Talking About Abuse

In 1980, one out of three women were found to have been physically battered by their male partner. Of those, 40-60% were pregnant at the time of the abuse. Abuse during pregnancy can take the form of blows to the abdomen, injuries to the breast and genitals, or sexual assault. Or it can take the subtle yet powerful form of emotional abuse or even financial control. Socioeconomic class, age, and even educational level do not predict susceptibility to abuse. It can be a very silent, very damaging and even deadly force against mothers and their babies.

These overwhelming statistics make it clear: All obstetrics and gynecology patients should be screened for abuse. A simple list of assessment questions will help the doula to approach this important yet frequently uncomfortable subject:

1. The direct approach:
   "What happened to you today?"
   "Did anyone cause you to be injured ?"
   "Are you in a relationship with that person?"
   "Are there children involved?"
2. The indirect approach:
   "I have seen other women with complaints like yours who are in relationships with people who are hurting them. Has anything like that happened in your life? I am asking you this because it is important for any woman who is in this kind of situation to know that she is not alone, it is not her fault, and help is available."
3. The prenatal screening approach:
   "Pregnancy is a time when many different things affect you and your baby, such as the foods you eat, the medicines you take, and your home situation, too. Sometimes women find themselves in a situation where they are being physically hurt or overly controlled by their partner, or their home situation is a source of stress and sadness. I have seen this before, and I can help when such things occur. It can be harmful to the unborn baby, and usually gets worse. That's why these questions are a regular part of my work with prenatal clients."
   1. Are you ever hurt by your partner?
   2. Is your relationship one that helps you feel good and comfortable about yourself? Or not?
   3. How do you and your partner usually resolve disagreements?

GENERAL GUIDELINES:

1. Ask about abuse more than once in the interview.
2. Include an abuse screen as part of your written questionnaire to patients.
3. Ask at every visit, just as you would ask about nutrition, or contractions. "How are things at home? Is your partner treating you well? Do you need anything?"
4. Women who admit to abuse should be referred for professional support.
5. General signs of abuse may include: Partner is conspicuously unwilling to leave the woman's side, speaks for her and belittles what she says, makes derogatory comments about the woman's appearance or behavior. Partner is oversolicitous to the care providers, emotionally out of tune with the woman. Woman appears afraid of the partner.
6. Be aware of your community resources.
7. If indicated, help her develop a safe plan: where she can go, how to handle her personal belongings, important papers and money. Place a key in a safe location.

Adapted from untitled information provided by the Maine Department of Public Health, 1995, and from Bohn, D., and Parker, B. (1993). Domestic Violence and Pregnancy. In J. Campbell and J. Humphreys (eds), *Nursing Care of Survivors of Family Violence.* Mosby: St. Louis.

HELPING WOMEN WHO ARE VICTIMS AND SURVIVORS OF ABUSE

Trish Booth

Domestic violence cuts across all economic and cultural boundaries. No one is sure of the number of pregnant women who are being abused by their spouses, boyfriends or others. Parker et al. (1993) estimate that it is one in five teens and one in six adults. In addition, 26% of the pregnant women in that study (31.6% of the teens and 23.6% of the adult women) indicated they had been abused within the past year. Although a greater number of teens reported abuse, the adult women suffered more emotional and physical abuse and were more likely to be in a long-term relationship with the abuser, making it more difficult to leave the situation.

When a woman is being abused, she is at a higher risk for pregnancy complications, preterm labor and poor birth outcome. The physical abuse directly threatens the woman and her developing baby; batterers commonly strike the woman's abdomen. The stress of the abuse increases the likelihood the woman will use alcohol and drugs. The social isolation inflicted by the abuser reduces her coping resources and often results in late entry into and sporadic use of prenatal care. In addition, the assaults on the woman's self-esteem erode her confidence in her ability to parent. Finally, the abuser may also hurt the baby after the baby is born.

Childbirth educators rarely recognize which women in their classes are victims of abuse. In addition, childbirth classes aren't designed to deal with abuse and the cycle of violence. However, childbirth educators need to be informed so that they can help a woman who shares that she or her children are being abused. They should know how to report child abuse and what community resources are available to victims of domestic violence, such as women's shelters and counseling services. Educators need to be sensitive to how difficult it is for women to leave an abusive situation.

Childbirth educators can also examine how they teach. Does their word choice suggest the dominance of the partner? Is there strong encouragement that the partner control relaxation or labor coping activities? Are partners expected to simulate contractions by applying pressure? Although these may not trigger abuse, they can put an abused woman in an uncomfortable situation.

Childhood sexual abuse is another hidden issue in childbirth. It is not known how many women are survivors of abuse. Estimates range from one in three to one in five. In addition, there is no research regarding the effects of childhood abuse on childbirth. For many women the abuse is buried in their subconscious and does not come into awareness until during or after giving birth. Then there can be

flashbacks, body memories, panic, decreased self-confidence and a range of strong emotions. Women who are aware of their abuse may not wish to share this information with educators or caregivers.

When a professional encounters a woman who acknowledges past abuse, Lowe (1992) suggests asking

- What has she done so far?
- Is she involved with a counselor or support group?
- Does she feel supported by her partner and family?
- How does she anticipate your being able to help her with her birth preparation?

The woman should define her needs for the caregiver or educator. It is important that professionals not assume they have the answer. They should not try to guess what effect the past abuse experience will have on the birth. However, trust, control and feeling safe are key issues for survivors.

At present the most effective way to deal with the issue of past abuse is for caregivers to be sensitive to all women and to be respectful of their bodies and feelings. Simkin (1992) has described some indicators that a woman is a survivor of past abuse. When women demonstrate these behaviors, childbirth educators should be sensitive, empathic and respectful rather than to try to force awareness or attempt a resolution. The signs include:

- Confusion and anxiety about body boundaries. This includes fear of pelvic exams, injections and exposing her body.
- Control issues. The woman may fear being vulnerable and dependent. As a result, she may attempt to maintain as much control as possible, both over her reactions and the environment.
- Fear of pain or injury to sexual body parts. This can be expressed in wanting a cesarean or demanding an early epidural block.
- Unwillingness to trust those in authority. The woman may not trust her caregiver or her childbirth educator to act in her best interest.
- Resistance to the language and expectations of a childbirth series. The woman may not want to lie down among strangers and be touched by her partner. She may want to have planned, intellectual responses to labor rather than “surrendering” to the contractions or “listening” to her body.

When an abuse survivor shares her birth story, she may relate that she had flashbacks or body memories that triggered reactions similar to those when she was abused, such as “checking out” mentally. She may also have shut down labor at a level of pain that she could manage. Then if medical interventions were used to force the completion of the birth process, she may feel as though she was abused by those interventions and her caregiver. This may leave her depressed and angry. The childbirth educator should respond respectfully and empathically, validating her distress. The educator can also provide information and offer practical support, such as a referral to support group or a therapist who specializes in childhood sexual abuse.

Childbirth classes have a significant number of women who are victims and survivors of abuse. Yet there seems to be little that childbirth educators can initiate on their own. When educators are aware of how abuse affects pregnant women, they can be more sensitive to families and more respectful of individual needs. This can foster trust and enable a woman to share information about her abuse. Then the educator can act appropriately to support her.

References

Booth, T. 1992. The battered woman. *Perinatal Connection 3*(1):1-2.

Kitzinger, J.V. 1992. Counteracting, not reenacting, the violation of women's bodies: The challenge for perinatal caregivers. *Birth 19*(4):219-220.

Lowe, C. 1992 Childhood sexual abuse and birthing women. *Midwifery Today 22* (Summer): 35-36.

Parker, B., J. McFarlane, K. Soeken, S. Torres and D. Campbell. 1993. Physical and emotional abuse in pregnancy: A comparison of adult and teenage women. *Nursing Research 42*(3):173-178.

Rose, A. 1992. Effects of childhood sexual abuse on childbirth: One woman's story. *Birth 19*(4):214-218.

Simkin, P. 1992. Overcoming the legacy of childhood sexual abuse: The role of caregivers and childbirth educators. *Birth 19*(4):224-225.

Table 8a. When your client discloses her abuse history, what do you say?

Non-helpful responses

- ***Shock/disgust:*** "Oh, my God. That's horrible. What kind of person would do such a disgusting thing to his own child?"
- ***Identification:*** "How did you get through that? I don't know if I could have survived so much abuse."
- ***Anger/rage:*** "Every time I hear something like that, I want to lock up every abuser and throw away the key."
- ***Disbelief:*** "Are you sure that happened? It was a long time ago and you were awfully young."
- ***Blame:*** "*Why* did you agree to have sex with him? *Why* did you not tell your mother? *Why* did it go on for so long? *Why* didn't you make him stop or run away? *Why* didn't you tell someone? *Why* did you let him do it?"
- ***Minimizing:*** "Since it's all over now, and you feel you've resolved it, why don't we focus on concerns you have today?"
- ***Intrusive interest:*** "What exactly did he do? How did you react? Did you respond?"
- ***Pity:*** "You poor thing. You must have suffered terribly."

Helpful responses

- ***Calm concern:*** "I'm blad you've shared your experiences with me. It's important to explore because sexual abuse can continue to have an impact, even in adulthood."
- ***Acknowledge difficulty of disclosure:*** "I imagine it is hard to tell me these things. It takes a lot of courage and I respect you for it."
- ***Reinforce client's control of disclosure process:*** "It can be very helpful in our work together if you can share your sexual abuse experiences since they may relate to your current concerns. However, I don't need any more detail than you are comfortable disclosing."
- ***Acknowledge feelings:*** "Sometimes, when people talk about their abuse experiences it brings up very strong feelings. How are you feeling right now?
- ***Assess well-being:*** "Do you feel unsafe or fearful in any way?"

Adapted from the book by Claire Burke Draucker, Counseling Survivors of Childhood Sexual Abuse, *London: SAGE Publications Ltd., 1992.*