Responding to Abuse During Pregnancy

Information from...

The National Clearinghouse on Family Violence

What is Abuse During Pregnancy?

Although a woman may be abused at virtually any point in her life—from childhood to old age— there is increasing evidence that a woman in her childbearing years is at higher risk. More than half of the women who had been assaulted by their husbands in the year prior to a 1993 national survey were between 18 and 34 years of age, a period that coincides with the main childbearing years.

Often, women abused during their childbearing years are abused in ways that are linked to reproduction (including sexuality, conception, pregnancy, childbirth and parenting). For example:

Before pregnancy an abuser may control a woman's decisions and choices around conception by:

- sexually assaulting her
- coercing her to have sex or refusing to engage in sex
- refusing to use, or to allow her to use, contraception (which could result in a forced pregnancy)
- forcing her to use contraception (which could prevent her from becoming pregnant)
- refusing to use protection to prevent the transmission of sexually transmitted diseases or HIV/AIDs. This is of particular concern in situations where the abuser is known to be engaging in high-risk behaviours, such as having sex with multiple partners and/or using injection drugs.

Once a woman is pregnant, an abuser may:

- force her to have an abortion
- injure her with the intent of causing her to lose the baby
- injure her so that she has a miscarriage
- force her to continue an unwanted pregnancy.

For a small number of abused women, becoming pregnant serves to decrease or stop the abuse. Consequently, these women may try to stay pregnant to try and protect themselves from abuse. Although this may work in a small number of cases, often the abuse begins again after the birth of the baby. Also, for most women, pregnancy actually serves to intensify abuse. The reality is that pregnant women are at risk of being abused. Pregnancy is also a dangerous period for the children of abused women.

During pregnancy, an abuser may:

- start, continue or change the pattern of abuse (e.g., abuse may escalate; physical assaults

may focus on a pregnant woman's abdomen, genitals, breasts)
- control, limit, delay or deny her access to prenatal care
- use her pregnancy as a weapon in emotional abuse by:
  - refusing sex on the grounds that her pregnant body appears unattractive to him
  - denying that the child is his
  - refusing to support her during the pregnancy
  - refusing to support her during the birth
- financially abuse her by refusing her access to money to buy food and supplies
- restrict her access to food
- threaten to leave her or report her to child welfare authorities as an unfit mother
- force her to work beyond her endurance during pregnancy.

During labour and birth, an abuser may:

- try to control decision making around the use or non-use of pain medication and/or other interventions
- demand that doctors restore the woman's vagina to the way it was before the birth
- make negative comments about the baby's gender when it is born.

After the baby is born, an abuser may:

- increase the amount of abuse
- begin using the woman's relationship with her baby as part of the abuse by:
  - denying her access to her newborn baby
  - not supporting her or helping out after she comes home with the baby
  - demanding sex soon after childbirth
  - blaming her because the infant is the "wrong" sex
  - sulking or trying to make her feel bad for time she spends with the baby
  - putting down her parenting ability
  - threatening to abduct or abducting the baby
  - telling her she will never get custody of the baby
  - making her stay at home with the baby
  - preventing her from taking a job or making her take a job
  - making or threatening to make false child abuse accusations against her
  - withholding money (e.g., for supplies for the baby such as formula, food, diapers)
  - blaming her for the baby's crying or other problems.

An abused woman may also be disempowered around breastfeeding her baby because:

- her partner makes the decision whether she will breastfeed or not
- her partner pressures or coerces her to breastfeed
- her partner forbids or discourages her from breastfeeding.

Abused women may not breastfeed successfully because:

- they have been made to feel uncomfortable breastfeeding
- they have been conditioned to believe that their bodies are not their own
- their sense of confidence and competence is undermined by negative comments from their partner
- they lack information about breastfeeding, or even if they have information, they lack the support to put it into practice
- they lack knowledge of breastfeeding. This may be due to lack of support, lack of access to resources, anxiety, the tension in the environment and the control of the partner who is jealous of the unique and close relationship that breastfeeding affords to the woman and her baby.

How Widespread is Abuse during Pregnancy?

While there are no statistics on the prevalence of abuse linked to reproduction, there is some information available about abuse during pregnancy. In 1993, a national survey of women in Canada found:

- 21% of women abused by their marital partners were assaulted during pregnancy
- 40% of the women who were abused during pregnancy reported that the abuse *began* when they were pregnant
- the women who were abused during pregnancy were four times as likely as other abused women to say they experienced very serious violence (beatings, chokings, gun/knife threats, sexual assaults)
- just over 100,000 women who were assaulted during pregnancy suffered a miscarriage or other internal injuries as a result of the abuse.

In addition, a study by Canadian researchers of 548 prenatal patients identified a 6.6% rate of abuse during pregnancy and found that:

- almost 11% of the women studied reported that they had experienced violence before their current pregnancy
- among the abused pregnant women, 86.1% reported previous abuse
- almost two thirds of the abused women (63.9%) reported that the abuse escalated during pregnancy.

A subsequent study found that 95% of women who were abused in the first trimester of their pregnancies were also abused in the three-month period after delivery. For these women, the abuse also *increased* after the baby was born.

There is also evidence that abuse during pregnancy is an important issue for younger women. The Violence Against Women Survey found that young women aged 18 to 24 are at particularly high risk of abuse in relationships, suggesting that young pregnant women are a high-risk group for being abused within their relationships. Furthermore, in Canada, the rate of teenage pregnancies (ages 15-19) has been increasing since 1987. The national rate of teenage pregnancy stood at 48.8 in 1994 and is much higher in some regions. Consequently, the risk of abuse during pregnancy is an issue to consider for this population.

Risk Factors for Abuse during Pregnancy

Becoming pregnant can trigger abuse or escalate ongoing abuse. The evidence indicates that, in some cases, abuse begins after a woman becomes pregnant. In most cases, however, abuse during pregnancy is **a continuation of abuse that began before pregnancy**. Often, violence escalates during pregnancy, and women may experience more severe, or specifically targeted, forms of violence when they are pregnant. Women who experience violence during pregnancy are also at continued or increased risk of experiencing violence once the baby is born. Young pregnant women are at even higher risk of violence.

One Canadian study has found **the strongest predictor of abuse during pregnancy is a past history of abuse**. Other risk factors identified in this study include social instability (including being younger, unmarried, less educated, unemployed and having an unplanned pregnancy); unhealthy lifestyle (including poor diet, alcohol use, illicit drug use and emotional problems); physical and psychological health problems (including prescription drug use) [As the authors state, some of these factors may in fact be the **result** of living with abuse.]

Another Canadian study has found that **women who are abused before or during their pregnancies are at increased risk of being abused once the baby is born**. A recent systematic review of the literature has found other risk factors that appear to be strongly linked to postpartum abuse, including lack of social support; recent stressful life events; current or past abuse of the mother; current or past psychiatric disorder in the mother; unwanted pregnancy (*Note: at least half of all pregnancies, including the majority of teen pregnancies, are unplanned)*; inadequate prenatal care; and alcohol or drug use by the mother or her partner. In addition, poor marital adjustment; traditional sex-role expectations; a history of childhood violence in the mother or her partner; low self-esteem in the mother; and prenatal care not started until the third trimester, are also risk factors for postpartum abuse.

The groups of women who are at high risk for abuse include: women who become pregnant; women whose pregnancies are unwanted or mistimed (increases by four times the risk of being physically abused) ; adolescent women who become pregnant; and women in the postpartum period.

What are the Health Consequences of Abuse during Pregnancy?

Health consequences of abuse on the woman & on the development of the fetus and infant

Women who are abused suffer a range of effects, including degradation and humiliation, psychological damage, physical injuries and death. Abuse during pregnancy can have serious health consequences and developmental effects on the fetus and newborn baby.

The effects of abuse during pregnancy may be direct or indirect. Many different complications and adverse pregnancy outcomes are linked to abuse. Some are the direct consequences of violence (e.g., due to physical trauma). Other effects are indirect and may stem from complex and interrelated factors, such as stress, substance abuse, suicide attempts, depression, inadequate prenatal care, and histories of obstetrical and gynecological complications.

Effects of violence

Violence is linked to both physical trauma and stress, both of which have well-documented health consequences during pregnancy.

Effects of physical trauma

Research has shown that pregnant women who experience severe physical trauma to their abdomen (Note: One Canadian study found that the most common area struck during pregnancy is the abdomen) may suffer adverse pregnancy outcomes, including:

- placental abruption (separation)
- preterm labour and delivery
- fetal death (independent of an abruption)
- previable death in utero
- spontaneous abortion
- direct fetal injury, including skull fractures, intracranial haemorrhage and bone fractures
- fetomaternal haemorrhage
- maternal shock (e.g., because of blood loss)
- rupture of the uterus, spleen, diaphragm and liver
- neonatal death.

Effects of stress

Some research also suggests that stress is associated with adverse pregnancy outcomes. Stress may affect pregnancy indirectly (e.g., as a result of either behaviour or physiologic effects) because it can cause women to behave in ways that are harmful to their health. For example, they may use smoking or substance abuse as a negative coping mechanism (see impacts of substance abuse below). Women under stress may also find it difficult to care for themselves, especially to obtain adequate nutrition, rest, exercise and medical care.

The few studies that have explored the physiologic effects of stress on pregnant women and fetuses have found that specific stress-induced health problems may include:

- upset of the nervous system and hormones
- blood pressure elevation
- decreased blood flow to the uterus and fetus
- increased susceptibility to infection
- preterm labour and delivery
- release of maternal B-endorphin which can influence the development of fetal nervous tissue.

Low birth weight

There is some evidence that women who experience violence during pregnancy may have a higher risk of having low birth weight babies and preterm births. The majority of low birth weight babies are the result of premature births. Low birth weight is linked to:

- infant death
- infant and child illness
- infant and child disabilities.

Effects of substance use and abuse during pregnancy

The link between woman abuse and substance use and abuse is clear:

"An average of 63% of women seeking assistance with violence issues are estimated to also have a substance abuse problem and an average of 66% of women seeking assistance with an addiction problem are estimated to have also had previous experience with violence".

Abused women have been found to have increased rates of drug and alcohol use, substance abuse and tobacco use during pregnancy. [1] Because the use of

[1] The LINK educational package (*LINK: Violence Against Women and Children in Relationships and the Use of Alcohol and Drugs: Searching for Solutions*) links front-line workers in the addiction field to those involved in addressing family violence.

cigarettes, alcohol or drugs may be a method of coping with anxiety and depression caused by abuse, trying to educate abused pregnant women about the effects of these substances on the fetus will not work (particularly if she does not believe that her behaviour has an effect on the health of the fetus, or that it is a question of chance). This approach will be ineffective unless her sense of self-esteem and power is improved, which is unlikely in an abusive home.

Children born to women who are abused during pregnancy can be indirectly affected by the abuse of their mothers. Many of these effects are complex and interrelated. For example, abused pregnant women who do not have a sense of "internal control" over the health of the fetus or the outcome of their pregnancies may be more likely to smoke, drink and use medications or drugs during their pregnancies.

Babies born to women who used smoking or substance abuse to deal with the stress of abuse may experience a variety of serious effects.

Smoking during pregnancy is linked with:

- low birth weight
- preterm birth
- intrauterine fetal demise
- premature rupture of the membranes
- placenta previa
- placental abruption
- other maternal-fetal/infant complications.

Drug use during pregnancy is linked to:

- low birth weight
- preterm birth
- congenital malformation
- intrauterine growth restriction
- intrauterine fetal demise
- asphyxia
- hyaline membrane disorders
- abnormal behaviour and state control
- mental retardation
- withdrawal symptoms
- cerebral infarction (from cocaine use)
- increased risk for sudden infant death syndrome (from cocaine use)
- miscarriage
- placental abruption
- delayed or absent prenatal care
- anemia
- sexually transmitted and other infectious diseases
- parenting problems.

HIV infection and addiction are also concerns.

Alcohol use during pregnancy, particularly chronic or heavy use, is linked to many problems for the fetus and infant, including:

- growth and mental retardation
- low birth weight
- microcephaly
- behavioural, facial, limb, cardiac, genital and neurological abnormalities.

Unwanted pregnancies

Some abused women become pregnant as the result of abuse (either they are forced to have sex or their partner refuses to practise birth control). This may be linked to the fact that abused women have more pregnancies than non-abused women. Abused women may have shorter intervals between pregnancies.

Some women are forced to continue a pregnancy

because they are prevented by their abuser from obtaining an abortion. Women who are forced to become pregnant and/or forced to continue an unwanted pregnancy can experience problems, including:

- infant attachment difficulties
- depression during pregnancy
- postpartum depression
- parenting difficulties—children living in situations where there is abuse may not receive the essential requisites for their emotional, psychological and physical development.

Abortion

Being abused can affect whether a pregnant woman continues her pregnancy. There is evidence that abused women are more likely to consider abortion, and to have a history of one or more elective abortions. This may be because the woman:

- fears that the pregnancy and the stress it causes will lead to more violence from her partner
- is unsure about the future relationship with her partner
- is forced by her partner to obtain an abortion
- fears the pregnancy will decrease her options.

Some women who choose to have abortions because of relationship problems may delay the abortion until the second trimester because they keep hoping the relationship will change. Abortions related to or caused by abuse can have serious consequences for women's psychological, emotional and physical health.

Miscarriages and spontaneous abortions

Abused women are more likely than non-abused women to have a history of one or more miscarriages. The literature includes much anecdotal evidence that abuse causes "spontaneous" abortions.

Delayed, inadequate or no prenatal care

Abused women often do not get adequate prenatal care, which means they may not get the support, assistance and advice they need during their pregnancies. There is some evidence that abused women are more likely to delay prenatal care until the third trimester. Abusers may prevent women from obtaining prenatal care in a number of different ways: not allowing her to go out; denying her access to transportation; or forcing her to miss or change prenatal appointments (because either she or the abuser does not want her injuries to be discovered). Some women will be forced to switch doctors or avoid health professionals altogether. Other reasons women may delay care include:

- conflicts with the father of the baby
- trying to decide whether to continue the pregnancy
- feelings of ambivalence or denial
- shame or fear of repercussions, such as losing her children (if abuse is discovered or if she is using or abusing substances).

The impacts of inadequate or no prenatal care include:

- not managing conditions such as hypertension, diabetes and infections, which could affect pregnancy outcomes
- low birth weight, premature labour and preterm births
- inadequate care for high-risk pregnancies resulting from trauma or substance abuse.

At the same time, some abused women may make frequent or repeated attempts to get help by visiting doctors' offices, clinics or hospitals to obtain treatment, often for unexplained symptoms or injuries.

Depression and attempted suicide

There is evidence that women who are abused during pregnancy have high rates of postpartum depression and attempted suicide (in general, depression and suicide attempts are common among abused women). For pregnant women, the effects of depression during pregnancy may include:

- poor or inadequate self-care
- problems with infant bonding and other developmental issues in pregnancy
- a link to postpartum depression
- parenting difficulties.

Suicide attempts may also affect a woman's health and that of her fetus or infant.

Sexual assault

Although the prevalence of sexual assault during pregnancy is uncertain, this form of assault is very common in abusive relationships. Pregnant women who were sexually assaulted by their partners have experienced miscarriages and stillbirths. Many abused women report being forced into sex shortly after childbirth. Sexual assault of pregnant or postpartum women could result in:

- complications during delivery
- problems with breastfeeding
- preterm labour
- endometritis
- problems in healing episiotomies or lacerations
- pain or trauma during vaginal examinations
- fetal retention syndrome (difficulty allowing labour and birth to proceed).

Sexually transmitted diseases

Abused women are at increased risk of contracting sexually transmitted diseases (STDs). A history of STDs or STDs contracted during pregnancy and postpartum can lead to:

- premature, preterm rupture of the membranes
- subsequent preterm birth and chorioamnionitis (from chlamydia trachomatis or Neisseira gonorrhoea)
- endometritis and other upper genital and peritoneal infections
- infant death or cesarean birth (from herpes)
- ectopic pregnancy
- infertility.

Poor or inadequate nutrition

Pregnant women who do not consume sufficient calories (either because their abusers restrict their diet or because the women diet in order to avoid criticism about their body size and weight) may experience:

- intrauterine growth restriction
- eating disorders
- poor weight gain
- other health problems related to inadequate nutrition.

Women living in fear of physical, psychological, verbal, sexual, financial and spiritual abuse may not make meal planning, shopping and cooking a priority. Eating may become erratic or it may be difficult to eat anything. During pregnancy, this could make it difficult to gain the appropriate
amount of weight. Some women may turn to alcohol, drugs or medication to help them cope, and these substances can be harmful to both the mother and the growing fetus.

Other Health Effects

There are anecdotal reports or case studies showing evidence of:

- fetal bruising
- intraventricular haemorrhage
- neonatal death
- newborn gastric ulceration and haemorrhage
- tibial deformity
- hip dislocation
- scleral opacities
- stillbirth.

In addition, bullet wounds are the "most frequent cause of penetrating injury during pregnancy and often result in life-threatening damage to the woman and fetus". Often, the gun was fired by the woman's partner.

Finally, the leading cause of trauma during pregnancy is motor vehicle accidents, and many abused women say they were in accidents in order to explain their injuries.

Impacts on other children in the family

Children living in violent homes are at high risk of either being abused themselves or being exposed to the violence inflicted on their mothers. Estimates suggest that the proportion of children of abused women who are exposed to the violence range from 40% to 80%. These children may suffer physical and/or psychological injuries, developmental damage and, potentially, the loss of their mother or family. These children may also develop a transgenerational legacy of abuse, becoming abusive in their own adult relationships.

Research has clearly shown that when a woman is abused, it has serious consequences for other children

in the family. Among other things, it can mean that children are

- exposed to the abuse of their mother
- neglected and abused themselves (30%–40% of children who witness wife assault are also physically abused themselves)
- at risk of developing similar coping strategies in adult life (transgenerational abuse).

Recently, children's exposure to the abuse of their mothers has been recognized as a form of child abuse. Children who see or hear their mothers being abused may experience emotional and behavioural problems as serious as those of children who are themselves abused, including:

- post-traumatic stress disorder (including nightmares, intrusive thoughts or images, flashbacks, fear, anxiety, tension, hypervigilance, irritability, outbursts of anger and aggression, and efforts to avoid being reminded of the abuse)
- depression
- withdrawal
- low self-esteem
- other emotional problems
- behaviour problems, including aggression with peers, non-compliance with adults, destructive behaviour and conflict with the law.

Other effects of being exposed to the abuse of their mothers include:

- suffering serious life disruption (e.g., having to leave familiar surroundings, community, neighbourhood, school, friends, family members)
- withdrawn, depressed, passive or over-compliant behaviour (particularly observed in girls)
- aggressive behaviour at school (particularly observed in boys)
- ambivalent feelings toward the abuser if the parents separate
- mixed feelings about the mother during adolescence
- lower academic achievement
- more absence from school, refusal to attend school, truancy
- inattention problems due to preoccupation and anxiety
- lowered social skills
- secretiveness about the abuse.

There are numerous age-specific effects of being exposed to abuse of their mothers:

- young children and infants may suffer sleeping and weight gain problems (failure to thrive) and may cry excessively
- preschool-aged children may be anxious, clinging or aggressive
- school-aged children may feel responsible and try to intervene
- children between the ages of 6 and 10 can have problems at school and with peers
- teenagers may be truant, or they may run away or drop out of school
- teenagers may also get involved in violent dating relationships
- teenagers may use denial to cope
- some studies have found that girls who see their mothers abused may be more likely to be withdrawn and depressed, and boys (especially those older than 11 years of age, who identify with their fathers) may be more aggressive (but girls and boys experience all of these problems).

Transgenerational abuse

Above all, being exposed to abuse of their mothers teaches children some very powerful lessons. Among other things, they learn that violence works as a means of controlling others. They become more willing to accept or excuse violence. As they become teenagers and then adults, they are at greater risk of accepting and/or repeating violence in their own relationships.

Costs of Abuse

Clearly, the costs of abuse are significant, for individual women, their children, and for communities.

Health care costs that are associated with treating the injuries and chronic health problems caused by abuse consume resources which could be directed elsewhere. Increased accident rates and reduced productivity in the workplace affect the economy. Women and children who are injured and traumatized lose their full potential to contribute to society. In terms of dollars and cents, the health-related costs of violence against women amount to an estimated $1.5 billion a year (a figure that is only the "tip of the iceberg," according to the author of the study).

How Can Health and Social Service Professionals Help?

Many different professionals provide services and support to women, including health professionals working in a variety of clinical and community health care settings and social service providers working in health care, child welfare, social services and mental health agencies. Often, these professionals work alongside one another on multidisciplinary teams. Although health and social service professionals may see abused women every day, they may lack the screening or assessment knowledge, skills or tools to recognize these cases. According to a Canada-wide survey of a sample of 963 family physicians and general practitioners published in 1994, 98.7% of respondents believed they are failing to identify cases of woman abuse. Of these, more than one-half (55.3%) estimate that they fail to identify 30% or more of all cases of abuse.

Professionals in the health and social service sectors are uniquely positioned to identify and respond to abused women. For example, abused women may come into more frequent contact with the health care system than with other systems of support because of their abuse-related injuries and other health concerns. The health care system is also a point of early intervention because abused women may seek medical help before they turn to the police or the courts. As well, it is a likely first point of contact for abused immigrant or refugee women who may be mistrustful of involving police (e.g., they may have experienced the police to be or perceive them to be agents of oppression), as well as for rural women who may not be comfortable turning to local authorities who know the abuser. In many northern and remote communities, nurses (and sometimes health care teams) are among the first to whom a woman may turn. The quality of medical care that an abused woman receives is a predictor of whether she will follow through with referrals to legal, social and health care agencies.

Abused women may have contact with social service professionals for a variety of reasons related to their personal well-being or that of other family members. This contact can help an abused woman take the first step to stop the abuse.

Learn to recognize the signs of abuse

Professionals should be aware that women who are

abused during pregnancy may not be willing or able to talk about their experiences. Professionals need to be alert to the physical, behavioural or emotional "cues" that may indicate abuse including:

- unwanted or mistimed pregnancies
- termination of pregnancy
- injuries and unexplained symptoms
- low birthweight or preterm births
- sexually transmitted diseases
- smoking or substance abuse during pregnancy
- suicide attempts
- inadequate or delayed prenatal care
- frequent medical visits
- poor nutrition and diet
- parenting difficulties
- depression, anxiety and fear.

The history, attitudes and behaviour of the abusive partner may also signal abuse. Professionals should be particularly alert to situations where partners appear overly solicitous, answer questions on behalf of the woman, and are unwilling to allow the woman privacy.

Prepare yourself and your colleagues to respond to abuse

Professionals—and their organizations—need to be adequately prepared to respond to women who are abused during pregnancy. For professionals, this may mean:

- exploring personal values and attitudes about abuse
- understanding the impact of—and seeking help to resolve— personal experiences of abuse
- addressing feelings of discomfort by getting more information and networking with others working in this area (and being prepared to make referrals to others, if necessary)
- learning about the barriers, issues and needs of pregnant women who are being abused
- learning to recognize and respect a woman's change process
- anticipating the behaviour of abusers professionals
- becoming part of a community-wide response to abuse.

Organizations need to allocate time and resources to:

- develop and implement protocols and tools
- create educational/training and discussion opportunities
- develop coordinated, interdisciplinary community-based responses
- build teams to respond to abuse
- monitor and evaluate progress
- support staff.

The focus should be on developing a safe environment for women to disclose abuse. Efforts to respond to abuse should not further endanger women and their children.

Effective screening

Pregnant women are regularly screened for a range of health problems. Unfortunately, the vast majority of cases of abuse remain undetected. A Canadian study of prenatal patients found that only 2.8% of those who had been abused during pregnancy told their health care providers about the abuse. Paradoxically, pregnant women have a higher risk of experiencing violence during pregnancy than they do of experiencing problems such as preeclampsia, placenta previa or gestational diabetes—health concerns for which they are routinely screened.

Screening is essential to detect abuse. Professionals

should routinely ask all women about abuse. In addition, screening for abuse should be a routine part of prenatal care. Pregnant women should be asked about abuse as early as possible in their pregnancies, throughout their pregnancies and after the baby is born.

Abuse screening questions should always be asked in private, and posed in a supportive and respectful manner. There are a number of screening tools available (see Further Reading list). There may be situations where professionals should refrain from asking about abuse due to the woman's condition (active labour) or endangered situation (presence of abusive partner). If necessary, use translators or signers who are not her family members or acquaintances.

If a woman does not wish to disclose abuse or make changes in her life, professionals should express support, and make it clear that they are willing to provide more information and help if needed in future.

Comprehensive assessment

Once a woman has disclosed that she is being abused, professionals should be ready to reaffirm their support, and listen closely to her experiences and her needs. She should be asked what she needs to be safe. She should be informed of any legal obligation by professionals to report cases of alleged or suspected child abuse so she can make decisions about protecting the safety and confidentiality of herself and her children. Women should also be informed that police in all provinces and territories have been directed to lay charges where there are reasonable and probable groups to believe that an assault has occurred.

Professionals should obtain a full history of the abuse and record this information clearly and accurately. The woman should be informed that a thorough physical examination—and documentation of observable injuries— is a very important part of collecting evidence. Professionals should also assess the risk of serious injury, suicide or domestic homicide using appropriate risk assessment questions (see Further Reading list). A safety plan should be developed (see Further Reading list)

Intervening safely and appropriately

Professionals should inform women about the sequence and pattern of abuse, and its potential impacts. They should help her explore her options and, when needed, provide up-to-date information about, and referrals to, other services available in the community including counselling, police, children's services, legal or victim's services, or shelters. Information printed on small cards which can be hidden can be a useful tool. If a woman decides to return to an abusive situation, professionals should discuss a safety plan with her. She should be warned not to tell her partner about her decision. Women who have just left an abusive partner are at very high risk for severe violence or murder. Appropriate follow up and referrals are extremely important to ensure that women have access to sources of information, support and safety.

Reporting requirements and confidentiality issues

Professionals need to be aware of existing reporting requirements for both child abuse and woman abuse and the consequences.

Professionals should inform a women of their legal obligation to report child abuse before asking her about child abuse so that she understands the reporting process and potential consequences. In some jurisdictions, authorities may be required to

investigate possible child abuse whenever a woman with children reports being abused.

Professionals must obtain a woman's consent before reporting abuse to the police. Once a woman consents to have abuse reported to the police, the police are required to lay charges where there are reasonable and probable grounds to believe that an assault has occurred.

Professionals must protect each woman's right to confidentiality. Information about her should never be released without her written, informed, voluntary consent. Professionals should inform themselves of their legal and professional obligations in this area.

Importance of documentation

Adequate documentation is very important because a woman may need to have this information if charges are laid or she becomes involved in child custody or other legal proceedings.

Professionals should note reported or suspected abuse in a woman's medical record, but not in any material that a woman might take home with her. The information in the medical record should include descriptions of who was present during the interview/examination; the presenting problem; the woman's own description of how the injuries occurred; detailed information about the injuries; reports made to authorities; results of lab tests; required treatment; details of hospital admission/discharge condition; information given to woman; collection and storage of physical evidence; any photographs (with woman's consent); and referrals/follow up plans.

Police and legal experts should be consulted to determine the best way to collect, handle and store evidence. Physical evidence must be preserved so that it can be located and used when needed.

Photographs, taken with a woman's consent, can be an important documentation tool that could be used as evidence. Hand-drawn or pre-printed injury location diagrams or "body maps" can be used to mark the location of injuries that will not show up in a photograph. Diagrams should be attached to the woman's medical record. In some cases, X-rays, CT scans or MRI results can also provide evidence of abuse.

Protecting a woman's security and preserving her confidentiality are a critical aspect of the documentation process.

How Can Abuse During Pregnancy be Prevented?

Overcoming barriers and finding solutions

Health and social service professionals often do not know how to deal with the issue of abuse and how to respond to it or prevent it. As a result, they can feel isolated and ill-equipped. Systemic barriers, such as shorter postpartum hospital stays, for example, may limit their opportunities to identify and follow up on women who are either being abused or who are at risk for abuse. The necessary services and supports, including shelters, may not be available in every community.

Connecting with others who share similar concerns and challenges is an important first step. Professionals need to learn as much as they can about the issue of abuse—including how others have responded effectively with limited resources—so they can work to improve their own and their organization's responses. There are a number of key resources available in Canada (see Further Reading list).

Clearly, women who are being abused also face enormous barriers to getting help and preventing further abuse in their lives. Women who must also cope with systemic barriers—such as institutional racism and sexism, cultural stereotypes and negative social attitudes—find it even more difficult to access services and support. For some women, pregnancy can increase their sense of vulnerability, powerlessness or dependency, while others find pregnancy to be a source of strength and motivation to make changes in their lives.

Professionals who are aware of the obstacles abused women face can make an important difference. For example, professionals can routinely and sensitively screen all women for abuse. They can also make a commitment to provide safe and accessible sources of information, support and referral for women who are or may be being abused.

Prevention strategies

There are many important initiatives underway across Canada to address abuse during pregnancy. Governmental and non-governmental organizations involved in health care, in particular, have been emphasizing professional education and training about abuse during pregnancy and the development of screening tools, protocols and guidelines. A number of these tools are included in the Further Reading list.

Health and social service professionals have an opportunity to get involved in and contribute to the momentum that is developing in this area. In addition to learning more about the issue of abuse during pregnancy and then using this knowledge to improve their detection of and response to women who are being abused, professionals can consider:

- establishing or joining an interdisciplinary committee on abuse during pregnancy
- supporting or getting involved in community groups or coalitions that are addressing this issue
- working to have this issue added to the agenda of coalitions or groups with which they are involved
- supporting innovative programs in the community, including strategies that address men directly (e.g., education campaigns, batterers' treatment programs)
- networking in the community
- combatting cultural stereotyping by working with communities to develop solutions
- addressing violence in the context of community development activities (e.g., in rural or small communities)
- helping to develop school and community-based education programs that teach alternatives to violence and violence prevention, including teaching conflict resolution, anger management and respectful gender relations beginning in elementary school, and delivering programs that address dating violence among adolescents
- helping to develop and/or supporting educational campaigns in the community (including speaking out on the issue, and integrating the subject of abuse into prenatal classes).

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