and the continual reverberations of this unresolved shock (Herman, 1992). The condition of shock greatly reduces the psyche's capacity to recover from stress (van der Kolk, 1994). Herman (1992) states, "Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection and meaning" (p. 33). Sexual assault or a particularly difficult birth constitute transmarginal stresses (Irving, 1995). It has become well recognized that sexual assault creates long lasting symptoms of Post Traumatic Stress Disorder (Burgess and Holmstrom, 1974). Solter (1984) states that for some babies, "Events occurring during labour and immediately after birth can cause severe psychological as well as physical pain." Verny (1981) concludes that birth, "is the first prolonged emotional and physical shock the child undergoes, and he never forgets it." Marcher (1990), suggests that for some infants birth is a physical and emotional annihilation which activates the dynamics of shock or what is categorized as Post Traumatic Stress Disorder (Irving, 1995). When a person has to cope with both birth and sexual abuse traumas the attributes of the psyche which manage shock interweaves the intense distress and fears of the two conditions. Marcher (1990) concurs: "Because birth is physiologically linked to shock, when any shock issue emerges in life, it may trigger birth memories." Carter (1991) states, "These [traumatic] events are so powerful to the psyche because they bring the individual to a confrontation with death and reactivate the birth trauma." It is possible for the client working on sexual abuse to be drawn into the shock states of earlier trauma, Macnaughton (1993) recognizes, "It is possible for them to slip into unfamiliar states of consciousness, access post traumatic shock experiences, or collapse into regression towards early wounds without adequate internal support to resolve these issues." .,.... Incidences of physical and psychological shock are coped with through splitting dissociation, derealization, depersonalization and disengagement (Andreason, 1985). The "breaks in mutual connection" to others which results from transmarginal experiences leaves the trauma victim isolated and without ability to reach out for the very support and humanity which could make a difference (Bernhardt and Marcher, 1992). During experiences of sexual abuse and traumatic birth there can be profound feelings of hopelessness, a total loss of safety and support and a sense of overwhelming terror (Alford, 1992; Hull, 1986). The shock of birth trauma and sexual assault induce altered states of consciousness (Herman, 1992; Noble, 1993). Due to the overwhelming qualities of transmarginal experiences they are not able to be deeply buried and tend to reverberate close to the surface of the unconscious in forms of extreme tension (van der Kolk, 1994). Dolan (1991) acknowledges, "Unfortunately, such dissociative attempts as amnesia, numbing, and 'spacing out' are rarely, if ever, fully successful in the original situation" (pp. 6-7). Due to the dissociative split of cognitive memory and body memory the sexual abuse survivor, according to Bass and Davis (1994), "may be assailed by unexplained physical pain or arousal, fear, confusion or any other sensory aspect of the abuse" (p. 83). For the survivors of birth trauma and sexual abuse these reoccurring somatic flashbacks and lingering trauma feelings create patterns of panic, fear, nightmares, physical pains, confusion and hypervigilance (SA-Herman, 1992; BT-Khamsi, 1987). BODY MEMORY The terrain of sexual abuse and birth traumas is the body (SA-Engel, 1989; BT-Carter, 1991), they are therefore likely to be managed and contained to a high degree through somatic or body memory (SA-Marcher et al., 1990; Fredrickson, 1992; Bass and Davis, 1994; BT-Lake, 1981b; Buchheimer, 1987; Garland, 1992); or in the realm of the non-verbal psyche (SA-Duncan, 1994; BT-Holden, 1975; 1977; 1983; Chamberlain, 1983; Roedding, 1991). Khamsi (1987) reports, "Birth feelings were described as intensely physical-an all-encompassing, pervasive, totally involving body experience" (p. 52). Long past birth and sexual assault incidences may be associated with little visual or auditory memory due to environmental conditions during the experience of the trauma (SA-Bass and Davis, 1994; BT-Janov, 1983). The wounds of sexual assault can be inflicted in the dark, often during wordless interactions as was the case in the passage of birth, significant elements of the traumas are not seen and not heard (Carter, 1991). Both traumas are rarely cognitively explained or verbally mentioned to the survivor. At the time of the trauma and later, the tactile and kinaesthetic somatic sensory and process systems can register and interpret these non-auditory/non-visual experiences rather than language consciousness (Bass and Davis, 1994). Cognitive knowledge of either trauma may be inherently dissociated from emotional or somatic awareness as the transmarginal qualities of both traumas are often coped with through a degree of splitting (Briere, 1989). The separation of body, feelings and cognition can also result through the trauma feelings and memories being stored and managed in dissociative structures or even specific hidden ego states (Watkins and Watkins, 1979; 1990). Hindman (1987) points out dissociation or amnesia is used by 57% of sexual abuse victims "who cannot put the pieces together, who cannot cope with the incongruity of sexual abuse" (p. 84). In addition the overwhelming nature of sexual assault means that it is difficult to conceptualize, contain or describe with words (Herman, 1992). The contribution of these numerous dynamics means that sexual assault, like the wounds of birth, may be significantly processed through mental and emotional processes outside the domain of verbal cognition and cerebral memory (SA-Tinnin, 1990; Joseph, 1992; BT-Stewart, 1987; Buchheimer, 1987). Therapies which emphasize verbal dialogue or discount somatic consciousness present difficulties for addressing traumata associated with a significant degree of body memory and nonverbal processes (Janov, 1970). Conversely, therapies primarily focusing on somatic body expression may not provide containment, structure and conceptualization for overwhelming and difficult to understand body feelings and memories (Feher, 1980). When both body and brain are valued and integrated profound somatic injuries can be identified, expressed and resolved (Verny, 1994). CONFUSION, CHAOS AND NAUSEA Feelings of confusion and chaos are associated with the retrieval of birth and prenatal trauma as the psyche reconnects with experiences which occurred before the development of language (Janov, 1971) and which have been stored and processed in nonverbal/preverbal regions of the mind (Feher, 1980). Many incidences of sexual assault are perpetrated with little or no verbal exchange and exist within a family system of covert silence (Courtois, 1988), resulting in the traumata being psychologically managed through nonverbal resources of the psyche (Tinnin, 1990). The child who is sexually abused is threatened to tell no one which compounds the non-verbal character of the trauma (Crewdson, 1988). Van der Kolk (1994) reports that, "When people are traumatized they are said to experience, 'speechless terror': the emotional impact of the event may interfere with the capacity to capture the experience in words or symbols" (p. 258). According to Janov (1983) confusion is a significant factor in traumatic birth because, "Events are taking place for which the baby has no name, no precedents and no control" (p. 172). The non-discussed, nonverbal and preverbal nature of the traumas contributes to making these rising feelings and memories confusing and foreign to the rational and cognitive language mind (SA-Duncan, 1994; BT-Catano and Catano, 1986). As overwhelming, unresolved and unintegrated psychological material surfaces in the therapeutic process a person can experience feelings of confusion and chaos (Herman, 1992). The feelings of hopelessness, confusion and going crazy can be direct expression of feelings which occurred during the original traumatic events (SA-Davis, 1991; BT-Janov, 1983) and/or can be an artifact of confronting overwhelming psychological material (Bernhardt, 1992). Psychologically shocking qualities of sexual assault or birth can make them verbally unfathomable and unintegrateable during their initial occurrence (SA-Joseph, 1992; BT-Lake, 1981b), therefore a degree of confusion is an innate artifact of the initial trauma experience and its latent memory and feelings (SA-Blume, 1990; BT-Noble, 1993). Children can be drugged or intoxicated to make them complacent during sexual assault (Oksana, 1984; Braum, 1986). As in the anaesthetized birth these drugged conditions distort and depress the initial traumatizing experience (SA-Oksana, 1994; BT-Brackbill, 1979; Verny, 1981) and when the emotional and somatic memory sensations of the drugs are present during therapeutic regression they can revivify the original confusion and deadness (SA-Marcher et al., 1990; BT-Janov, 1983). Chamberlain (1987) maintains that, "The effect of drugs and anaesthesia on the cognitive activities of babies is potentially profound" (p. 49). When a drugged or intoxicated sexual assault is layered on a drugged birth the psychological defenses learned during the initial birth anaesthesia can be reactivated, intensified and more deeply ingrained as a coping strategy of going numb under stress (Roedding, 1991). Bass and Davis (1994) note that, "During the trauma of sexual abuse, children often numb themselves, just as surgery patients [and sometimes mother and child during birth] are anaesthetized to avoid excruciating pain" (p. 220). In the therapeutic healing process the emotional and cognitive numbing and deadening attributes of anaesthesia and drugs from trauma presents difficulties for therapist and client alike. Noble (1993) notes that, "During regression these people may go limp, black out, smell ether, become numb, or feel in a fog." These elements of the rising trauma stifle therapeutic abreaction, insight and resolution in much the same way they inhibited consciousness at the time of the initial trauma. To keep the therapy "moving" the client may need additional support and encouragement when anaesthetized feelings of going dead or wanting to space out surface (Noble, 1993). Clients with sexual abuse or birth memories surfacing may have mild to intense experiences of nausea (SA-

Engel, 1989; BT-Hendricks and Hendricks, 1987). The nausea can be a side effect of drugs during sexual assault or be side effects of birth anaesthesia (Janov, 1983). The nausea can be an artifact of confronting and moving through physical and psychological shock (Briere, 1989). Confusion and nausea sometimes occur when dissociative barriers of sexual abuse or perinatal trauma are lowered or broken through. These can be symptoms similar to the nausea and headache of migraines (Lake, 1978b). The type of migraine symptoms of sexual abuse or birth trauma can be quite similar although with birth trauma the cranial pain or "belt headache" (Grof, 1985) may be close to the surface of the skull with a band of pressure squeezing in against the scalp (birth canal) (Janov, 1983), accompanied by a feeling of wanting to push through the pain (birth canal) (Feher, 1980) or twist away from it (forceps) (Verney, 1981). Grof (1985) and Noble (1993) also relate the birth regression migraine to the lack of oxygen at birth. Blume (1990) reports, "Cluster migraines, a particularly relentless form of migraine headaches are characteristic of the postincest experience" (p. 198). While connecting with sexual abuse material the feelings of nausea, along with a great need to get something out of the body, may be more intense than the headache (Irving, 1993b). Nausea can be a psychological expression in response to terrible wrongs like sexual invasion (Blume, 1990; Irving in Carter, 1991). Sexual assault is called a sickening experience because, in part, it makes one sick to know about it and be aware of it (Hunter, 1990). Sexual abuse nausea is often associated with feelings of shame and violation and this can be one on the distinguishing features between arising sexual abuse or birth trauma nausea. Some individuals though, particularly unwanted pregnancies or wrong gender prenates, can also report profound feelings of shame upon being born (Irving, 1995). For prenates of overt or covert rape or supposed illegitimacy the feelings of shame and even a sense of sexual assault can be present around the time of birth. Some of the sensation of gagging and nausea during regressions to birth or sexual abuse experiences can be a manifestation of the original experience of suffocating or being choked (SA-Blume, 1990; BT-Grof, 1985). Nausea associated with birth suffocation is often more intensified when anesthesia was used during the birth (Janov, 1983). It is likely the anaesthesia given to the mother inhibits the physical and emotional ability of the infant to cope with the conditions of depressed oxygen during the arduous birth experience. SUFFOCATION AND CHOKING Language metaphors such as constriction and not having breathing room are tell tale signs that a person's therapeutic issues are birth related (Janov, 1983). When these language metaphors are concurrent with analogous physical sensations and feelings of suffocation and pressure it is even more likely that birth issues and memories are being therapeutically presented. If the therapist creates a womb environment out of cushions and applies pressure to the head when metaphors and sensations of pressure, suffocation and being trapped are intense the client is likely to drop into a birth abreaction. Yet all of these metaphors, feelings and sensations could be expressions of a surfacing childhood sexual assault. My clinical experience has been that sexual abuse victims in particular have these metaphors, feelings, and sensations associated with both traumas. Due to recapitulation as reinforcement of perinatal trauma it is likely that most sexual abuse survivors with physical or metaphorical pressure and suffocation issues will have some degree of compounded birth trauma. The majority of individuals presenting with birth trauma will not have been sexually abused and the therapist should not expect or imply that a relationship of birth trauma and sexual abuse will be discovered. Abreactions of intense feelings of suffocation and other near death experiences are not easy to work through (Lake, 1981b). The surfacing feelings of life threat can be experienced as very real in the present (SA-Briere, 1989; BT-Hull, 1986). This can be to the degree that the client may fear death could actually occur during the regression process (Janov, 1983). Near death traumas of birth which are compounded and layered with sexual abuse traumas can be psychologically overpowering to the healing attributes of the psyche (Marcher et al., 1990). When intense expression of overwhelming trauma is externally viewed it can appear to be exploding outward as though it is being let go of, but in fact dramatic looking abreaction can be crashing back in on the psyche (Emerson, 1986). In an imploding abreaction the expression of trauma is turned inward on the self and not truly vented outwards (Bernhardt, 1992). According to Emerson (1987), "This has the sum effect of forming attachments to primal pain, and complicating the separation and individuation process" (p. 65). Abreactive implosion can lack effective therapeutic discharge and can actually be revictimizing (Emerson, 1987). MERGING AND VIOLATION OF BOUNDARIES Sexual assault is a violation of boundaries (McClure, 1990). Perpetrators do not respect where they end and the victim begins (SA-Forward and Buck, 1978). There is a total loss of personal separateness and integrity of self and body (SA-Lew, 1988). The perpetrator's illness, energy and physical body merges with the being of the child as the child's body and soul is penetrated and invaded (SA-Kasl, 1989). Birth and prenatal trauma and stressful conditions can also be experienced as penetration, invasion and toxic merging (deMause, 1982). Prenatally and at birth the close physical proximity (Fodor, 1949) and the umbilical connection (Feher, 1980; Verny, 1981) facilitates a merging of prenate and mother. Chamberlain (1982) states. "Research has ended the idea of placenta as 'barrier' and given us placenta as Organ of transfer' which guarantees that most of what goes into the mother goes into the fetus" (p. 223). Lake (1981b) considers: What passes to and fro through the umbilical cord is of the utmost importance, not just as to the passage of the necessary nutrients, but as to powerful emotional messages from the mother about what is going on inside her. (p. 155) This is generally a positive exchange, though various maternal toxins or stresses can create negative womb conditions (Ward, 1987). Dunbar (1994) states, "The physiology of the mother is charged when she is under emotional strain and the effect of these changes is transmitted to the foetus through the placental circulation and other ways." Carter (1991) relates a person's experience of merging with maternal emotions at birth: I was my Mother. I was me . . . . I could feel what my mother was going through at the time. She was really worried about being embarrassed, about grimacing, and losing face in front of the doctors. I could feel her emotions: losing face, fear of the unknown, the birth struggle and the fear in that, and the aggression. (p. 384) The prenate, in the maternal environment, can be invaded by highly toxic and charged hormones, chemicals or emotions which do not belong to the prenate (Lake, 1981b); and according to Marcher (1990) can even, "have the feeling of being invaded with poison." Intense or repeated pre- and prenatal conditions can be experienced as a merging and disintegration of boundary between self and other (Verny, 1981). In toxic perinatal merging there becomes a lack of clarity of where the prenate begins and ends (Findeisen, 1993), a condition similar to sexual inappropriateness (Blume, 1990). McClure (1990) considers in an incestuous family, "A child is raised with the expectation that he or she is responsible for a parent's feelings or emotional well-being [and] is experiencing enmeshed boundaries" (p. 7). As in sexual assault the boundary distortions of birth and prenatal conditions can predispose the person to life long problems with boundary issues (SA-Gutheil and Gubbard, 1993; BT-Findeisen, 1993). Lake (1981b) suggests a multitude of boundaries in life, "can be experienced precisely as he or she experienced the boundaries of the womb" (p. 42). To cope with unwanted physical and emotional intrusion of the pre- and perinatal realm or sexual assault, barriers may be erected which do not let others in (Noble, 1993). Conversely, in boundaries being totally shattered by birth or abuse traumas there can be a splitting off or burying meaning to, and awareness of, personal boundaries. The individual without boundaries is constantly invaded by, and merged with, unwelcome aspects of the social environment (Duncan, 1994). Often when trauma has annihilated a sense of appropriate boundary the survivor swings from one extreme to another-at times blocking out everyone or at other times not being able to have separateness from intrusive individuals or conditions (SA-Kasl, 1989; Blume, 1990; BT-Van Husen, 1988). WOMB/MOTHER AS SEXUAL ABUSE VICTIM One condition in which the prenate can be dramatically affected by pre- and perinatal merging is when the pregnant mother is coping with the burden of unresolved sexual abuse issues (Irving, 1995). Repeated maternal stresses and fears can create a womb which feels like a toxic environment (deMause, 1982). When the mother has been a sexual abuse victim the prenate in the womb lives, grows and develops in the "traumatized area of her body" and the somatization of the traumata (Capacchione and Bardsley, 1994). In essence the developing prenate can "marinate" in that energy (Lake, 1986). Peterson notes, "Every hormone in the [mother's] body affects the fetus and an overabundance of stress hormones can create distress" (p. 63). In Khamsi's (1987) research some, "Subjects claimed to have 'known' in utero something about the state of their mother's emotions" (p. 55). When the mother's unresolved sexual abuse repeatedly presents intense fears, shames and stresses the prenate can internalize the maternal emotions and energy (Irving, 1995). People have reported they felt as though they were sexually abused while in the womb (Emerson, 1988; Irving, 1995). When an adult survivor of childhood sexual abuse has a resentment about her pregnancy due to its association with sexual activity or because of a fear the growing child will grow into an abuser the person can be left with a fear of being abused or a fear of becoming a perpetrator. Capacchione and Bardsley (1994) recognize that, "During labor a woman who has a history of sexual abuse . . .may experience the birthing baby as an invader in this traumatized area of her body" (p. 204). These various dynamics can leave a life long pattern of trying to "make it up to mother" for the sexual abuse she endured, or create an obsession with trying to prove one is not an abuser, but always fearing one is. The dynamics can be compounded, and is particularly sad, if the child is later sexually abused (Irving, 1995). Without consciously knowing why, the child can feel intense feelings of self blame for the abuse, feeling what is being inflicted is what has always been deserved, but dreaded. Alford (1992) states, 'Taking personal responsibility for a bad outcome is a consistent finding among trauma victims, including survivors of incest and rape ..." (p. 4). The sexually abused child who merged with maternal abuse issues can doubly feel as though the due punishment was being inflicted for some vague, yet intensely sensed crime previously committed (Irving, 1995). I have observed individuals working through these shame feelings rage out in pre- and perinatal regression, "I am not your abuser" or "Your abuse is not me," thereby finally becoming free of the unwarranted guilt of "being an abuser." Certainly the survivor can feel mutual sympathy for the sexual abuse which had previously been inflicted against the mother, but in healing there is also the need to establish separateness between the identity of self and the abuse the mother suffered. Some of the strongest prenatal feelings of sexual assault have been presented by individuals who felt one or the other of the parents did not want to conceive a child, but felt forced into having sex (Farrant, 1987); or the parent may have wanted a child but had strong feelings of revulsion to the sexual act; or when a sexual assault occurs during pregnancy. Emerson (1988) states, "When expectant mothers are sexually or physically abused, their unborn child also suffers from the abuse" (p. 114). According to Noble (1993) some regressions to, "Unwanted conceptions, such as during rape, are often experienced as gagging, retching, even spitting up the unwelcome invader" (p. 147). As definition, clarity and separateness in relation toward maternal trauma healing is established some individuals who suspect they were sexually abused no longer have those feelings after working through the prenatal merging with the mother's sexual abuse issues. For others, resolving the legacy of an emotionally toxic womb is just part of the larger picture of addressing the issues of childhood sexual assault. PREGNANCY FOR THE SEXUAL ABUSE VICTIM Pregnancy and giving birth can present particular issues and concerns for the female sexual abuse survivor (Fagan, 1991; Simkin, 1992; Walton, 1994). According to Peterson (1984), during pregnancy, "Sexual conflicts already present are magnified" (p. 132). Noble (1993) concurs, stating, "Sexual abuse, memories of which are often buried deep in the unconscious, can lead to major problems during pregnancy and labour" (pp. 227-228). Becoming pregnant comes about through a sexual act which can trigger painful feelings and memories for an abuse victim. The visible physical condition of being pregnant is an overt sign that sexual activity has taken place. When there has been strong denial of an abuse history or threats to silence during childhood sexual abuse, a pregnant woman or a woman in labor may consciously or unconsciously feel "people now know" (Walton, 1994). Secrecy as a form of self protection is no longer psychologically available. Sexual abuse survivors often cope by splitting off from, numbing and escaping the body (van der Kolk, 1994). The undeniability of the body and its often intense feelings and sensation during pregnancy may place the abuse victim in touch with body memories and feelings which have been long buried (Pagan, 1991; Capacchione and Bardsley, 1994). Issues of control and personal empowerment can be challenged as the pregnancy, the fetus in the womb and biology seem to usurp and take over control of the woman's body (Davis-Floyd, 1994). Davis (1991) also recognizes that, "For a woman pregnancy can be a trigger: her body is changing and the changes are out of her control, an experience that echoes back to the [childhood sexual] abuse" (p. 116). These feelings of loss of control can greatly intensify when a medical system denies the extraordinary power of the pregnant woman and the woman giving birth (Davis-Floyd, 1992). Control issues which are vulnerable and significant for the abuse survivor can be undermined by the double forces of a biology seeming to go wild and a patriarchal and insensitive medical establishment. Birth can be a profoundly intimate aspect of a couple's relationship and a woman can experience a variety of sexual feelings while giving birth (Davis-Floyd, 1990). There are numerous ways in which a sexual assault can revisit a woman while she is giving birth. Being vulnerable, needing to rely on others (Peterson, 1993), becoming a parent (Schwartz, 1980), having control taken away by others (Capacchione and Bardsley, 1994), having to give control over to a body going through an organismic release (Janov, 1983) can all be triggers to past sexual abuse experiences. Madsen (1994) states that for the delivering woman, "Birth trauma can result in posttraumatic stress disorder (PTSD)" (p. 20). The intense physical pain and the need to open up while giving birth may dramatically trigger previous violent and physically painful sexual assaults (Madsen, 1994). Medical examinations and conditions of delivery expose a woman's body, initiating vulnerability and issues of privacy and boundary for any woman (Klaus, 1995). Courtois (1988) states that while undergoing medical examinations and procedures, "The survivor may fear having her body exposed and may hold the belief that anyone looking at her will somehow know of the abuse" (p. 320). These concerns are greatly intensified for the survivor of the violation of sexual abuse (Macnaughton et al., 1993; Frye, 1995). Noble (1993) describes a woman who, "was sexually molested and attacked with a knife at age three." She experienced a cesarean delivery "as another surrender to a man with a knife." The experience was intensified as, "Her hands were tied down for the Cesarean just like during the childhood rape" (p. 173). Peterson (1993) refers to, "A woman who experienced neglect and sexual abuse in childhood. Feelings of abandonment were repeated during her first childbirth when she was left alone in a delivery room to deliver a stillbirth" (p. 26). Each woman moving through pregnancy and birth has her own personal story and distinct individual needs (Madsen, 1994). An adult sexual abuse survivor can fully expect to prepare herself to deal with the powerful passage of giving birth (Peterson and Mehl, 1994). The clinician can help the pregnant woman explore and determine how she is going to retain her sense of control and power, and how to go about informing health care professionals about her particular needs and concerns (Peterson, 1993; Capacchione and Bardsley, 1994). Care and empowerment is desired, but clear permission for touch, and an explanation of various procedures is important for a sense of control and safety (Frye, 1995). While giving birth no woman, particularly no sexual abuse survivor, should have her personal empowerment stripped by being infantalized, patronized, tied down, or told leave it all in our hands-the authorities know best (Oakley, 1990). No health care professional has the right to simply walk up and enter a woman's private space or examine her body without the overt and subtle negotiations for trust and permission (Kitzinger, 1992). Many aspects of "routine invasion" like predelivery enemas, strapping hands, lithotomy position in stirrups or dressing a woman in a gown which provides neither comfort, privacy nor dignity, are simply impolite and inappropriate (Davis-Floyd, 1990). Some medical routines such as deliberate rupturing of membranes or shaving a woman's pubic area are personally and hygienically uncalled for and are clearly contraindicated (World Health Organization (WHO), 1986; Davis-Floyd, 1992). The overuse of episiotomy suggests a form of widespread covert sexual assault, as is telling a husband, "She'll feel great now, I sewed her up real tight"-a comment I heard several obstetricians joke about over dinner. Moran (1992) suggests modern medical birth can be so invasive and violating that some women, "compared it to being raped" (p. 269). An examination of obstetrical journal advertisements showed them to be as sexually exploitive as Playboy (Moyer, 1975). A review of the attitudes and role of sexualization and sexism in obstetrics is warranted to bring the profession up to appropriate ethical standards and practices in regards to sexual appropriateness (Walton, 1994). Pregnancy and childbirth offer significant opportunities to repattern negative feelings and issues around sexual abuse (Capacchione and Bardsley, 1994; Klaus, 1995). Health care providers need to respect a woman's boundaries; not assume role and position gives license, but rather always ask permission to touch during each stage and incidence of examination. This is appropriate human relating and is imperative for the survivor of childhood or adult sexual abuse (Kitzinger, 1992). The health care provider, not being able to know who is a sexual assault survivor, should treat all clients with the utmost dignity and respect. THERAPEUTIC IMPLICATIONS The expression of these dynamics can be a confusing experience for psychotherapist and client alike. Even the therapist cognizant of both areas can be presented with concerns of distinguishing when sexual abuse and perinatal symptoms and issues are present or have become interrelated. These conditions introduce dilemmas and opportunities in the therapeutic setting. When personal issues present in the therapy setting they have come to a place where resolution is possible. The client and clinician are confronted with the challenge of identifying the specific trauma or traumas which are induced symptomology (Marcher et al., 1990). The similarities of birth trauma and sexual assault and the psychological interrelation of the two traumas implores therapists to avoid using packaged check lists to assess a history of either trauma. When it is clear symptomology had origins in one of the traumas and the issues and material seemingly should have been thoroughly worked through, yet symptomology persists, it may be worthy to consider a compounded dynamic of the other trauma. There can be overwhelming qualities to healing and recovery process which need particular therapeutic sensitivity, and support for a person whose history and therapeutic issues are rooted in both traumas. When birth difficulties and sexual abuse are at the root of symptomology there are therapeutic times to clearly separate the incidences, issues or feelings in order to discharge and work through powerful psychological material. A primary rationale for separating the therapeutic work on these issues is that individually, sexual abuse or birth trauma can be overwhelming psychological material to address. Marcher et al. (1990) suggests that: If a client has been sexually abused, that it is very difficult for that person to separate the rebirth situation from the sexual abuse situation. This is not only confusing and overwhelming to the client, but makes it difficult to resolve either the abuse or the birth issues, (p. 14) Simultaneously dealing with the full emotion and power of two significant shock level wounds can be devastating and even psychologically revictimizing (Marcher et al., 1990). There are also times along the continuum of healing to explore and discover interconnections about the two traumas in order to facilitate full therapeutic resolution. Some affect regression and immersion in the shared emotions and traumata of the two traumas can assist the client in a "feeling" realization and cognitive insight for how the traumas were similarly experienced. The affect immersion can also connect primary feelings of the traumas with interrelated life patterns and issues. At various stages of the healing process it is certainly valuable to have cognitive discussion with the client about the original traumatic experiences and their influences on emotional perceptions, responses to stress and the dynamics of the person's relationships (Marcher et al., 1990). A highly effective means to facilitate regression into birth feelings involves physical touch, pressure and manipulation which recreates the sensations of birth or which stimulates those sites which store the body memory of birth (Emerson, 1989). For the sexual abuse survivor however physical contact, particularly that which does not have overt permission can be experienced as invasive and retraumatizing (Crowder, 1993). Conversely, and importantly, healing and repatterning of sexual abuse traumata can occur through a therapist assisting a person with birth feelings while being highly sensitive and respectful of boundaries and seeking permission at each stage of physical contact. Even asking permission to apply physical simulation of birth, being told no by the client, and then acknowledging and respecting that client boundary can be a therapeutic healing experience. In effect, then, no intervention is the healing intervention. Assistance which can be just as effectively accomplished without physical touch should be the more preferred intervention in working psychotherapeutically with sexual abuse survivors who are working at healing of birth trauma. Fortunately much pre- and perinatal somatic release and repatterning for sexual abuse survivors can be accomplished through Cranio-Sacral Therapy, Bodynamic Therapy, Feldenkrais, yoga, massage and other forms of body work which can be clearly designated as non-sexual and non-invasive (Lew, 1988; Crowder, 1993). These modalities are well defined settings for physical interventions and somatic contact, and can help to create a distinction between vulnerability of psychotherapy and the need for extended touch (Macnaughton et al., 1993; Roachman, 1993). Crowder (1993) suggests, "The body worker and psychotherapist should generally be two different people to reduce the possibility of developing negative transference in the psychotherapeutic process" (p. 74). When ready the survivor can receive body work for assistance with memory retrieval, emotional release, energy balancing, working through physical blocks and somatic repatterning (Timms and Connors, 1990). Working with deeply traumatized sexual abuse survivors, for which there is often a high degree of splitting and dissociation, requires exceptional care and sensitivity for "knowing" one has permission to touch and that the client does not become "spacey or checks out" (Thompson and Smith, 1993). Crowder (1993) considers "A skillful body worker will always ask the client's permission before proceeding with any form of physical contact [and] . . .notices any nonverbal client discomfort" (p. 75). Survivors wishing to please may agree to touch when they are not sure (Bates and Brodsky, 1989). As an artifact of splitting an aspect of the self may want to work in a physical modality, but a dissociative structure or entity of the self may be adamantly opposed to touch. Bernhardt (1992) assures, "It is the therapist's responsibility to observe the client's non-verbal and unconscious communications, because some clients either can't say or are unaware of touch that doesn't feel good" (p. 17). In moving too quickly or too intrusively in birth work with dissociative and highly traumatized clients the survivor can feel greatly traumatized by an intervention which a therapist expected was appropriate and helpful (Macnaughton, 1993). A rule of thumb with touch or movement with a specific site of trauma is to check out that the intervention feels safe and has permission and to always lean on the side of caution. A survivor who has been violated and betrayed on the deepest levels can be highly appreciative of the boundaries provided by a respectful and sensitive therapist (Rutter, 1989). A trusted authority figure modelling appropriate boundaries can send a powerful message of support to a survivor who has been emotionally, physically and sexually abused by what should have been safe and protective care providers (Pope and Bouhoutsos, 1986; Briere, 1989). Sexual abuse survivors who learned that being sexualized was a way to please and not be hurt so much by their perpetrators can eventually bring those issues to therapy (Bates and Brodsky, 1989). Clients' sexualized languaged, energy or demeanour while working through birth material is a presentation of issues, likely from during childhood, that need to be therapeutically addressed (Horowitz, 1986; Putnam, 1989). Sexual energy or comments by clients' are not opportunities for therapists to take care of their own needs or to feel good about themselves (Schoener, 1986; Gonsiorek, 1987; Pope, 1990). The sexualized feelings and gestures expressed by clients can be flattering to a naive or needy therapist (Carr and Robinson, 1990), but it should be foremost to recognize that these actions are the clients' clear portrayal of a history of trauma and boundary violations (Blume, 1990) and a cry for non-exploitive assistance (Disch, 1989). The therapist should never add to this betrayal and victimization (Pope, 1988). These are areas which require great sensitivity and skill (Herman, 1981). If a clinician has any uncertainty or confusion about working with this material, supervision should be sought immediately with someone skilled in providing therapy to sexual abuse survivors, and/or a direct referral out may serve the greater needs of the client (Vasquez, 1988). Like working with the energy, feelings and issues of sexual abuse, birth work also requires a sense of respect for the clients' boundaries and process (Macnaughton, 1993; Verny, 1994). As Khamsi (1987) extrapolates: Birth feeling can help or harm. Consequently, psychotherapists should be particularly sensitive with alleged birth material. Clients need neither be pushed nor invalidated with respect to birth material. Clients need to feel safe in order to relinquish control and complete the experience; birth feelings seem to emerge and be integrated only under such conditions. It is imperative that the clients be allowed to move at their own pace, and to verbalize their experiences in their own ways. (p. 57) The nonverbal and highly traumatic nature of sexual abuse and birth trauma demand the therapist to take particular caution with interpretation, pacing and boundaries (SA-Duncan, 1994; BT-Marcher et al., 1990; Verny, 1994). Sexual abuse and birth traumas need significant abreaction to release their intense latent energy (SA-Engel, 1989; Steel and Colrain, 1990; BT-Noble, 1993). Therapists working with these issues need to be comfortable with the sight, sound and energy of clients intensely expressing powerful emotions (SA-Briere, 1989; BT-Irving, 1993a). Due to the ability of profound and repeated trauma to overwhelm the survivor's psyche, the clinician needs to have skills and resources for managing and pacing therapeutic discharge (Dolan, 1991; Steele and Colrain, 1991). In addition to deep feeling abreaction, art activity can be highly effective in releasing emotion, gaining insight and reframing related to powerful traumatic experiences (SA-Dalley, 1984; BT-Grof, 1988). Keyes (1983) states, "psychotherapy using the arts characteristically releases a significant amount of energy" (p. 108). Artistic expression provides emotional expression and has a particular propensity for addressing the nonverbal and preverbal nature of sexual abuse and birth trauma (SA-Allan, 1988; Serrano, 1989; BT-Kellogg, 1977; van Husen, 1988; Irving, 1986; 1988; 1989; 1995; Fincher, 1991). When trauma is overwhelming and/or is somatized and not clearly identified it can still be healed through identification, expression, and repatterning with art (Rhyne, 1984). In drawing this can be achieved by focusing on the somatic tension or sensation and then drawing this sensed trauma on a paper, and further drawing nurturing and repatterning colors and content to repattern. One approach to this process is to draw on two large pieces of paper a "trauma drawing" and a "healing drawing" (Irving, 1995). When the healing drawing is being created it can lay right on top of the trauma drawing. As the drawings develop the person can actually lay on the trauma drawing and underneath the healing drawing to further explore and express the body feelings and therapeutic issues. While surrounded by a "sandwich" of the drawings, the trauma can be felt/imaged as draining out of the body into the trauma drawing; and simultaneously the nurturing and repatterning can be experienced as flowing from the healing drawing down into the body. For some sexual abuse survivors the womb surround created by paper and drawing facilitates greater safety and pacing then the potentially invasive techniques of simulating a womb through massive physical touch and pressure (Irving, 1995). SUMMARY This paper has demonstrated that birth trauma and sexual assault share similarities with the results that their legacies can be interrelated in the psyche. The recognition of these dynamics is important for therapists working with pre- and perinatal or sexual abuse issues. Distresses in childhood, particularly traumas including somatic components, are likely to reactivate and intensify birth and prenatal trauma (Grof, 1985). The more trauma present in childhood the greater will be the significance of any birth trauma. Because of the significance of recapitulation factors individuals eventually manifesting birth trauma concerns in personality are more likely to have had experiences of some form of childhood traumas or severe stresses, including sexual abuse. Due to sexual assault further compounding birth trauma or activating latent birth stresses those therapists working with birth concerns are more likely to encounter sexual abuse issues than the abuse percentages present in the general population. There is an even higher likelihood that individuals working through sexual abuse issues will present some form of birth trauma material, than individuals presenting birth issues will uncover sexual abuse. An important concern introduced by the variety of similarities of birth trauma and sexual assault is that therapists trained primarily in sexual abuse (rape trauma syndrome) issues may miss the birth content in presenting affect and symptoms. Similarly therapists conversant with pre- and perinatal dynamics may not be effectively working with sexual abuse experiences compounded upon, and psychologically connected to, the birth trauma. The clinician is confronted with challenges of distinguishing: 1) when sexual abuse and perinatal symptoms and issues have become interrelated; 2) when to help the client separate these issues out to work on them separately; and 3) circumstances to assist the client in exploring their interrelatedness. When a traumatic birth and later sexual assault are issues for a client it is important that they be both be addressed (Grof, 1975). Verny (1994) states, "No consideration of pre- or perinatal traumas has value unless subsequent traumas are also worked through and vice versa (p. 184). Burgess and Holmstrom (1979) report that six years after rape victims were seen in a hospital emergency room 26 percent felt they had not recovered. Emerson (1984) reports, "Twenty-five percent of adults thought to have had normal births evidence significant birth trauma during regression therapy" (p. 4). These nearly corresponding figures do not directly conclude a causal relationship, but in light of the patterns presented in this paper investigations of birth trauma possibly compounding with sexual assault are worthy of consideration. Due to the interrelated dynamics of birth and sexual abuse it is imperative that therapists working with birth material become acquainted with sexual abuse issues; and likewise, for therapists working with sexual abuse to be conversant with pre- and perinatal concerns. If the therapist is not going to become proficient in the other area, than there at least needs to be familiarity with the possible duality of these symptoms and issues and good referral sources. Therapists' unfamiliarity with the trauma of birth or sexual abuse concerns can be overcome through further education, and at times taking the opportunity to work through their own issues. In our society most individuals, through a sexualized mass media and human interaction, have been confronted with life stresses and issues concerning sexuality, personal boundaries and safety. In addition all people have experienced the passages of birth. Direct reconnection with and working through personal material associated with these realms provide invaluable means of learning and clears the therapist of personal blocks and defenses (Macnaughton et al., 1993). I have presented therapeutic dilemmas on the relationship of sexual abuse and birth trauma. I have certainly unearthed more questions in regards to the clinical setting than I have offered answers. Some of the dilemmas presented here, about client symptoms, feelings and issues existing as a result of sexual abuse or birth trauma, will not have answers as one moves through the challenges of facilitating psychotherapy. I believe there are times when it is not necessary for the clinician to be 100 percent certain of the full origin and scope of psychological material suggested by metaphorical expressions and nonverbal material (Weinrib, 1983). What is most important when understandings are vague is for the therapist to be aware of the essence of what is being expressed (Duncan, 1994) and honestly share in a relationship of deepest trust. Emerson (1989) imparts, "To the extent that compassion and empathy exist, the relationship is healing" (p. 196). For the profoundly wounded, the therapist needs to be a mindful witness who acknowledges what they have seen and heard and who gives back deep and authentic human empathy and compassion. SOCIAL EPILOGUE I: CONSIDERING THE PERPETRATOR IN PERINATAL REGRESSION It may be that, in part, sexual predators act out unconscious conflicts from their own childhood sexual abuse and birth trauma (SAKaufman, 1989; BT-deMause, 1982; 1994). Grof (1985) states that: While the experience of the victim has many elements in common with that of the child in the birth canal, the rapist exteriorizes and acts out the introjected forces of the birth canal, while simultaneously taking revenge on a mother surrogate. (1985) I have observed a significant number of sexual abuse survivors whose perpetrators inflicted assaults which appeared to be recreations of the traumas of birth (Irving, 1995). This includes rhythmic pounding of the victim's head into a wall or headboard-analogous to battering through the birth canal; pressure and weight whose purpose seemed to be in part the creation of an experience of imprisonment or suffocation-reminiscent of an unrelenting cervix; dragging a victim around by the head or hair-recreating the perpetrator's forceps trauma; wiping blood, urine or faeces on the victim-reproducing the scatological material of birth; tying up or locking the victim in a confined space or box-serving as a confining womb (Irving in Carter, 1991). Elsewhere (Irving, 1995) I have stated, "In the most extreme forms of ritual abuse, children are placed in the abdomen of a dead animal and are taken through a death-rebirth simulation as part of a sexual ceremony and orgy" (p. 874). These conditions suggest that, in part, perpetrators can be pathologically returning to their birth traumas during their sexual assault ritual (Irving, 1995). It is clear that many perpetrators recreate a sexual assault ritual containing elements of their own childhood sexual abuse experiences (Butler, 1978; Kaufman, 1989). According to Bass and Davis (1994), "Their subsequent [sexual] perpetration against children is sometimes a reenactment of what they themselves experienced" (p. 517) and Solter (1984) submits, "When people become parents, they compulsively and unthinkingly re-enact with their own babies the very hurts that were inflicted on them" (p. 70). Given the compounding nature of the influence of birth trauma it should not be surprising that it would be a shadowing element in victimization rituals (deMause, 1982; Grof, 1985; Rice, 1985). As the perpetrator recreates and projects birth energy and content into the assault ritual the nuances of that level of energy can, in part, throw the victim into the perinatal psychological realm. The victim returns to the previously processed birth trauma, to help in coping with the transmarginal qualities of sexual assault; the victim is also connected with the perinatal level as a result of the reverberating perinatal energy of the perpetrator. Grof (1985) and deMause (1982) have extensively demonstrated significant relationships between "Basic Perinatal Matrices" and individual and collective acts of cruelty and violence. Carter (1991) suggests: Birth sets up an ambivalence towards the body, sexuality, and anything related to that cataclysmic event, especially the mother and her genitals . . . [and] The denigration of women evolve in reaction to this initial trauma, and represents a need to keep the anxiety and trauma from birth out of awareness. (p. 423) It may be construed that one indication of the degree of unresolved womb and birth rage is evidenced in the highest proportion of domestic violence occurring during the pregnancy period and often begins during the first pregnancy (Roberts, 1983). Walker's (1979) research on battered women found, "that physical violence became more acute during pregnancy and their child's infancy" (p. 105); and Walker (1979) referred to this form of battery as, "a case of prenatal child abuse" (p. 106). Walker (1979) notes much of the sexual mutilation of women occurs during pregnancy, stating, "Women have suffered mutilated vaginas, nipples sliced off and repeated blows to their protruding stomachs" (p. 106). I believe the baby being a reminder of the womb and birth period may also be a partial explanation for infancy being the highest period of serious childhood physical assault (Walker, 1979); Mufson and Kranz (1991) explain, "Some 40 percent of infant abuse is considered severe, as opposed to only 3 percent of teenager abuse" (p. 3). The depth of latent and compounded perinatal rage projected on the infant is possibly witnessed in the high proportion of infant murders; as Mufson and Kranz (1991) report, "Tragically, very young children, particularly infants are the most likely to be abused severely enough to die from it" (p. 3). Mufson and Kranz (1991) note the youngest 28 percent of children account for 74 percent of deaths from child abuse. As inconceivable as it may seem, some research (Durfee, 1985) suggests significant childhood sexual abuse, "occurs in infancy and peaks in incidence from two to four years of age" (p. 8). Reports about violent cults suggest fetuses and infants are the most likely candidates for ritualistic sacrifice and cannibalism (deMause, 1982; Sachs, 1990; Sakheim and Devine, 1992). There is evidence that some paedophiles may not be reenacting childhood sexual abuse traumata. If some perpetrators are not acting out from a personal history of sexual abuse, they may be unconsciously and pathologically reacting to the wounds from a particularly traumatic birth. The impressionistic data referred to directly above suggests merit worthy of further research investigating an interrelation of a history of birth trauma, and reenactment ritual of sexual perpetrators. If such a connection exists then putting an end to sexual predators may, in part, require putting an end to the legacy of a trauma of birth. SOCIAL EPILOGUE II: PREVENTING THE STRESS OF BIRTH AS A TRAUMATIC INFLUENCE As a final anecdote I believe discoveries about the dynamics of sexual abuse as a trauma have important contributions to make to our understanding of the initial development of birth trauma. Hindman (1987) points out an early model of the degree of the traumatizing nature of sexual abuse was logically equated with, "I) the age of the victim and perpetrator; 2) the type of sexual activity involved; 3) the amount of violence involved; 4) the number and frequency of crimes" (p. 27). In actual fact these presupposed patterns did not always pan out (Hindman, 1987). In the most dramatic cases some children violently raped by a knife wielding stranger has less long lasting trauma symptomology than a child inappropriately fondled by a gentle model teacher in a small community. Hindman (1987) and others (Engel, 1989) proposed an alternative trauma theory which regarded the degree of trauma inversely proportional to the overt recognition, validation and support for the child's experience as wronged and pained victim. Hindman's (1987) research in the area showed: "Those children who clearly viewed themselves as being innocent and who viewed the perpetrator as being responsible had the greatest chance for rehabilitation. Those children who were confused about the victim/offender identity; because the perpetrator had positive attributes and the victim had low self-esteem, demonstrated difficulty with recovery." (p. 178) In the cases previously cited the child violently assaulted by a stranger was sympathized with, and acknowledged, by family, community and the courts. Whereas the child violated by an outstanding figure in the community was isolated and ostracized. The child's initial confusion and distress was not responded to with compassion, acceptance and validation, hence being stroked about the thighs left wounds indicative of severe sexual assault. The lesson here for our treatment of newborns is that trauma feelings and symptomology may be more related to the insensitivity, isolation, lack of overtly expressed acknowledgment, compassion and support during and after undergoing adverse experiences (Rice, 1985). As with sexual abuse trauma it has been reported that infants can feel they deserve, or are to blame, for the pain experienced at birth, particularly when there is no emotional support or connection (Khamsi, 1987). Parents and health care providers assisting at birth should not be labelled as abusers and perpetrators, but there is a great need to give the newborn recognition of the arduous transition which has just been encountered, suffered through and survived (Mehl, 1993). Some of the tribulation of birth may not be able to be avoided, but we can certainly say to the newborn, "That must have been really tough. It is so nice to finally see you." When we do not know exactly what the newborn is feeling and thinking, lots of "oohs," "aaws" and gentle touching may go a long way to calming the stress from an arduous passage and affirming the validity of the little person in our presence (Rice, 1985). Even in cases of highly traumatic birth a life long history of the symptoms of transmarginal stress can be averted by acknowledging and being compassionate with the experience of the infant in active recovery from trauma, stress and shock of birth (Solter, 1984). References

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widely recognized for his extraordinary sculptures which depict various stages of pre- and perinatal life. Dr. Irving is currently sculpting the first major memorial dedicated to survivors of child abuse. He may be contacted at 274 Rhodes Ave., Tbronto, Ontario, Canada, M4L 3A3. Author's Note: I would like to acknowledge that human birth in itself is not generically traumatizing. Peterson (1984) concurs, "Birth is a stress. Hopefully it does not become a distress." Peterson (1984) further emphasizes, "A belief in birth as inherently traumatic is disrespectful of the naturally healthy and very normal process of birth." Lake (1981b) renders an alarming view that the passages of birth, "Travel through the pelvis, is at best an energetic struggle, at worst a brain-destroying, suffocation, twisting, tearing, crushing torture." It must be remembered that it is traumatic births which are traumatic. A nurturing and supportive infancy and childhood can circumvent a lasting legacy to many normal birth stresses (Solter, 1984).

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